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**USAID**  
**ASSIST PROJECT**  
*Applying Science to Strengthen  
and Improve Systems*

## USAID APPLYING SCIENCE TO STRENGTHEN AND IMPROVE SYSTEMS

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# Semi-Annual Performance Monitoring Report

**Cooperative Agreement No.:**

AID-OAA-A-12-00101

**USAID Funding Office:**

Office of Health Systems

**Performance Period:**

October 1, 2013 – March 31, 2014

**MAY 15, 2014**

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USAID ASSIST Project: Semi-Annual Performance Monitoring Report FY14

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**DISCLAIMER**

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For more information on the work of the USAID ASSIST Project, please visit [www.usaidassist.org](http://www.usaidassist.org) or write [assist-info@urc-chs.com](mailto:assist-info@urc-chs.com).

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## Acronyms

ACSM	Advocacy and social mobilization
AGPAHI	Ariel Glaser Pediatric AIDS Healthcare Initiative
AIDS	Acquired immunodeficiency syndrome
AIMGAPS	Assuring Infants and Mothers Get All PMTCT Services
AMTSL	Active management of the third stage of labor
ANC	Antenatal care
ANPPCAN	African Network for the Protection and Prevention of Child Abuse and Neglect
AOR	Agreement Officer’s Representative
APHIA	AIDS, Population, and Health Integrated Assistance
ART	Antiretroviral therapy
ARV	Antiretroviral virus
ASSIST	USAID Applying Sciences to Strengthen and Improve Systems
ATR	Accoucheuse traditionnelle (traditional birth attendant)
BCC	Behavior change communication
BMJ	British Medical Journal
CBO	Community Based Organizations
CCM	Chronic Care Model
CCPC	Community child protection committees
CDC	U.S. Centers for Disease Control and Prevention
CDO	Community Development Officers
CDP	Continuing Professional Development
CHBC	Community home-based care
CHF	Community-health facility
CHMT	Council Health Management Team (Tanzania)
CHW	Community health workers
CMS	Central Medical Stores
CNLS	National AIDS Control Council (Burundi)
COE	Centres of Excellence
COP	Chief of Party
CP	Child protection
CRS	Catholic Relief Service
CSA	Community Support Agents
CSI	Child Status Index
CSO	Civil society organization
CTC	Care and treatment center
DBS	Dried blood spot

DHO	District Health Office
DNA	Deoxyribonucleic acid
DOTS	Directly Observed Therapy
DPMAS	Provincial Directorate of Woman and Social Welfare
DSC	Department of Children Services
DSW	Department of Social Welfare
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EHCP	Essential Health Care Package
EmONC	Emergency Obstetric and Neonatal Care
eMTCT	Elimination of mother-to-child transmission of HIV
ENC	Essential newborn care
EQA	External Quality Assessment
FANTA	Food and Nutrition Technical Assistance Project
FCT	Federal Capital Territory
FP	Family planning
FY	Fiscal year
GWHA	Global Health Workforce Alliance
HBB	Helping Babies Breathe
HBC	Home-based care
HCI	USAID Health Care Improvement Project
HCW	Health care workers
HEI	HIV-exposed infant
HIA	Health Initiatives Africa
HIV	Human immunodeficiency virus
HMIS	Health management information system
HQ	Headquarters
HR	Human resources
HRH	Human resources for health
HSS	Health systems strengthening
HTC	HIV testing and counseling
HTW	Health Through Walls
HWD	Health workforce development
IBESR	Institut du Bien Etre Social et de la Recherche (Haiti)
ICF	Intensified case finding
IP	Implementing partners
IPC	Infection prevention and control
IPT	Isoniazid preventive therapy
IRB	Institutional Review Board
IST	In-service training
I-TECH	International Training and Education Center for Health
IYCF	Infant and young child feeding
JHU CCP	Johns Hopkins University Center for Communication Programs
KARS	Komisi Akreditasi Rumah Sakit (Indonesia)
KM	Knowledge management

KMC	Kangaroo Mother Care
M&E	Monitoring and evaluation
M-B	Mother-baby pair
MDG	Millennium Development Goals
MDR-TB	Multidrug-resistant tuberculosis
MGSO4	Magnesium sulfate
MICODE	Mission for Community Development
MLSS&S	Ministry of Labour, Social Security, and Services (Kenya)
MMAS	Ministry of Women and Social Action (Mozambique)
MMRI	Maternal Mortality Reduction Initiative
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MVC	Most vulnerable children
MVCC	Most Vulnerable Children Committee (Tanzania)
NACS	Nutrition assessment, counseling and support
NASCOP	National AIDS and STI Control Programme (Kenya)
NCLS	National Clinical Laboratory Services (Swaziland)
NGO	Non-governmental organizations
NTCP	National TB Control Program (Swaziland)
NTF	National Task Force
NUMCOV	Multisectoral Nucleus for OVC
NVP	Nevirapine resistance
OHA	USAID Office of HIV/AIDS
OPD	Outpatient department
OVC	Orphans and vulnerable children
PCR	Polymerase chain reaction
PDSA	Plan-do-study-act
PE/E	Pre-eclampsia/eclampsia
PEPFAR	President's Emergency Plan for AIDS Relief
PHFS	Partnership for HIV-Free Survival
PLHIV	Persons living with HIV
PMTCT	Prevention of mother-to-Child transmission of HIV
PNLS	National AIDS Control Program (Burundi)
PPH	Post-partum hemorrhage
PSS	Psychosocial support
QA	Quality assurance
QAP	Quality Assurance Project
QI	Quality improvement
QIF &SP	Quality Improvement Framework and Strategic Plan
QIT	Quality improvement team
R&E	Research and evaluation
RC	Relais communautaire (community health workers)
RCH	Reproductive and child health

RCQHC	Regional Center for Quality in Health Care
REPPSI	Regional Psychosocial Support Initiative
RHMT	Regional Health Management Team
SADC	Southern Africa Development Community
SBC	Social and Behavior Change
SCI	Save the Children International
SDS	Service Delivery and Safety Department
SES	Standard evaluation system
SMaCKM	Safe Male Circumcision Knowledge Management
SMC	Safe male circumcision
SMGL	Saving Mothers Giving Life
SNAP	Swaziland National AIDS Program
SPAQS	Service de la Promotion de l'Assurance Qualité en Santé
TA	Technical assistance
TB	Tuberculosis
TBD	To be determined
THPS	Tanzania Health Promotion Services
TWG	Technical working group
UGM	Umbrella Grant Mechanism
UHC	Universal health coverage
UI-CFW	Universitas Indonesia (UI) – Center for Family Welfare
UNICEF	The United Nations Children's Fund
URC	University Research Co., LLC
USAID	United States Agency for International Development
USG	United States Government
VHT	Village Health Team
VMMC	Voluntary medical male circumcision
VS&L	Village Savings and Loan
VSLA	Village savings and loan associations
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 and a half of implementation of the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. This report is the third Semi-Annual Performance Monitoring Report for the project and aims to summarize the accomplishments and results toward the program objectives of USAID ASSIST activities during quarter (Q)1 and 2 of Fiscal Year 2014 (FY14).

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 the first six months of FY14, USAID ASSIST provided technical assistance with field support funding in 20 countries: Botswana, Burundi, Cote d'Ivoire, Democratic Republic of Congo, Georgia, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mali, Mozambique, Nicaragua, Nigeria, South Africa, Swaziland, Tanzania, and Uganda. The project also provided technical assistance to the Regional Center for Quality in Health Care with field support from the East Africa Region. Funds from the USAID Office of HIV/AIDS supported activities in community health and health workforce development in Uganda and Tanzania; HIV/AIDS activities in Uganda, Tanzania, and Swaziland; nutrition assessment, counseling and support (NACS) in Malawi, and the Partnership for HIV-Free Survival (PHFS) in Tanzania, Uganda, Kenya, Lesotho, and Mozambique. USAID cross-bureau-funded activities, through the Office of Health Systems, supported family planning (FP) activities in Niger, pilot maternal and child health activities in Mali and Senegal, and testing for FP quality of care measures. In addition, cross-bureau funds supported maternal, neonatal, and child health activities in Uganda as well as regional initiatives in Latin America and East/Central/Southern Africa (ECSA) region as well as mHealth and non-communicable diseases activities.

The field 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. An innovation in the application of modern improvement methods through the USAID ASSIST Project in the past six months was designation of "design teams" and development of a new "ASSIST design template" to be developed for each improvement activity. Chiefs of Party were asked to name the members of the design team for each improvement activity, to identify who would be contributing content expertise, local country content expertise, and improvement expertise. These teams are conferring, in person or virtually, to develop the content of each improvement activity and to finalize the indicators to be used to measure achievement of aims. The product of the design team's work will be a completed design template which outlines the goal and aims of the improvement activity, explains the phasing of the improvement work, describes the package of evidence-based interventions (technical content) that will be implemented through the improvement activity, and the process and outcome measures (indicators) that will be used to measure results. Planning is underway to convene in-person regional content design meetings which will help country teams to improve and develop a standardized set of aims, measures and changes in key technical areas.

To support the project's learning agenda, ASSIST provided technical assistance in knowledge management (KM) to field teams in Tanzania, Kenya, Uganda, Malawi, and India to strengthen staff capacity in KM and assist technical teams to incorporate KM approaches in their work. In addition, training was provided to country teams in Georgia and Ukraine to integrate gender into their improvement work. The ASSIST Knowledge Portal went live in March 2014, the ASSIST Facebook page was launched, and the ASSIST Twitter page gained many new followers.

The project's research and evaluation (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 the first half of FY14, the R&E team supported country-led

research programs in seven countries (Burundi, Mali, Nigeria, Swaziland, Tanzania, Uganda, and Ukraine) as well as a multi-country study on orphans and vulnerable children in Africa. 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.

In the first half of FY14, project staff published one peer-reviewed article and had a second accepted for publication. The project published 11 case studies, two technical reports, 13 short reports, one improvement guide, and 10 annual reports. During the first half of FY14, ASSIST delivered 47 presentations or sessions featuring ASSIST-related results and improvement methods at regional and international conferences, thereby sharing knowledge of lessons learned from the use of modern improvement approaches.

Major global technical leadership activities included: working with counties to increase the extent to which gender is being integrated into their work plans and activities; the significant contribution of ASSIST to the development of the *FY2014 PEPFAR Quality Strategy: Phase I: Institutionalization of Countries' Ability to Improve HIV Clinical Programs*, published in March 2014; Dr. Rashad Massoud co-chairing in the Global Human Resources for Health (HRH) Strategy Task Team working group on Quality Improvement and Regulation; and convening a new working group on the quality of care in the context of Universal Health Coverage (UHC), which is chaired by the WHO Service Delivery and Safety Department and seeks to define an action agenda for the partners to take forward to assure high quality UHC.

While the technical work under ASSIST is proceeding, there remain some funding issues for ASSIST. Overall, additional obligations have been made by various missions and bureaus. Planning for specific missions is difficult as future funding is unknown or said to have been obligated but has still not reached the ASSIST agreement via a formal obligation. This results in confusion between mission and ASSIST field staff. In addition to the missions, there is still pending core funding that ASSIST is waiting for which is reported to be imminent. The core-funded work supports a portfolio of personnel and multi-year activities that are adversely affected by these gaps in funding.

# 1 Field Support-Funded Activities

## AFRICA

### 1.1 Botswana

#### Background

The USAID ASSIST Project started working in Botswana in January 2013, building on planning activities conducted in 2012 through HCI. The project is supporting the Ministry of Health in pursuing its national level goal of reducing maternal mortality from 160 to 80 per 100,000 live births (MDG5), setting a clear implementation schedule of quality improvement (QI) activities with explicit delegation of responsibilities and aligning activities at all levels to meet the national level goal.

#### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. National Maternal Mortality Reduction Initiative (MMRI)	<ul style="list-style-type: none"> <li>• Reduce maternal mortality through implementation of evidence-based high-impact interventions with focus on:               <ul style="list-style-type: none"> <li>○ Obstetric best practices</li> <li>○ PPH management</li> <li>○ PE/E management</li> <li>○ Post abortion complications management</li> </ul> </li> </ul>	Countrywide (27 Health Districts) Population: 2,098,018 Births per year (2013): 47,599 HIV+ pregnant women (2013):13,902 (29%)	x	

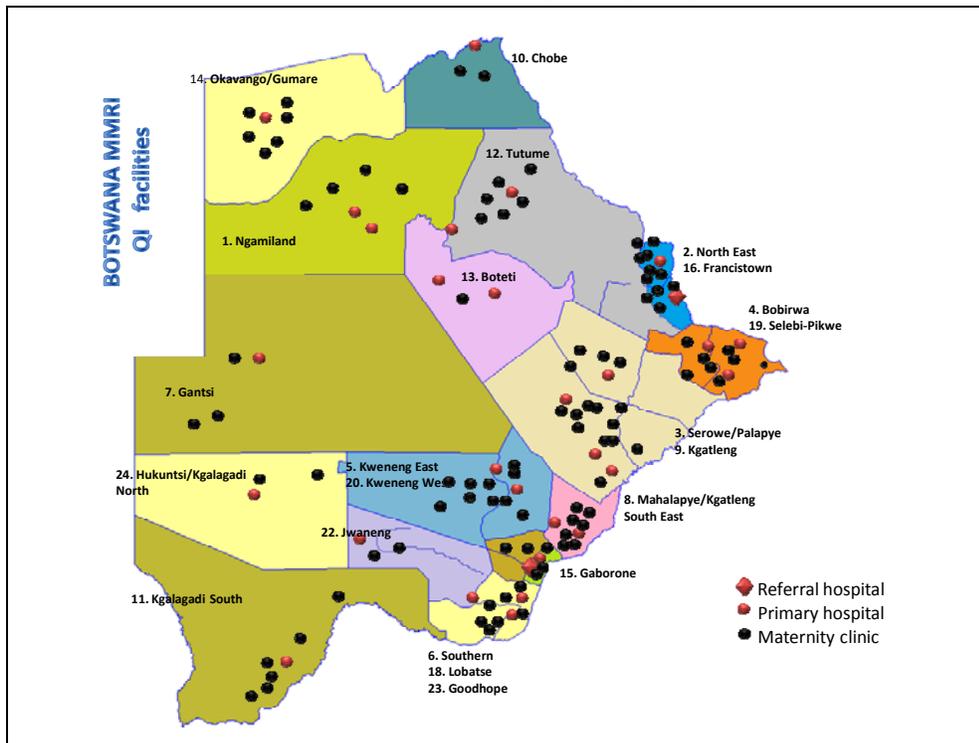
#### Key Activities, Accomplishments, and Results

##### Activity 1. National Maternal Mortality Reduction Initiative

##### Accomplishments:

- **Conducted two week Emergency Management Obstetric Neonatal Care (EmONC) trainings** for 120 midwives and doctors that included practical sessions to improve skills
- **Conducted a full day workshop for hospital directors on how to support improvement teams in facilities.** The workshop was conducted by M. Rashad Massoud, Morrison Sinvula and Cathy Green in Q1.
- **Conducted data collection for baseline assessment of the MMRI**
  - Data were collected from 63 of the 126 facilities participating in the MMRI QI initiative in February 2014. The sample included the two referral hospitals, 22 district and primary hospitals, one private hospital, and 79 clinics with maternity services from 24 districts.
  - Data was collected on:
    - ANC visits: screening for anaemia, anaemia management, screening for high blood pressure, screening for proteinuria, management of pre-eclampsia/eclampsia (PE/E) and HIV screening and management (ARV).
    - Best practices during labor: use of partogram, active management of the third stage of labor (AMTSL), monitoring for danger signs during 4th stage of labor, placenta examination, examination for tears and lacerations, sepsis prophylaxis, early detection and management of obstetric complications: obstructed labor, postpartum hemorrhage (PPH) early detection, PPH management (uterine atony, retained placenta, lacerations), PE/E management, and sepsis management
    - Postabortion complications management and incomplete abortion

**Figure 1: Locations of 126 health facilities participating in the Botswana QI MMRI**



- **ASSIST conducted trainings in QI methodology to MOH MMRI officers/coordinators**
  - The first QI training session was held in Gaborone, January 13-14, 2014. All 11 midwife MMRI coordinators attended in addition to personnel from the MOH. Participants were exposed to process mapping, driver diagrams and fishbone tools, and each coordinator calculated a rare events graph for days between maternal deaths in their own districts and proposed an improvement aim based on the calculations.
  - The second QI training session was held in Gaborone, February 10-12, 2014 and included improvement work presentations, a work plan review, and a weekly schedule to visit each health facility was developed by each coordinator.
- **Developed recording and reporting tools, pilot tested, and finalized**
  - Feedback was included in an improved version of the tools that includes automatic calculation of indicators per facility and automatic plotting for run charts of selected key indicators in each facility providing maternal services.
- **Conducted training in data collection and reporting**
  - Training in the use of MMRI data collection tools. Gaborone, January 14-16, 2014. USAID ASSIST designed four paper-based data collection tools and one electronic data collection tool were designed to support collection and reporting of data for the Maternal Mortality Reduction Initiative (MMRI):
    - MMRI 1 tool: ANC Data Collection Tool
    - MMRI 2 tool: ANC Monthly Data Collection Tool
    - MMRI 3 tool: Maternal/Post abortion Data Collection Tool
    - MMRI 4 tool: Maternal/ Post Abortion Monthly Data Collection Tool
    - E-MMRI tool: District reporting tool. Computer-based tool to capture and consolidate data at the district level with automatic calculation of indicators and time series charts at the facility and district levels.
- **Supported the initiation of QI teams**
  - On March 17-20, 2014 personnel from the MOH, an ASSIST QI consultant, and the National MMRI Coordinator provided coaching to the QI teams in the referral hospital Princess Marina (PMH, Gaborone) and District Hospital Scottish Livingstone (Kweneng East). The visiting

team helped facilitate the first QI meeting, set objectives, provided feedback and met with the Hospital Superintendent of PMH to request his support and involvement in recruiting the Head of the OB/GYN Department to participate in the team.

- A scheduling template was prepared for each coordinator to include a visit to each facility under their area of coverage twice a month to provide support to the QI teams and to gather data from the facilities for the ongoing M&E component of the MMRI. The MOH participated in the redistribution and final adjustments to the coverage area for each coordinator.
- A follow up visit on April 4<sup>th</sup>, 2014 to the PMH QI Team was conducted by the QI ASSIST consultant Cathy Green and Dr. Sinvula. Gaps were identified in access to patient records. The QI coaching team engaged the Hospital Superintendent to intervene and coordinated with the Head of Medical Records to release medical files for review. A meeting was also conducted with OB/GYNs and anesthetists to coordinate process of care steps in the operating theatre and set an agenda with follow up steps.
- **Developed job aids for prevention and management of most frequent obstetric complications**
  - Job aids covering prevention, early detection and management of PPH, pre-eclampsia/eclampsia, and post abortion complications were developed, shared with the country technical team, and approved by the MOH.
- **Conducted capacity building at the central level for management and analysis of MMRI data**
  - During January 20-24, 2014, Dr. Maria Insua, Senior Technical Advisor for ASSIST, provided capacity building to the MMRI personnel in the MOH for consolidation, management, and analysis of data collected under the MMRI M&E system. Trackers for monthly data from the districts were developed and a master database was created to aggregate data.
- **Monitored availability of essential drugs to provide maternal/neonatal services**
  - ASSIST developed a monitoring tool for monitoring essential drug availability in facilities.
  - Drug availability is being reported by midwife coordinators weekly and this information is shared with Central Medical Stores (CMS) for rapid response to dwindling drug levels in facilities.
  - The CMS drug availability report is being released weekly for facilities to check what is available centrally
  - The MOH has put a mechanism in place for emergency orders where needed.

**Update to Integrated Design of Improvement Activity**  
 The MMRI project was requested to report on some PMTCT indicators as part of the PEPFAR Quality Strategy (PQS). Separate reporting occurs for PEPFAR activities.

## How Do We Know We Are Improving?

### Improvement in Key Indicators:

Activity	Indicators	Baseline- February 2014 (# facilities reporting)*
Activity 1: National Maternal Mortality Reduction Initiative	% Administered oxytocin in the first minute after delivery (AMTSL)	84% (52 facilities)
	% Women monitored during the 4th stage labor per protocol	58% (46 facilities)
	PPH +Uterine atony managed per protocol	100% (8 facilities)
	% Severe PE (labour) managed per protocol (MGSO4+delivery)	19% (7 facilities)
	% Incomplete abortion managed as per protocol within 2 hours of diagnosis	56% (12 facilities)
PEPFAR	% PEPFAR supported clinical service sites with QI	126 facilities included in

Activity	Indicators	Baseline- February 2014 (# facilities reporting)*
Quality Strategy Indicators	activities	the QI MMRI
	Facilities reporting delivering women HIV + (baseline)	52 facilities
	Number of HIV+ delivering women	651
	Number of HIV+ women receiving ARV (ANC)	556
	New HIV+ delivering women identified during labour	25
	% of HIV+ delivering women in treatment with ARV	85%
	% of HIV + delivering women	35%

\*Provisional data

### Directions for Q2 and Q3 FY14

- The first QI MMRI sharing session is planned for May 12 -15, 2014. The coordinators will present progress made with QI activities in their facilities and propose changes to overcome specific gaps in the provision of services to reduce and manage PPH, PE/E and post abortion complications.
- A QI support visit to the second referral hospital in Francistown is planned for May 7-8, 2014.

### Improvement Strategy

The MMRI is run by the MOH through the SRH division. ASSIST is working together with the Ministry to provide support in the implementation of the QI component of the Initiative.

## 1.2 Burundi

### Background

The USAID ASSIST Project began being implemented in Burundi in January 2013, building on a prevention of mother-to-child transmission of HIV (PMTCT) service delivery assessment and human performance technology assessment conducted in 2012 under HCI. The project is working with the Ministry of Health to: improve the uptake and quality of PMTCT services for mothers, their partners, and their infants and improve retention of mothers and infants along the PMTCT cascade.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Implementing a PMTCT improvement intervention in 8 provinces of Burundi	<ul style="list-style-type: none"> <li>• Improve uptake of PMTCT services (by mothers, infants, and partners)</li> <li>• Improve retention of mothers and infants along the PMTCT cascade</li> <li>• Improve quality of PMTCT services</li> <li>• Strengthening Community System to improve the performance of CHWs to provide quality of PMTCT services at the community level</li> </ul>	<p>8 out of 17 provinces</p> <p>25 out of 25 health districts in the 8 provinces; 25 out of 47 health districts in 17 provinces</p> <p>70 out of 150 PMTCT sites in the 12 previous districts</p> <p>5,608,308 inhabitants covered by ASSIST out of 10,557,259 inhabitants</p> <p>Community activities will cover 24 sub-collines surrounding 6 (6/15) peripheral facilities in Giteranyi district</p>	x	

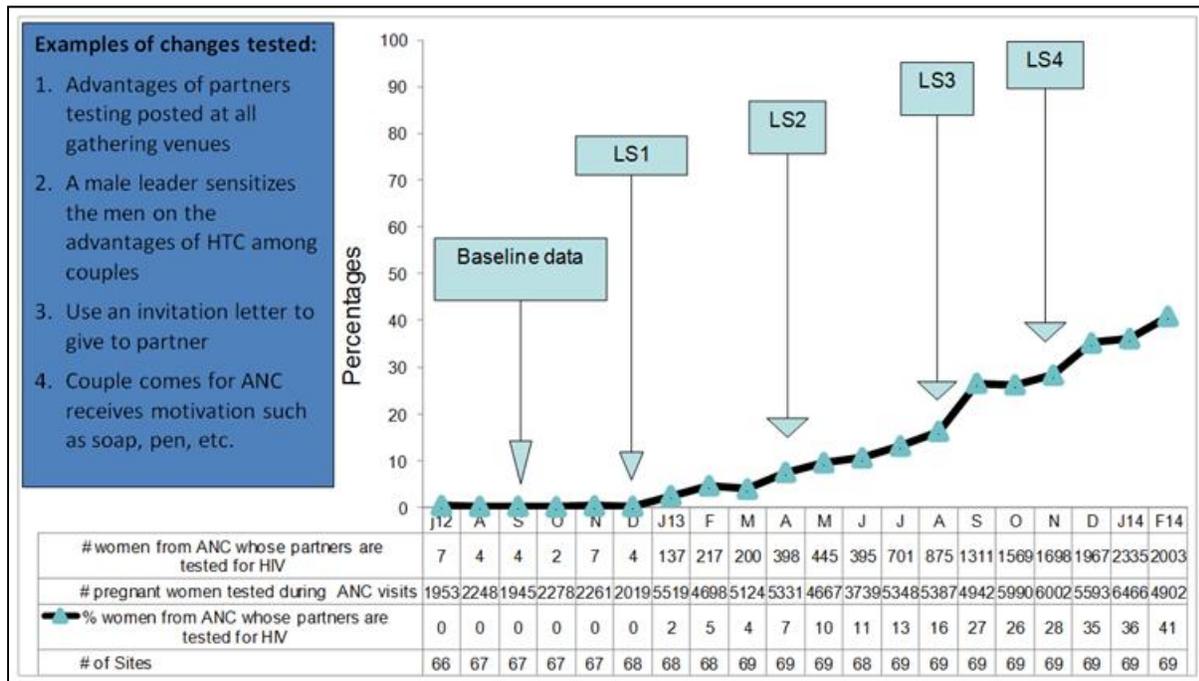
## Key Activities, Accomplishments, and Results

### Activity 1. Implementing a PMTCT improvement intervention in 8 provinces of Burundi

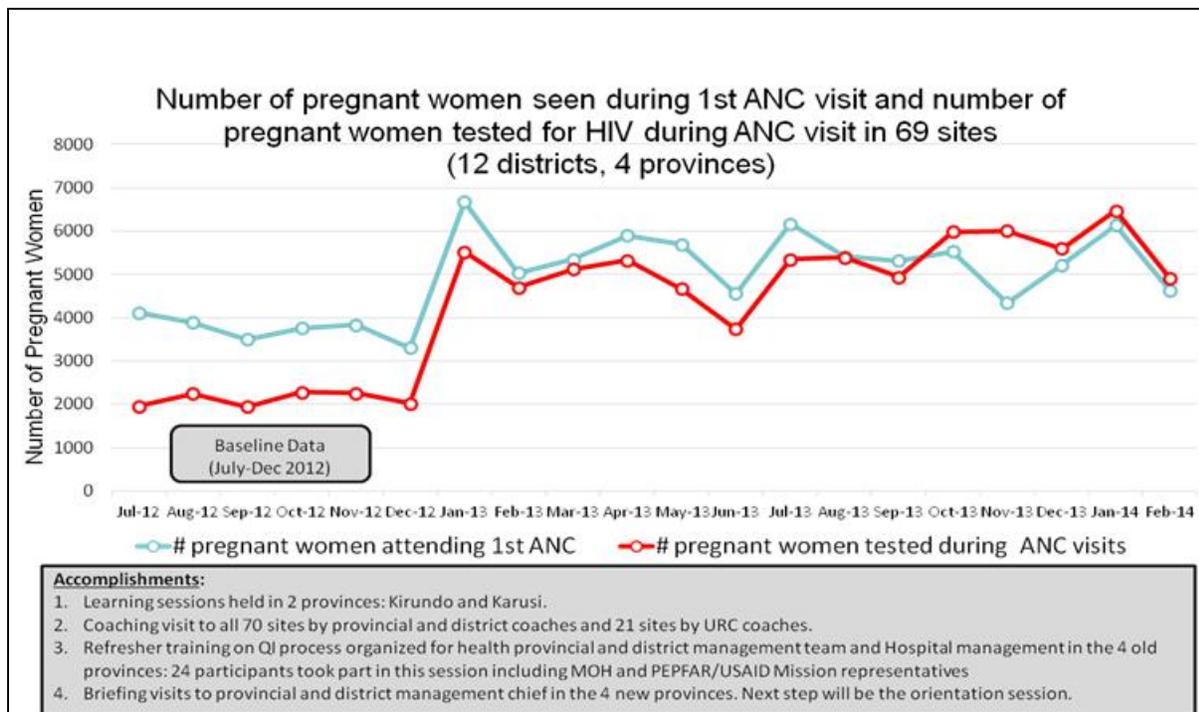
#### Accomplishments:

- **Conducted site coaching visits.** During this reporting period, the coaches continued coaching visits in all of the 70 PMTCT sites. Coaching visits with a team of district coaches and ASSIST technical staff were carried out in 30 sites (Q1) and in 21 sites (Q2) to assess and support the functionality of QI teams. During those visits some weaknesses were identified in the coaching process.
- **Refresher training for coaches.** With the technical assistance of Sabou Djibrina, Quality Improvement Advisor from the Regional Office in Niger, the ASSIST Burundi team, in close collaboration with the MOH, organized a three-day workshop (Q1) for the district coaches to strengthen their capacities to address improvement gaps identified during the coaching visits.
- **Conducted fourth learning session (Q1).**
  - During the first quarter, ASSIST Burundi conducted the fourth learning session. The learning session was organized for 70 QI teams from the four targeted provinces (Kayanza, Kirundo, Karusi and Muyinga) covered by the PMTCT QI Collaborative activities. Sabou Djibrina provided support and technical assistance. A total of 160 participants attended the session, including site QI team representatives, coaches and members of District and Provincial Health Management Teams. The main objective was the experience sharing through the presentations of the sites and feedback related to the last coaching visits. At the time of this learning session, the participants chose the best sites per district and province referring to predefined criteria. Ideas of change have been collected and this will help to identify the ideas of change which really produced changes.
- **Health Facility QI Collaborative: Conducted the fourth learning session in Kirundo and Karusi provinces (Q2).**
  - In January 2014, in collaboration with MOH National AIDS Control Program (PNLS), ASSIST Burundi conducted the fourth learning session for the 35 sites located in two provinces implementing PMTCT improvement activities in Karusi and Kirundo. A total of 81 participants attended the training, including site representatives, coaches and members of the District and Provincial Health Management Teams (DHMT and PHMT). The main objective was to strengthen the capacity of key stakeholders in the process of implementing the PMTCT improvement collaborative. During this learning session, change ideas were collected and help was given to identify the practices which produced the most changes. Also, during this learning session, the participants chose the best sites per district and province, according to predefined criteria.
- **Improvements were observed in women from ANC whose partners are tested for HIV (Figure 2) and in decreasing the gap between the number of pregnant women enrolled in the first ANC visit and those who were tested for HIV (Figure 3).**
- **Research protocol finalized for “Factors associated with HIV testing among male partners of women in antenatal care study” (February 2014).**
  - During the period, data collectors for the study were trained and a pre-test study data collection tool was conducted.
- **Organized refresher training on QI process for health provincial and district management team and Hospital Chief Management in the 4 initial provinces.**
  - During March 2014, in collaboration with PNLS, ASSIST organized a refresher training on the QI process for health provincial and district management teams and hospital directors in the four initial provinces in which ASSIST was working; the 24 participants included MOH and PEPFAR/USAID Mission representatives. This training was organized in order to reinforce the capacity of medical doctors, Chief of Health District Office & Provincial Office of Health as well as hospital directors on the collaborative approach for improvement of PMTCT activities. It was also an opportunity to discuss their roles and responsibilities in the coordination of collaborative activities at each level (DHMT, PHMT and hospital) with the aim to encourage them to integrate those activities in their respective activity plans at each level.

**Figure 2: Burundi: Percentage women from ANC whose partners are tested for HIV (July 2012 – Feb 2014)**



**Figure 3: Burundi: Number of pregnant women seen during 1st ANC visit and number of pregnant women tested for HIV (July 2012–Feb 2014)**



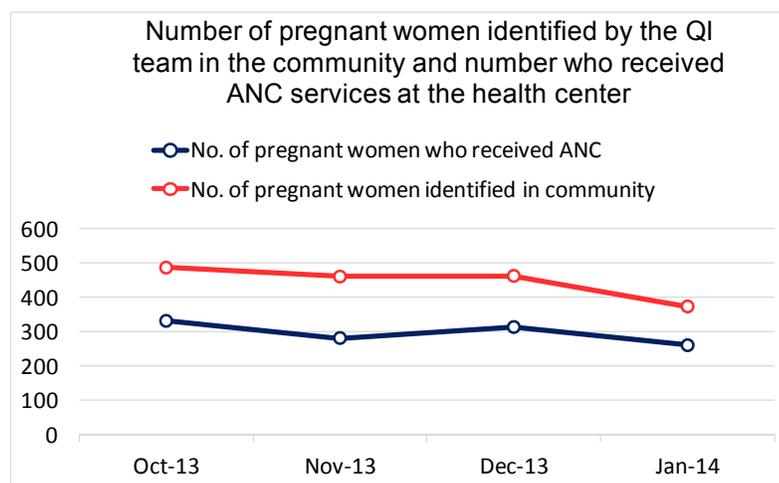
- **Extend the collaborative approach in the new PEPFAR provinces (Gitega, Ngozi, Bujumbura and urban Bujumbura).**
  - During March 2014, ASSIST staff conducted briefing visits to the provincial and district management chiefs in the four new provinces. During these visits, the following was

achieved: Presentation of ASSIST as new partner in the province, introduction of the ASSIST Project and its technical content within the HIV/AIDS Program in Burundi, the QI collaborative approach, and proposed next steps.

- **Conducted community QI collaborative activities within Giteranyi Health District as pilot site (Muyinga).**
  - During this reporting period, after the collection and the analysis of basic information for mapping community groups in surrounding health facilities in Giteranyi district, ASSIST Burundi started the community activities by organizing a community coaches training and an orientation session for community groups. Ram Shrestha provided support and technical assistance. Sixteen community coaches were trained. The community groups' orientation session targeted local chiefs of collines and leaders of community groups. A total of 68 community group members, including local leaders and community workers, attended the orientation session. At the time of the community coaches training and orientation session, 24 community committees were created and the following three community QI indicators were identified:
    - % of pregnant women attending the health facility (HF) for first visit of ANC before 14 weeks of pregnancy
    - % of pregnant women attending ANC facilities tested for HIV
    - % of pregnant women from ANC facilities whose partners are tested for HIV
- **Conducted community QI team meetings.**
  - From January 2014, at least two meetings were held by each community QI team. A first indicator was chosen by QI teams to be collected by the community: the number of pregnant women attending HF for an ANC visit in each sub colline.
  - Community QI teams began educating their communities on the importance of the ANC visits. Also, each QI team has established a register to record all pregnant women within the sub colline.
- **Conducted coaching visits for the community QI Teams.**
  - During this reporting period, the community activities were focused on coaching visits. Three coaching visits were conducted and all the 24 community committees were visited either by the TPS coaches only or TPS coaches with ASSIST and PNLs coaches.
- **Results show an increased number of pregnant women identified by QI teams in community and who received ANC.** Data were collected from October - December 2013 (period before the orientation session) and for January 2014 (after the implementation of community QI teams) (Figure 4).

**Figure 4: Burundi: Number of pregnant women identified by the QI team in the community and who received ANC services at the health center (Oct 2013 – Jan 2014)**

Accomplishments:	
1.	Feedback meetings of the orientation session for other members of community groups organized
2.	From Jan 2014, at least two meetings held by each community QI team
3.	1 <sup>st</sup> indicator chosen by QI teams to be collected by the community: number of pregnant women attending health facility for ANC visit in each sub colline
4.	Community QI teams began educating the community on the importance of ANC visits
5.	Each QI team established a register to record all pregnant women
6.	Three coaching visits of the 24 community QI teams held



	Oct-13	Nov-13	Dec-13	Jan-14
<b>Number of pregnant women who received ANC</b>	332	282	314	261
<b>Number of pregnant women identified in community</b>	487	461	463	374
<b>Ratio</b>	68%	61%	68%	70%

- **Participated in government and partner relationships.**
  - In January 2014, ASSIST participated in a discussion meeting between the National AIDS Control Council (CNLS), PNLs, PEPFAR/USAID team and its implementing partners which focused on the coordination of HIV/ AIDS activities in Burundi.
  - In February 2014, ASSIST attended the launching ceremonies of the USAID Integrated Health Project in Burundi. The ceremonies were led by the US Ambassador in Burundi and the Ministry of the Public Health and the fight against AIDS.
  - In March 2014, ASSIST participated in a dissemination workshop of the new WHO PMTCT guidelines and a validation workshop of the roadmap on decentralization of ARV treatment organized by the PNLs.
  - In March 2014, ASSIST attended a coordination meeting of the health partners organized by Kayanza's health province.

## How Do We Know We Are Improving?

### Improvement in Key Indicators:

Activity	Indicators	Baseline (July 2012)	Last value (Feb 2014)
Implementing a PMTCT improvement intervention in 8 provinces of Burundi	Proportion of pregnant women tested during ANC visits	47%	106%
	Proportion of partners tested (husbands or partners of enrolled women in PMTCT services)	0%	41%
	Number of exposed children tested at 18 months	9	17

### Directions for Q2 and Q3 FY14

- Continue coaching visits to all sites including community coaching
- Continue testing of standards using PDSA model for improvement
- Organize the fifth learning session for Kayanza, Muyinga, Kirundo and Karusi provinces
- Design spread strategies of the first phase and elaborate upon the change package for the second phase of the collaborative
- Organize an orientation meeting for the new provinces of Gitega, Ngozi, Bujumbura and Urban Bujumbura
- Support teams to document processes, changes and success stories
- Begin the study: "Factors associated with HIV testing among male partners of women in antenatal care"

## 1.3 Cote d'Ivoire

### Background

Since April 2013, the USAID ASSIST Project is supporting the Ministry of Health and the National HIV Program in Cote d'Ivoire to:

- Improve the quality of antiretroviral therapy and PMTCT services;
- Support the WHO/CDC laboratory accreditation program; and
- Support the development of a policy document to address national health information standards for each level of the health system.

This work builds on the QI interventions implemented under HCI in the country since 2008.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Other Activity
1. Improve quality HIV/AIDS care and treatment services in Cote d'Ivoire	<ul style="list-style-type: none"> <li>• Strengthen leadership, management and planning of Ministry of Health (MOH) QI unit in coordinating quality improvement activity design and implementation</li> </ul>	Central level 4 university hospitals 27/82 health districts Expected coverage: 6,000,000 out of 23,000,000 inhabitants	x	
	<ul style="list-style-type: none"> <li>• Establish QA/QI system in university hospitals</li> </ul>	4 university hospitals (District Abidjan South, East and North; and Bouake)		
	<ul style="list-style-type: none"> <li>• Improve retention in care HIV+ patients on ART</li> <li>• Improve the percentage of pregnant women who receive prophylaxis for PMTCT</li> </ul>	10/20 regions 27/82 districts 60 sites selected and distributed among these regions and 70 health districts Expected coverage: 6,000,000 out of 23,000,000 inhabitants		
	<ul style="list-style-type: none"> <li>• Build capacity of Implementing Partners to establish collaborative activities within their supported health facilities</li> </ul>	10/20 regions 27/82 districts 60 sites selected and distributed among these regions and 70 health districts Expected coverage: 6,000,000 out of 23,000,000 inhabitants		
2. Support the WHO/CDC Laboratory Quality Improvement Process Towards Accreditation	<ul style="list-style-type: none"> <li>• Enable national structures involved in the process to coordinate and monitor WHO-AFRO Stepwise Laboratory Quality Improvement Process Towards Accreditation of Laboratories (SLIPTA)</li> <li>• Strengthen capacity of laboratory staff to improve their skills for efficient interventions</li> <li>• Ensure follow-up and periodic evaluation of the progress of laboratories involved</li> </ul>	15/21 labs from 1 <sup>st</sup> cohort 10/21 labs from 2 <sup>nd</sup> cohort 10 districts and 10 health regions		x

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Other Activity
3. Improve the strategic information system	<ul style="list-style-type: none"> <li>Support development of procedures for data use and promotion of information use culture</li> <li>Support new QI initiative with accurate data used for decision making at all levels</li> </ul>	National scale		x

## Key Activities, Accomplishments, and Results

### Activity 1. Improve quality HIV/AIDS care and treatment services in Cote d'Ivoire

#### Accomplishments:

- **Establishing QI system for ART services in four university hospitals.**
  - Initiated conversations with the current MOH unit in charge of Quality Assurance (le Service de la Promotion de l'Assurance Qualité en Santé – SPAQS). This unit is responsible for establishing QI units in health institutions. Although in place for many years, SPAQS is not functioning as it should. According to SPAQS, it does not have the necessary financial support from the MOH to initiate activities. In addition, due to the lack of a clear relationship between SPAQS and the administrations of university hospitals, SPAQS has not been able to initiate activities in the hospitals. ASSIST is therefore looking into other means for establishing QI systems in university hospitals, building on SPAQS' experience.
- **Conducted policy seminar on infrastructure and policy for quality of care in Cote d'Ivoire.**
  - A one-day seminar entitled, "Thoughtful Conversation on National Improvement Strategies and Infrastructure for Improving Health Care" was convened on February 26, 2014.
    - The meeting was officiated by the Director General of the MOH. Fifty-seven (57) participants participated. Over 30 of the participants were senior MOH, implementing partner (IP) and USAID staff. External USAID ASSIST participants were: Dr. Rashad Massoud, Director; Dr. Maina Boucar, Regional Director; and Lyle Mikowicz, Project Coordinator. The meeting raised the question of how the government of Cote d'Ivoire can best pursue improvement. One conclusion of the meeting was that the current infrastructure is non-functional and according to the MOH, another institution will be handling improvement.
- **Technical assistance to PEPFAR implementing partners on new QI initiative.**
  - In Q1, the team conducted a series of meetings with USAID/CDC and PEPAR IPs to organize the preparation phase of an improvement collaborative. ASSIST was asked to provide technical assistance to all IPs to implement the collaborative in 70 pilot health facilities (10 health facilities per partner).
  - In Q1, the team conducted a three-day workshop with PEPFAR Technical and IPs on concerted actions of PEPFAR to improve the quality of HIV care in Cote d'Ivoire and to design a structure for implementation.
  - In Q1, the team conducted three sessions of five-day classroom trainings on Collaborative Quality Improvement methods and Knowledge Management methods which registered participants of six PEPFAR clinical partners (Aconda-VS, EGPAF, ICAP, Ariel, SEV-CI, HAI), one technical partner (Jhpiego), the donor (PEPFAR) and the MoH (PNPEC, MLSL).
  - In Q1, the team organized and conducted preparation meetings on the establishment of QA/QI systems in university hospitals with three out of four PEPFAR clinical partners providing support to these health facilities (HAI, ICAP, ACONDA).
  - In Q1, the team held discussions with FHI-360 on collaboration for development of HIV Care Standard Operating Procedures.



- The training was organized in two sessions - theoretical and practical – in order to allow IPs to have a good understanding of the tools and the evaluations process.
- Development of presentations and organization of field activities for the capacity building session on QI evaluation tool management.
- Theoretical training held on March 18, 2014 at “USAC-Treichville” with 24 participants from the six PEPFAR clinical partners. Presentations and exercises were conducted on the indicators, the sampling and the completion of the ART and PMTCT tools. The discussions, questions and answers led participants to a better understanding of the tools.
- The “Practical” portion of the training was held from March 19-20, 2014 in six ART/PMTCT health facilities. Six teams were formed and every person in a team participated in the evaluation of one of the six ART/PMTCT sites selected for this step. In each site we proceeded to the entire evaluation. All participants pilot-tested sampling, asking questions, reviewing patient medical records and completing the tools.
- After the trainings, the baseline evaluation by IPs was planned.

**Activity 2. Support the WHO/CDC Laboratory Quality Improvement Process Towards Accreditation**

**Accomplishments:**

- **Assessed 21 laboratories involved in the process towards accreditation (Q1).**
- **Conducted coaching visits to five of 21 laboratories (Q1).**
- **Conducted workshops to debrief on results of the SLMTA (Strengthening Laboratory Management Towards Accreditation) process assessment:** February 11-12, 2014 for laboratories from Abidjan; February 11-14, 2014 for laboratories throughout the country.
- **Organized a coordinating meeting to identify the next steps of WHO-AFRO program after debriefing (March 14, 2014).**
- **Organized a coordination meeting to identify a new cohort of laboratories for the new SLMTA initiative (March 24, 2014).**

**Activity 3. Improve the Strategic Information system**

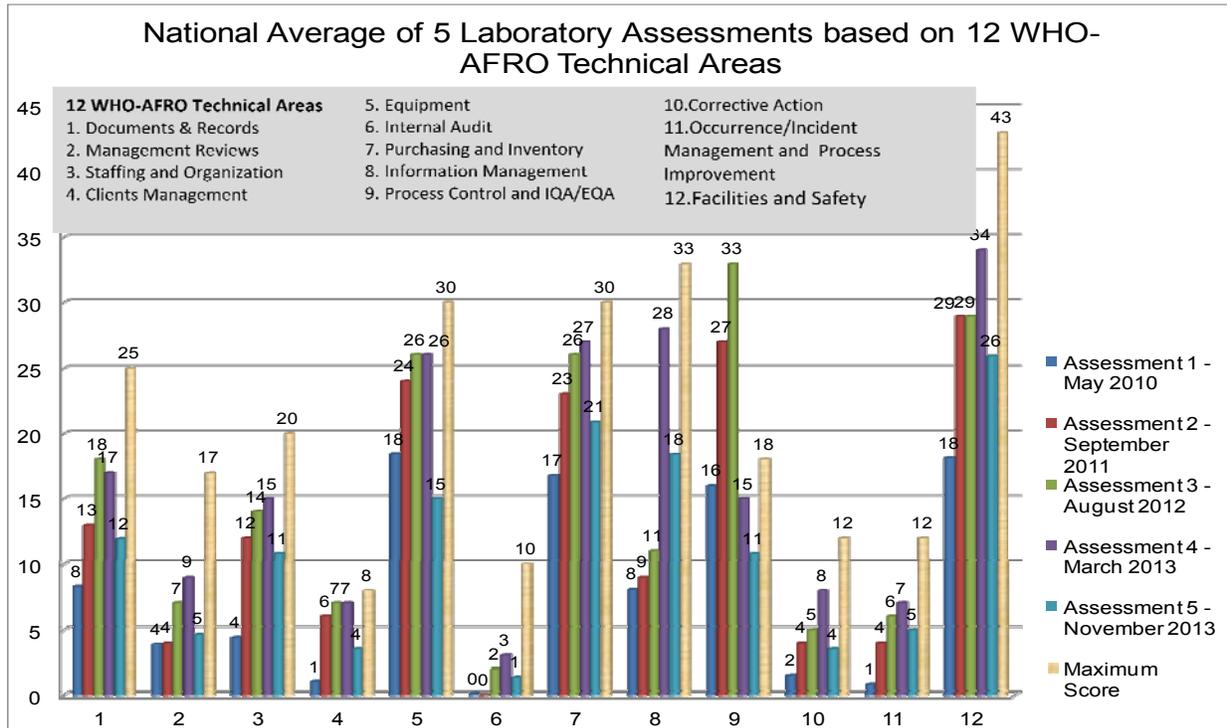
**Accomplishments:**

- **Conducted informational and preparatory meetings with DIPE and MEASURE Evaluation for the development of standards for the use of health information for decision making (Q1).**
- **Currently developing the first draft of the standard on data use for decision making which will be sent to the other partners involved in the process (DIPE and MEASURE) for inputs.** As a next step, USAID ASSIST, DIPE and MEASURE will meet to obtain the draft version of standards that the Technical Working Group (TWG) will use.

**Update to Integrated Design of Improvement Activity**

We have launched the PEPFAR Cote d'Ivoire Quality Improvement Initiative engaging all implementing partners. The USAID ASSIST Project will provide technical assistance in piloting the initiative during COP-13.

**Figure 6: Cote d'Ivoire: National average of 5 laboratory assessments based on 12 WHO-AFRO technical areas (May 2010 – Nov 2013)**



**Directions for Q3 and Q4 FY14**

- **ART/ PMTCT**
  - Conduct first coaching visit for sites
  - Conduct second learning session for sites
  - Meet with managers in charge of quality at the four university hospitals
  - Train managers in charge of quality on their role in coordinating quality improvement collaboratives
  - Conduct first learning session for sites of the four university hospitals
  - Organize the TWG around the development of HIV standards of care
  - Develop the first draft of national HIV standards of care
  - Research: Development of a protocol related to partner collaborative activities
- **Health Strategic Information**
  - Development of first draft of the Health Information Strategic standard
  - Testing of standard
  - Review of standard with the Technical Working Group
  - Organize a workshop to validate the Health Information System standards on data use for decision making
- **Laboratory**
  - Sensitize Regional and District Directors, health facilities Directors on the WHO-AFRO accreditation program
  - Conduct the baseline assessment for the new cohort of laboratories involved
  - Conduct debrief laboratory baseline assessment outcomes to MOH and stakeholders (i.e., lab technicians)

## 1.4 Democratic Republic of Congo

### Background

Beginning in FY14, the USAID ASSIST Project is supporting the Ministry of Health in the Democratic Republic of Congo to improve nutrition services for HIV clients through integration of nutritional assessment, counseling and support (NACS) into HIV care and treatment, in coordination with other implementing partners.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Quality improvement technical assistance for integrating NACS into HIV care and services	Improve management and nutritional status of malnourished HIV clients by: <ul style="list-style-type: none"> <li>Integrating NACS into facility-based ART, PMTCT and MNCH services</li> <li>Strengthening the capacities of district health managers and care providers to apply improvement skills</li> </ul>	16 facilities in 2 provinces (Kinshasa and Katanga)	x	

### Key Activities, Accomplishments, and Results

#### Activity 1. Quality improvement technical assistance for integrating NACS into HIV care and services

##### Accomplishments:

- Joint trip to DRC with partner organizations to determine NACS opportunities:** At the request of USAID/DRC, FHI 360's Food and Nutrition Technical Assistance Project (FANTA) and Livelihoods and Food Security Technical Assistance Project (LIFT) and ASSIST made a joint trip to DRC in order to assess opportunities to integrate NACS into HIV care and treatment services in the country, including referrals of NACS clients between health care facilities and economic strengthening, livelihoods, and food security support and quality improvement of NACS services.
- A joint work plan was developed from which ASSIST will run these key activities:**
  - Implement a collaborative approach in Kinshasa and Katanga provinces for a rapid improvement of NACS activities in the 16 selected sites.
  - Build capacities of health system managers for QI institutionalization in the health system mainly for people living with HIV (PLHIV).
  - Conduct formative supervisions and coaching sessions to improve quality of services.
  - Implement a NACS monitoring and evaluation plan to be integrated into the National M&E System as an integral part of the National M&E system.
  - Develop an extension plan based on lessons learned from initial NACS sites review.
- Sixteen facilities were jointly selected for the initial intervention in 2 provinces of Kinshasa and Katanga (city of Lubumbashi).**

##### Directions for Q3 and Q4 FY14

- Train key stakeholders on QI/collaborative in Kinshasa and Lubumbashi (FANTA, LIFT, PNLS and PRONANUT's staff and District health teams)
- Train health system supervisors on coaching in Kinshasa and Lubumbashi
- Set up QI teams in all collaborative sites (10 in Kinshasa province and 6 in Lubumbashi, Katanga province)
- Organize monthly coaching visits for QI teams in all collaborative sites
- Follow up on performance of sites through changes tested and level of indicators
- Document best practices implemented by QI teams in NACS continuum of care

- Organize a quarterly learning session to share experiences between QI teams in Kinshasa and Lubumbashi
- Launch the process of recruiting two QI technical advisors for ASSIST based in DRC, one in Kinshasa and another one in Lubumbashi. These advisors will collaborate with FANTA and LIFT staff and other PEPFAR implementing partners such as PROVIC, EGPAF and ICAP.

## 1.5 East Africa Region

### Background

Since January 2013, the USAID ASSIST Project is providing technical assistance and support to the Regional Centre for Quality of Health Care to develop and validate a health quality improvement core competency framework. The competency framework builds on a regional stakeholder meeting convened by HCI in October 2011.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Technical assistance and support to the Regional Centre for Quality of Health Care (RCQHC) to develop and validate a Health Quality Improvement Core Competency Framework	<ul style="list-style-type: none"> <li>• Build RCQHC capacity in methodologies to develop, validate, and apply competency frameworks</li> <li>• Provide technical guidance at each stage of the development and validation process</li> </ul>	East Africa Region		x

### Key Activities, Accomplishments, and Results

#### **Activity 1. Technical assistance and support to the Regional Centre for Quality of Health Care (RCQHC) to develop and validate a Health Quality Improvement Core Competency Framework**

##### Accomplishments:

- **Finalized, revised and re-scoped competency framework in response to technical reviewer's feedback.**
  - Supported RCQHC to manage a modified Delphi approach to ensure content validity of the competency framework. Comprises of two rounds of independent technical review by a group of 12 improvement experts (ASSIST, WHO, MOH, ICAP, PATH). Templates developed in excel to ascertain level of agreement on competency framework content and obtain input on revisions, additions and improvements.
  - Draft framework and reviewers template sent to all experts on November 5th.
  - RCQHC and ASSIST met on 17th Jan to review responses and discuss revisions for competency framework content for which consensus was not achieved (<90% agreement amongst reviewers). Framework was revised accordingly and sent out to experts for final round of review.
  - Coached RCQHC staff over multiple Skype calls between February–March, 2014 to review all feedback from reviewers and make decisions on revisions of the framework's content.
  - Decided to re-scope the competency framework to focus on basic improvement competencies required to undertake single-site improvement. Reviewer comments on the advanced competencies included in the first draft recognized the limitations of the draft content related to advanced competencies – requiring major rework and revision. Competencies that RCQHC is most focused on are basic competencies and this aligns well with their mandate. Possibility of developing an advanced competency framework in the future could be explored when more resources and time could enable this.

- **East Africa Regional Workshop “Towards integrating improvement competencies into health worker education and training”**
  - Held December 11-13, 2013 in Nairobi, Kenya and hosted by the RCQHC with technical support from ASSIST (Tana Wuliji, Esther Karamagi/Uganda, Subiri Obwogo/Kenya). Five countries participated: Kenya, Tanzania, Burundi, Uganda, Rwanda. Participants included Ministry of Health Heads of Quality Assurance, Teaching hospitals, Deans/Heads of medical/public health/nursing academic institutions, and nursing councils/unions.
  - Workshop objectives were achieved, including:
    1. Complete review of competency framework to provide feedback on layout, structure, clarity and suggestions on the framework’s dissemination and use
    2. Share current country situations and lessons learnt on integration of improvement competencies into health worker education and training
    3. Self-assess strengths, weaknesses, opportunities and threats (SWOT analysis) and readiness towards integration of improvement competencies into pre-service education and training
    4. Brainstorm next steps at regional and country level to move the agenda forward
  - Each country set country-specific strategic objectives and brainstormed specific actions to be taken towards integration of improvement competencies, taking into consideration current strengths, weaknesses, opportunities and threats.
  - Interest amongst countries for regional cooperation towards common goal of integrating improvement competencies: e.g., establishment of a regional technical committee, sharing of technical resources (curricula etc), sharing of challenges and lessons learnt through community of practice (learning visits between countries, information system to track progress and share experiences (e.g., portal, regional database)
  - Technical and resource support required to develop/strengthen curricula, build academic capacity to teach improvement, evaluate effectiveness, and facilitate learning between countries.

### Directions for Q3 and Q4 FY14

- Complete revision of the competency framework in preparation for final round of technical review
- Complete final round of technical review
- Develop guidance for curriculum development for basic improvement competencies

## 1.6 Kenya

### Background

In Kenya, ASSIST builds on the work of HCI and aims to support the Ministries of Health (MOH), and the Ministry of Labor, Social Security and Services (MLSS&S) and other relevant partners such as the United States Government (USG) implementing partners and county governments to design, develop, and implement strategies that will enhance the quality of service delivery in the health sector and the care of orphans and vulnerable children (OVC) in the country. The ASSIST approach is guided by the National Health Sector Strategic Plan II and MLSS&S priorities for improving quality of services for OVC. The project design for the ASSIST Kenya project is divided into two phases: Phase one involves the development of national frameworks to support institutionalization of QI as well developing change packages through the centres of excellence (COEs) in order to harvest change ideas that can be scaled up across Kenya.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Capacity Development: Support	<ul style="list-style-type: none"> <li>• Support the government through the MOH and the MLSS&amp;S to</li> </ul>	National level		x

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
institutionalization of QI at the national level	establish a framework for institutionalization of QI at the national level			
2. Capacity development for OVC at the national level	<ul style="list-style-type: none"> <li>Promote the country government's capacity in identifying and addressing priority improvement issues in child protection and OVC</li> <li>Support the MLSS&amp;S and Welfare at national level in institutionalization of QI in OVC, child protection and national social protection programs</li> </ul>	National Level		x
3. Improve health service delivery	<ul style="list-style-type: none"> <li>Support the Ministry of Health, APHIA Plus and other USAID implementing partners to improve health service delivery by applying QI techniques</li> </ul>	<p>National</p> <p>Initial Phase: Six APHIA Plus partners, 7 counties, 8 sub-counties, 203 facilities serving an approximate population of 2 million people</p> <p>Second Phase: Six APHIA Plus, other USG implementing partners, 32 counties, 10 high volume health facilities in each county; 320 high volume facilities in the country, approximately serving 24 million people</p>	x	
4. Strengthen OVC at the facility level	<ul style="list-style-type: none"> <li>Strengthen systems within the county government to support the institutionalization of QI in child protection and OVC to improve the welfare of children</li> </ul>	National	x	

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
5. Strengthen service delivery systems	<ul style="list-style-type: none"> <li>Strengthen systems within national programs (National AIDS/STI Control Programme – NASCOP-, Family Health, Primary Health Directorate of Preventive and Promotive services - to support QI</li> </ul>	National	x	

## Key Activities, Accomplishments, and Results

### **Activity 1. Capacity Development: Support institutionalization of QI at the national level**

#### **Background and accomplishments:**

Under this activity and to ensure institutionalization and sustainability of QI, ASSIST is working with key national directorates and departments, including the Directorate of Preventive and Promotive Services (responsible for issues including the Reproductive and Child Health Programme, the Malaria Control Programme, the Occupational Health Programme, the Parasite Diseases Control Programme and, in particular, NASCOP (the national programme that spearheads the fight against HIV/AIDS), the Department of Children services that deals with children and social protection issues, and the Directorate of Quality and Standards - charged with health care improvement in line with the Kenya Quality Model of Health. These directorates are key partners in the development of a national QI policy, strategy, indicators, monitoring and evaluation (M&E) framework and syllabus as core frameworks for the institutionalization of QI in Kenya. ASSIST is working with the key departments mentioned above and other key stakeholders to identify gaps and opportunities for QI policy and standards development.

- **During the reporting period, consultants were hired, data collection tools were piloted and the data collection for the situational analysis is now under way.** The report of the situational analysis will provide a comprehensive report on the gaps and opportunities for QI policy and standards development.

### **Activity 2. Capacity development for OVC at the national level**

In Kenya the ASSIST OVC work supports the MLSS&S and other relevant partners, including the USAID/Kenya service delivery partners and county governments to strengthen child protection and national social protection programs in the country. This work is guided by the MLSS&S priorities for improving quality of services for OVC.

- **IEC materials for the social protection secretariat were developed and translated into four local languages (Kiswahili, Kikuyu, Luo and Kamba) for use by community members.** The communication materials are aimed at promoting the work of the National Social Protection Secretariat and enhancing community engagement in social protection activities.
- **ASSIST further supported the national social protection secretariat to print 5000 copies of the national Social Protection Policy.** The copies will be disseminated to key stakeholders in social protection across the country. A two-day meeting to disseminate the policy was held in Q1 for the South Rift region of Kenya with implementers drawn from five counties including; Nakuru, Narok, Kajiado, Baringo, Kericho, Bomet and Laikipia.
- **ASSIST supported the ministry to launch the Psychosocial Services (PSS) situational analysis report in a national stakeholder's forum** (February 2014). The government called upon partners and stakeholders to support the Department of Children Services in the development of a national framework for PSS. A team of 10 organizations with key interests in PSS was constituted to support the department and the quality improvement technical working group in providing technical direction for the framework development.
- **A national consultative forum was held for the county coordinators for children services,**

**ASSIST and USG partners** (March 2014). The meeting helped identify county priorities for mainstreaming QI in the department's activities. Among the key resolutions made were:

- Lobbying the Department of Children Services (DCS) to include QI activities in the officers national work plans and performance contracts
- USG partners and the DCS to hold joint work plan meetings, reporting forums and review meetings
- The DCS to take leadership in driving the QI agenda and bring on board non USG funded partners in their regions

The meeting supported the development and finalization of national stakeholder mapping tool and a national referral tool that has been shared with the ministry for official endorsement before their roll out.

### **Activity 3. Improve health service delivery**

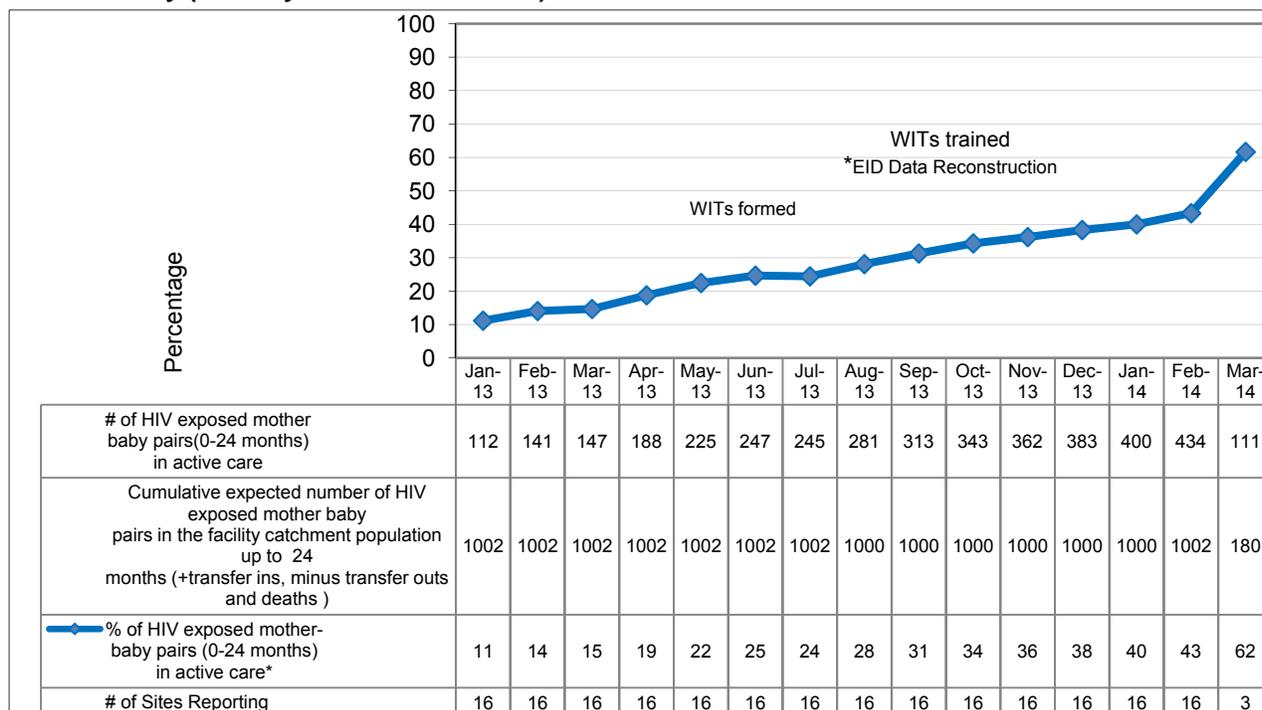
#### **Background and accomplishments:**

ASSIST's strategy is to apply a system approach to QI. The strategy focuses on a sample of sub-counties with a spectrum of facilities selected and developed as Centers of Excellence (COE) through which the QI model is applied to generate change ideas that can be scaled up across the system the criteria for selecting the COEs was based on APHIA+'s zones. ASSIST requested each APHIA+ in collaboration with the county government to select high volume counties and sub-counties within the selected counties. From the selected sub-counties, all public facilities and high volume private facilities were included as COEs. The rationale for doing this was to get a comprehensive slice of the health system that represents different levels of the health service delivery. In these seven sub-counties, 203 facilities at different levels of the health care system (i.e., dispensaries, health centres, sub-county and county hospitals) were identified, and assisted to actively apply the science and model of QI to develop and test change ideas for HIV care and treatment, including PHFS. The seven sub-counties were Nairobi (APHIA Nairobi Coast), Nakuru (APHIA Nuru ya Bonde), Meru (APHIA Kamili), Isiolo (APHIA Imarisha), Nyamira (APHIA Western), and Kwale and Kilifi (APHIA Nairobi Coast). From the experiences with the COEs, ASSIST has developed change ideas and packages that can be implemented through QI to increase linkages and retention in care. Building on this success and to bring this work to a larger scale, in FY14 and 15, ASSIST will support the USAID Kenya service delivery partners including APHIA +, AMPATH Plus and COGRI and county governments to scale up the model for QI and these change ideas to new high volume sites. During the reporting period ASSIST's achievements were as follows:

- **ASSIST sensitised 17 facilities on HIV Free Survival and supported formation of WITs in the 17 health facilities and trained 30 HIV Free Survival coaches and launched PFHS in 2 counties. From the results of the PHFS work ASSIST developed 2 case studies (Q1).**
- **ASSIST COP and QI Advisor attended the international PHFS learning session/conference in Kampala, Uganda, ASSIST also supported 2 ministry of health managers attend the conference.**
- **ASSIST provided technical support to seven counties to ensure that QI is a central pillar in their strategic plans.**
- **ASSIST together with NASCOP, ASSIST Kenya organized a workshop for development of NASCOP-QI framework for rolling out QI for HIV/AIDS services in the country, and also continued to support the COEs but also started to prepare for phase two of the QI scale-up with the USG implementing partners (January – March 2014).**
- **There were changes with the USAID/PEPFAR funding for Kenya and this required a review of the work plans and development of a strategy for national scale-up of QI in collaboration with the AIDS Population and Health Integrated Assistance (APHIA Plus). This entailed the following activities:**
  - In March 2014, ASSIST presented improvement outcomes from the seven established COEs (Phase One) to the USAID Kenya mission and all the USAID implementing partners under the APHIA Plus. From the presentation and the discussions that followed, the USAID Kenya mission and the partners agreed that the QI scale-up should start from the COEs to more sites and counties targeting high volume facilities for HIV/AIDS care and treatment, PMTCT (under Partnership for HIV Free Survival), and maternity services.

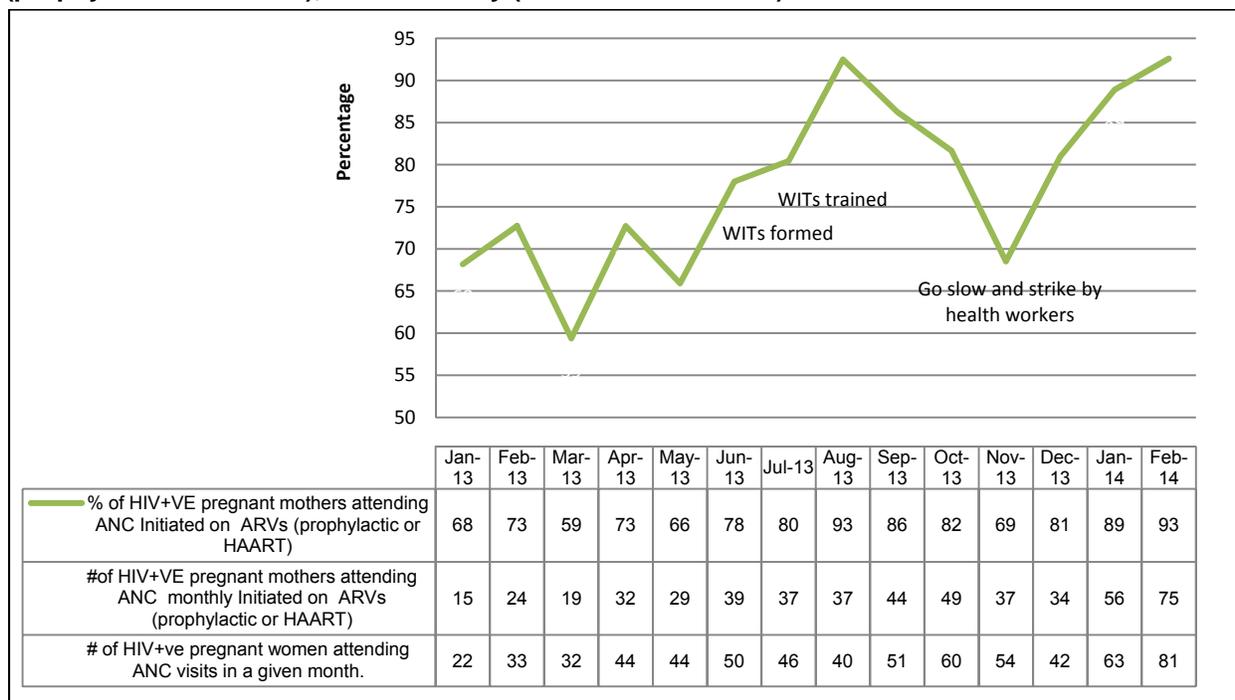
- In addition ASSIST Kenya was mandated to support the entire capacity building for rapid scale up of QI in the country starting with 24 high HIV-PMTCT burden counties in 2014.
- As a result of the meeting mentioned above, **ASSIST has developed a new work plan for ASSIST that will guide the scale-up whereby the APHIAs will prioritize 5-10 high volume sites in each of the counties they are supporting for the initial phase of the scale up this year.** This will add close to 200 new improvement sites in the country bringing our total to more 400 sites. Importantly this will initiate improvement work in close to 20 new counties in the country. This is in-line with ASSIST mandate of technical assistance to National, County and Service delivery partners. The improvement work will still focus on retention in HIV care and treatment, MNCH and FP and eMTCT. The scale up will be underpinned by the change ideas derived from the COEs but the QITs and the WITs will be trained in QI so that they can develop their own change ideas.
- **ASSIST has continued to work closely with the core health directorates at the MOH:** Directorate of Health Standards, Quality Assurance and Regulatory Services and the Directorate of Preventive and Promotive Health Services. This close collaboration has ensured that ASSIST work is embedded at relevant national technical working groups. Through Directorate of Health Standards and Quality Assurance and regulatory services the quality management TWG strongly supports and is involved in ASSIST activities to scale up QI in the country. Through the Directorate of Preventive and Promotive Health Services, the PMTCT-TWG is strongly supportive and involved in scaling up QI under PHFS initiative. Importantly ASSIST working closely with the directorate to finalize and roll out the Kenya HIV Quality Improvement Framework. A final workshop was held in March 2014 to finalize the draft NASCOP-QI framework started in Q1.
- **Sample Health Improvement Results from some ASSIST supported sub-counties in Phase One (ANC, Delivery and Post Natal Services).**
- **APHIA Plus Nairobi – Coast:** ASSIST worked in collaborative with APHIA Plus Nairobi – Coast in selected facilities in Kwale County to support retention of mother baby pairs in HIV care to address PMTCT. The change ideas implemented were: Use of improvised diaries/ register to help in follow up of mother-baby pair; improved filing system; having psychosocial support system; active defaulter tracing mechanisms (Figures 7-8).

**Figure 7: Kenya: Percentage of HIV exposed mother- baby pairs (0-24 months) in active care\*, Kwale County (January 2013 – March 2014)**



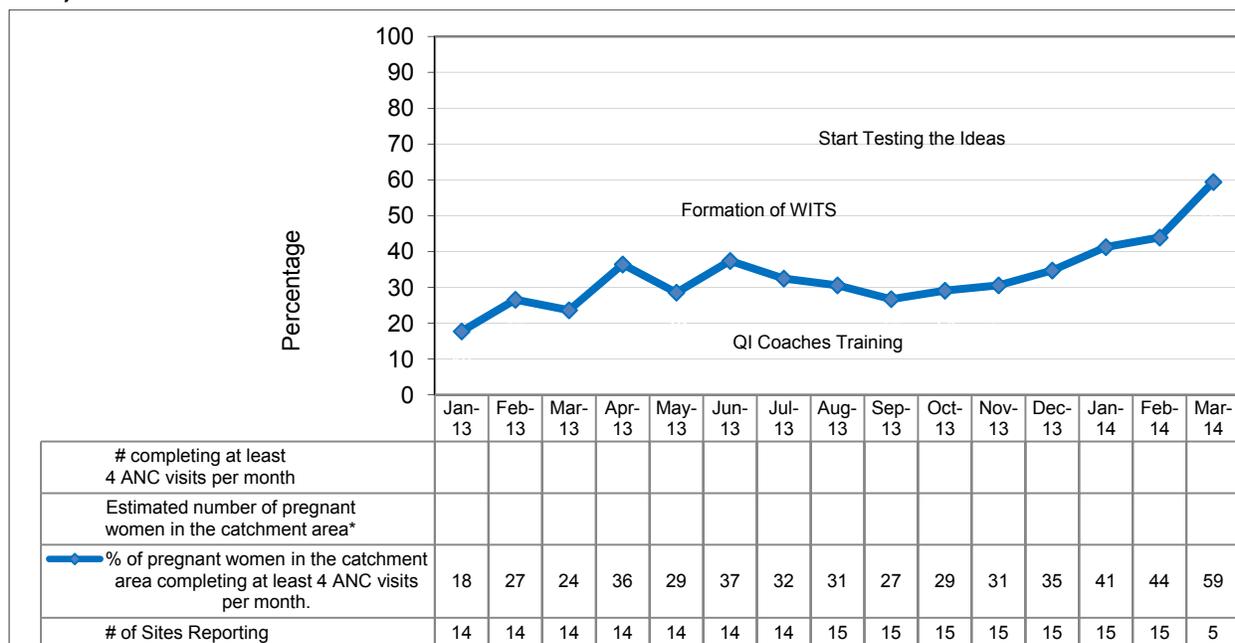
\* Sep 2013, the QITs did data reconstruction for HIV exposed babies data, since they realized that this data was incomplete and was being recorded in other tools and not the MOH registers

**Figure 8: Kenya: Percentage of HIV+ pregnant mothers attending ANC Initiated on ARVs (prophylactic or HAART), Kwale County (Jan 2013 – Feb 2014)**



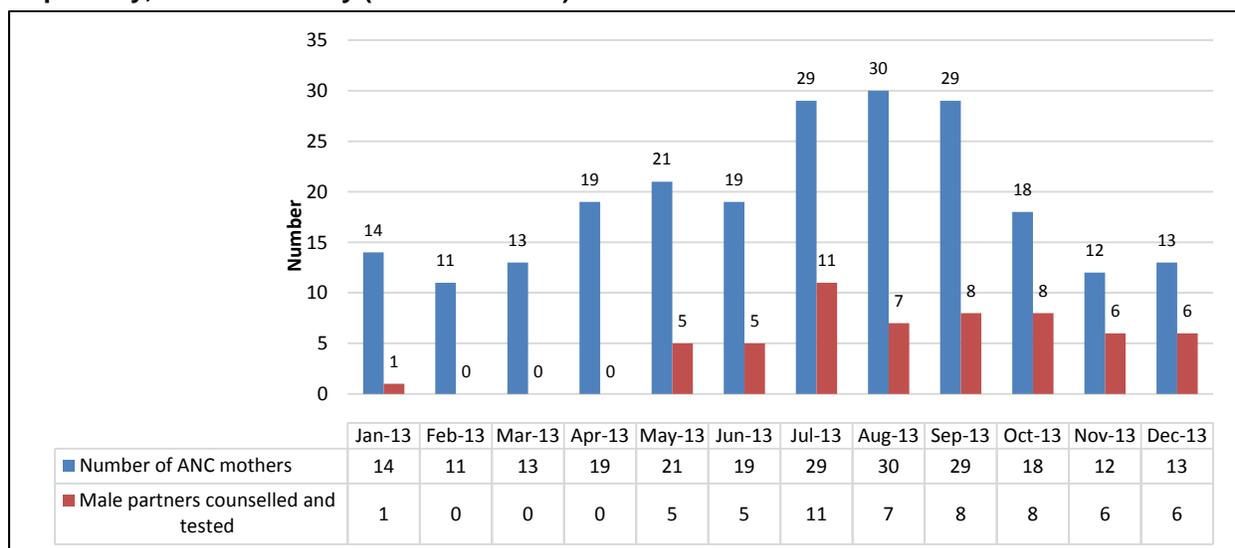
- APHIA Plus Imarisha:** In Upper East and Northern Kenya, ASSIST worked in collaboration with APHIA plus Imarisha and the following activities took place:
  - Facilities in the QI collaborative were reduced to 15 from 23 removing those that the QI teams were not active
  - The active WITs consciously looking at their performance data and discussing ideas for improvement
  - Structures established at facility level for documenting meetings and monthly reviews of data per facility
  - Quarterly CMEs with coaches on QI topics arranged
  - 1st learning session held at end of March 2014 with participation of all facilities.
  - Improvement seen in post-natal care, 4th ANC completion and facility delivery by HIV +ve women. The change ideas implemented include: ANC Focus Days – target market days; client feedback on quality of service; community dialogue days; analysis of processes of care; review of MCH charges in FBO facilities; mother-baby package at completion of 4 ANC visits by Aphia Plus Imarisha; continuous client education; focused follow-up of all HIV positive women in ANC with birth plan; active link to support resources available; APHIA plus to support mentor mother program in 2014 (Figure 9).

**Figure 9: Kenya: Pregnant women completing at least 4 ANC visits, Isiolo (Jan 2013 – March 2014)**



- APHIA Plus Nuru ya Bonde**
  - In collaboration with APHIA Plus Nuru ya Bonde, ASSIST introduced male involvement as a change idea to improve ANC attendance in Nakuru county. Arimi dispensary is a facility in Molo sub county, Nakuru County. It offers among other services ANC to pregnant women from their locality.
  - Before introducing QI, the facility decided to involve men in the decisions that we make pertaining to their wives so that they could understand and support them in the home and to improve the maternal health among pregnant mothers. The change idea they introduced was to give priority to women who brought their partners for ANC clinics, so that they do not have to queue. This increased: male involvement and support; facility deliveries; and partner testing in the facility (Figure 10).

**Figure 10: Kenya: Number of pregnant women vs. male partners tested for HIV, Arimi dispensary, Nakuru country (Jan – Dec 2013)**



#### **Update to Integrated Design of Improvement Activity**

During Q2 and as a result of significant data challenges, we started managing data directly, enabling ASSIST to validate the data and cross check with partners. This has significantly improved our data quality.

Under OVC we have also started to collate sex disaggregated data to assess the needs for OVC along gender lines. Results for the baseline data have been collected and improvement results will be shared in the next reporting period.

#### **Activity 4. Strengthen OVC at the facility level**

##### **Background and accomplishments:**

The Ministry of Labour and Social Service and Services (MLSS&S), through the Department of Children Services (DCS), launched the Minimum Service Standards for QI of OVC programmes in July 2012. With that launch, ASSIST supported the dissemination process and worked on additional material such as job aids, including the Child Status Index (CSI), Children Right to Essential Actions Guide and community volunteers' job aids. ASSIST has continued to work with service delivery partners, including APHIA/AMPATH plus, the Reformed Church of East Africa (RCEA), Life Skills International and AMURT and Children of God Relief Institute (COGRI).

- **ASSIST jointly with the APHIA plus Implementers mapped Volunteer Children Officers (VCO) in the country and have a database of all VCOs drawn from the 25 counties supported by USAID.** The data base will help plan for the trainings of the officers and link them to CBOs implementing QI interventions for additional community level coaching and mentorship.
- **APHIA Plus Nuru ya Bonde, APHIA Plus Western Kenya, APHIA Plus Kamili, APHIA Plus Imarisha, and AMPATH plus have continued working with the department of children services in 43 counties in ensuring institutionalization of QI at the point of service delivery in child protection and improvement of child welfare in the respective counties.** Through the support from the QI teams the projects are rolling out sustainable interventions in addressing issues affecting children.
- **Coaching and mentorship was done for the 41 OVC QI teams in the Centre of Excellence.** The teams were at different implementation levels and were helped to address the challenges they were experiencing.
- **A five-day coaches training was conducted for new USAID partners** (Wezesh Project and Ananda Marga Universal Relief Team (AMURT). The coaches now work with community level teams to mainstream QI at the point of care the two projects have six Community QI teams.
- **AMPATH Plus:** AMPATH plus has seven Quality Improvement Teams (QIT) scattered around North Rift Valley and Western parts of the country. The teams include Chepkoilel, Kapsaret, Kapsoya, Pioneer, Tulwet, Bunyala South and Bunyala North. In this quarter AMPATH assessed their QIT on functionality. From the results all teams are at the same functionality level.
  - **Bunyala North QI team - Service Area: Education:** The QI team is working towards improvement of the education service which scored lowest at 2.8 in the September 2013 CSI assessments and was validated after applying the self-assessment tool.
  - **Improvement Objectives:** To monitor performance of 100 secondary school-going children through review of monthly school attendance registers, end-term class performance and school fees beneficiaries meetings by April 2014. To identify a role model from both genders that the children can identify with and link them to the children for continuous mentorship.
  - **Change Ideas:** Enhance parents, school administration and caregivers in education of their children. Ensure payment of school levies and other educational materials to promote school attendance and performance.
  - **Improvements** have been noted in the number of OVC who attend school regularly and mean grade of students' performance.
  - **Kapsoya QI team Uasin Gishu County:** Kapsoya QI team is one of the teams in AMPATH Plus and are currently on their second cycle addressing food and nutrition services. They are yet to conduct their second CSI data collection and analysis. Their improvement objective is to build capacity of 50 households on food production and food security through GISE by the end of April 2014. Their change idea is to improve food production through farming activities

and small businesses targeting caregivers in Kapsoya location. To date, four care giver groups have been formed with a membership of 81; all four groups have been trained on small business management and farming; and 54 care givers engaging in small businesses after the training.

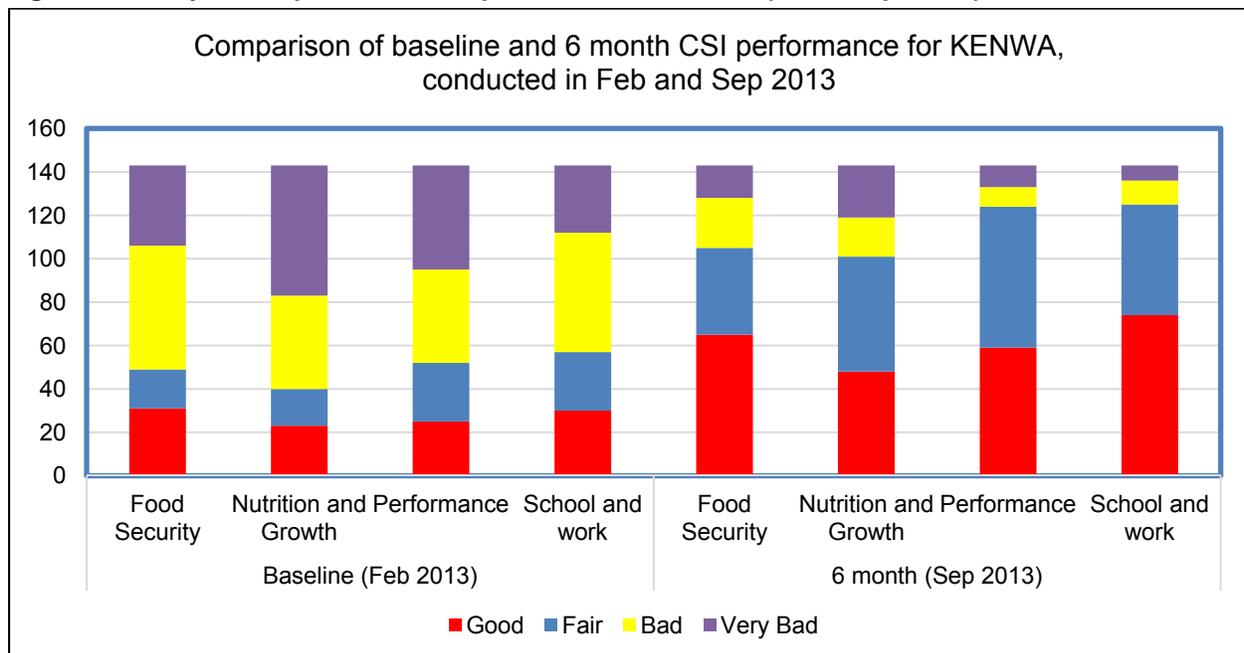
- **APHIA Plus Kamili**

- Hope Valley Family Initiative Olkalao QI team- (HVFI OLK), Nyandarua County.  
HVFI OLK is one of the QI teams supported by Hope Valley Family Initiative which is an APHIA Plus Kamili local IP. For the CSI assessment, the QI team sampled 136 OVC out 500 in Olkalau. Results showed that three major areas in need of attention were health care, legal protection, and care and shelter. The following were listed as leading to poor access to health care services for OVC and their households: Lack of transport to access the health facilities as majority of the hospital were at a distance; lack of the money charged for card and consultancy fees; caregivers' ignorance on childhood illnesses, preventive methods and basic treatment.
- Change ideas: Educate and sensitize parents, caregivers, community health volunteers and older children on preventive methods and basic treatment and referrals. Establish linkages with health facilities to boost access to curative health care through HVFI. Advocate for medical waivers for OVC from the Ministry of Health through HVFI and their area Governor. Identify existing health financing mechanisms and link OVC households to benefit from them (e.g. insurance schemes).
- The team has developed a work plan to address these challenges that will be implemented over the next six months.

- **APHIA Plus Nairobi Coast**

- KENWA QI in Nairobi: Kenwa QI team is located in Nairobi slums. The QI team conducted a CSI and a self-assessment on 30% of 479 children.
- Change ideas: Food and nutrition: Link caregivers to VS&L programmes to increase household income (60% OVC had 3 meals a day & 80% caregivers joined VS&L and started small businesses). Education: Negotiate with schools to waive lunch levy for vulnerable children. Engage well-wishers to donate uniforms. Work with the government of Kenya to rescue children from child labour.
- Improvements were seen on all CSI performance indicators, when comparing baseline to 6 month follow-up (Figure 11).

**Figure 11: Kenya: Comparison of CSI performance, KENWA (Feb – Sept 2013)**



- Shirikisho location QI teams, Tana River County. The QI team was formed and trained in September 2013 and has since undertaken key major steps in mainstreaming improvement in their OVC care programs. In October 2013, they administered the self-assessment tool, sampling 100 children and conducted household verification on all the children who scored “bad” and “very bad”. Priority gaps that needed attention were identified: house renovation, bedding improvement, provision of decent clothing for OVCs. and came up three priority gaps that needed attention under shelter. Improvement indicators were developed.
- **APHIA Plus Western Kenya**
  - Kawiri CBO Migori County. Implementations of change ideas, resulting from the July 2013 baseline assessment (July – December 2013): The team encouraged formation of smaller support groups of about five caregiver (Watano initiative). The Watano initiative was aimed at ensuring members acquired solar lamps that their children can use for night studies, kitchen gardens and smaller livestock that would boost for their house hold income and food security and that members joined saving and loaning groups. They would then ensure all children are enrolled in school, attend regularly and are in child level peer support groups. The team also identified certain activities that would directly involve the children These included formation of education support groups where children in upper classes would support those in lower classes especially in topics that the needed support on. To enhance girl child performance, the team set up a girl child mentorship program that was led by trained mentors. They also planned for education days where key stakeholders in education would be engaged to share various topics on education to create awareness on importance of education to both children and caregivers.
  - Improvement in performance over the period was noted for both boys and girls in primary and secondary school. The caregivers were able to help ensure that their children attended school and improved their performance. The peer support groups strengthened the drop out monitoring system at school and curbed truancy since the children act as their own keepers.
- **APHIA plus Nairobi – Coast**
  - Kisumu Ndogo CBO Kilifi County:The team conducted a CSI in January 2014 with 150 children. Child Protection scored poorly. Discussions with the caregivers, community gatekeepers and the children identified 100 children who were abusing drugs hence not attending school and spending most of their time in the streets or drug peddlers’ dens.  
Change ideas: Work with the parents, teachers, the community and the affected OVC and other children to help them address the dangers of drug and substance abuse in the community.
  - Results: By March 2014, 110 community children were undergoing counseling and community mentorship to address drug use related challenges. The children were followed up both at home and in school through linkages to community drug use peer education programmes.
  - Bura QI team – Taita Taveta County: The teams’ work in Bura and Mwachabo locations of Mwatate Sub-County. After carrying out the self-assessment, the Bura QI team realized that most OVC had challenges accessing health services, child protection, and food and nutrition. Because of poverty, guardians could not feed their children well as the area is dry. Child labor existed for children living with sick or old guardians in the nearby sisal estates. Below is a list of change concepts, change ideas, and results for this QI team.

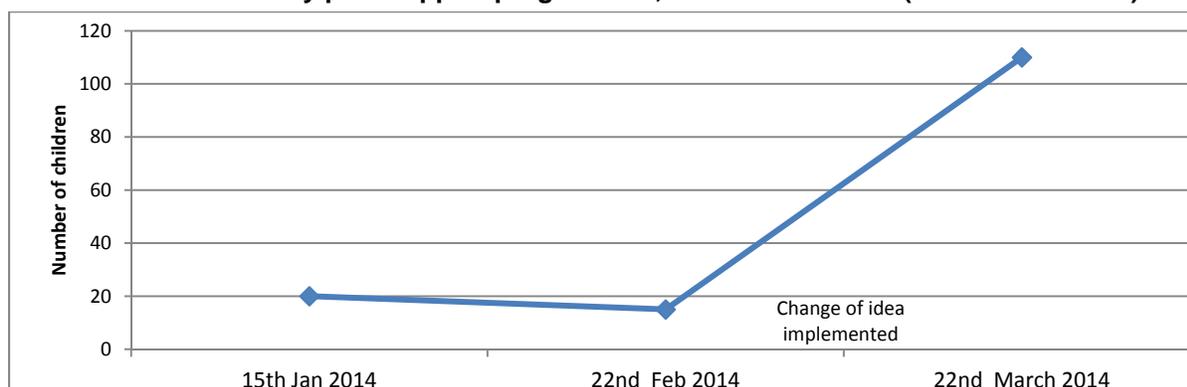
**Table 1: Kenya: Results for Bura QI Team, Taita Taveta County**

Service area: Economic Strengthening.			
Change concept	Specific change idea	Start month team	Results
<ul style="list-style-type: none"> <li>● Eradication of dependence syndrome</li> </ul>	<ul style="list-style-type: none"> <li>● Formation of SILC groups</li> <li>● Provision of IGA’s in form</li> </ul>	<ul style="list-style-type: none"> <li>● Jan. 2013- Nov 2013</li> <li>● Jan. and Feb. 2013</li> </ul>	<ul style="list-style-type: none"> <li>● A total of 48 groups formed.</li> <li>● Total members 1038.</li> <li>● Total saving ksh.1,027,980 by caregivers.</li> </ul>

<ul style="list-style-type: none"> <li>Improvement of household living standards</li> </ul>	<ul style="list-style-type: none"> <li>of material kind</li> </ul>	<ul style="list-style-type: none"> <li>Stock boost to 38 caregivers worth ksh.190,000/= provided by Aphia+ .</li> <li>12 greenhouses to 600 caregivers provided by Aphia+ and a local NGO</li> <li>Established a community busary fund and have provided scholarships to 5 children</li> </ul>
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- Chumvini QI team: Results show an increase in the numbers of children rescued from drug use, reintegrated into the school system, and linked to community peer support programs through the change ideas that had been previously identified (May 2013) (Figure 12): Nutrition education to guardians at homes and with OVC in schools on the importance of eating health balanced diet. Encourage guardians to plant certified seeds for maximum harvest. Guardian’s support group farming “mwedhia” where guardians formed community working groups and cultivated land together where one day the group works in one’s farm and the next day move another. This way they were able to have all OVC household land cultivated and planted.

**Figure 12: Kenya: Number of children rescued from drug use, reintegrated into school system and linked to community peer support programmes, Chumvini QI team (Jan – March 2014)**



- Wezesha and AMURT Projects: Identification of counties in which they would implement QI WEZESHA (Migori, Kisii and Homabay Counties). AMURT identified two sub counties (Bondo and Rarieda in Siaya County).
- The two projects consulted with the Department of Children Services at the County through Coordinator Coordinators and the Sub County Children Officers and ensured that they provide leadership throughout the process.
- Identification and training of QI teams: AMURT has two QI teams in Siaya County while WEZESHA formed four QI teams in Homabay, Kisii, Migori and Nyamira counties.
- All the new teams have been trained on QI. Trainings carried out jointly with the Department of Children Services representatives and the partners.
- **Community Health Services**
  - ASSIST supported the MOH, Community Health Services (CHS) Unit, to host a meeting to share feedback on the results of the CHS Situational analysis (SITAN) that was conducted in December 2013 with stakeholders. Participants included national and county officers drawn from the counties where data was collected. The SITAN report highlighted the need to develop national standards and guideline for Tier one level of health service delivery. This will work in tandem with other efforts to streamline CHSs into the national and county health agenda and realign to the Kenya Quality Model (KQMH) framework to achieve basic quality healthcare for all.
  - Challenges: Re-alignment of budgets and PEPFAR work plans to new strategy. A lot of planned activities were not implemented due to the overall country strategy restructuring. The ASSIST project role was re-defined hence the need to develop new project specific strategies

- Conducted coaching sessions: Coaching sessions were done at the COE sites during the reporting period. This was done jointly by the government officials from the Ministry, APHIA plus and ASSIST QI Advisors. The coaching sessions helped teams better organize their work, understand data and use it for decision making. A meeting was held with the coaches from APHIA plus Western Kenya on the new tool to help validate the functionality of QI team.s

**Activity 5: Strengthen service delivery systems.**

**Accomplishments:**

- **ASSIST Kenya supported a National conference on HTC (HIV testing and counselling).**
- **ASSIST Kenya supported development of national quality improvement framework for NASCOP.**

**Directions for Q3 and Q4 FY14**

With the ongoing PEPFAR budget changes and realignment of the ASSIST project as a technical assistant project for USAID implementing partners, ASSIST has been mandate to revise its project work plan and to work more closely with the APHIAs to increase the scale up of QI.

- Consequently the new work plan for ASSIST Kenya is captured by the six objectives below:
  - Country ownership and institutionalization of QI at the national level: Support development of a national QI policy, standards and syllabus in collaboration with the National AIDS and STI Control Programme (NASCOP), Family Health, Primary Health and Directorate of Health Standards, Quality Assurance and Regulations and other key stakeholders to institutionalize QI in healthcare.
  - Capacity development for QI: Provide training on the science of improvement and develop QIT and WITs in facilities from high volume sites in collaboration with APHIAs and other USG implementing partners to drive the scale-up of QI.
  - HIV Care and Treatment: Provide QI TA to county governments and APHIAs to strengthen and improve the HIV chronic care model and enroll and retain more adults and children in HIV care and treatment.
  - OVC and Child Protection: Strengthen systems at national and county government levels to support the institutionalization of QI in child protection and OVC programmes to improve the welfare of children
  - Maternal and Neonatal Child Health (MNCH) and Reproductive health (RH): Provide QI TA to county governments and APHIAs to improve and strengthen MNCH and RH services in Kenya.
  - Malaria: Apply QI techniques and, in collaboration with county governments and USG implementing partners, strengthen capacity in programme management in order to achieve malaria programme objectives at all levels of the health care system.

## 1.7 Lesotho

### Background

USAID ASSIST began working in Lesotho in November 2013. The project is supporting the Ministry of Health and other partners for the implementation of the Partnership for HIV-Free Survival (PHFS). USAID ASSIST will now begin working with the MOH and partners on applying a uniform QI approach across all programs consistent with the new PEPFAR Quality Strategy.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Quality Improvement technical assistance for	<ul style="list-style-type: none"> <li>● Reduce HIV transmission to exposed infants and reduce infant mortality by ensuring</li> </ul>	3 Districts: Thaba Tseka,	x	

the PHFS	<p>care is provided in line with 2010 WHO Prevention of Mother to Child Transmission (PMTCT) guidelines</p> <ul style="list-style-type: none"> <li>• Improve retention of mother-baby pairs</li> <li>• Improve data quality (completeness and accuracy)</li> <li>• Improve delivery of standard services during routine visit for mother-baby (M-B) pair</li> </ul>	Mohale's Hoek, and Butha-Buthe; 12 facilities, 4 sites in each district		
2. QI strategy and capacity building for all HIV/AIDS activities to include ANC, MNCH, ART, and HTC (HIV Testing and Counselling)	<ul style="list-style-type: none"> <li>• Develop a uniform QI approach across all programs including structure and functional capability</li> </ul>	National	X	X

## Key Activities, Accomplishments, and Results

### Activity 1. Quality Improvement technical assistance for the PHFS

#### Accomplishments:

- **Conducted first learning session (Q1)**
  - The first learning session took place on November 25-26. Participants included:
    - Ministry of Health and Social Welfare (Head of Quality Assurance Department and Nutrition Assessment, Counselling and Support [NACS] focal person)
    - USAID and CDC representatives (Charles Ajaya and Fred Mugenyi Asiimwe, respectively)
    - District coaches from all 3 demonstration districts
    - Site representatives from all 12 demonstration sites
    - Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) national and district staff
  - Two to three journals completed per site on the prioritized focus areas (improvement aim, indicator, changes, run chart started). These remained with each site team and are to be filed at the site.
  - Focus areas for improvement in Lesotho were agreed upon (summarized in Table 2).

**Table 2: Lesotho: Focus Areas for Improvement**

Focus areas	Components
Data quality	<ul style="list-style-type: none"> <li>• Data completeness</li> <li>• Data accuracy</li> </ul>
Retention of M-B pairs	<ul style="list-style-type: none"> <li>• Baby any service in under 5 register in month of interest</li> <li>• Mother received ART in month of interest</li> </ul>
Routine visits	<ul style="list-style-type: none"> <li>• Infant and Young Child Feeding counselling</li> <li>• Nutrition assessment for the baby</li> <li>• Nutrition assessment for the mother</li> <li>• Vital signs for the mother and baby</li> <li>• Prophylaxis (NVP) / CTX for the baby depending on age</li> <li>• ARVs for the mother</li> <li>• Counselling on adherence</li> <li>• Screening for opportunistic infections and TB</li> <li>• Give appointment for the next visit</li> </ul>

Focus areas	Components
	<ul style="list-style-type: none"> <li>Update the data tools</li> </ul>
6 week visit	<ul style="list-style-type: none"> <li>DNA/ PCR for the baby</li> <li>Exclusive breastfeeding</li> <li>Immunization</li> </ul>
10 week visit	<ul style="list-style-type: none"> <li>immunization</li> </ul>
14 week visit	<ul style="list-style-type: none"> <li>2nd DNA/ PCR for the baby</li> <li>Immunization</li> </ul>
6 months visit	<ul style="list-style-type: none"> <li>Complementary feeding</li> <li>Vitamin A supplementation</li> </ul>
9 months visit	<ul style="list-style-type: none"> <li>Rapid test</li> <li>Immunization</li> </ul>
13.5 month visit	<ul style="list-style-type: none"> <li>Post breast feeding dried blood spot testing</li> </ul>
18 months visit	<ul style="list-style-type: none"> <li>Vitamin A supplementation</li> <li>Albendazole</li> </ul>
Malnourished mother/baby	<ul style="list-style-type: none"> <li>Treat malnutrition</li> </ul>
Mothers with unknown/HIV negative status	<ul style="list-style-type: none"> <li>Test for HIV</li> <li>Enroll in care if positive</li> </ul>
ART naïve positive mothers	<ul style="list-style-type: none"> <li>Provider-initiated testing and counselling</li> <li>Initiate ART</li> </ul>
HIV positive baby	<ul style="list-style-type: none"> <li>Enroll on ART</li> <li>Start presumptive treatment if suspect</li> </ul>

- **Conducted coaches' meeting (Q1)**
  - Conducted coaches' meeting on November 27 which included national coaches from EGPAF, MoHSW QAD and NACS coordinators in addition to district coaches from the 3 demonstration districts (Mohale's Hoek, Butha-Buthe and Thaba Tseka).
  - The outputs of the meeting included terms of reference for coaching visit 1, a revised coaching guide, and a copy of ASSIST multi-facility database to be used by coaches.
- **Conducted coaching visits (Q1).**
  - Conducted coaching visits at two sites: one large hospital (Ntseke Hospital in Mohale's Hoek) and one small health unit (St. Paul's Hospital in Butha-Buthe). All coaches (national and district) participated in at least one coaching visit. Baseline data for three improvement data was collected.
- **Travelled with Lesotho MOH PHFS/NACS Coordinator to all three districts to check on facility progress since November 2013 Learning Session and coach facility staff with district staff on current performance and next steps (Q2).**
- **Collected baseline performance data (Q2).**
- **Introduced and oriented new Chief of Party to PHFS work (Q2).**
- **Discussed initial planning to integrate PHFS activities into overall PMTCT program (Q2).**
- **Met with EGPAF staff (Q2).**

**Activity 2. QI strategy and capacity building for all HIV/AIDS activities to include ANC, MNCH, ART, and HTC**

**Accomplishments:**

- **Completed Country Operation Plan for 2014/2015.**

- Hired Lesotho Chief of Party.

## How Do We Know We Are Improving?

### Improvement in Key Indicators:

Activity	Indicators	Baseline (Sept 2013)	Last value (March 2014)
PHFS Retention of M-B pairs	% of eligible mother-baby pairs who receive ART and under 5 care each month	0%	33%
Data Quality	% of mothers and babies whose data is accurately and completely filled by the end of the month	Still being analyzed	
Routine Visits	% of mother-baby pairs who attend under 5 and ART clinic and receive the standard package of services	0%	74%

### Directions for Q3 and Q4 FY14

- Development of detailed ASSIST work plan for PMTCT, PHFS and ART
- Provision of support for quarterly QA visits to three districts
- Conduct second PHFS learning session for three districts

## 1.8 Malawi

### Background

The USAID ASSIST Project started working in Malawi in January 2013 and is building on previous orphans and vulnerable children (OVC) assistance provided through HCI in the country since 2011. In FY13, ASSIST piloted and finalized the OVC national standards to improve quality of social services in four districts. ASSIST was asked to initiate the implementation of the OVC standards using quality improvement methods in Mangochi and Balaka Districts to learn from these two districts. The project is working with five community-based teams: Nancholi, Mkata, Chingwenya, Toleza, and Chanthunya. In the last quarter the teams were trained in basic quality improvement and use of the OVC national standards to improve quality of social services in their communities.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Improve quality of care and protection services for vulnerable children and their families	<ul style="list-style-type: none"> <li>• Implement OVC national service standards, identify and address critical barriers in scaling up and sustaining services to vulnerable children and their families</li> </ul>	2 districts of Balaka and Mangochi.	x	
	<ul style="list-style-type: none"> <li>• Distribute national OVC service standards in all the 28 districts through conducting three regional meetings in North, South and Central regions of Malawi</li> </ul>	All 28 districts		

### Key Activities, Accomplishments and Results

#### Activity 1: Improve quality of care and protection services for vulnerable children and their families

## Accomplishments:

- **Conducted a QI training for District and Community social service providers.**  
Conducted a QI training for 4 pilot districts and one additional district implementing the OVC standards (November 2013). A total of 60 participants attending the training, including: District Social Welfare Officers, Social Welfare Officers, Community Child Protection Officers, Community Based Organizations' Directors and Field Officers. After the training the coaches set up six QI teams in the communities who are meeting bi-weekly.
- **Conducted District Executive Committees briefing meetings on piloting the OVC standards.** Conducted three District Executive Committee briefings on the OVC standards, how the standards were implemented, and results accomplished by the piloting districts. Approximately 150 District Executive Committee members were briefed in the 3 pilot districts.
- **Established two QI teams in surrounding villages.** After the QI training, coaches in Balaka District conducted meetings in the surrounding 27 villages with support from the Community Child Protection Workers from the area. The coaches facilitated the establishment of two QI teams in the area with the composition listed in Box 1.
- **Conducted CSI assessments for OVC.** The newly formulated QI teams reviewed existing OVC registers and updated them before sampling a quarter of the vulnerable children from surrounding 27 villages in the two Traditional Authorities. The team oriented the volunteers and members of the QI team on the use of the CSI form and how to conduct the assessments. The teams assessed 180 vulnerable children from the existing OVC registers.
- **Conducted fish bone analyses for the priority problems identified.** The QI teams identified the following factors as contributing to the poor performance of the children in the catchment area.
  - Staffing: Limited numbers of primary school teachers in the surrounding schools; minimal supervision of teachers; and poor housing for teachers in the area.
  - Absenteeism: Lack of parental guidance; lack of role models; lack of scholastic materials; and peer pressure to miss classes.
  - Cultural: Child labor; cultural practices interfering with school calendars.
  - Infrastructure: Inadequate school blocks leading to overcrowding in classes; inadequate latrines in the primary schools to cater for large numbers of children.
- **Conducted quality improvement coaching visits to five QI teams in two districts.**
  - ASSIST, in collaboration with the Ministry of Gender, Children and Social welfare (MOGCSW), conducted coaching visits to the five QI teams in two districts of Mangochi and Balaka. This was done to follow up progress on the following: CSI assessments, problems analysis, developing improvement aims, indicators, changes to be tested and organization of data on results.
  - The five QI teams have registered a total of 3,280 vulnerable children and out of these 790 (24%) vulnerable children were randomly selected and assessed on all six CSI domains<sup>1</sup> After the assessments the teams compiled the results using a simple template to summarize all the scores.

### Box 1: QI Team composition

- Primary Education Advisor
- Primary School Headmaster
- Community Child Protection Worker
- Health Surveillance Assistant
- Agricultural Extension Worker
- Group Village Headman Toleza
- Malawi Council for the handicapped representative in the area
- Project Concern Field Officer
- Area Development Committee representative
- CBO Volunteer
- Representative of an NGO (Positive steps) Social Welfare Officer
- Social Welfare Officer

<sup>1</sup> The CSI domains include food security, nutrition, shelter, care, abuse, legal protection, wellness, health care, emotional, social educational performance and education and work.

- Using the CSI summary table, each QI team isolated and identified two domains that were poorly rated by volunteers during child assessments. The teams then developed improvement aims for the poorly rated domains. The teams also outlined changes to be tested guided by the OVC national standards. Figure 13 shows a summary of percentages of poor scores in CSI assessments conducted in 16 villages in Chingwenya catchment area in Mangochi District.

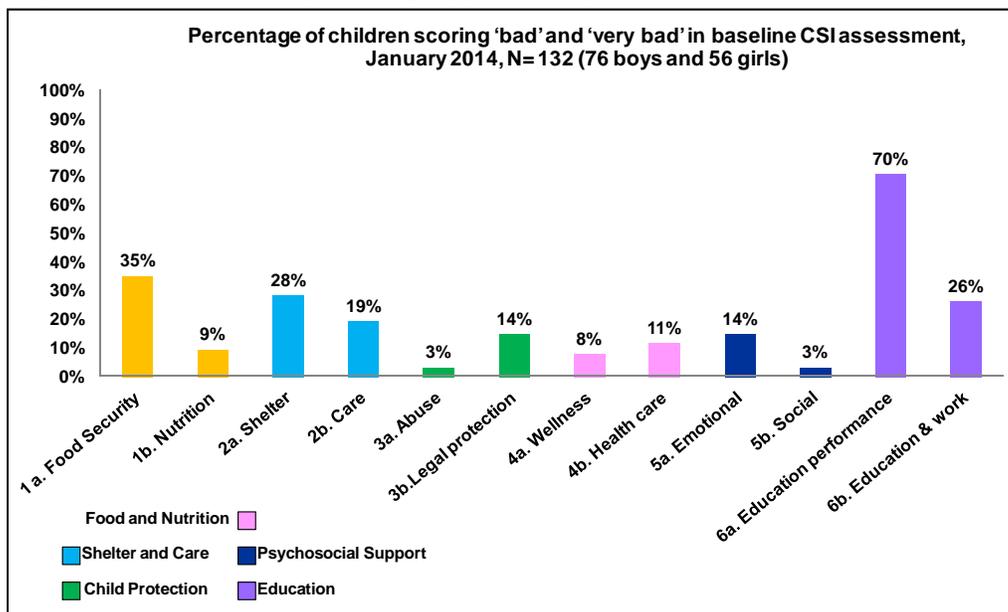
**Chingwenya QI Team**

- The Chingwenya CBO was formed in 2009. The QI team started working with 15 members from the surrounding villages in December 2013. The QI team has registered a total of 528 vulnerable children in 16 villages with a total population of 20,405 people. A total of 132 children (76 boys and 56 girls) were randomly selected and assessed using CSI in the area. As shown in Figure 13, education performance was cited as one of the social services that needs improvement in the area.
- The QI team developed the following improvement aim to work on this fiscal year: Chingwenya QI team will improve the pass rate of learners from 30%-80% in 4 Primary schools under Group Village Head Namwera in Mangochi District through intensifying community involvement in primary schools by the end of September 2014.
- Baseline: During CSI assessments the team discovered that out of the 132 children that were assessed 70% had poor education performance scores. The team decided to improve the education performance of learners in the four surrounding primary schools in the area with a total enrolment of 3,082 (1601 boys and 1481 girls).
- After summarizing the CSI assessments results, the team brainstormed the contributing factors to the poor education performance among children in these schools. The team used Fishbone diagrams to analyze education service delivery in the area. The team referred to the recommended actions in the OVC national standards to improve education service area.

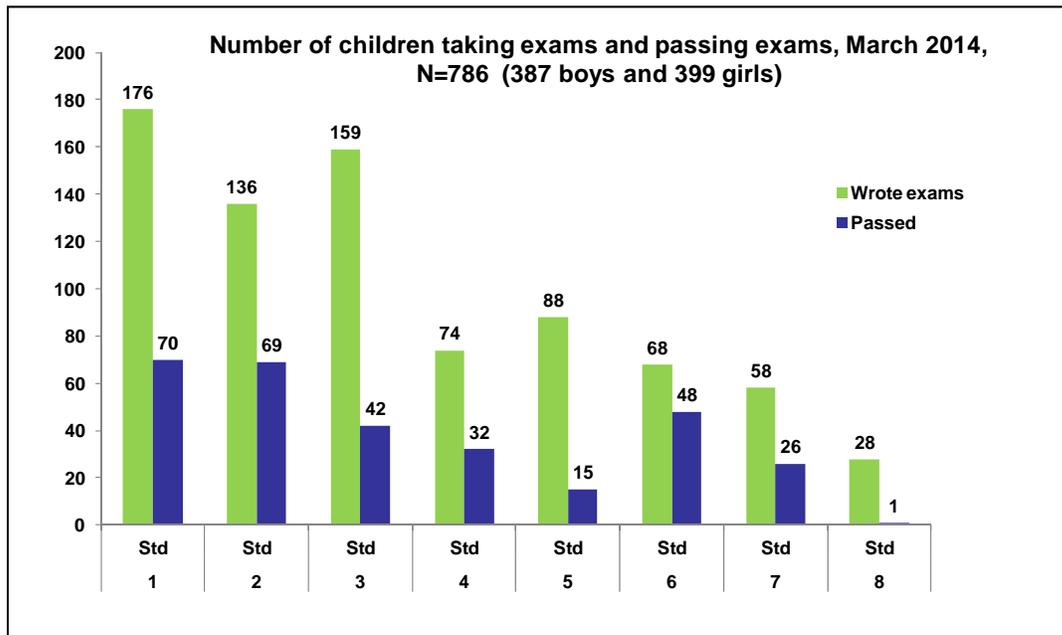
**Toleza QI team**

- Similarly the Toleza QI team in Balaka District also discovered that most vulnerable children in their nine villages were also facing challenges in education performance. The Toleza QI team registered 338 vulnerable children out of which 83 (25%) (76 boys and 56 girls) were assessed. The team decided to compile some recent test results in Toleza Primary school. Figure 14 summarizes the baseline educational performance results of the school.

**Figure 13: Mangochi District, Malawi: Percentage of poor scores in CSI assessments in Chingwenya’s catchment area (16 villages) (Jan 2014)**

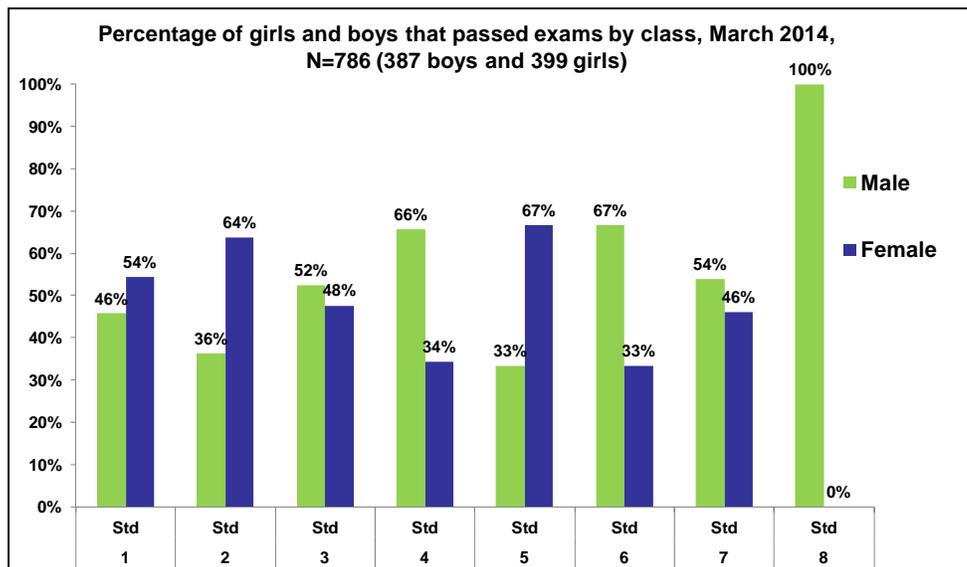


**Figure 14: Balaka District, Malawi: Number of children examined and passed, Toleza Primary School (March 2014)**



- The QI team also discovered that there was a gender disparity in the performance among girls and boys as shown in Figure 15. Most girls passed in the lower classes such as standard 1, 2 and 5 while boys did well in standard 3, 4, 6 and 7. The team conducted their root-cause analysis and learned that the girls in standard 3 and 4 were sometimes disturbed with traditional cultural practices and the girls were absent from school for 3-4 weeks.

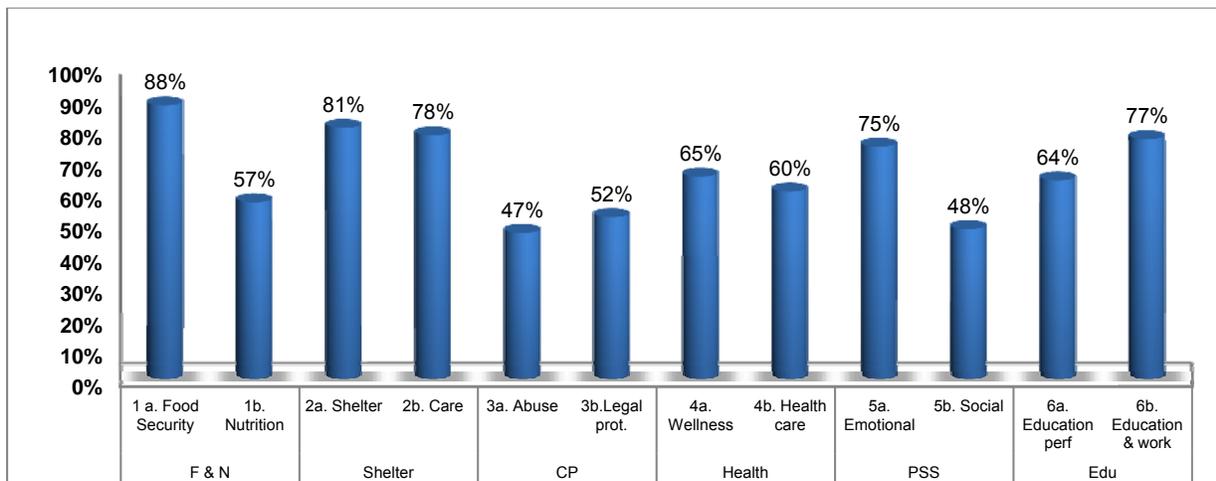
**Figure 15: Balaka District, Malawi: Percentage of pupils that passed each standard by gender, Toleza Primary School (March 2014)**



- The following were some of the changes that were suggested by the teams in Toleza and Chingwenya CBOs to be tested in the area.
  - Link with District Educational Manager to increase performance in primary schools by redistributing teachers in schools with inadequate numbers of teachers

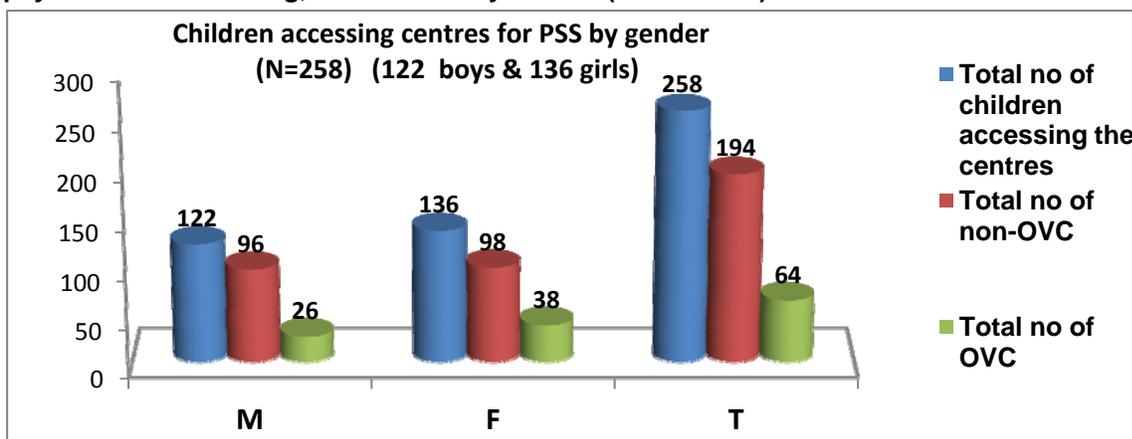
- Identify role models to motivate girl-children in standard 3,4, 6, 7 and 8 to work harder to excel in their primary education
- Introduce Maths clubs, quiz, spellings, debate, Best Performance Incentives in schools to encourage children to perform well in their classes
- Conduct regular inspection of video show rooms with the child protection committees to identify truants in primary schools
- Conduct counselling and guidance sessions for non-performing pupils to improve how they perform in school
- o Apart from education performance the team in Toleza also discovered from their CSI summary data that psychosocial wellbeing of children in the area was also a problem as it is seen from the lowest percentages on domains 2b, 4a and 5a (Figure 16). As a result the team developed a specific improvement aim to improve access to psychosocial support activities in the surrounding villages. Figure 17 shows how vulnerable children assessed fared in terms of psychosocial wellbeing questions.
- o Only 9% of children accessing a newly established community children center indicated that they have someone that shows them love and affection

**Figure 16: Balaka District, Malawi: Percent of lowest CSI scores (2's and 1's), Toleza Primary School (Jan 2014)**



- o The team observed that the newly established centers in the catchment area were being patronized by 258 children (122 boys and 136 girls) but only 25% were vulnerable children as shown in Figure 17. The gender disaggregation on the data on children accessing the centers showed minimal gender gaps among vulnerable children across gender categories.

**Figure 17: Balaka District, Malawi: Children accessing children's corner centers for psychosocial wellbeing, Toleza Primary School (March 2014)**



- Changes to test to improve psychosocial wellbeing
  - Establish 4 children's corner centers in Tolesa catchment area to target 9 villages
  - Conduct experiential learning games and play activities during the children's corner sessions each weekend
  - Undertake home visits for children in need of counselling and follow up
  - Identify and refer children with psychosocial issues to the District Social Welfare Office especially cases that communities cannot appropriately manage
  - Conduct life skills building for children in children's corner centers
  - Orient caregivers in Early Childhood Centers and children's corner centers in psychosocial support topics such as counselling and general management of centers
  - Diversify the types of food stored in strategic food reserves at community level

#### **Chanthunya QI Team**

- The QI team developed the following improvement aim to work on this fiscal year: Within 12 months Chanthunya QI team will improve food security in vulnerable households from 31.6% to 50% through sensitizing families on modern farming methods and economic activities in Thamanda and Phingo villages in Traditional Authority Chanthunya in Balaka District.
- Only 31.6% of OVC households that were interviewed were food secure in the 19 villages in Chanthunya catchment area. After brainstorming the food security service area using Fish bone diagrams the team agreed to test the following changes guided by the OVC national standards:
  - Conduct community awareness activities on modern agricultural methods, livestock production
  - Encourage community members especially vulnerable households to improve household structures in all the villages for the safety, sanitation and general protection of children
  - Strengthen farmers clubs in the villages
  - Promote kitchen gardens at household level especially in vulnerable households
  - Promote formation of Village Savings and Loan groups
- **Conducted a learning session for five QI teams:** In collaboration with the Ministry of Gender Children and Social Welfare, ASSIST conducted a learning session on 26-28th March 2014 for five QI teams representatives from Balaka and Mangochi Districts. A total of 32 participants attended the learning session to discuss the following: Share progress in the improvement plans; how to use OVC national standards to develop changes for testing; review the process of testing changes using PDSA cycles; and document results of changes being tested in all service areas.
  - Key message: Involvement of relevant government staff such as Primary school headmasters within the team is key to help in mentoring efforts

#### **Directions for Q3 and Q4 FY14**

- Dissemination of the final OVC standards in the Southern Region of Malawi targeting 12 out of the 28 districts
- QI coaching in the two districts
- Participating in the OVC TWG to disseminate the OVC standards
- Finalizing the improvement design template

## **1.9 Mali**

### **Background**

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 Ministry of Health (MOH) and USAID in strengthening maternal and newborn services, the USAID ASSIST Project in Mali is strengthening and expanding the activities in FY14, both in technical content and coverage, that were carried out through HCI in previous years.

## Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Improvement of EONC intervention at facility and community levels in Kayes Region	Improve evidence based maternal and newborn care and post-partum family planning services at facility and community levels in target districts in the Kayes Region	1 region (1/7) (Kayes Region), 149 facilities (149/164) in 6 districts (6/7) for 1,130,366 inhabitants (out of 1,687,116) Type of target facilities include peripheral facilities (142), district hospitals (6) and the regional hospital (1) Target districts in Kayes Region include: Bafoulabé, Diéma, Kayes, Nioro, Kenieba and Yelimané	x	
2. Improvement of anemia prevention and control activities in Bougouni district (Sikasso Region)	Improve delivery of evidence based interventions to reduce anemia among pregnant women and infants at facility and community levels in Bougouni districts (Sikasso Region)	1 region - Sikasso (1/9), 25 facilities (25/37) in 1 Bougouni district (1/9) for 525,000 inhabitants (out of 2,625,919) Type of target facilities include peripheral facilities (24) and district hospital (1)	x	

### Key Activities, Accomplishments, and Results

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

##### Accomplishments:

- **Trainings**
  - **Conducted HBB trainings (Q1):** 155 providers including 100 women were trained on newborn resuscitation or "Helping Babies Breathe" (HBB) from two districts (Kayes and Yelimané) and the regional hospital. Trainers were from ASSIST headquarters, ASSIST Mali, MOH and the Regional Directorate. The training focused on simple techniques like keeping the baby warm, rubbing the baby dry, and if necessary, suctioning the baby's mouth and correct application of a resuscitator for face mask ventilation. These simple skills can prevent up to 80% of deaths due to newborn birth asphyxia. HBB training was integrated into essential newborn care (ENC)/active management of the third stage of labor (AMTSL) as all occurred at the same time. The quality improvement (QI) portion of the discussions focused on analyzing major obstacles in applying these standards at all levels of the health system in Mali, from the operational to the management levels. Also, priority improvement aims, indicators, and initial changes that can be tested to address these challenges and improve care to all newborns in need of HBB was discussed. The most challenging part was how to document essential tasks performed and actions taken mostly during the golden minute, on existing HIS registers and other forms. Participants analyzed all existing registers, forms and partograms and decided to test ideas on how to improve them and have key tasks recorded in appropriate registers and partograms.
  - **Refreshed 184 providers and coaches** including 177 women of Diéma, Kayes, Nioro and Yélimané districts on postpartum family planning practices.
  - **Refreshed 43 providers and coaches** from districts in Kayes, Diéma and Yélimané on screening and management for pre- eclampsia-/ eclampsia.
- **Held the second community learning session in two communes of Diéma with 112 participants including 31 women and 21 village heads (Q1).** The topic was prenatal care at

the community level. The intervention focused on prenatal care at this level including home visits and qualified personnel visits.

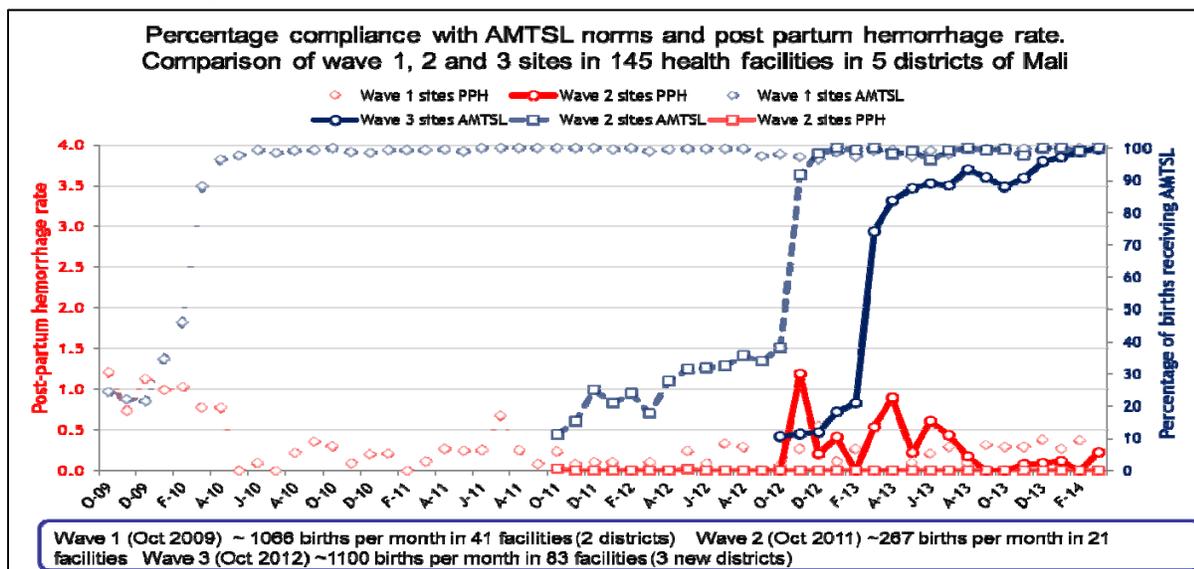
- **Held coaching visits (Q1 and Q2):**
  - **Carried out a coaching visit to all AMTSL/ENC/PE/E extension sites** in 3 target districts of Niore, Bafoulabé and Yélimané (Kayes Region). The main purpose was to document which “best changes” were implemented and what results through data were obtained.
  - **Held a coaching visit for the community QI teams** in Diéma (Q2). We observed that 29 of the 35 community health workers (CHWs) had mastered the content of messages to women and their husbands. In Farabougou village, all pregnancies were detected in the first quarter.
  - **Follow up/coaching visits were performed to all newly trained providers on HBB (Q1).** Results were very encouraging as providers started applying new skills and also testing some changes.
- **Conducted orientation sessions on QI and ASSIST Project for newly recruited technical staff:** Reviewed ASSIST Mali programs and their performance before elaborating on the FY14 Mali Improvement design. This exercise allowed all staff to be a part of the process and take ownership of activities before committing to achieve them and get the best results.
- **Held workshop to validate HBB monitoring indicators** and determine how to document essential tasks performed and actions taken during the “golden minute”, on existing HIS registers and other forms (Q2). It was decided to use a stamp for notification on partograms. In addition, data collection tools were developed and distributed to coaches.
- **Hired eight new staff:** R&E advisor, MNCH clinical advisor for Bamako Office, an EONC clinical advisor for Kayes and two behavior change communication (BCC) advisors for the anemia work in Bougouni (Q1); Operation manager, administrative assistant, and human resources and logistics manager for Bamako (Q2).

### Spread Strategy

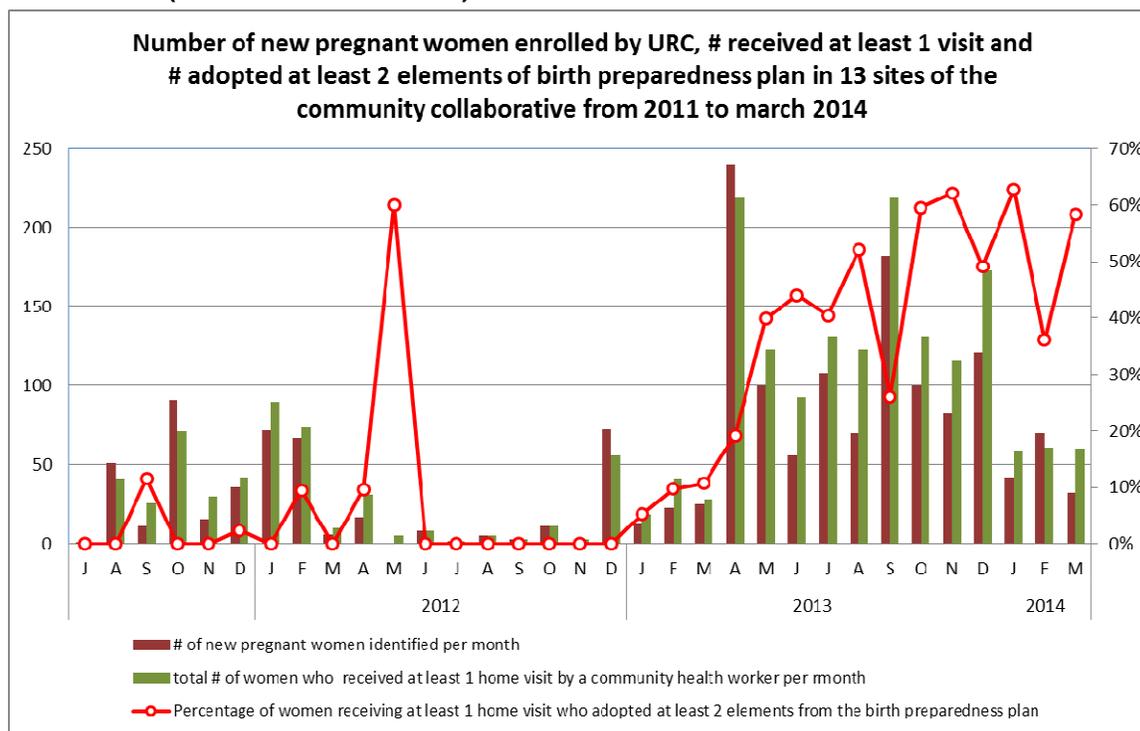
Best practices on AMTSL/ENC/PE/E from previous years were spread to three new districts in Kayes Region. Only orientation on QI and sharing of these practices were performed in these districts. A workshop was subsequently held on how to integrate QI activities into the work plans and budgets in order to sustain these gains. During the period, data was collected and changes implemented.

- Results for improving delivery of AMTSL and birth preparedness are shown in Figures 18 and 19, respectively. Table 3 summarizes best practices that have been developed by improvement teams, and Table 4 lists changes implemented by community teams to improve birth preparedness.

**Figure 18: Mali: Percent compliance with AMTSL norms and post partum hemorrhage rate (Oct 2009 – Feb 2014)**



**Figure 19: Mali: Birth preparedness of enrolled pregnant women at 13 community EONC sites, Diema district (Jan 2011 – March 2014)**



**Table 3: Mali: Community EONC, Diema district achievements**

<u>Domains</u>	<u>Best Practices</u>
<u>Identification of pregnancy and tracking of women</u>	<ul style="list-style-type: none"> <li>• Contacting the CCom (health facility) midwife to establish a list of women who have done ANC but who are not currently on the register</li> <li>• Recognizing pregnant women by re-trained traditional birth attendants (TBAs) or other village elders who communicate their names to the CHW</li> </ul>
<u>Access to skilled health care</u>	<ul style="list-style-type: none"> <li>• Women who are 8 months pregnant no longer go to the fields to work</li> <li>• In cases where it is difficult to achieve advanced strategies, the CHW regroups women with the same appointment period and brings them to CCom.</li> <li>• Commitment of women to attend ANC visits and give birth at the center, despite the reluctance of their husbands, by organizing to buy a cart to help them.</li> <li>• Establishment of a fund to finance the transport of village women to CCom</li> </ul>
<u>Motivation of intermediaries/TBAs</u>	<ul style="list-style-type: none"> <li>• Free services for all CHWs and their families if they orient enough clients</li> </ul>

**Table 4: Mali: EONC intervention – Changes implemented**

<u>Changes implemented</u>
<ul style="list-style-type: none"> <li>• Noting the full address of women in the register during their first ANC visit (name of the head of household). The intermediary is informed if the woman misses the meeting to actively find her.</li> </ul>
<ul style="list-style-type: none"> <li>• Sensitization meeting on the preparation of giving birth and the advantages of doing so at the center</li> </ul>
<ul style="list-style-type: none"> <li>• Information on the elements of childbirth preparation and verification of the adopted elements one</li> </ul>

Changes implemented
month before giving birth.
<ul style="list-style-type: none"> <li>• Involvement of the village chief in solving problems encountered during the Vitamin A Deficiency</li> <li>• The elderly women watch the sympathetic signs of pregnancy and informs the intermediary</li> <li>• Vitamin A Deficiency in women near the end of their term on the advantages of giving birth at the center and the signs of labor</li> <li>• Visit of households by an intermediary supervisor to check their understanding of the messages given in the households</li> </ul>

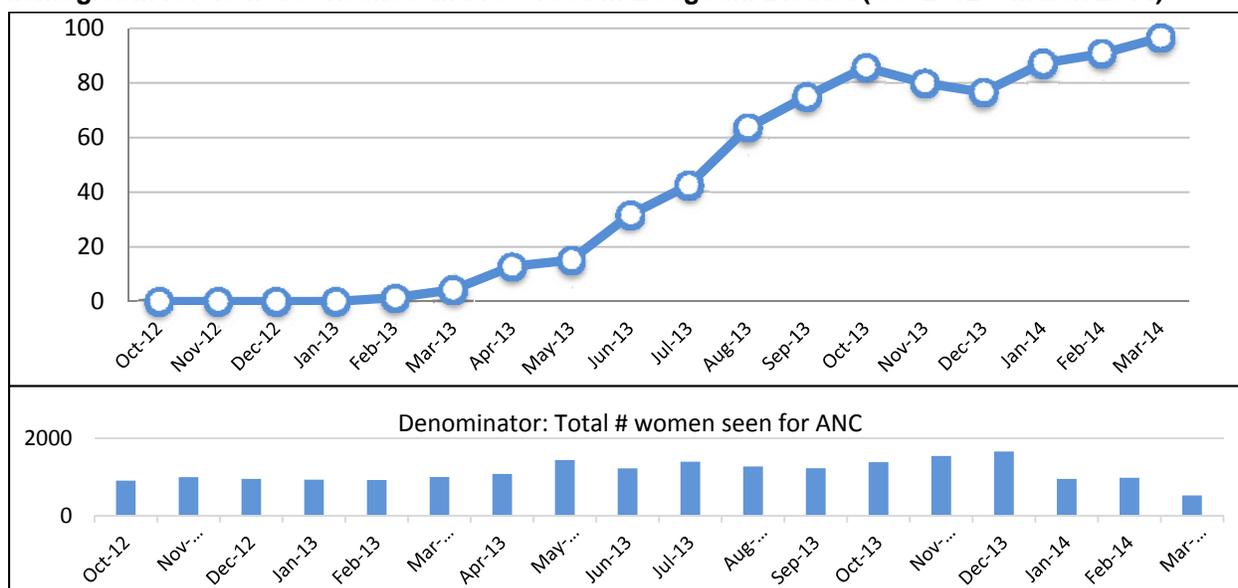
**Spread Strategy**  
 Best practices on AMTSL/ENC/PE/E from previous years were spread to three new districts in Kayes Region. An orientation on QI and sharing of best practices was conducted in these districts. Next, a workshop was held on how to integrate QI activities into the work plans and budgets in order to sustain these gains. During the period, data was collected and changes implemented.

**Activity 2. Improvement of anemia prevention and control activities in Bougouni district in the Sikasso Region**

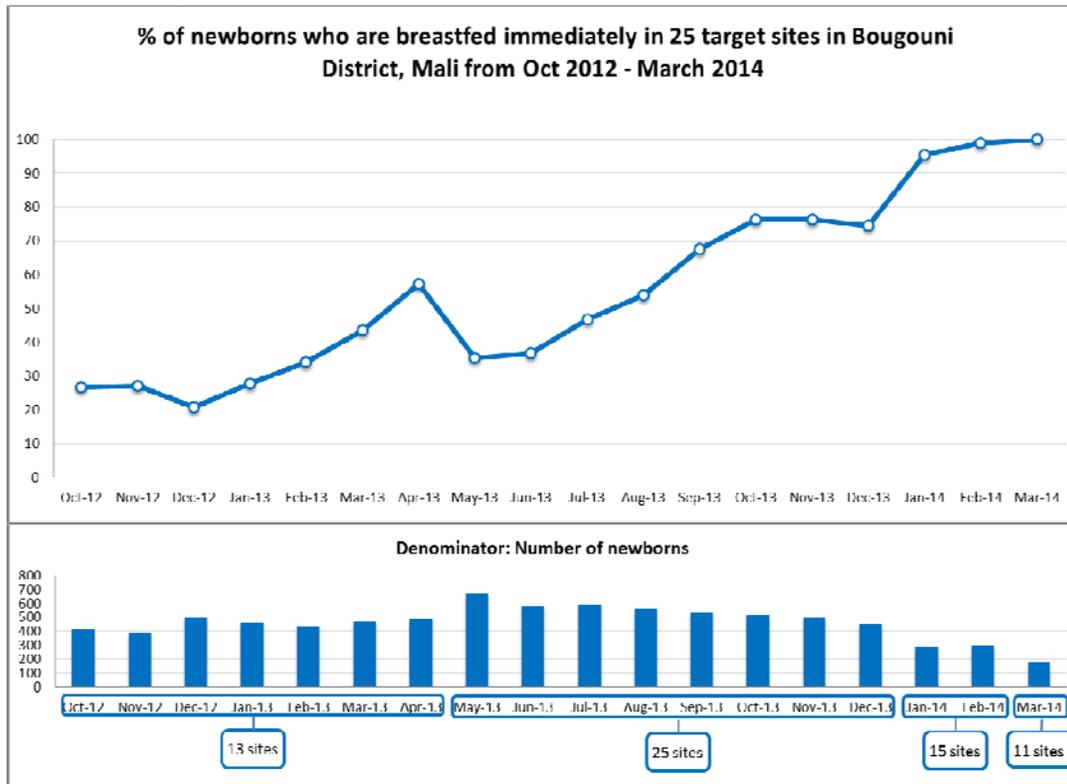
**Accomplishments:**

- **Introduced a community health system approach in Bougouni through situational analysis and coaches training with the technical assistance from ASSIST HQ (Q1).** Fifty six (56) participants (CHWs) were subsequently oriented, including 24 women, on the community health system for the anemia program. Each target member returned to his community and identified formalized community groups in four health areas (Koumantou, Sanso, Sido and Zantiébougou).
- **Data were collected on HR performance and engagement for anemia collaborative in Bougouni.**
- **Twenty-four community groups were selected among 189 identified for the implementation of the community health system under the anemia collaborative.** Then, 249 members of community groups were trained on anemia and the community health system in the four target sites of anemia collaborative. They began data collection and received a first coaching visit.
- **Held the second learning session to share experiences and best practices.**
- **Results are presented in Figures 20-22.**

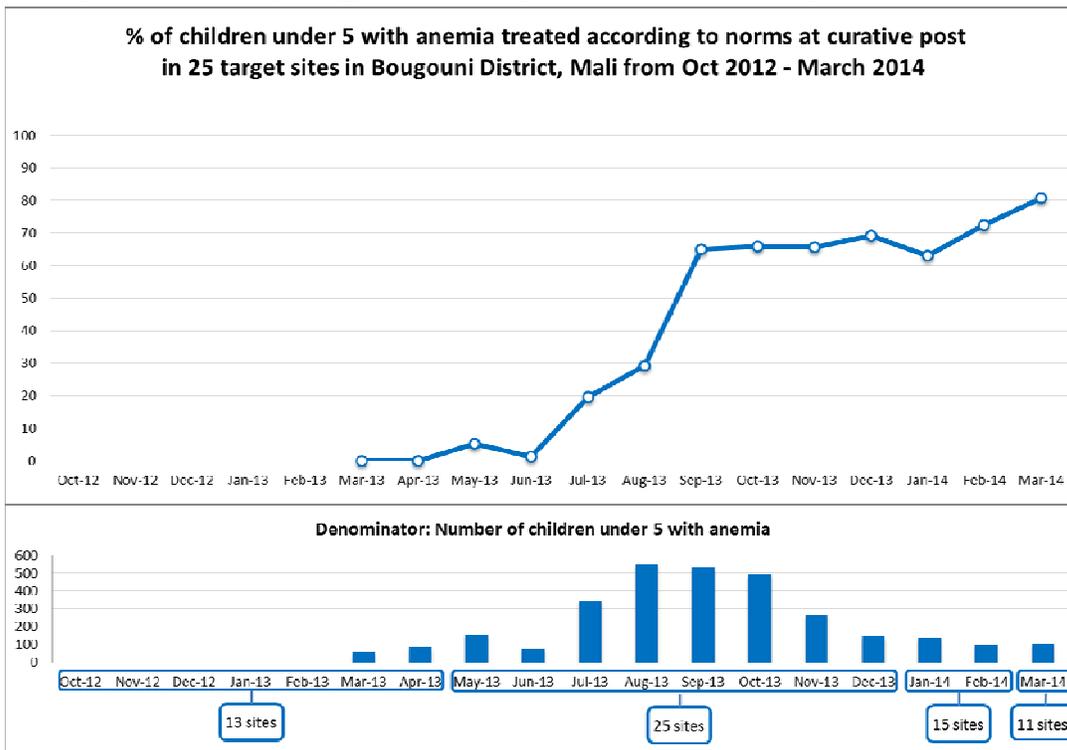
**Figure 20: Mali: Percentage of pregnant women (new and returning) for whom pallor and hemoglobin levels were checked and recorded in Bougouni District (Oct 2012 – March 2014)**



**Figure 21: Mali: Percent newborns breastfed immediately at 25 sites in Bougouni district (Oct 2012 – March 2014)**



**Figure 22: Mali: Percent of children under 5 with anemia that were treated according to norms at curative post at 25 sites, Bougouni district (Oct 2012 – March 2014)**



## How Do We Know We Are Improving?

### Improvement Key Indicators:

Activity	Indicator	Baseline	Last value (March 2014)
Improvement of EONC intervention at facility level in Kayes Region	Compliance to 3 key AMTSL norms	0%	100%
	PPH rate	1.2%	0%
	Compliance to ENC norms	39%	100%
	Compliance to PE/E diagnostic standards	25%	85%
	Compliance to PE/E treatment standards	0%	94%
Improvement of EONC intervention at community level in Diema district (Kayes Region )	New pregnant women enrolled	0	35
	Women who received at least 1 home visit	0	32
	Women who adopted at least elements of birth preparedness	0	94
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%	97%
	% Pregnant women who received good counseling on how to prevent anemia during ANC visits	0%	100%
	Immediate breast feeding	27%	100%
	Provision of iron	68%	100%

### Directions for Q3 and Q4 FY14

- **AMTSL/ENC/PE/E/PPFP/HBB**
  - Organize a coaching visit on HBB in Kayes and Yélimané
  - Organize a training of trainers and coaches on the WHO Safe Birth Checklist and QI in Kéniéba
  - Organize a regional learning session on PE/E
  - Organize a coaching visit in spread sites of Bafoulabé Nioro and Yélimané
- **Anemia**
  - Organize a review session for coaches on coaching techniques (Bougouni and Sikasso coaches and managers)
  - Organize coaching visits in all 25 sites
  - Organize a workshop for development and adaptation of appropriate behaviour change messages for the prevention and control of anemia
  - Organize a meeting of all stakeholders (DRS CSREF, ASACO, NGOs, civil society, associations / female groups)
  - Organize a regional meeting of coaches
  - Organize a workshop to define and adopt the service package to prevent anemia which must be provided by the stakeholder community
  - Organize coaching visit to target groups
  - Organize a learning session between target groups in a health area
  - Align the appropriate staff on the institutionalization of quality improvement and the implementation of the collaborative approach.

## 1.10 Mozambique

### Background

Since June 2013, USAID ASSIST is providing technical assistance to the Government of

Mozambique and implementing partners to improve the quality of services offered to vulnerable children and families affected by HIV and to implement approved standards. ASSIST is building on previous orphans and vulnerable children work implemented in Mozambique through HCI since 2010. The project is also piloting draft standards for home-based care and supporting Partnership for HIV-Free Survival activities at the community level.

## Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Improving care and support of vulnerable children and their families	<ul style="list-style-type: none"> <li>Improve the quality of services and care for vulnerable children through distribution of national service standards in 11 provinces</li> </ul>	Distribution of standards to 11 provinces through 3 regional meetings in North, South, and Central	x	
	<ul style="list-style-type: none"> <li>Identify and address critical barriers in the scale up and sustaining of effective high-impact interventions provided to vulnerable children and their families</li> </ul>	One district in each of two provinces, sites to be determined in collaboration with MMAS and USAID		
2. Draft and pilot Home Based Care Standards (HBC)	<ul style="list-style-type: none"> <li>Finalize the HBC standards in Mozambique</li> </ul>	Pilot in 2 communities in 1 district in each province of Gaza, Sofala and Cabo Delgado	x	

## Key Activities, Accomplishments, and Results

### Activity 1. Improving care and support of vulnerable children and their families

#### Accomplishments:

- Supported MMAS in conducting a national mapping exercise** that sought to identify Implementing Partners (IP) with human and financial resources targeting vulnerable children in all 11 provinces in Mozambique. A simple tool was developed for contacting provincial-level organizations to assist in the assessment process. A total of 147 IPs working with vulnerable children were identified. The mapping was the first step in establishing a comprehensive picture of all the partners in each province that would be reached through the roll out of the service standards. The mapping provided information on who the partners were, what services they provided, what groups of children their programs served, identified in which districts and communities they were implementing their programs. The mapping exercise identified the major stakeholders USAID ASSIST needed to engage throughout the roll out of the service standards.
- Provided technical assistance to MMAS to conduct regional workshops:**
  - The Southern OVC regional workshop (covering Maputo, Gaza, Inhambane) brought together 40 USG and Non-USG funded partners, and highlighted the need for improved coordination once every month through the Provincial Directorate of Woman and Social Welfare (DPMAS). For example, in Inhambane Province, Plan International will support DPMAS, and lead other Provincial IPs in the setting up of the Provincial OVC Technical Working Group (TWG).
    - At the end of the 3 day workshop, each province came up with a provincial level action plan to implement the OVC standards with technical support from USAID ASSIST. The IPs made commitment to meet once every quarter to share and learn from each other lessons learned from implementing OVC standards.
    - USAID Mozambique in turn committed to lead and put into place measures that all USG funded partners utilize and follow the OVC standard guidance in implementing OVC programs.

- The approval of the OVC standards was a major highlight at the Multisectoral Nucleus for OVC (NUMCOV) meeting held in Maputo in December 2013 where almost all presentations including that from the Minister of Women and Social Welfare, Iolanda Cintura spoke highly of the OVC standards, and the need for their implementation at all levels.
- o Two regional workshops (central and northern regions) took place in January and February 2014. The main purpose of the workshops was to disseminate the OVC standards and support teams and their IPs to design and come up with implementation plans of the OVC standards at the provincial level.
- o In addition, ASSIST supported MMAS in following up with all 11 provinces to see how far the provincial teams had disseminated and integrated the standards into their organizational implementation plans. Seven of 11 provinces organized provincial meetings with the OVC provincial TWG to present the standards, the tools, and refined the implementation plans for the standards that were developed at the end of each of the three regional workshops.
- **Facilitated training of trainers of community child protection committees (CCPC) led by UNICEF and MMAS.** ASSIST was invited as a member of the TWG to be part of the facilitation group of three regional trainings of trainers on CCPCs. The first regional training took place in the southern region in March 2014. It involved four provinces and 34 participants. ASSIST took advantage of the opportunity to share and disseminate the OVC standards tools. Both MMAS and UNICEF have both concurred that for the present, no new tools would be developed other than those tools developed and approved together with the OVC standards in July 2013. It was equally agreed by all parties that the OVC tools would be incorporated into the CCPC training of trainers manual.
- **Mozambique's OVC standards' experience was showcased at the Southern Africa Development Community (SADC) Minimum Package of Services training and review meeting held in Johannesburg, South Africa.**
  - o Mozambique was represented by Dr. Francisca Lucas, the Director for Social Action in MMAS at the "Regional Training and Review meeting on the implementation of the SADC Minimum Package of Services (MPS) for OVC & Youth" that was hosted by the SADC Secretariat on March 20-21, 2014 in Johannesburg, South Africa.
  - o ASSIST provided Dr. Francisca with a power point presentation on key results from the pilot phase, including the data of children who improved their status through the implementation of standards in all three pilot provinces, and the steps that have been taken after the standards approval as well as the outcomes from the OVC regional dissemination workshops concluded in February 2014.
  - o Feedback from Dr. Francisca Lucas upon her return to Maputo after the meeting was "Mozambique received some resounding ovation from the participants for being the only SADC country so far with the OVC standards approved and disseminated at national level, with provincial implementation plans in place."

## **Activity 2. Draft and Pilot Home Based Care (HBC) Standards**

### **Accomplishments:**

- **USAID Mozambique project managers approved the draft HBC standards (Q1).** The HBC standards document is currently going through review by MoH before piloting. The Mission has approved the work plans for this activity and is currently working on the funding for FY14 (Q2). ASSIST recently shared the pipeline information with the activity manager. The TWG is currently engaged in reviewing the indicators for this activity.

### **Directions for Q3 and Q4 FY14**

- Organize coaching visits in five provinces (Gaza, Manica, Zambezia, Tete and Maputo).
- Organize learning session in at least two provinces to be yet decided upon in coordination with MMAS.
- Produce at least one case study on how OVC standards contributed to making some remarkable improvement in the life of a child.
- Conduct the 1st community QI learning session in Gaza in the 2nd week of May 2014.

- Determine and agree on the number of community QI teams in Zambezia, and conduct coaches' training in May 2014.
- Provide support supervision to Sofala community QI teams so that they are able to start meeting and collect data in April 2014.

## 1.11 Nigeria

### Background

The USAID ASSIST project began implementing activities in Nigeria in October 2012, building on the activities carried out under HCI since 2011. The project is building the capacity of the Federal and State Ministry of Women and Social Development and implementing partners to improve the quality of care and support services for orphans and vulnerable children and their caregivers in 10 states.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Improve the quality of services for vulnerable children in Nigeria	<ul style="list-style-type: none"> <li>• Improve health, education, psychosocial support, child protection, food and nutrition and economic strengthening services for vulnerable children and their caregivers in 10 states in Nigeria by Sept 2014</li> </ul>	<p>Work in 28 out of 208 LGAs in 9 out of 36 states and the Federal Capital Territory (FCT) in Nigeria</p> <p>Work in 100 communities</p> <p>Target population: 200,000 vulnerable children</p> <p>9 State Ministry of Women Affairs and 100 Civil Society Organization (CSOs)</p> <p>Sokoto, Kano, Kaduna, Plateau and Bauchi States– Save the Children/STEER project</p> <p>Edo, Kogi, Benue, FCT &amp; Nasawara States– Catholic Relief Service/SMILE project</p>	x	

### Key Activities, Accomplishments, and Results

#### Activity 1: Improve the quality of services for vulnerable children in Nigeria

##### Accomplishments:

- **Trained 15 management staff of Catholic Relief Service (CRS, SMILE Project team) and 18 management staff of Save the Children International (SCI, STEER Project team) on improvement science and its application on program implementation for vulnerable children in Nigeria.** The duration of the training was 3 days and covered improvement methodology, the Plan-Do-Study-Act (PDSA) cycle, learning sessions, and monitoring progress.
- **ASSIST has drafted an MOU with Catholic Relief Services and Save the Children International for partnership in the SMILE and STEER project.** This MOU defines the roles that each partner will play in building the capacity of the two Umbrella Grant Mechanism (UGM) implementing partners (IPs) and the sub-grantees who are selected Community Based Organizations (CBO) by SCI and CRS.
- **Trained the existing state technical working group on vulnerable children in Federal Capital Territory (FCT) and Kogi State on improvement methodology and how to use the National orphans and vulnerable children (OVC) Standards.**
  - During the four day training, participants were trained on the four major steps of improvement methodology through participatory training among three teams. At the end of each exercise, teams made presentations on what they worked on. The team also elected their officials and agreed on the composition of the local government improvement team, the community improvement team and learning session invitees. The FCT and Kogi State improvement

teams were inaugurated at the end of the workshop by the Director Child for FCT and Commissioner for Women Affairs and Social Development, Mrs. Patience Mameh for Kogi state.

### Directions for Q3 and Q4 FY14

- Training and formation of state improvement teams
- Training and formation of LGA improvement teams
- Training and formation of community improvement teams
- Training selected CBO's of STEER on improvement methodology

## 1.12 South Africa

### Background

Building on URC assistance to the National and Provincial Departments of Health (DOH) since 2000, ASSIST's work began in South Africa in October 2013 and provides technical assistance in health systems strengthening at national and provincial levels as a "Specialized Provincial Partner for Quality." The project is working with provincial and district health authorities to increase the quality of HIV prevention, care, and treatment services and to build capacity at all levels in strategic planning, supervision, program review, training and mentorship, development of clinical skills, and policy development. ASSIST's scope of practice includes support for improving the quality of HIV and maternal, newborn, and child health services, strategic planning, district development, and supervision in five priority provinces: Eastern Cape (EC), KwaZulu-Natal (KZN), Limpopo, Mpumalanga (MP), and North West.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Increase quality of HIV prevention, care, and treatment services	<ul style="list-style-type: none"> <li>• Increase HIV counselling and testing (HCT) uptake by 20% in 12 months</li> <li>• Reduce time to ART initiation for HIV+ clients by 20%</li> <li>• Increase retention of HIV+ clients on ART in care by 30%</li> </ul>	5 out of 9 provinces, (56% of all Primary Health Care [PHC] facilities in 9 provinces)	x	
2. Build capacity of DOH staff	<ul style="list-style-type: none"> <li>• Build capacity of key DOH staff (PHC supervisors and facility managers) in all provinces in strategic planning, supervision, program review, training, and mentorship</li> </ul>	All provinces		x

### Key Activities, Accomplishments, and Results

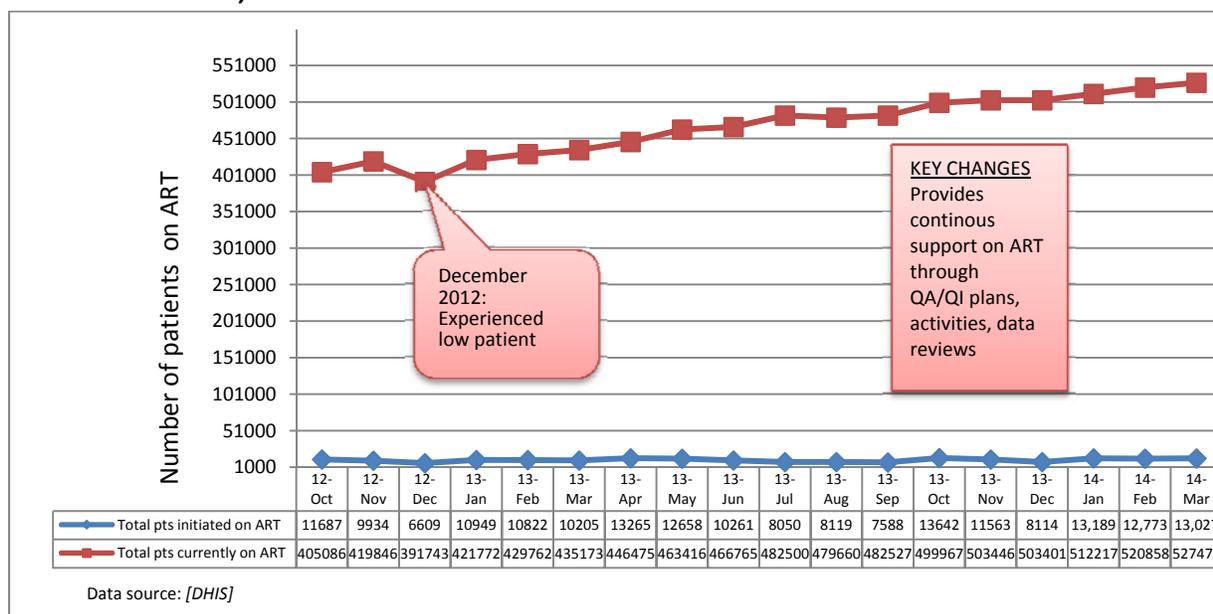
#### Activity 1. Increase quality of HIV prevention, care, and treatment services

##### Accomplishments:

- **Conducted QA/QI learning sessions (Q1).**
  - Conducted two learning sessions for health care workers (HCWs) in two provinces implementing PMTCT QI activities. Two parallel sessions were organized and a total of 91 participants attended including DOH staff, PEPFAR implementing partner organizations and NGO stakeholders.
  - Conducted five learning sessions for health care workers in one province on the newly launched National Contraceptive and Fertility Preservation guidelines. Sequential training sessions were held in 5 different districts within KZN province, and a total of 103 primary health care nurses were trained.

- **Developed Action Plans.**
  - Developed suitable implementation plans and IEC materials to improve HCT, PMTCT and maternal health care in three provinces.
  - Conducted community dialogues in two provinces to encourage women to attend ANC early, test for HIV during their first ANC visit, and consider family planning (FP) options in the postnatal period.
- **Conducted PHC Facility Assessments.**
  - Provided lead mentorship and technical assistance during assessment of 16 PHC facilities in one province to gauge progress with implementation of National FP guidelines & quality of FP services.
  - ASSIST staff formed part of the team selected to assess four facilities on the quality of ART and maternal, child, and women’s health services.
- **Supported the Eastern Cape with data validation and verification, during the quarterly “Data Mop-up” exercise (Q2).** This resulted in verification of over 20,000 HCT clients who had not been formally recorded.
- **Participated in Provincial assessment of ART programs** – which showed that accurate and timely recording and reporting has improved by 40%.
- **Results show** increased number of patients on ART in supported districts to 527,476 (Figure 23). PMTCT programs reveal improving Nevirapine uptake rates (99%) and declining PCR positivity rates (<3%).

**Figure 23: South Africa: Patients on Antiretroviral Therapy, Mpumalanga & Eastern Cape (Oct 2012 – March 2014)\***



\*March 2014 data is still provisional

### **Activity 2. Build capacity of DOH staff**

#### **Accomplishments:**

- **Provided lead mentorship and technical assistance during:** Training of 25 PHC supervisors in two provinces; data verification process in five sub-districts in one province; and inspection of two private facilities for licensing and accreditation.
- **Finalized data collection and data analysis for the ‘Evaluation of PHC supervision in 96 facilities’ in one province (Q1).**
- **Developed a draft National PHC Clinic Supervision Policy and Capacity Development Framework for PHC supervisors (Q1).**

- **FP: Trained 68 HCW on “implanon insertions and theory” at UThungulu District-KZN.** This resulted in over 30 clients receiving “implanon inserts” at URC-ASSIST mentored facilities.
- **Coordinated and facilitated a workshop on National Core Standards for Health Establishments (NCS) in MP that was attended by 40 participants.**
- **Provided ongoing mentoring in monitoring and evaluation to provincial staff (EC & MP).**

### How Do We Know We Are Improving?

#### Improvement in Key Indicators:

Activity	Indicators	Baseline (month)	Last value (month)*
Increase quality of HIV prevention, care, and treatment services	HCT uptake (general population)	259,396 (April 2013)	360,949 (March 2014)
	No. of individuals receiving ART (cumulative)	405,086 (Oct 2012)	527,476 (March 2014)

\*March 2014 data is still provisional

#### Directions for Q3 and Q4 FY14

- Finalize PHC Evaluation (Mpumalanga) report
- Commence NACS training & mentoring for FHI 360 South Africa team
- Commence VMMC quality improvement activities

## 1.13 Swaziland

### Background

The USAID ASSIST Project began working in Swaziland in October 2012. Building on the work done by HCI from 2008, ASSIST continues to support the Ministry of Health Quality Assurance Program and stakeholders to institutionalize modern quality improvement in health care by: improving the national capacity to conduct QI planning, implementation, and evaluation; building the capacity of health care workers and QI mentors on quality improvement; and improving health care QI performance measurement at national, regional, and health facility levels. In addition ASSIST works with the National Tuberculosis Control Program (NTCP) and the Swaziland National AIDS Program (SNAP) to expand the coverage of integrated TB/HIV diagnostics and treatment services improving TB treatment outcomes as well as the quality of TB, TB/HIV, and multidrug-resistant tuberculosis (MDR-TB) services using modern quality improvement approaches. USAID ASSIST works with the Ministry of Health (MOH) through the NTCP, the SNAP, the National Quality Management Programme (QMP) and the National Clinical Laboratory Services (NCLS) to apply lessons learned from established HIV/AIDS and TB quality improvement activities and spread integrated service delivery models and algorithms for health facilities and providers in Swaziland. FY14 saw an introduction of in-service training National Framework for In-service Training.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Support the MOH and implementing partners to institutionalize modern Quality Improvement approaches.	<ul style="list-style-type: none"> <li>• Improve national capacity health care QI planning, implementation and evaluation.</li> <li>• Build the capacity of health care workers (HCWs), and QI mentors on quality improvement.</li> <li>• Improve health care QI performance measurement, at national, regional and health</li> </ul>	National level: 4 regions, 74 TB diagnostic clinics.	x	

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
<p>2. Establish integrated TB/HIV/NCD model clinics and Centres of Excellence to (COE) MDR-TB clinics to improve implementation of Essential Healthcare Package (EHCP).</p>	<p>facility levels.</p> <ul style="list-style-type: none"> <li>Establish integrated TB/HIV/NCD health services.</li> <li>Implement the Essential Healthcare package in facilities.</li> </ul>	<p>Regions: 3 out of 4 regions</p> <ul style="list-style-type: none"> <li>-Hhohho Region (3 model clinics and 4 TB/HIV Comprehensive Care Clinics)</li> <li>-Manzini region (1TB/HIV Comprehensive Care Clinic)</li> <li>-Lubombo region (1 TB/HIV Comprehensive Care Clinic)</li> </ul>	x	
<ul style="list-style-type: none"> <li>Establish the MDR-TB Hospital and TB Centre as Centres of Excellence.</li> </ul>	<p>Manzini region (TB hospital in Moneni and TB Centre and clinic in Manzini)</p>			
<p>3. Implement high quality Directly Observed Treatment Short-course (DOTS) expansion for TB &amp; MDR-TB strengthening implementation of integrated TB/HIV prevention, care, and treatment.</p>	<ul style="list-style-type: none"> <li>Increase case detection of TB.</li> <li>Increase TB treatment success.</li> <li>Increase TB/HIV integrated management.</li> <li>Ensure proper management of MDR-TB.</li> <li>Strengthen TB infection control.</li> <li>Increase research and use of evidence in designing in priority areas interventions and policies.</li> </ul>	<p>The target population: 1,141,000.</p> <p>Regions: 3 out of 4 regions</p> <ul style="list-style-type: none"> <li>-Hhohho – 309,184</li> <li>-Manzini – 352,568</li> <li>-Lubombo – 180,000</li> </ul> <p>-Part time support to Shiselweni,</p> <p>Hhohho Region: 20 health facilities (2 hospitals, 2 health centers, 2 prisons, 2 private clinics and 12 primary health clinics).</p> <p>Manzini sub region: 21 health facilities in (3 hospitals, 1 specialized clinic, 5 private clinics and 12 primary health clinics).</p> <p>Lubombo region: 15 facilities in ( 2 hospitals, 1 health Centre, 3 private industrial clinics and 7 primary health clinics).</p>	x	

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
4. Implement advocacy and social mobilization (ACSM) interventions to improve/HIV and MDR-TB services uptake and outcomes.	<ul style="list-style-type: none"> <li>Strengthen the capacity of NTCP to develop and implement a TB ACSM strategy.</li> <li>Improve early detection of TB, TB/HIV and MDR-TB health facilities and communities.</li> <li>Increase community engagement by supporting TB patient treatment adherence.</li> </ul>	Health facilities in the 4 regions. (Hhohho, Lubombo, Manzini & Shiselweni).		X
5. National Framework for In-service Training.	<ul style="list-style-type: none"> <li>Design and implement a national framework for in-service training in Swaziland.</li> </ul>	<ul style="list-style-type: none"> <li>-National;</li> <li>-All implementing partners with In-service training programs.</li> <li>-Facility in-service training coordinators.</li> </ul>	X	

## Key Activities, Accomplishments, and Results

### Activity 1. Support the Ministry of Health and implementing partners to institutionalize modern Quality Improvement approaches

#### Improvement Aim:

- To improve the capacity of the national Quality Management programme to plan, coordinate, implement and monitor quality assurance and quality improvement at national, regional and health facilities level.

#### Accomplishments:

- Built the capacity of HCWs, and QI mentors on quality improvement (Q1).**
  - Conducted 6 facility coaching sessions to TB/HIV clinics in the Hhohho and Manzini regions with the National TB control program regional TB coordinators. These coordinators have received previous training and are being mentored to serve as mentors/ coaches for the TB/HIV clinics.
- Conducted facility-based review meetings (3 facilities).**
  - To improve health care QI performance measurement, at national, regional and health facility levels. A total of 38 health care workers participated. QI projects included early anti-retroviral treatment (ART) initiation among HIV infected TB patients.
- Conducted/participated in a QA/QI (Quality Assurance/ Quality Improvement) training for healthcare workers and mentors (Q2).**
  - The training included 36 ASSIST staff and counterparts from the TB hospital, TB Centre, the SHLS and the QMP attended a training on QA/QI. The training was facilitated by Tina Maartens a Senior Quality Improvement Advisor from URC-South Africa. The main objective of the training was to improve participant skills on identifying and utilizing Quality improvement tools, during coaching and mentoring of the health facilities.
- Conducted on-site facility trainings on QA and QI (Q2).**
  - On February 28, 2014 Good Shepherd Hospital staff in the Lubombo region were trained on QI methodologies and supported to start their first Quality Improvement Projects (QIP). Subsequently from March 11-13, 2014, 20 HCWs from Mbabane Government Hospital and Mahwalala Red Cross Clinic in Hhohho region were trained on QI methodologies and approaches. The training objectives were met to assist healthcare workers to develop quality

improvement projects and tools for their facilities, which would in turn improve service delivery at the health facilities.

- **Supported collaborative feedback sessions at regional and national level (Q2).**
  - ASSIST supported QMP to conduct collaborative interdepartmental feedback sessions at the facility level for Mankayane and Mbabane hospitals (February 12, 2014). A joint collaborative learning session was also held on the 19<sup>th</sup> February for the Shiselweni region clinics which included Moti, Ntshanini, Nhletsheni, Mfishane, Hluti, Nkwene, OLOs, and Mahlandle clinics. Table 5 shows examples of QI projects from various clinics.

**Table 5: Swaziland: Facility Quality Improvement Project status**

Health facility	Quality Improvement project	Status
Mankayane hospital	<ul style="list-style-type: none"> <li>• Improving referral and linkage of occupational therapy-rehab patients from in patients ward to outpatient department.</li> </ul>	Ongoing
Mbabane Government Hospital	<ul style="list-style-type: none"> <li>• Use of the surgical checklists in Mbabane hospital Theatre.</li> </ul>	Ongoing
	<ul style="list-style-type: none"> <li>• Reduce hospital acquired infection (diarrheal diseases) among in surgical ward.</li> </ul>	Ongoing
Moti Clinic	<ul style="list-style-type: none"> <li>• TB screening in Out-patient department (OPD).</li> </ul>	Ongoing
OLOS	<ul style="list-style-type: none"> <li>• Increasing uptake to HIV testing and counselling in the OPD.</li> </ul>	Ongoing
Raleigh Fitkin Memorial (RFM)	<ul style="list-style-type: none"> <li>• Improving the quality of sputum submitted for GeneXpert.</li> </ul>	Ongoing
	<ul style="list-style-type: none"> <li>• Improving the proportion of TB /HIV patients initiated on ART two week post TB initiation.</li> </ul>	Ongoing
Nhletsheni clinic	<ul style="list-style-type: none"> <li>• Increasing HIV testing among exposed infants.</li> </ul>	Ongoing

- **Supported staff quarterly review meeting (QRM) for 34 URC-Swaziland staff, who were given the platform to share their day-to-day activities on Centre for Disease Control (CDC) -Lab and ASSIST projects (Q2).**
  - The workshop allowed for effective monitoring of progress towards set targets, provided an opportunity of collective sharing and learning sessions to project staff.
- **Provided support for the scale up use of standard evaluation and documentation tools for QI activities in health facilities (Q2).**
  - Provided support for scaling up the use of SES journal in health facilities in Lubombo region after recruiting a TB/HIV regional coordinator in the region. Additional support was also provided to Mkhuzweni Health Centre (HC), Dvokolwako HC, Piggs' Peak hospital, Mbabane Hospital, TB Centre, RFM hospital, and the TB Hospital to develop QI annotated trend graphs, developed story boards and displayed them in their facilities.
- **Developed a customer satisfaction survey tool and protocol and submitted to the Scientific Ethics committee (Q2).**
  - In the next reporting period the customer care focal person will be oriented on the tool and data will be collected with support of the national Strategic Information Department (SID).

**Activity 2. Establish integrated TB/HIV/NCD model clinics and Centres of Excellence to MDR-TB clinics to improve implementation of the essential health care package**

**Improvement Aim:**

- To improve the quality of integrated TB/HIV/NCD management through the establishment of model clinics at 3 PHC clinics, 6 comprehensive TB/HIV care centres and 2 centres of excellence; the National TB Hospital and the TB Centre Clinic.

**Accomplishments:**

- **Worked to establish integrated TB/HIV/NCD Model Clinics (Q1).**
  - Following the selection of the model clinics to implement the essential health care package, two of the three model clinics were supported to finalize their work plans which will include

integration of bidirectional screening for diabetes and tuberculosis, provision of integrated TB/HIV care and integrated sexual reproductive health services like STI treatment and family planning. One of the activities is to integrate TB screening in all departments of the clinics.

- **Worked to establish the MDR-TB Hospital and TB Centre as Centres of Excellence (Q2).**
  - The assessment of the MDR-TB hospital as a centre of excellence was completed. It showed that treatment availability, human resource capacity and infrastructure were areas of great strength while the areas of paediatric MDR TB diagnosis and community MDR TB care need strengthening. An improvement work plan is in development to address these areas. The directorate of clinical services has been involved in the implementation of the COE and this will contribute to the sustainability and oversight for the activity.
  - A death audit of MDR-TB patients at the National DR-TB hospital was conducted as part of the improvement activity and the initial results show that the death rate was 12%. The majority of deaths were due to electrolyte imbalance, renal failure and HIV co-morbidity.
- **Developed bidirectional screening for diabetes among TB patients.**
  - A bi-directional TB screening concept note was developed that articulates TB screening for diabetes patients and diabetes screening among TB patients and has been shared with selected facilities. These include the TB Hospital, Mbabane Government hospital, Piggs' Peak Government hospital, RFM hospital and Good Shepherd Hospital; focal persons have been identified and a training schedule has been developed.
  - A work plan for bi-directional screening was developed for the RFM hospital.
- **Equipped hospital management with management and leadership skills.**
  - In the reporting period, ASSIST conducted a number of workshops to build capacity of the hospital management and Heads of Departments to function efficiently and effectively. Key output results of the workshop was the development of a vision for the TB centre, objectives and activities incorporated into a work plan matrix, motivating the staff to implement the work plan and corrective measure in infection control and patient management.
- **Supported model clinics to implement Essential Health Care Package (EHCP).**
  - During the reporting period ASSIST supported the three model clinics to implement the EHCP. Technical support was provided to Horo and Ngowane Clinic to develop work plans and start implementation. Progress has been made in one of the primary health care clinics, Ezulwini Satellite clinic with an increase in TB screening among all patients visiting the clinic.

### **Activity 3. Implement high quality DOTS expansion for TB & MDR-TB and strengthen implementation of integrated TB/HIV prevention, care, and treatment**

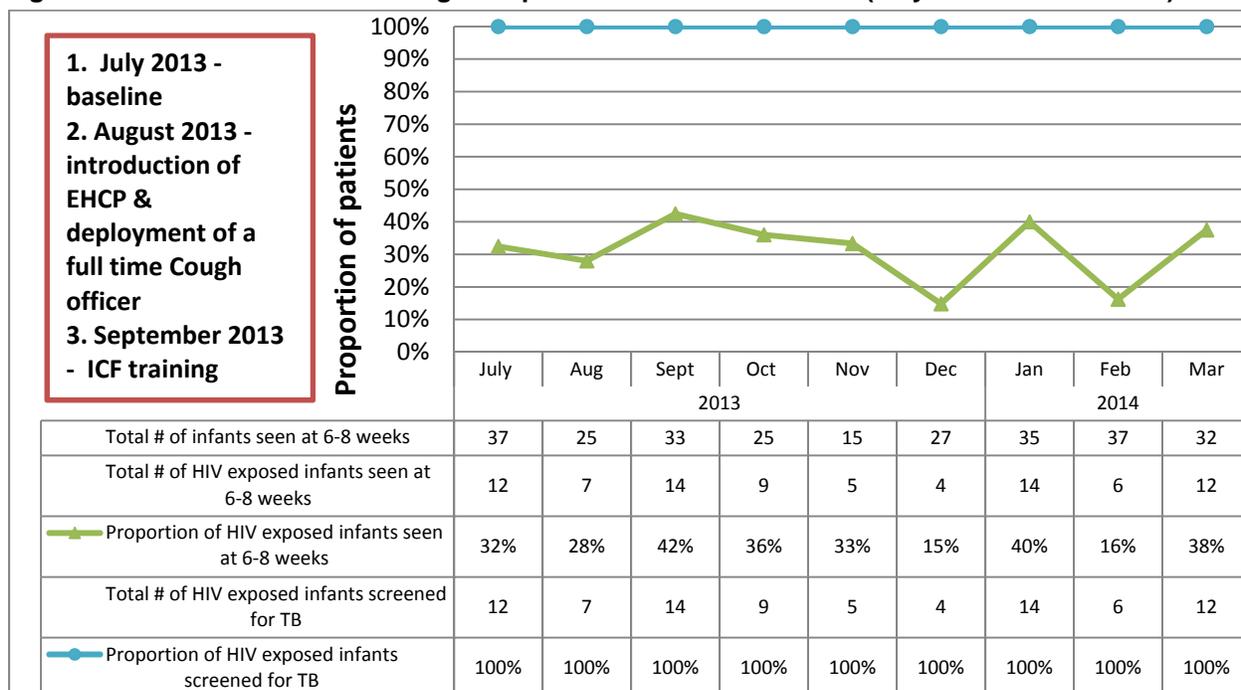
#### **Improvement Aims:**

- Accelerate TB case finding and treatment in Swaziland and sustain or exceed the detection of at least 70 percent of sputum smear-positive cases of TB and successfully treating at least 85 percent of cases detected.
- Diagnose and initiate treatment of at least 80% of MDR-TB cases detected and increase treatment success rate from 50% to 65% by 2014.
- Expand coverage of TB/HIV interventions and increase uptake of HIV treatment among TB patients co-infected with HIV from 70% in 2013 to 90% in 2015.

#### **Accomplishments:**

- **Increased case detection of TB.**
  - ASSIST supports the NTCP to ensure that clinics have access to quality assured bacteriology. The TB management guidelines recommend use of GeneXpert MTB/RIF for the diagnosis of TB where it is available. There are currently 22 functional GeneXpert MTB Rif machines in the country. Using the National Sample Transportation system (NSTS), all TB diagnostic clinics and primary health clinics have access to this platform. There has been a notable reduction in the numbers of sputum not done and an increase in the bacteriological confirmation of TB among patients started on anti-TB treatment since the scale up of GeneXpert MTB Rif (see Figure 24).

**Figure 24: Swaziland: TB screening of exposed infants at 6-8 weeks (July 2013 – March 2014)**



**Increased TB treatment success**

- There are 74 TB diagnostic units in Swaziland: 19 in Hhohho, 18 in Manzini, 12 in Lubombo and 25 in Shiselweni. ASSIST provides facility support to all the clinics in the Hhohho, Manzini and Lubombo regions and at national level to all the clinics in the country with quarterly joint supportive supervision and data verification.
- Conducted joint clinical mentoring to 31 TB diagnostic facilities during Q1. Clinical mentoring focused on bacteriological confirmation and HIV/TB activities especially the early ART initiation; these also formed part of the QI interventions at the TB clinics. Reduction in default rates from 7% to 5% has contributed to improved treatment success rates in all TB patients from 77% to 79%. (See Figure 25 below.)
- National HIV testing and Cotrimoxazole preventive therapy (CPT) uptake continue to be high at 96% and 100% respectively. Early ART initiation within 8 weeks of anti-TB treatment initiation is supported; clinical mentoring and implementation of QI projects in this area have been supported over the course of the calendar year. ART uptake has increased (Figure 26).

**Figure 25: Swaziland: National Treatment Success rates for Swaziland (Q1 FY10 – Q2 FY14)**

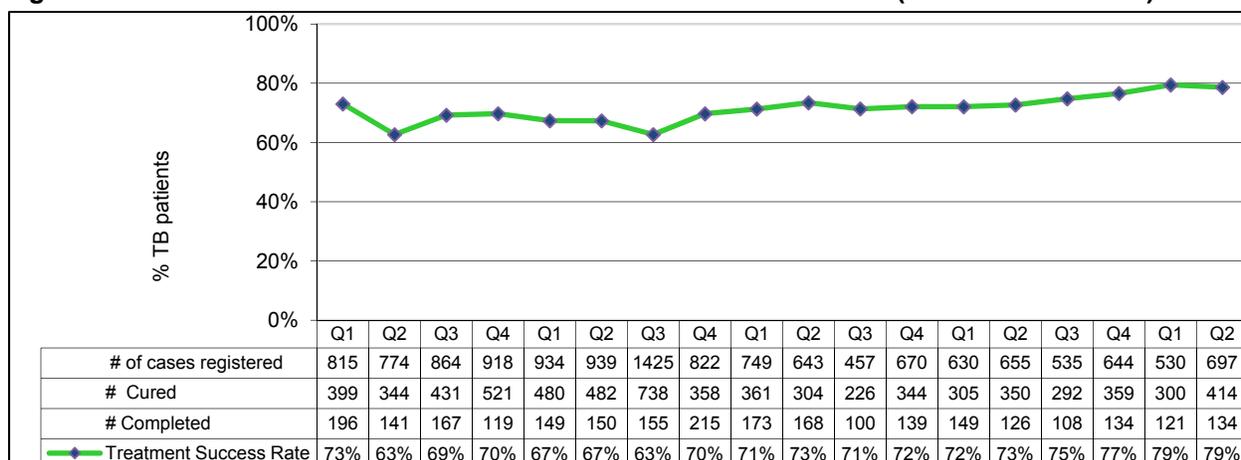
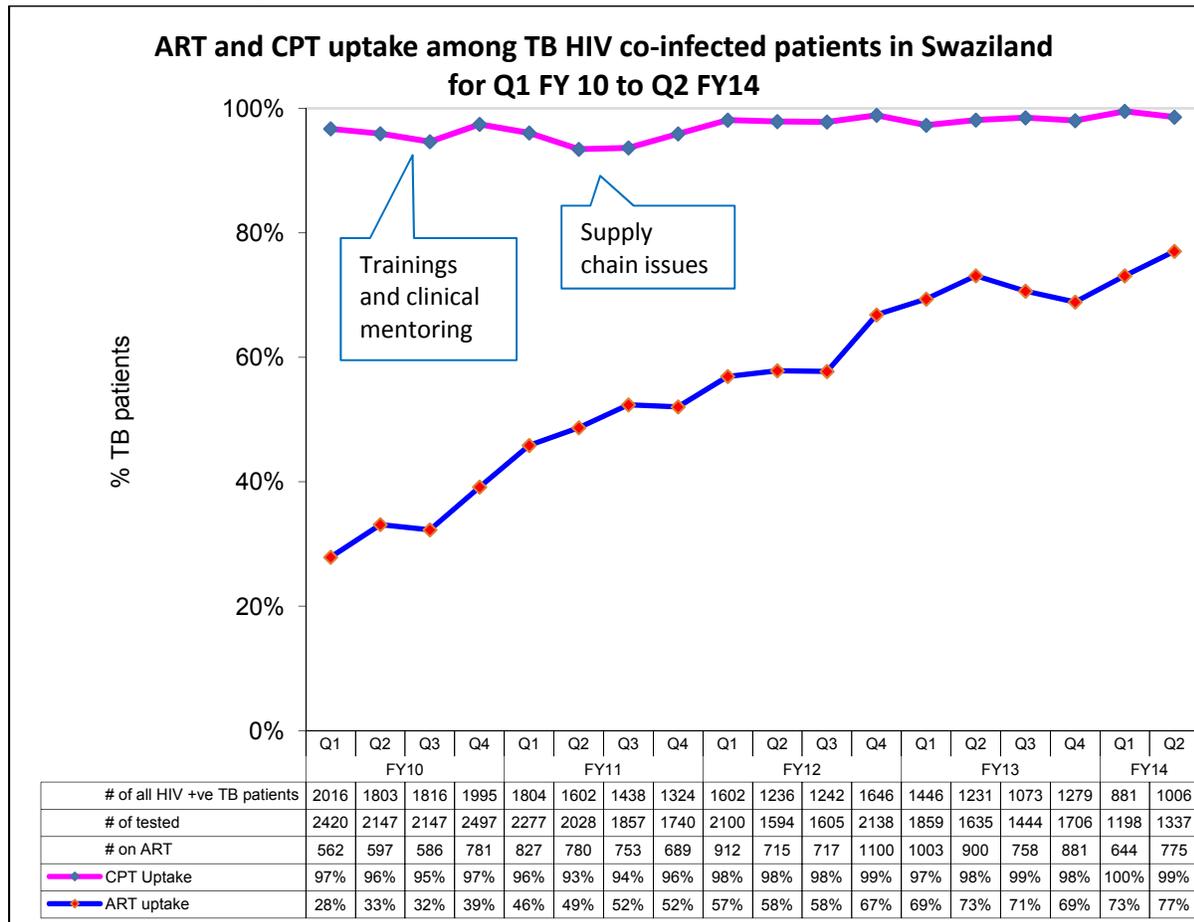
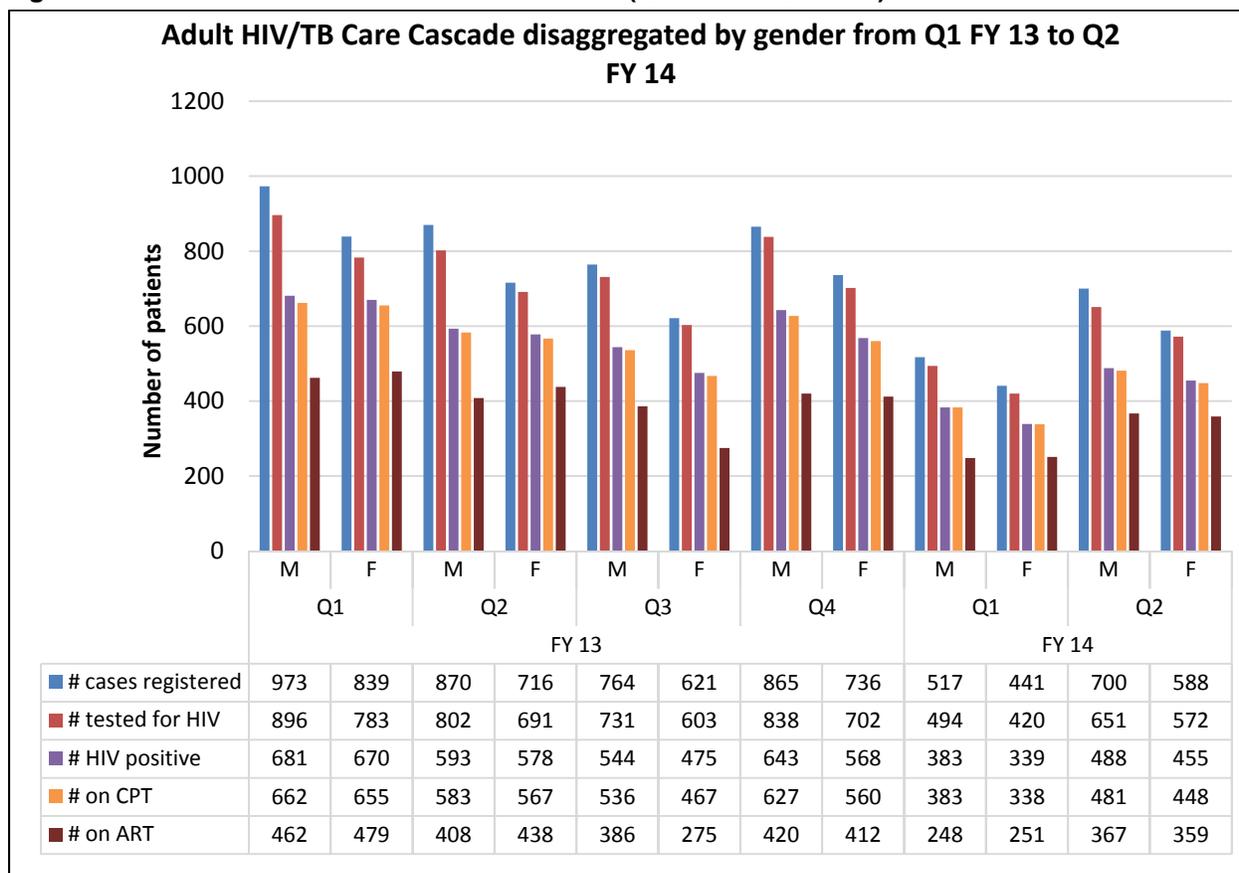


Figure 26: Swaziland: National trends in ART and CPT uptake among HIV infected TB patients (Q1 FY08 – Q1 FY14)



- o Isoniazid Preventive Therapy (IPT) has become a major area of intervention in the country with ASSIST providing the technical assistance to both the National HIV and Tuberculosis programs. Following the IPT Indaba held in September 2013, a task group was formed to address implementation challenges. ASSIST provides technical assistance and resources to strengthen the TB/HIV care cascade in the TB clinical settings. The data is disaggregated by sex and age to inform interventions that will improve the TB treatment outcomes. Figure 27 depicts the adult (> 15 years) TB/HIV care cascade. The CPT uptake remains at above 98% over the last 4 quarters. The ART uptake in adults is lower than in the children at 69% and this proportion has been stable over the last 3 quarters. Females have higher ART uptake at 74% in comparison to the men at 65%. Patient information targeting the men is being developed to address this issue.

Figure 27: Swaziland: Adult TB/HIV care cascade (Q1 FY13 – Q2 FY14)



- **Helped ensure proper management of MDR-TB**
  - Revised MDR-TB guidelines have been printed and are being distributed to health facilities. Onsite trainings on identifying high risk populations for MDR-TB were conducted for 26 HCWs at 10 primary health clinics. These trainings were to increase the capacity of the HCWs to suspect and investigate high risk patients for MDR-TB and link them to care. Over a quarter, 14 patients were diagnosed with MDR-TB, 20 were put on treatment. Of those diagnosed in the quarter 12 (86%) of the 14 were initiated on treatment.
  - Through the use of community care for MDR-TB patients, patients defaulting treatment are traced and brought back to care. Home assessments are conducted and patients with social difficulties are admitted to the hospital at least for the duration of the injectable phase. This has contributed to improved interim outcomes and the treatment success rates. During the quarter, 52 patients benefitted from home assessments and 22 patients who had missed clinic appointments received a home visit and were brought back to care.
- **Strengthened TB infection control.** All TB diagnostic clinics have received clinical mentoring on implementing infection control through providing disposable masks for all patients, highlighting the open window policy and implementing the Find TB Actively Separate Safely and Treat (FAST) strategy. Information Education Communication (IEC) material for TB infection control has been distributed. An assessment of the Mbabane Government Hospital was conducted
- **Addressed TB in the vulnerable populations**
  - ASSIST has continued to work with TB in the mines over the reporting period. In collaboration with University Research South Africa (URC\_SA), an advocacy activity was conducted in partnership with Ministry of Health and the Miners Association for continuation of TB care and treatment while they were on holiday in Swaziland. The Minister of Health met with 8 current miners and 10 ex-miners to discuss challenges they face in accessing care and treatment

- when they come home and were provided with information resources to improve their accessibility to care and treatment.
- ASSIST continues to support TB screening in maternal and child health settings. Over the last 12 months, efforts to increase TB screening have included onsite trainings for the nurses and clinical mentoring to increase TB case finding among this group of vulnerable populations.
  - **Increased research and use of evidence in designing in priority areas interventions and policies.**
    - Paediatric situational analysis on TB and MDR-TB was conducted and the report finalized (Q1). The analysis showed that a majority of the facilities are not conducting procedures for diagnosing TB in children; even when the children are diagnosed, the nurses in the clinics are unable to initiate TB treatment for the children. The nurses are still not comfortable providing comprehensive TB/HIV including MDR-TB care and treatment for children.
  - **Development of NTCP National Strategic Plan 2015-2019.** The project provided technical assistance and resources for the review and development of the NTCP NSP 2015-2019. This was a consultative process with all the relevant stakeholders including involvement and participation of CDC consultant, the NSP incorporated a monitoring and evaluation (M&E) plan, and costing of the plan is on-going. NTCP staff was trained on monitoring and evaluation concepts and approaches with training outputs. M&E tools were developed to monitor the new TB NSP.
  - **Accreditation assessment for clinics to offer TB services.** ASSIST staff were able to support and access Mpaka Refugee Camp clinic which is a refugee camp that houses about 200 to 300 individuals from different countries in Africa namely Burundi, Somalia, Rwanda, Democratic Republic of Congo (DRC) and Ethiopia. It provides HIV Testing and Counselling, ART initiation plus follow-up, TB screening and diagnosis for TB after which a patient is referred to another facility for initiation on TB treatment and follow-up mainly by Good Shepherd hospital. This is constraint as the majority of the patients diagnosed with TB cannot afford the financial costs incurred by the transport fees. Following discussions with the team working in the facility, it was decided that the facility should become a TB treatment initiation site. Areas of improvement identified by the team included inadequate consultation rooms for TB patients, staff shortage, and poor ventilation in the facility.
  - **Community TB screening in 3 communities in 2 regions.**
    - The project continued to support NTCP to reach different communities including schools, prisons and the general public, providing health education and TB screening in order to find, test and treat for TB.
  - **Provided support to correctional facilities (prisons)** (Bhalekane, Piggs' Peak, Sidwashini and Matsapha prisons) (Q2). In March the mobile clinic in Matsapha enrolled patients and recording in TB registers and are refilling medication for patients who were already on treatment. The facility is in the process of starting IPT on inmates. Drugs, recording and reporting tools have been availed in the facilities. The nurses have already been trained on IPT initiation however, they still require refresher training. Provide technical assistance (TA) to the Technical Working Group (TWG) for Correctional services for integrated TB and HIV care.
  - **Provided TA to address paediatric TB** (Q1 and Q2).
    - Orientation on the new provider initiated testing guidelines was conducted in TB facilities to address testing among children. TA was provided to integrate paediatric TB screening into school health, maternal and child health and integrated management of childhood illnesses policies. TB symptom screening questionnaire was integrated in child health card.
  - **Decentralization of MDR-TB initiation sites to increase access and retention in MDR-TB diagnostic and treatment.**
    - ASSIST continued to provide Support to Good Shepherd Hospital to prepare the facility to start initiating MDR-TB patients in April. Additional support was also provided to TB hospital and Piggs' Peak Hospital to strengthen DR-TB patient management, there has been an increase in culture conversion rate from 73% to 80% and treatment success rate of 57% to 58% (Figures 28 – 29).

Figure 28: Swaziland: Trends of cure rate, completion rate and treatment success rates (Jan 2011 – March 2011)

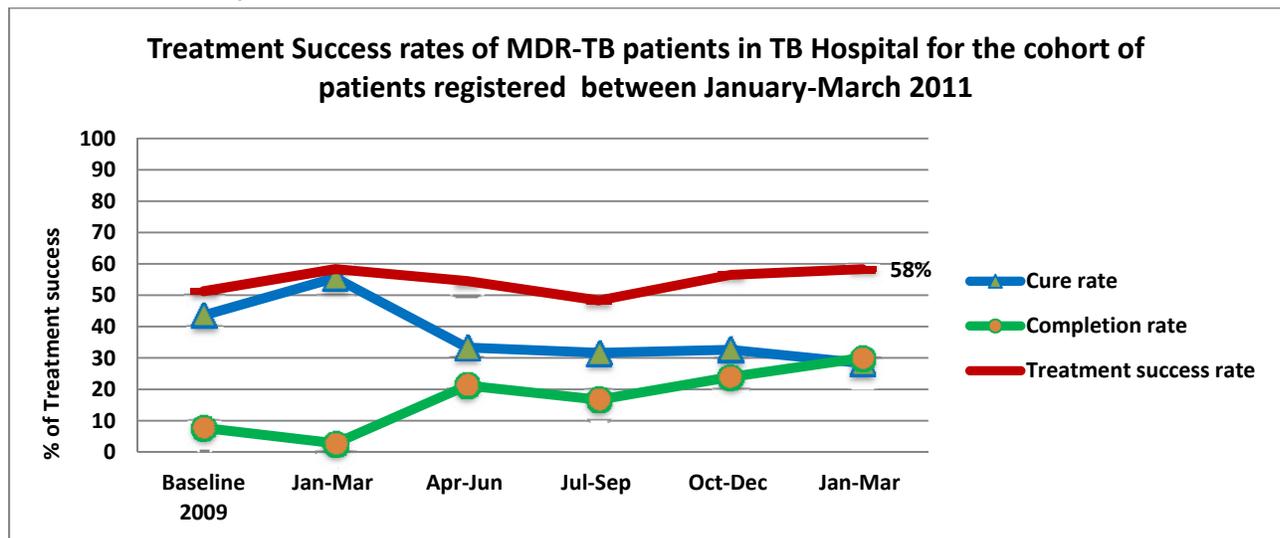
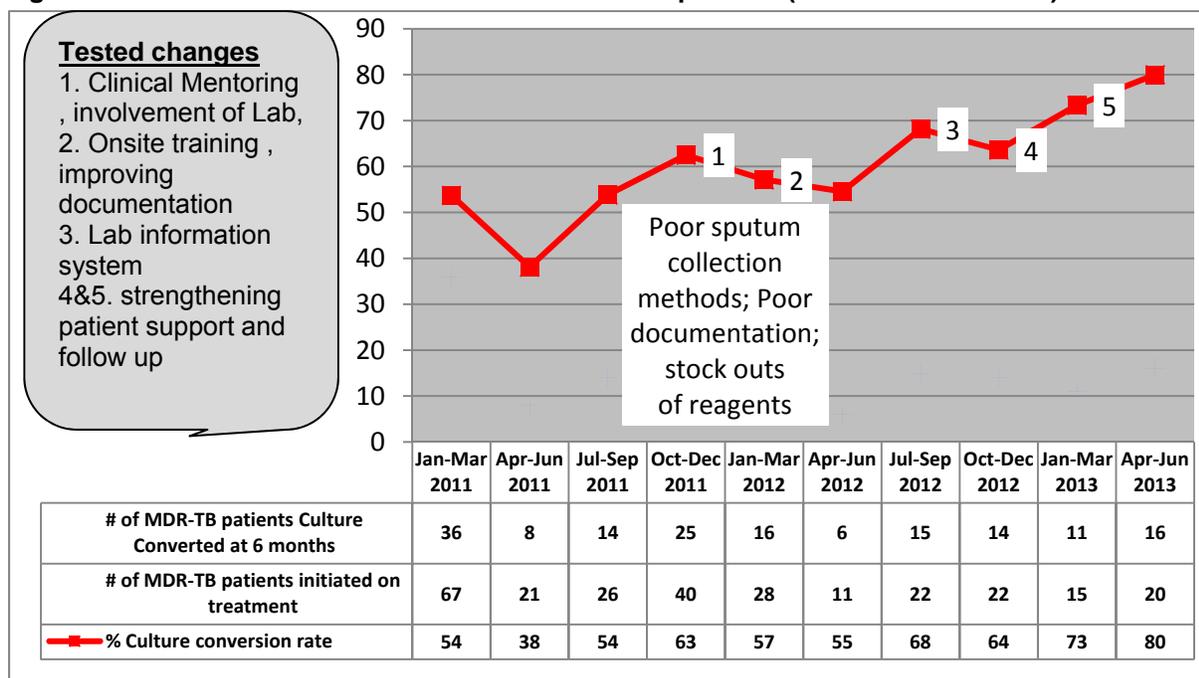


Figure 29: Swaziland: Culture conversion of MDR-TB patients (Jan 2011 – Jun 2013)



- Provided TA and mobilized resources to support the scale up of TB diagnostic services (Q2).
  - With assistance of the CDC lab strengthening project run by URC, 5 more GeneXpert machines were installed bringing the total number of GeneXperts in the country to 26. Facilities have received training on algorithm for using the GeneXpert machine for diagnosis and follow up mentoring provided. Using the national sample transport system, all diagnostic facilities have access to the GeneXpert.
- **Conducted clinical mentoring and supportive supervision to facilities providing TB services (Q2).**
  - Project staff conducted clinical mentoring and supportive supervision to 16 health facilities in Lubombo region 20 in Hhohho region and 21 in Manzini region with a total of 57 in the three regions. This support has ensured HCWs to comply with TB and TB/HIV management

manuals, guidelines and SOPs. In addition the Lubombo regional TB team supported in conducting baseline assessments of three health facilities in the region.

- **Promoting IPT for eligible people living with HIV (Q2).**
- The project supported an IPT cohort study in order to assess patient adherence, determining patient outcomes, identifying critical periods for future interventions and investigating existing data collection practices in TB and ART clinics in 4 sites. IPT data was collected in February from different hospitals in the country. Four hundred and one (401) patient records from centralized electronic databases were reviewed. These were patients initiated on IPT between September 2011 and January 2013. Of the 401 records, about two thirds were female, and 95% of the study population was between the ages of 20-60. Tracing patient outcomes revealed that only 32% (128) of patients reviewed during the study completed treatment, while 56% (224) of patients defaulted on their course of IPT, 5% of patients were Lost To Follow Up and 2% (8) transferred out. 30% of all patients with traceable default dates adhered through 4 months of treatment before defaulting within 2 months of their completion date, while 28% defaulted after their initial isoniazid prescription. On average, defaulting patients adhered to ART treatment for 18 months following their discontinuation of IPT.
- **Utilized Geographic Information System (GIS) mapping of MDR-TB patients and supporters to strengthen linkages (Q2).**
  - To identify outbreaks/hotspots and improve patient support by clinical teams a cumulative total of 962 drug-resistant (DR-TB) patients out of 7 DR-TB sites were identified and mapped using GIS mapping.
- **Strengthen IPC infection control.**
  - The project supported a Quality Assurance Infection Prevention and Control (QAIPC) TWG workshop on the 6<sup>th</sup> of March. A total of 11 participants were in attendance at this meeting. Objectives of this meeting were to get updates for the commemoration of Hand Wash Day; to produce the final IPC manual for HCWs; and to discuss the identified gaps by PPCU team on the draft of the National IPC guidelines.
  - TB Infection Prevention and Control (IPC) and HIV Sensitization workshop for public transport operators was conducted on the 5<sup>th</sup> of March, 28 public transport owners were reached during this workshop. The objective of the workshop was to teach public transport owners on the basics of TB and prevention and to raise awareness on employee wellness issues pertaining to TB. Five hundred 500 *Open Windows* stickers were distributed during this workshop.
  - IPC Focal Persons Training on the 3<sup>rd</sup> – 7<sup>th</sup> of February. This training was attended by 36 representatives from the MOH and other health facilities. The key objective of the training was to capacitate health care workers on Infection prevention control issues by improving their skills and knowledge.

#### **Activity 4. Implement advocacy communication and social mobilization (ACSM) interventions to improve/HIV and MDR-TB services uptake and outcomes**

##### **Accomplishments:**

- **Worked to strengthen the capacity of NTCP to develop and implement a TB ACSM strategy (Q1).** An initial draft of the ACSM strategy has been developed in conjunction with the STOP TB partnership in Swaziland.
- **Provided resources and TA for World TB Day Commemoration (WTBD) (Q2).**
  - Printing and distribution of IEC materials - Poster, banners, pamphlets, stickers and promotional materials were produced and distributed. Messages printed on the banners and posters encouraged stopping the spread of TB as well as identifying the missed 7000 TB cases in the country which need to be found, treated and cured. Media – three mediums were used to sensitize the general public on TB and for promoting World TB Day.
- **Developed, printed and distributed IEC materials and job aids on TB, TB/HIV and MDR-TB.**
- **Reached out to populations at risk.** This included visits to schools, prisons, mines, military and the police where health education was provided and screening conducted. In Mhlume High School in the Lubombo region a total number of 700 people received health education and 158 children and teachers were screened for TB. Focusing on prisons, two days after the actual

commemoration of WTBD, Bhalekane Prison Farm hosted a TB Day for over 300 offenders and 50 warders. The military and the police were targeted during the national celebrations of WTBD.

### **Activity 5. National Framework for In-service Training**

#### **Improvement Aim:**

- Improve the quality and effectiveness of in-service training (IST) for healthcare workers through improved design, delivery, coordination and tracking of all IST:

#### **Accomplishments:**

- **Recruited and hired a national In-service training advisor (Q1).**
- **Presented the IST improvement framework to stakeholders.** In order to sensitize and create buy in of the different stakeholders, the IST improvement framework was presented to the Human Resources for health technical working group (HRH TWG), the Nursing Council, program managers, and the PEPFAR partners, non-governmental organisations (NGOs), training institutions and IST coordinators. The result of this was:
  - The core IST improvement activities have been included in the HRH TWG work plan, this means the TWG will provide technical support (e.g. advocacy in addition to building up ownership and sustainability).
  - A sub technical working group within the HRH TWG has been created to focus on IST issues.
  - An operational working team has been created to run the day today activities of the project. This team constitutes two staff from the training unit, one HR officer from the ministry of public service, the IST improvement advisor, and a representative from the strategic information department. The team is receiving mentorship on IST improvement.
- **Two stakeholder consultation meetings were held on 22<sup>nd</sup> January and 6<sup>th</sup> February 2014. The deliverables from these meetings were:**
  - Designed the IST improvement theory of change for Swaziland.
  - Got feedback on IST baseline survey objectives and tools.
  - Agreed IST coordination changes to be prototyped.
- **Literature review on IST coordination.**
  - In an effort to learn from other countries globally on improving IST coordination, we undertook literature review which was mainly web based. There was very little related information found (i.e. we only found published information from Sudan and Nepal on their IST coordination experience). We followed up with the Nepal study and held a Skype call to learn more about what they have done.
  - We are currently writing commentary to be published in the HRH journal to inform the world about what we are trying to achieve but most importantly, the need for sharing information regarding IST coordination globally.
- Conducted IST baseline survey: Survey objectives were agreed upon with stakeholders (NGOs, MoH partners, training institutions, programs etc.). Tools were designed and piloted and the survey was sent out online on March 18, 2014. Tools for focus group discussions held in April are being developed.

### **How Do We Know We Are Improving?**

#### **Improvement in Key Indicators:**

<b>Activity</b>	<b>Indicators</b>	<b>Baseline (Sept 2013)</b>	<b>Value (Dec 2013)</b>	<b>Last value (Mar 2014)</b>
Support the MOH and implementing partners to institutionalize modern Quality Improvement approaches.	Number of health facilities participating in QI/QA activities.  Number of health care workers trained on QA/Q.I	Hhohho region:5  Manzini region: 12	Hhohho region: 5  Manzini region:12	Hhohho region: 5 Manzini region:12 Lubombo region: 4  36 project staff & MOH QMP; 48 HCW trained

Implement high quality DOTS expansion for TB & MDR-TB and strengthen implementation of integrated TB/HIV prevention, care, and treatment.	TB case notification	1782	1341	1208 excluded Lubombo region
	TB treatment success rate	77%	77%	80%
	HTC uptake	96%	96%	95%
	CPT uptake	98%	99%	99%
	ART uptake	69%	72%	84%
	MDR-TB case enrolment	76%	14/20	75%
	MDR-TB 6 months interim outcome	68%	73%	80%
	MDR-TB treatment success rate	59%	57%	58%

### **Directions for Q3 and Q4 FY14**

#### **Activity 1. Support the MOH and implementing partners to institutionalize modern Quality Improvement approaches**

- Provide TA and resources to the MOH QMP unit to conduct the National Annual Quality Forum.
- Develop a TOT manual and conduct QI coaching to regional and health facility teams.
- Support Collaborative feedback sessions nationally and regionally.
- Scale up use of standard Evaluation and documentation tools for QI activities in health facilities and model clinics; compile, print and disseminate QI storyboards.

#### **Activity 2. Establish integrated TB/HIV/NCD model clinics and Centres of Excellence to MDR-TB clinics to improve implementation of the essential health care package**

- Conduct training and mentoring of HCWs at the sites to improve TB diagnosis and management and TB/HIV integrated management, and diabetes care.
- Provide job aids and IEC materials for the HCWs and patients.
- Review and adapt TB and Diabetes treatment protocol and guidelines.

#### **Activity 3. Implement high quality DOTS expansion for TB & MDR-TB and strengthen implementation of integrated TB/HIV prevention, care, and treatment**

- Provide TA and resources to MOH and NTCP conduct TB Program Review
- Provide TA to ensure TB screening is done at all entry points and strengthen early ART initiation in both drug sensitive and drug resistant TB patients
- Conduct research in paediatrics TB, MDR-TB resistance patterns, TB and Diabetes
- Conduct training on new TB and MDR-TB guidelines and conduct clinical mentoring visits to facilities to support the compliance with guidelines and SOPs for DOTs.
- Provide TA and resources using M-Health to conduct defaulter tracing in TB clinics.
- Promote IPT for eligible people living with HIV and healthcare workers and work with Wellness Centre to scale up TB screening among HCWs.

#### **Activity 4. Implement advocacy communication and social mobilization interventions to improve/HIV and MDR-TB services uptake and outcomes**

- Provide resources and TA to the NTCP to develop, print and distribute the ACSM strategy.
- Conduct training for NTCP staff and stakeholders on ACSM.
- Increase HCW awareness on early TB detection and referral and conduct community awareness campaigns on TB, TB/HIV and MDR-TB to increase community awareness.

#### **Activity 5. National Framework for In-service Training**

- Develop IST M&E framework and compile IST survey report.
- Finalize IST improvement strategy.

- Strengthen IST coordination mechanism.

## 1.14 Tanzania

### Background

USAID ASSIST was invited by the Mission in Tanzania to continue supporting the Ministry of Health and Social Welfare (MOHSW) and PEPFAR ART/PMTCT IPs in building capacity to improve the quality of care. This work is building on work started under the HCI in 2008. ASSIST supports activities geared to strengthening access, retention and effectiveness of ART/PMTCT care; services and protection of most vulnerable children; and community based services. Furthermore, and in partnership with the PHFS Group, ASSIST is also supporting activities aimed at eliminating HIV infection in children and reducing deaths among HIV-infected mothers including national scale-up of PMTCT Option B+. Other technical areas of interest include support to efforts improving the quality of ART care to infants and children exposed or infected with HIV.

ASSIST's chosen approach is building the capacity of Regional Health Management Teams (RHMTs) and Council Health Management Team (CHMTs) to coach and mentor facility-based improvement teams to test changes that will improve access and retention in care, increase TB screening, improve adherence to anti-retroviral drugs, and improve nutritional care for HIV-positive mothers and exposed infants.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. To support the MOHSW and PMTCT IPs to scale up programs providing women and their families improved access to HIV prevention, testing, care, treatment and support through quality improvement approaches along the PMTCT cascade	<ul style="list-style-type: none"> <li>• To improve access to HIV prevention, testing, care treatment and support</li> <li>• To improve optimal ARV care for mothers and infants attending post-natal care</li> <li>• To support the MOHSW, IPs and stakeholders to design, test and adopt performance benchmark and standards for effective implementation of option B+</li> <li>• To support MOHW, RHMT/CHMT to improve early infant diagnosis among HIV children in Mbeya urban</li> </ul>	<p><b>New Learning Sites:</b> 60 new QITs were established in Mwanza, Singida, Mbeya, and Dodoma where 284 HWC were trained in QI and developed improvement work plans.</p> <p><b>Old sites:</b> QI coaching visits were conducted in 88 sites in six regions (Kilimanjaro, Shinyanga, Lindi, Mtwara Morogoro and Tanga) where 412 HCW were supported.</p> <p><b>Pediatric ART:</b> 10 improvement sites started Mbeya. Ten QITs of 32 HCWs are testing changes to improve access, retention and wellbeing.</p>	x	
2. To support the MOHSW and HIV Free Survival IPs towards elimination of HIV infection in children and reducing deaths among HIV-infected mothers	<ul style="list-style-type: none"> <li>• To improve optimal ARV care for mothers and infants attending post-natal care</li> <li>• To improve retention all mother-infant pairs in post-natal care regardless of their HIV status</li> <li>• To improve monitoring of well-being of HIV+ mothers</li> </ul>	<p>3 out of 26 regions (Tabora, Iringa and Mbeya)</p> <p>1 district in each of the three regions (Nzega, Mufindi and Mbeya Municipal)</p> <p>10 sites in each of the three districts</p>	x	

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
	attending post-natal services and their infants <ul style="list-style-type: none"> <li>To improve provision of optimal nutritional care for mother – infant post-natal care at the health facility and community level</li> </ul>			
3. To support the MOHSW and IPs to scale up improvement activities for ART services to achieve sustainable patients coverage, retention and clinical outcomes	<ul style="list-style-type: none"> <li>To support MOHW, RHMT/CHMT and IP to scale up HIV/AIDS care improvement to 4 new regions</li> <li>To provide TA to MOHSW, RHMT and CHMT in integrating essential services with ART program</li> <li>To strengthen follow up of ART patients for better retention and clinical outcomes</li> <li>To test changes to improve care- patient centeredness</li> </ul>	Mwanza - 1 out of 6 districts; 10 sites Singida - 1 out of 6 districts; 10 sites Dodoma - 1 out of 6 districts; 10 sites Mbeya – 10 sites in 1 district  Morogoro - 42 out of 50 sites, Shinyanga - 28 out of 34 sites, Iringa - 20 out of 37 sites, Njombe - 7 out of 7 sites; Lindi - 8 out of 66 sites, Mtwara - 20 out of 60 sites, Kilimanjaro - 13 out of 31 sites, Manyara - 10 out of 27 sites, Tabora - 15 out of 40 sites, Tanga - 12 out of 71 sites  14 facilities in Morogoro urban and rural	x	
4. To support the MOHSW, MVC, IPs and local structures to strengthen quality of care, support and protection to Most Vulnerable Children (MVC) through Improvement approaches	<ul style="list-style-type: none"> <li>To support the Department of Social Welfare (DSW) of the MOHSW and MVC IPs in improving and strengthening the MVC care response system</li> </ul>	National Child Protection (CP) Model district - Mkuranga	x	
5. Work with the MOHSW and stakeholders to develop a community home-	<ul style="list-style-type: none"> <li>To support the Department of Social Welfare (DSW) of the MOHSW and MVC IPs in improving and strengthening the MVC care response system</li> </ul>	National 3 out 24 wards in Bagamoyo district	x	

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
based care (CHBC) quality improvement program and monitoring framework and support country wide scaling up	<ul style="list-style-type: none"> <li>To support the DSW, LGAs and IPs in developing a comprehensive MVC care and protection framework</li> <li>Implement a comprehensive MVC care package addressing child protection needs i.e. violence, abuse, neglect in a model district</li> </ul>	3 wards in Mkuranga district		
6. To support the MOHSW and partners to develop, field test and scaling up plan of national Quality Improvement Framework for PMTCT Option B+	<ul style="list-style-type: none"> <li>Support the MOHSW, IPs and stakeholders to design, test and adopt performance benchmark and standards for effective implementation of option B+</li> </ul>	National		
	<ul style="list-style-type: none"> <li>Support the MOHSW, IPs and stakeholders to design, test tools for facilitation of implementation of a coordinated and integrated PMTCT option B+ strategic approach at district level</li> <li>Support field testing of the common PMTCT Option B+ improvement plan in one model district in Mwanza</li> </ul>	10 facilities in one District of Mwanza region	x	
7. To support MOHSW and IPs to improve the quality of ART care for infants and children exposed or infected with HIV	<ul style="list-style-type: none"> <li>To support MOHW, RHMT/CHMT to improve early infant diagnoses among HIV children in Mbeya urban</li> </ul>	All health facilities of Mbeya urban	x	
	<ul style="list-style-type: none"> <li>To improve pediatric ART treatment</li> </ul>			
	<ul style="list-style-type: none"> <li>To strengthen follow up of pediatric ART patients for better clinical and immunological monitoring</li> </ul>			
	<ul style="list-style-type: none"> <li>To strengthen retention and outcomes of HIV-infected infants and children</li> </ul>			

### Key Activities, Accomplishments, and Results

**Activity 1. To support the MOHSW and PMTCT IPs to scale up programs providing women and their families improved access to HIV prevention, testing, care, treatment and support through quality improvement approaches along the PMTCT cascade**

#### Improvement Aims:

- Increase the percentage of HIV+ve pregnant women and lactating mothers on ART for PMTCT to

90% in four model districts each in Singida, Mwanza, Dodoma and Mbeya regions by September 2014 through system strengthening.

- Increase access to family planning among women of child bearing age living with HIV from the current 50% to 75% in four model districts each in Singida Mwanza, Dodoma and Mbeya regions by September 2014 through service integration.
- Increase the proportion of HIV exposed children receiving confirmatory HIV testing 6 weeks after weaning from current 40% to 75% in four model districts each in Singida, Mwanza, Dodoma and Mbeya regions by September 2014 through system strengthening.
- Increase the proportion of HIV-infected mother-infant pairs retained in care up to 18 months by 80% in four model districts each in Singida, Mwanza, Dodoma and Mbeya regions by 2014 through system strengthening.
- Sustain the improvement gains in Kilimanjaro, Shinyanga, Lindi, Mtwara, Morogoro and Tanga regions and scale up to Singida and Mwanza, Dodoma and Mbeya regions by September 2014 through system strengthening.

#### **Accomplishments:**

- **Iringa district council scale up sites: All scale up sites except one have switched to Option B+ and ART services are integrated at RCH. In Iringa District Council the 13 scale up sites initiated QI implementation through:**
  - Strengthening health education at RCH on: Importance of HIV positive mothers to use ARVs for prophylaxis or for lifelong treatment; HIV positive pregnant women to bring back their babies for postnatal care where they will be linked to child follow up till their HIV status is finally determined.
  - Linking with village leaders and facility board members to advocate on: Early ANC booking, men to escort their female partners for ANC.
  - Use HBC providers to track HEI who do not turn up for results.
  - Some Option B+ sites with site based CTC are practicing daily entering PMTCT clients' information to data base to minimize losing data.
  - Some facilities have initiated interfacility linkage where they can borrow reagents, ARVs or other supplies at times of shortages and use ledger books to record supplies given or received from other facilities.
  - One facility tried on the job peer training on conducting DBS test and is observing increasing number of children receiving DBS test.
- **Kilimanjaro: QI teams with support from RHMT, CHMT and IPs continue to implement changes to narrow the implementation gaps on the priority PMTCT improvement areas.**

#### **Update to Integrated Design of Improvement Activity**

ASSIST is providing TA to IPs, R/CHMTs in the scale up sites. All sites in the district are participating in the improvement process. ASSIST is collaborating with IPs to advocate for use of district QI funds to support CHMTs to conduct coaching and mentoring as an integral part of supportive supervision. To ensure sustainability and institutionalization, CHMTs continue to be supported to oversee teams on identifying and conducting gap analysis, test and document changes in Standard Evaluation System (SES), proper documentation in registers, accurate collection of monthly QI data, plotting and annotating in SES for monitoring progress.

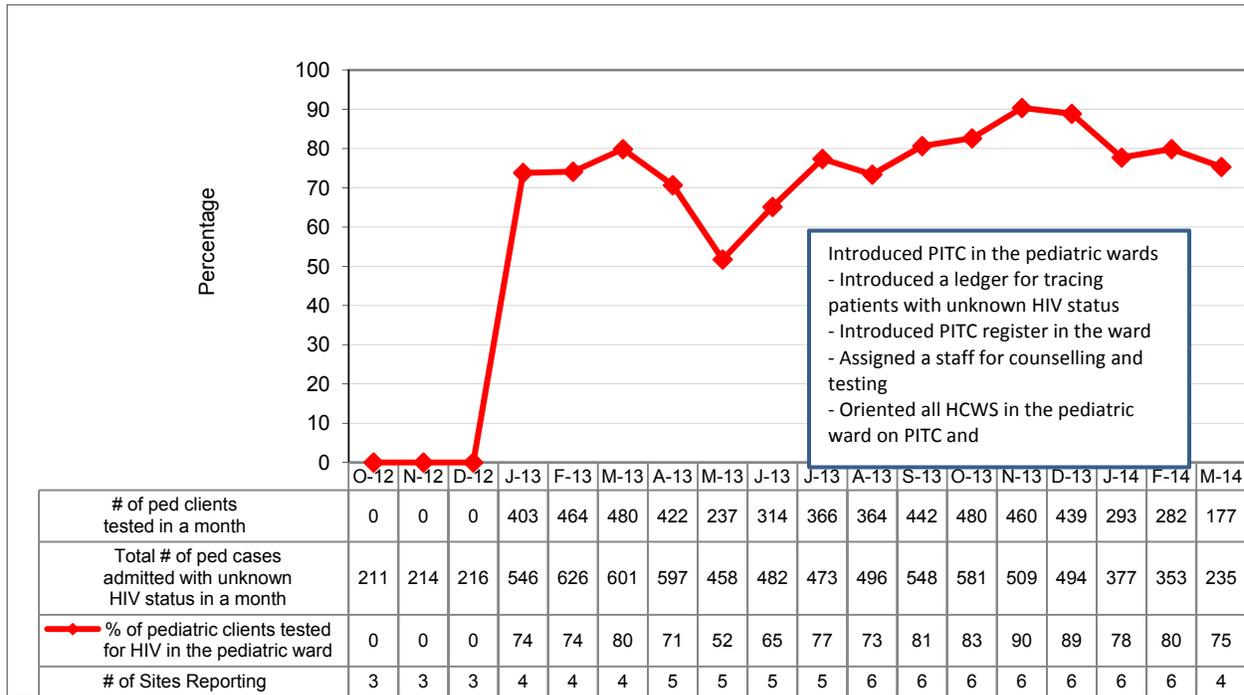
#### **Spread Strategy**

ASSIST is working with IPs, and R/CHMTs supporting them to identify and package effective changes as best practices which will be applied in other sites in the districts.

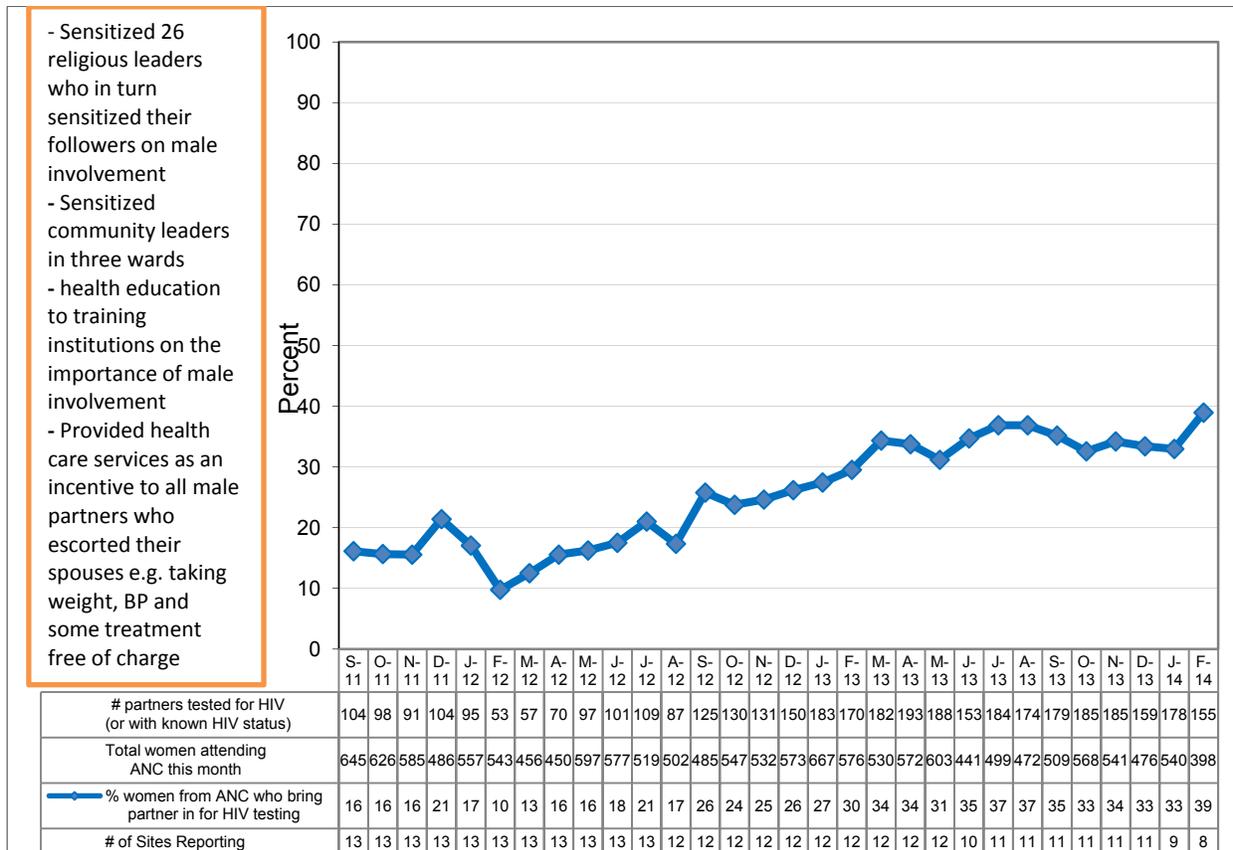
- **Iramba district, Singida region: Conducted baseline assessment and learning session (Q2).**
  - A baseline assessment was conducted at six facilities of Iramba district and the findings were shared and discussed with the RHMT, CHMT and HCWs from 35 facilities. The findings revealed that: only Kiomboi was implementing QI activities with support from JICA. Implementation of PMTCT option B+ had started at the district hospital, while the other facilities were waiting for ARVs to start treatment. There was shortage of HIV test kits (rapid & DNA/PCR), opportunistic infection (OI) drugs (e.g., Cotrimoxazole and ARVs for pediatric

- clients). There was inadequate post natal follow up of HIV+ mother and baby, and weak community linkages; Documentation is a big problem in all the facilities assessed and in some facilities PMTCT and PITC registers were not in place.
- The first learning session was conducted for all 35 facilities in the district. One member from the regional IP - TUNAJALI, two RHMT members, eight CHMT members, and 70 health care workers from the 35 health facilities participated. Facilities formed improvement teams which were then assisted to develop workplans for action. The teams agreed to focus on improving: Early ANC booking (before 12 weeks of pregnancy); couple testing at RCH; uptake of lifelong ART for HIV+ pregnant and breast feeding women; paediatric PITC; Cotrimoxazole uptake among HIV exposed infants; integration of HIV and FP services at RCH; integration of TB and HIV services; postnatal follow up of HIV+ mother baby pairs; and supply chain management for HIV test kits, CD4 reagents, ART for PMTCT-TLE and Cotrimoxazole.
  - **Lindi region: Held leaning session** (March 2013). Two RHMT members, eight staff members from EGPAF and 45 members from nine health facilities in Lindi region participated in a learning session organized by EGPAF. ASSIST was invited to provide technical assistance on reviewing of QI indicators, facilitation of experience sharing among teams, development of improvement changes and how to test changes in order to know if they resulted in improvement or not. ASSIST also supported training on improvement science, QI principles and its dimensions. Teams agreed on the following new priority areas for improvement: Uptake of lifelong ART for HIV+ pregnant and breast feeding women; early infant diagnosis of HIV; couple testing at RCH; TB and HIV service integration; HIV and FP services integration at RCH; postnatal follow up of HIV+ mother baby pairs; PITC for pediatric clients and adults receiving in-patient and OPD services; supply chain management of: HIV test kits, CD4 reagents, ART for PMTCT-TLE and Cotrimoxazole. Plans of QI activities for 2014/2015 were developed hoping that they would be included into CCHPs. EGPAF will support learning sessions and coaching visits while URC will continue to provide technical support to this region.
  - **Mtwara region: Conducted indicator review** (March 2014). ASSIST conducted an indicator review meeting in the Mtwara region. The meeting involved participants from: regional ART &PMTCT implementing partners (three from EGPAF and one from Tanzania Health Promotion Services -THPS), two RHMT members, five CHMT members and 44 QI team members from eight collaborating facilities in the region. The teams shared QI implementation progress and reviewed clinical indicators to accommodate PMTCT option B+, paediatric indicators and TB/HIV services integration. Ten indicators were selected to be used to monitor performance over time. The teams developed plans of action using SES journal for the next action period.
  - **Kilimanjaro region: Conducted learning session** (Q1). A third learning session was conducted for 15 health facilities in the Kilimanjaro region. The learning session was attended by four RHMT members lead by RACC, nine CHMT members, nine staff from EGPAF and 60 health care workers. The facilities shared progress of QI implementation at their health facilities. During the learning session it was observed that most of the facilities had their data updated. The teams also agreed on the indicators to be monitored and those to be added as a result of Option B+. The QI teams prepared a work plan for the next action period. Experience in this region shows that improving processes contributes to sustained and improved access to exclusive breastfeeding and other HIV paediatric care. Figure 30 shows that there was improvement uptake of infant testing through expanding services to other departments within the same facility in Kilimanjaro region. In addition, improvement was noted in the percentage of women from ANC who bring partner for HIV testing (Figure 31).

**Figure 30: Kilimanjaro region, Tanzania: HIV testing of pediatric clients, 6 sites (Oct 2012 – March 2014)**



**Figure 31: Kilimanjaro region, Tanzania: Percentage of women from ANC who bring partner for HIV testing, 13 sites (Sept 2011 – Feb 2014)**



- **Iringa region: Conducted endline assessment for AIMGAPS** (Feb 2014). The qualitative and quantitative assessment was conducted in four districts, with Regional and District Reproductive and Child Health Coordinators participating. The qualitative component focused on obtaining perspectives of services from: clients, providers and community quality improvement teams. In-depth interviews were conducted with 11 service providers and 32 clients. Members of Community Quality Improvement Teams from 11 villages implementing community component of AIMGAPS were involved in Focus Group Discussion to gain their insights on involving community groups to improve PMTCT service uptake and retention. The quantitative component entailed retrospective data collection from 543 client records to determine services received by HIV positive women during ANC, labour and delivery, postnatal and child follow up.

**Activity 2. To support the MOHSW and HIV Free Survival Implementing Partners towards elimination of HIV infection in children and reducing deaths among HIV-infected mothers**

**Improvement Aims:**

- Increase coverage of ARVS uptake by HIV-positive pregnant women, mothers and infants attending post-natal care in 10 sites each in the three districts; Nzega district Tabora region, Mufindi district Iringa region and Mbeya urban district Mbeya region from the current level 46% to 80% by September 2015 through timely and correct ordering of ARV and adherence counselling.
- Increase the proportion of mother-infant pairs retained in post-natal care at 10 sites in each of the three districts from the current 20% to 80% by September 2014 through system strengthening, community involvement and QI innovations.
- Increase the proportion of HIV-exposed infants below two years of age who are confirmed of their HIV status through DNA/PCR or antibody testing in 10 sites of each of the three districts of Nzega, Mufindi and Mbeya urban from the current 26% to 70 by September 2014 through system strengthening
- Increase the uptake of NACS care package in 10 sites of each of the three districts from the present 0% to 50% by September 2014 through initiation of the program, provision of the NACS tools and training of health care workers on NACS and system strengthening.

**Accomplishments:**

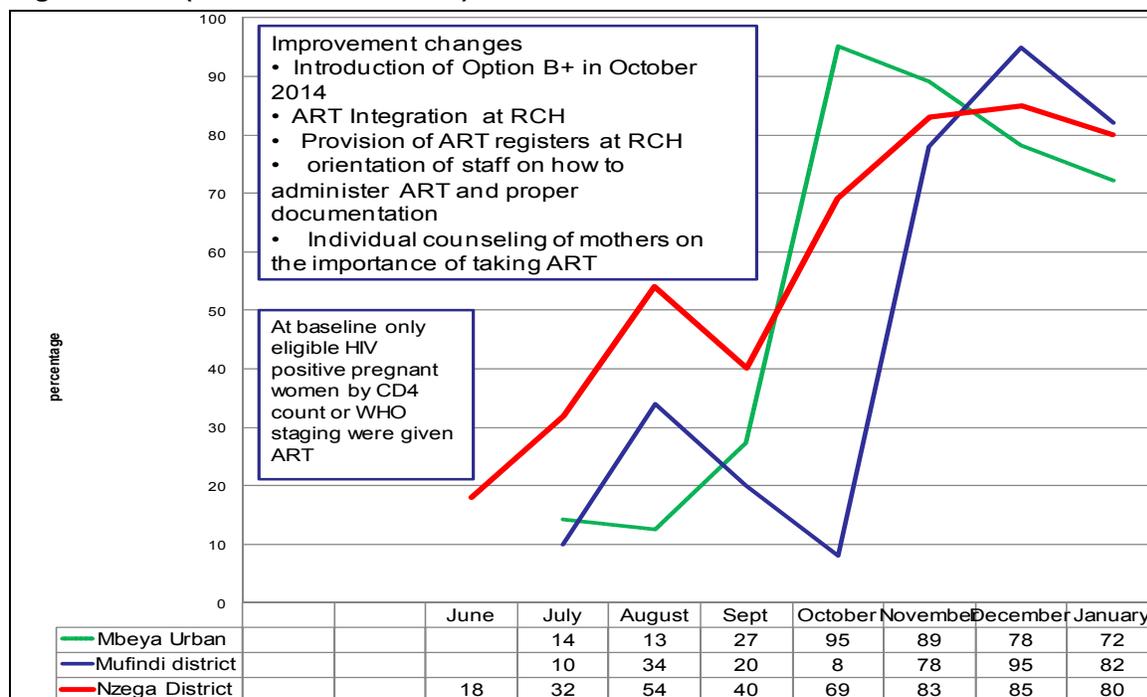
- **PHFS, Mufindi, Tabora: ASSIST in partnership with TUNAJALI-Deloitte and R/CHMT conducted baseline assessment (Q1):** Ten sites selected for implementation of HIV Free survival from Mufindi district, Iringa region were assessed. Data was collected to determine the status of quality improvement activities, facility readiness for PMTCT option B+ and status of nutritional services in the selected facilities. Assessment results revealed: Quality Improvement (QI) activities are implemented in only two health facilities; Mafinga and Lugoda Hospitals; five sites received training on NACS, but needed support to implement; health facilities were ready for PMTCT B+, however, there is a need to improve, ART and RCH service; inadequate follow up of mother baby pair; inadequate community linkage; and documentation is a challenge in many facilities.
- **ASSIST in partnership with TUNAJALI-Deloitte and R/CHMT conducted orientation of R/CHMTs on quality improvement for PHFS (Q1).**
- **Held first learning session for the PHFS sites (Q1).** Twenty-eight service providers and four CHMT members attended. During the learning session:
  - Findings from the baseline assessment were shared and areas that needed improvement were discussed and Indicators for monitoring of the priority areas were also selected.
  - Participants were introduced to: Terms and definitions related to quality and quality improvement; Dimensions of Quality; Principles of Quality; steps in quality improvement; quality improvement model and the Plan Do Study Act Cycle of QI; developing work plans and use of the Standard Evaluation System tool for planning and monitoring progress.
  - Quality improvement teams were formed for each facility, drawing members responsible for PMTCT, CTC and Nutrition Assessment and Counselling Services.
  - Each facility developed work plans covering all the indicators.
- **Two ASSIST staff attended a three days regional meeting in Kampala, Uganda where they shared their experiences with the other two countries, Kenya and Uganda,** implementing

partners of all the three countries and the ministries of health of the these countries. They also developed plans to be implemented for the next six months with the implementing partners (Q1).

- **Conducted coaching and mentoring/ learning sessions.**
  - **Nzega district:** Coaching and mentoring was conducted in Q2 at 10 sites of Nzega district which were implementing the PHFS initiative. A joint coaching and mentoring visit was conducted by ASSIST, EGPAF and CHMT from Nzega district on assessing the functionality of the QI teams. It was found that majority of the teams had conducted at least one QI meeting. The coaches clarified issues raised by QI teams such as definition of indicators, sources of data and assisted teams to update the SES journal.
  - **Tabora region:** In Q2 11 sites were trained in QI for ART/PMTCT services for five days with a total of 27 health care workers participating in the training. In addition, a total of 32 QI team members implementing PHFS participated in a five days second learning session conducted by ASSIST in collaboration with EGPAF and CHMT.
    - The content of the training time table was completed as planned. The major topics covered included: Concepts of quality and quality in health care; dimensions of quality; improvement steps; and application of the PDSA model in improving quality of health care. Principles of quality included examples of QI work in Tanzania and development and testing of change ideas.
    - The participants had opportunity to review a list of indicators and selected 12 indicators for ART/PMTCT QI initiatives. The priority areas they agreed upon included: ART initiation for HIV positive pregnant women and lactating mothers; HIV infected infants and children below two years; HIV testing for children at OPD, RCH and inpatient wards; family planning for HIV positive women of child bearing age attending CTC services; male partner testing at RCH; follow up CD4 count monitoring among PLHIV at six and twelve months after ART initiation; and pregnant women booking at 12 wks of gestation.
    - Each facility developed action plans for each of the 12 indicators selected. Each site presented their improvement work plans and incorporated comments and inputs from others. Each site identified list of members who would form QI teams at their facility.
  - **Iringa region:** ASSIST in collaboration with the CHMT and Tunajali conducted coaching and mentoring visits to 10 sites implementing PHFS in Mufindi District. QI team functionality as well as progress of QI implementation was assessed. It was found that the QI teams had conducted one meeting, but no data was updated in the SES journal despite of team testing some of the improvement changes. In this district, a second learning session was conducted for 19 service providers from 8 sites which were implementing the PHFS initiative.
  - **Mbeya region:** ASSIST in collaboration with Baylor Paediatric AIDS initiative and CHMT of Mbeya urban conducted coaching and mentoring visits at 10 sites which were implementing PHFS. During the coaching visit QI functionality as well as progress of QI implementation was assessed by coaches. Some sites had conducted QI meetings but no site had updated the SES journal. The QI team members were coached on how to extract data from relevant data sources and the SES journals were updated. The definitions of indicators were clarified at each site. In this region, a three day refresher QI learning session was conducted for 32 health care providers, from the 10 health facilities implementing changes to address the prevailing gaps in PHFS.
  - Key results from the three learning sessions for the three districts included:
    - Participants shared their experiences, accomplishments and challenges in implementing the PHFS program. Some of the tested changes shared included: giving mother and her baby the same day appointment, serving mother and baby in one service point/room, using phones to provide feedback to mothers when DNA/ PCR have been brought to the facility, providing health education on the importance of ARV to mother and baby and shifting of postnatal women who are HIV positive from CTC to RCH so that the mother and baby can receive services during one clinic visit.
    - Participants were given an overview of the progress of the PHFS program.
    - The team discussed the indicators which were not clear and agreed on the denominators and data sources

- Refresher training was provided on concepts of QI and Quality of Health care, Principles of QI focusing on measurements, client needs and expectation, systems and processes. Also the process analysis was emphasised and its rationale in identifying current problematic steps and causes for the prevailing quality gaps were demonstrated.
  - QI teams were also oriented on: how to develop and implement changes, roles and responsibilities of QI teams at facility level, importance of proper documentation and follow up of the identified PHFS priority areas to ensure achievement of the stated improvement goals.
  - Participants were advised to work on NACS indicators and include all clients who are supposed to be assessed and counselled (all HIV positive pregnant women, exposed children and HIV positive lactating mothers).
  - Each facility developed action plans (11 each) using the MOSHW/URC Standard Evaluation System.
- **Results from the PHFS sites for HIV-positive pregnant women receiving ART are shown in Figure 32.**

**Figure 32: Tanzania: Percent pregnant women receiving ART treatment, Mbeya, Mufindi, and Nzega districts (June 2013 – Jan 2014)**



**Activity 3: To support the MOHSW and IPs to scale up improvement activities for ART services to achieve sustainable patients coverage, retention and clinical outcomes**

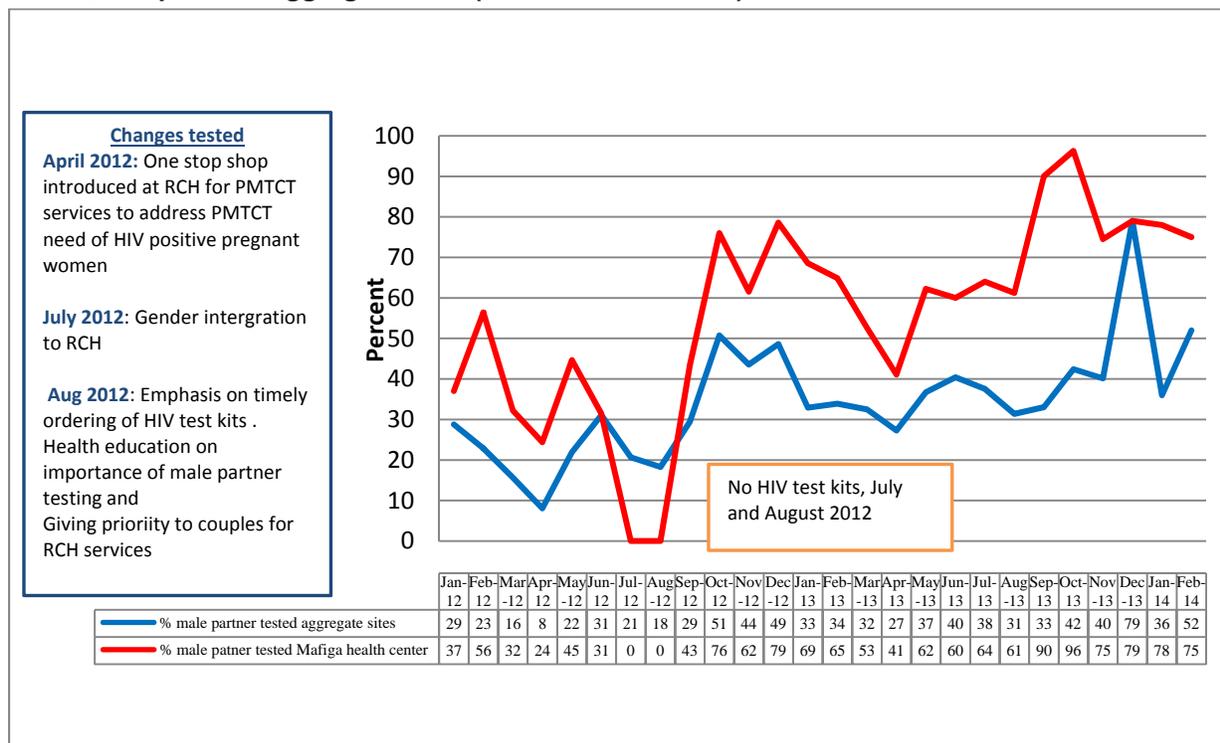
**Improvement Aims:**

- To support MOHSW, RHMTs/CHMTs and IPs to scale up HIV/AIDS care improvement efforts from the current 12 to 16 regions (new regions: Singida, Mwanza, Dodoma and Mbeya) by September 2014 through TA for quality improvement.
- To improve access to TB screening from current 60% to 100% and FP for patients on ART from the current 25% to 60% in 12 regions (Morogoro, Shinyanga, Iringa, Njombe, Lindi, Mtwara, Kilimanjaro, Manyara, Arusha, Tabora and Tanga) by September 2014 through system strengthening.
- To reduce loss to follow up for patients on ART from the current level of 25% to 10% in 12 regions above by September 2015 through strengthening community follow up and improved patient centeredness.

**Accomplishments:**

- **Quality improvement has been integrated to regional and district quarterly supportive supervision visits.** The RHMT and CHMT in collaboration with regional implementing partners are continuing to supervise QI in the region. The integration has resulted to increased service uptake (Figure 33).

**Figure 33: Morogoro region, Tanzania: Percent of male partner testing for HIV in Mafiga Health Center, compared to aggregate sites (Jan 2012 – Feb 2014)**



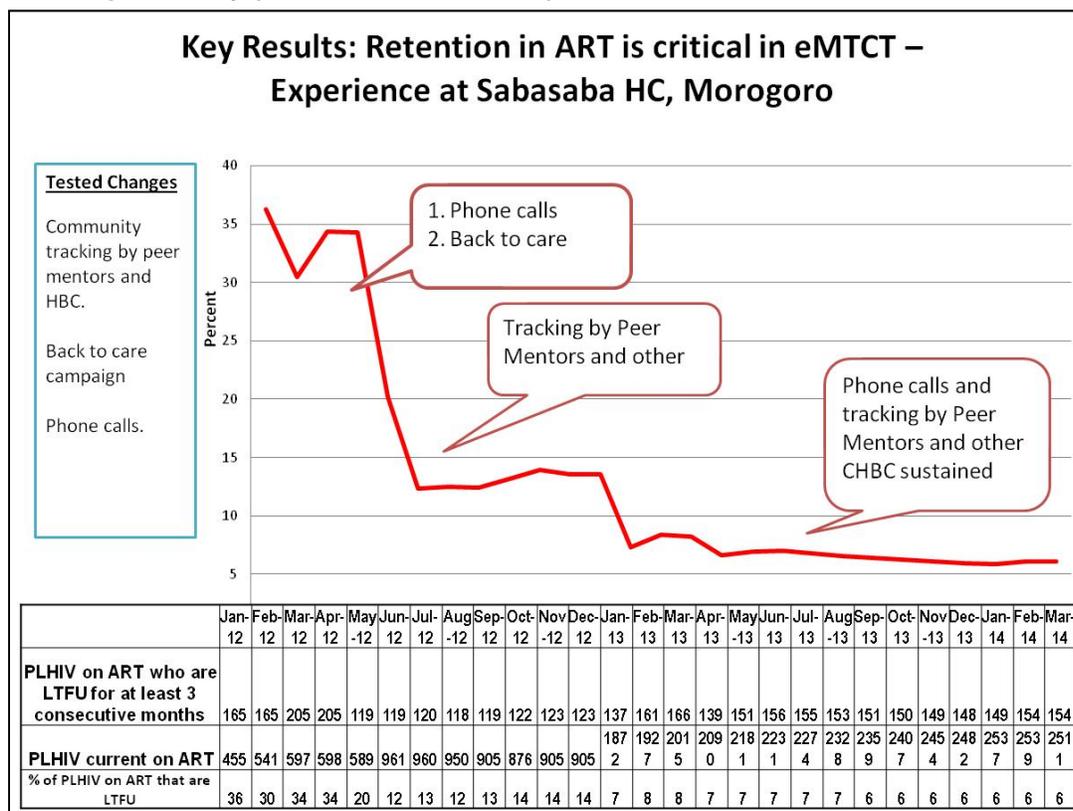
**Update to Integrated Design of Improvement Activity**

ASSIST was working with RHMTs, CHMTs and regional IPs throughout the reported period. Although the frequency of URC visiting the sites had been reduced, QI supervision had been continuing during their routine supportive supervision while ASSIST has continued follow up through emails and phone calls to the teams.

Emphasis has been made to QI teams to document changes and other QI activities taking place at the sites in the Standard Evaluation Systems tools which helped to plan, test and document changes and monitor improvement on priority technical areas.

- **Conducted mentoring and coaching visit, Morogoro region** (February 2014). ASSIST conducted coaching for 10 improvement teams with 67 health care providers. Teams were coached on the analysis of tested improvement changes, reviewing QI team functions and identifying new QI members to replace those who had left the facility and development of work plans for the next action period. The coaching team noted that there was improvement in bridging several gaps that were identified in January 2013. For example at the Sabasaba health center there was remarkable reduction in number of PLHIV on ART that were lost to follow-up. This improvement was made possible through team’s initiative by introducing the following changes; use of expert patients to help with tracking of those who were lost, contacts made using mobile phone calls to lost cases. Figure 34 illustrates the progress in reduction of lost to follow-up cases.

**Figure 34: Morogoro region, Tanzania: Percent of HIV-positive patients on ART who are lost to follow-up, 1 facility (Jan 2012 – March 2014)**



- **Conducted orientation of peer mentors.** A one day meeting was organized for 53 peer mentors from Morogoro municipal and district councils. In this meeting peer mentors were oriented to new PMTCT option B+ approach and their roles in ensuring all HIV+ pregnant and breast feeding mothers take lifelong ART for PMTCT. Peer mentors would help in: alleviation of fear and anxiety in newly identified HIV+ mothers; and adherence to treatment and tracking of client who missed their appointment. Expert patients developed work plans on how they can support pregnant and postnatal women attending RCH clinics on adherence to ART.
- **Conducted learning and coaching sessions in Shinyanga.** From February to March 2014 two ASSIST Improvement Advisors working with staff members from AGPAHI, the regional implementing partner of Shinyanga conducted a four day learning session for new 14 PMTCT/ART QITs and 30 Health care workers participated. This was immediately followed by 6 day coaching and mentorship sessions at 10 old sites in Shinyanga and Simiyu regions for 100 HCWs.
- **Results:** Almost all of the QI teams were dormant (not conducted meetings to discuss or set improvement objectives, plans developed during learning session one were not implemented or documented in SES). The teams did not have clear understanding of indicator definition. The teams were taken through indicator matrix which shows numerator, denominator and data source for each indicator. ASSIST built the capacity of QI teams to abstract appropriate indicator data (both numerator and denominator) from right sources. The teams were facilitated to develop plans for the next action period for six indicators.

**Activity 4. To support the MOHSW, MVC, IPs and local structures to strengthen quality of care, support and protection to Most Vulnerable Children through Improvement approaches**

**Improvement Aims:**

- To increase access to basic education, health services and nutrition from 50% to 80% for MVC in Bagamoyo, Mkuranga and Kigoma urban districts by September 2014 through system

strengthening, awareness creation and local resource mobilization.

- To increase proportion of MVC with birth certificates from 25% to 60% in Mkuranga district by September 2014 through awareness creation on birth registration and strengthening local resource mobilization.
- To reduce the proportion of children experiencing episodes of physical violence in the three wards of Mkuranga district from current level 68% to 60% by September 2014 through community counseling, strengthening of children clubs and response systems.

#### **Accomplishments:**

- **URC/ASSIST in collaboration with Bagamoyo District Council continued to support MVCCs/QITs through:** Coaching session in three wards of Magomeni, Kiwangwa, and Fukayosi. A total of 17 QITs/MVCC participated together with ward and village leaders. QITs have continued to work and collaborate with village authorities in mobilization of various resources in supporting MVC.
- **In Magomeni ward, teams have been working to ensure children are protected against exploitation, abuse and violence.** Two cases of abuse were identified by MVCC and CJF and reported to authorities for actions.

#### **Update to Integrated Design of Improvement Activity**

During implementation of this activity, the district authority (specifically those involved with MVC services -- the Social Welfare Office and Community Development) have been involved to ensure ownership and sustainability. Furthermore ward and village authorities have been engaged to ensure they provide support to QITs/MVCC, MVC and caregivers. Meetings to communities on supporting MVC have been held to ensure the communities take roles and responsibilities in protecting MVC.

#### **Spread Strategy**

We have been advocating for MVC improvement activities and support for MVC services to be across sectors and departments in the council such as Education, TACAIDS, TASAF and Health.

- **Organized the first meeting with QI Task force meeting to discuss the process of developing new MVC QI guideline** (March, 2014). TOR for the consultant was developed and submitted to DSW for review and approval.
- **In collaboration with DSW conducted an introductory visit to Mkuranga district council for Initiation of Most Vulnerable Children Improvement Activities especially addressing Child Protection (CP) issues in Mkuranga District** (February 2014). The visit revealed that:
  - There were no MVCC/or specific board at the district level for overseeing MVC activities, and only five of 18 wards had formed MVCCs. Even where they existed, the MVCCs were not functioning.
  - At village level only 74 out of 121 villages had MVCC, but not active.
  - There were no budgets for child protection activities as well as annual plans for child protection activities at district, ward, and village levels.
  - Most organizations (CBO) provided direct aid like school supplies, fees and food.
  - Most of children do not know where to report child abuse cases and very few have courage to report abuses due to cultural issues.
  - There was inadequate skills and knowledge among key actors dealing with CP issues that was why some of them were not well addressed.
  - There is weak documentation and reporting, including application of data during planning due to lack of specific targets and indicators.
  - There is also low understanding of the children's' rights among community members.

#### **Activity 5. To support the MOHSW and partners to develop, field test and scaling up plan of national Quality Improvement Framework for PMTCT Option B+**

##### **Improvement Aims:**

- To optimize prevention of HIV Drug Resistance (DR) through implementing an HIVDR Early Warning Indicator (EWI) monitoring system in 10 facilities in Magu district Mwanza by September 2014.

### Accomplishments:

- **ASSIST conducted coaching and mentorship sessions to health providers from 12 health facilities in Magu district, Mwanza** (February 10-22, 2014). These sessions aimed at strengthening district and facility-level response mechanisms to address stock outs of ARVs, test kits and other supplies. Other objectives of the coaching visits included strengthening facility early warning response mechanisms to prevent development of virologic failure and emergence of HIV drug resistance and proper documentation of improvement interventions. During the period under report, two RHMT, four CHMT and 104 health care workers participated in coaching sessions, QI teams were able to identify system deficiencies contributing to frequent stock out of test kits, DBS kits and came out with change ideas including sending weekly alerts of existing stocks of commodities (testing kits and ARVs) through SMS to district authority (DRCHCO, DACC) and CSSC the regional implementing partner. QI teams were also guided on how to properly fill various PMTCT registers, the SES Journal and abstracting appropriate indicator data for each improvement objective they were working on.

### **Update to Integrated Design of Improvement Activity**

Process-based improvement and PDSA models will be used to support RHMT, CHMT and facility QI teams to identify, analyze and test changes. Validated EWI and QI indicators will be used to monitor performance across sites.

### **Spread Strategy:**

Once field testing of the indicators is complete, the plan is to scale up through regional training in line with the National PMTCT Option B+ scale up plan.

### **Activity 6. To support MOHSW and IPs to improve the quality of ART care for infants and children exposed or infected with HIV**

#### **Improvement Aims:**

- Increase the proportion of HIV-exposed children and children at outpatient and inpatient tested for HIV in 4 model districts each in Iringa, Njombe, Tabora and Shinyanga by 50 % by September 2014 through system strengthening.
- Increase the proportion of HIV-exposed children who receive HIV DNA/ PCR test results within four weeks of sample collection by 50% in 4 model districts each in Iringa, Njombe, Tabora and Shinyanga by September 2014 through strengthening of reporting system of DBS results.
- Increase proportion of HIV positive infants and children who are on ART by 60 % in 4 model districts each in Iringa, Njombe, Tabora and Shinyanga by September 2014 through strengthening of the ordering system.
- Increase the proportion of HIV infected infants and children who are retained on ART by 60 % from the current status in 4 model districts each in Iringa, Njombe, Tabora and Shinyanga by September 2014.

#### **Accomplishments:**

- **ASSIST supported the MOHSW and PMTCT IP to develop national Early Warning (EWI) and QI indicators as well as assessment tools for PMTCT Option B+ (Q1).** Furthermore, design and preliminary measures for piloting of EWI and QI indicators in 10 health facilities in Magu district – Mwanza were accomplished.
- **During a pre-work visit in Magu district, a baseline assessment of early-warning responses by health facility teams as required by EWI and QI indicators was conducted in 10 health facilities (Q1).** The ASSIST team supported RHMT, CHMT and facility QI team on how to address encountered clinical and logistical gaps through on-site coaching and mentorship.
- **Conducted baseline assessment, Mbeya District Council (Q2).** A baseline assessment for the Paediatric QI initiative was conducted in Mbeya to understand current Paediatric ART coverage among children enrolled into Care and Treatment sites of Mbeya. Also HIV testing performance among children below 15 yrs was assessed in order for us to understand to what extent children who accessed Health services in those facilities access HIV testing and counselling services and the level of linkage to care for those identified as HIV positive through PITC.
- **Key findings.** By December 2013 children below 15 yrs enrolled into HIV care services represent

6 % of the total cumulative enrollment into care. Among the HIV infected children who were enrolled into HIV care, 90% had been started on ART. However 43% of the children enrolled into ART were not on ART by the end of reporting period (October-December 2013). The number of children receiving ART in those facilities represented about 6% of the total number of PLHIV receiving ART services during the same period (Oct–Dec 2013). Also five out of 18 HIV infected children diagnosed as HIV positive through PITC program were enrolled into HIV care during the period of Oct-Dec 2013. HIV testing performance was poor in all the four facilities visited.

**Improvement Key Indicators:**

Activity	Indicators	Baseline	Last value
To support the MOHSW and PMTCT IPs scale up programs along the PMTCT cascade	% pregnant women who book ANC by 14 week of pregnancy	9% (Sept. 2011, Kilimanjaro)	55% (March 2014, Kilimanjaro)
	% Non-pregnant women accessing FP tested for HIV	8% (Jan. 2012, Manyara)	100% (March 2014, Manyara)
	% of male tested at RCH	29% (January 2012, Morogoro)	52% (Feb 2014, Morogoro)
To support the MOHSW and HIV Free Survival IPs towards elimination of HIV infection in children and reducing deaths among HIV-infected mothers	% infants who are exclusively breastfed	29 % (April 2013, Tabora)	80% (Jan 2014, Tabora)
	% infants tested by DNA/PCR and receive results	0% (April 2013, Tabora)	33% (Jan 2014, Tabora)
	% mother-baby pairs attending post-natal clinic	0% (April 2013, Tabora)	33% (Jan 2014, Tabora)
	% HIV-infected infants <2yrs initiated on ART	33% (April 2013, Tabora)	50% (Jan 2014, Tabora)
To support the MOHSW and IPs to scale up improvement activities for ART services	% of HIV patients receiving CD4 test every 6 months	70% (Oct. 2012, Tandahimba-Mtwara)	100 % (March 2014 Tandahimba-Mtwara)
	% of HIV patients assessed for active TB	71% (Oct. 2008, Morogoro)	94% (Feb 2014 Morogoro)
	% of women counseled for FP at CTC	1% (Sept. 2011, Kilimanjaro)	94% (March 2014 Kilimanjaro)
To support the MOHSW, MVC, IPs and local structures to strengthen quality of care, support and protection to MVCs	% of MVCs sleeping under ITNs	24% (June 2011, Bagamoyo)	94% (June 2013, Bagamoyo)
	% of MVC above 5 years with CHF cards	0% (June 2011, Bagamoyo)	56% (June 2013, Bagamoyo)
Work with the MOHSW and stakeholders to develop and scale up a CHBC quality improvement program and monitoring framework	% of HBC clients referred to multiple services	13% (April 2011, Tanga)	58% (Jan. 2013, Tanga)
To support the MOHSW and partners to develop, field test and scaling up plan of national Quality	% of pregnant women tested for HIV at ANC	59% (Oct 2013, Magu-Mwanza)	100% (March 2014, Magu – Mwanza)
	% of women tested for HIV at labour and delivery	7% (Oct 2013 Magu – Mwanza)	85% ( March 2014, Magu – Mwanza)

Activity	Indicators	Baseline	Last value
Improvement Framework for PMTCT Option B+	% of mother-baby pair in care	14% (Oct 2013, Magu –Mwanza)	24% (March 2014, Magu- Mwanza)
To support MOHSW and Implementing Partners to improve the quality of ART care for infants and children exposed or infected with HIV	% of HIV infected infant and children started on ART	Collecting data	
	% of HIV exposed children tested for HIV by DNA PCR within 4-6 weeks of age.	Collecting data	
	% of HIV infected children who are currently on ART with follow up CD4 counts	Collecting data	

### Directions for Q3 and Q4 FY14

- Conduct coaching and mentoring visits to Singida, Morogoro, Manyara, Lindi, Mtwara, Mwanza and Shinyanga.
- Conduct indicator review in Bagamoyo and Arusha.
- Conduct learning sessions in Mwanza, Mkuranga, Mbeya, Iringa and Tabora.
- Conduct review of MVC QI Guidelines.
- Implement Patient Centered Care Model District in Morogoro.
- Set up pediatric ART Quality improvement collaborative in 4 districts from four regions of Tabora, Iringa, Shinyanga and Njombe through conducting one coaching visit and one learning session.

## 1.15 Uganda

### Background

USAID ASSIST is following on support to health care improvement in Uganda since 2005 under the Quality Assurance Project and then HCI. The ASSIST project began working in Uganda in October 2012 and is supporting the Ministry of Health (MOH), districts, implementing partners, and health facilities to improve the HIV continuum of response, improve the quality of safe male circumcision services, improve TB case detection and treatment and TB-HIV care, and implement the PHFS initiative. The project also supports the MOH to apply improvement methods to improve maternal and newborn health services and integrate family planning services in primary care and referral facilities and apply lessons from pilot facilities to other sites. ASSIST Uganda is also working with the Ministry of Gender, Labor and Social Development and implementing partners to apply standards to improve services for vulnerable children.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity
1. Improve HIV care (Continuum of Response)	<ul style="list-style-type: none"> <li>• Build capacity of USG implementing partners (IPs) to improve quality of HIV/AIDS services in Uganda</li> </ul>	<p>Work with 10 USG implementing partners in 49 facilities in 40 districts in the South western, Eastern, East central, Central and Northern regions of Uganda. Public, private not-for profit and private facilities will be engaged in this work at the level of HC III to general hospitals</p> <p>At the community level, work with</p>	x

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity
	<ul style="list-style-type: none"> <li>Build capacity of the MOH to coordinate and oversee implementation of national quality improvement plans and strategies</li> <li>Generate new knowledge on how to meaningfully engage leaders in the efforts to adapt quality improvement as an in-built approach to doing health care work</li> </ul>	<p>2 USG partners who requested for ASSIST support at the community level. Twenty-four villages will be covered in total</p> <p>National level Quality Improvement Framework and Strategic Plan(QIF &amp;SP) demonstration is in 1 health region (Rwenzori region), 7 district, 12 HSDs and 19 health facilities</p> <p>3 districts (Busia, Kisoro and Manafa), in 4 sites per district</p>	
2. Safe Male Circumcision	<ul style="list-style-type: none"> <li>Improve the quality and safety of SMC services through building the capacity of IPs to identify and address gaps within the SMC program</li> <li>Support MOH to have and to roll out standard SMC tools that support efforts to improve the quality of SMC services</li> <li>Once the process of developing a standard SMC training manual commences, ensure QI is integrated into this manual and SMC trainings thereafter</li> <li>Generate new knowledge related to SMC</li> </ul>	Thirty (30) sites in 26 districts directly supported by USAID ASSIST and selected extra IP sites	x
3. Partnership for Free HIV survival	<ul style="list-style-type: none"> <li>Achieve HIV-free survival for infants.</li> <li>Learn how best to improve the quality of pre and postnatal EMTCT care, including nutrition interventions</li> <li>Build capacity of IPs to use the QI approach to integrate and improve the quality of EMTCT and nutrition work</li> </ul>	<p>22 health facilities in 6 districts in 2 regions</p> <p>22 health facilities in 6 districts in 2 regions</p> <p>4 implementing partners (TASO, STAR EC, STAR SW, SPRING) in 22 demonstration sites</p>	x
4. Improve TB care	<ul style="list-style-type: none"> <li>Build capacity of the IPs in rolling out provision of quality TB services with special focus on Track TB project</li> <li>Build capacity of Districts and MOH</li> </ul>	7 facilities supported by Track TB.	x

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity
	NTLP in rolling out provision of quality TB care using the CQI <ul style="list-style-type: none"> <li>• Generate new knowledge related to TB</li> </ul>		
5. Improve maternal, newborn and child health	<ul style="list-style-type: none"> <li>• Build capacity of IPs through joint onsite coach visits and quarterly peer to peer learning meetings to continuously learn how to improve the quality of MNCH services in the SMGL districts of Uganda in FY14</li> <li>• Coordination of the QI cluster of the SMGL partnership through monthly QI cluster meetings, bi monthly inter cluster meetings and development of the working document for the QI cluster.</li> <li>• Build capacity of MOH through engaging the district health teams in joint onsite coach visits and quarterly learning meetings to enable them learn how to improve the quality of MNCH services in the 4 SMGL districts of Uganda.</li> <li>• Generate new knowledge and best practices in improving the quality of MNCH services as part of the continuous learning and adapting agenda</li> <li>• Build capacity of MOH to provide quality newborn health services Provide technical support to MOH; Provide technical support to MOH to ensure that functional newborn health data systems are set up</li> <li>• Plan and integrate newborn health care in national plans and strategies</li> <li>• Build the capacity of partners to support districts to scale-up provision of quality newborn health care services</li> </ul>	20 High volume facilities of 4 SMGL National level (MOH) 24 Health experts (TOTs) 7 Health regions 10 partners supporting newborn health Continuous mapping to track adoption and scaling-up of interventions by partners	x
6. Integrate family planning into maternal newborn and child health	<ul style="list-style-type: none"> <li>• Build capacity of Marie Stopes Uganda to improve the quality of family planning services by involving them in monthly site coaching sessions, quarterly peer to peer QI learning sessions, QI performance review and the QI cluster co-ordination meetings.</li> </ul>	6 facilities supported by Marie Stopes Uganda in the 4 SMGL districts of western Uganda	x

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity
	<ul style="list-style-type: none"> <li>Generate new knowledge on integrating FP into MNCH. This will be done through learning sessions, during site coaching</li> </ul>	18 sites of the 4 SMGL districts.	
7. Improve quality of Orphans and Vulnerable Children (OVC) services	<ul style="list-style-type: none"> <li>Provide technical support to MGLSD and partners to employ proven modern QI approaches to ensure continuous improvement in quality of services received by every OVC in Uganda</li> </ul>	4 districts 11 sub counties 10 CSOs 10 SOVCCs 24 villages	x
	<ul style="list-style-type: none"> <li>Build the capacity of MGLSD to provide a coordinated approach to improving the quality of services for OVC</li> </ul>	National levels (Ministry to provide information on expected partners)	
	<ul style="list-style-type: none"> <li>Generate knowledge on how to improve compliance to OVC standards for improved quality of OVC services</li> </ul>	10 CSOs, 4 districts, 11 sub-counties	

## Key Activities, Accomplishments, and Results

### Activity 1. Improving HIV care (continuum of response)

#### Accomplishments:

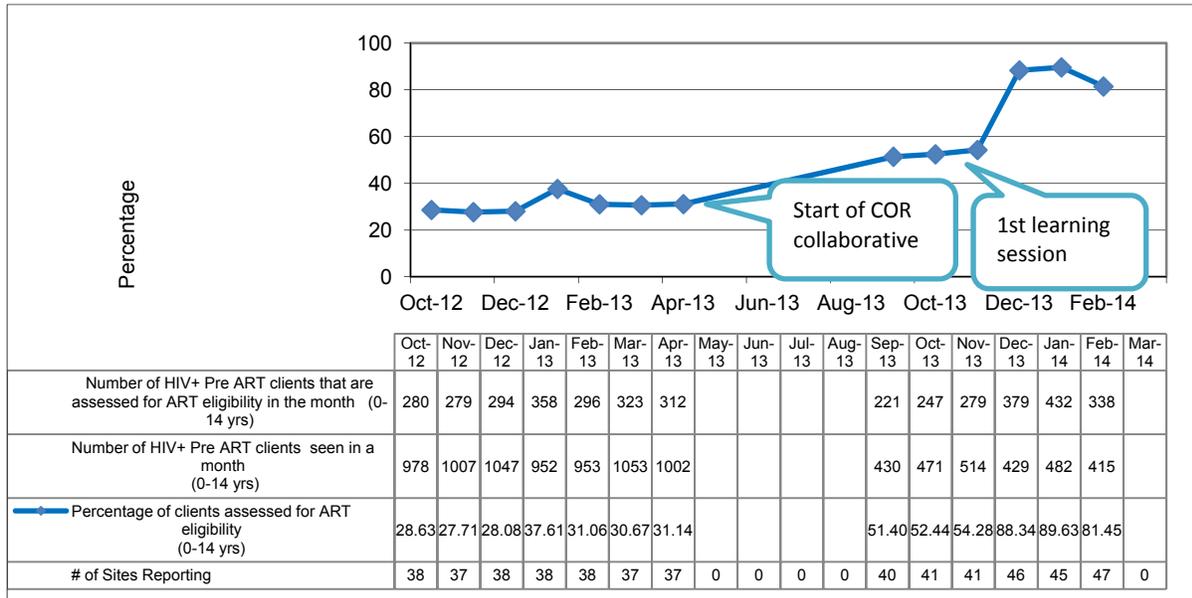
- **Joint coaching activity.** to support the facilities improve all HIV COR indicators across the board, from the processes involved in coverage and then eligibility assessment.
- **Learning sessions.** the first learning session was held with 49 facilities in the first quarter. During the second quarter, conducted the first learning session for the 13 selected special facilities in the 4 regions implementing HIV COR activities.

#### Key Results:

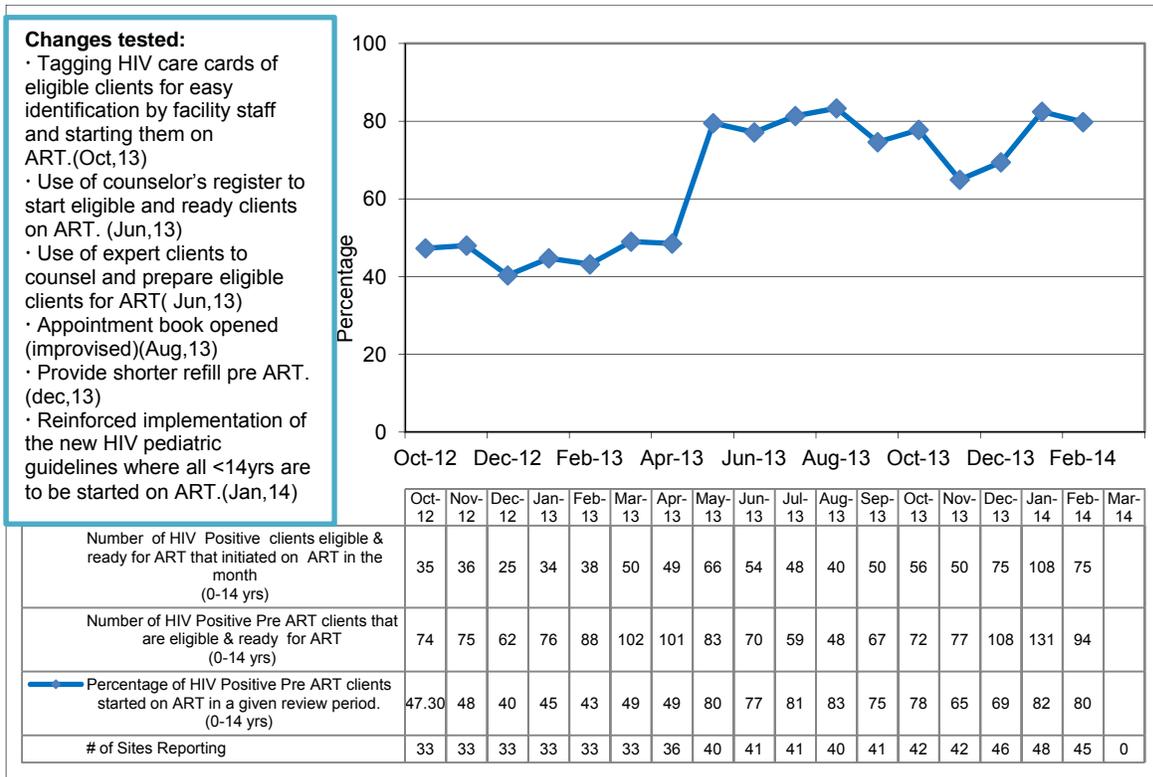
- **Identifying HIV positive clients.**
  - The baseline assessment indicated that staff needed to improve provider initiated testing and counseling (PITC) within the outpatient department (OPD). Improvement was noted, from 10.4% of clients attending OPD being tested for HIV in April 2013 to 94.5% by December 2013.
  - At 48 facilities, identified positives are being linked to HIV chronic care either within the health facility (intra linkage) or other neighboring facilities. On arrival, clients are enrolled into care and assigned a pre ART number, counseling on positive living is conducted, co-trimoxazole prophylaxis initiated, assessment for eligibility done by either WHO clinical staging or CD4 and appointment date given.
- **ART initiation among the eligible.** To create sustainable improvement in the number of ART naïve eligible clients started on ART, the HIV COR facilities have been supported to think through the different processes to ART initiation. These were:
  - Identification and creation of a pool of the eligible clients.
  - Patient files have all been retrieved and assessed for ART status, those already eligible but not on ART have been traced, files tagged with stickers to remind health workers on need to prepare them for ART while those whose CD4 was last taken more than 6 months have been called back for repeat CD4 to ascertain eligibility status and preparation of the eligible for ART.

- ART counseling sessions have been reduced from 3 to 1 pre ART session and 2 sessions (when a client is already started on ART). This has reduced the time it takes to be ready for ART.
- Figures 35 and 36 indicate the results and specific changes for the groups.

**Figure 35: Uganda: Percentage of clients assessed for ART eligibility (0-14 yrs) (Oct 2012 – February 2014)**

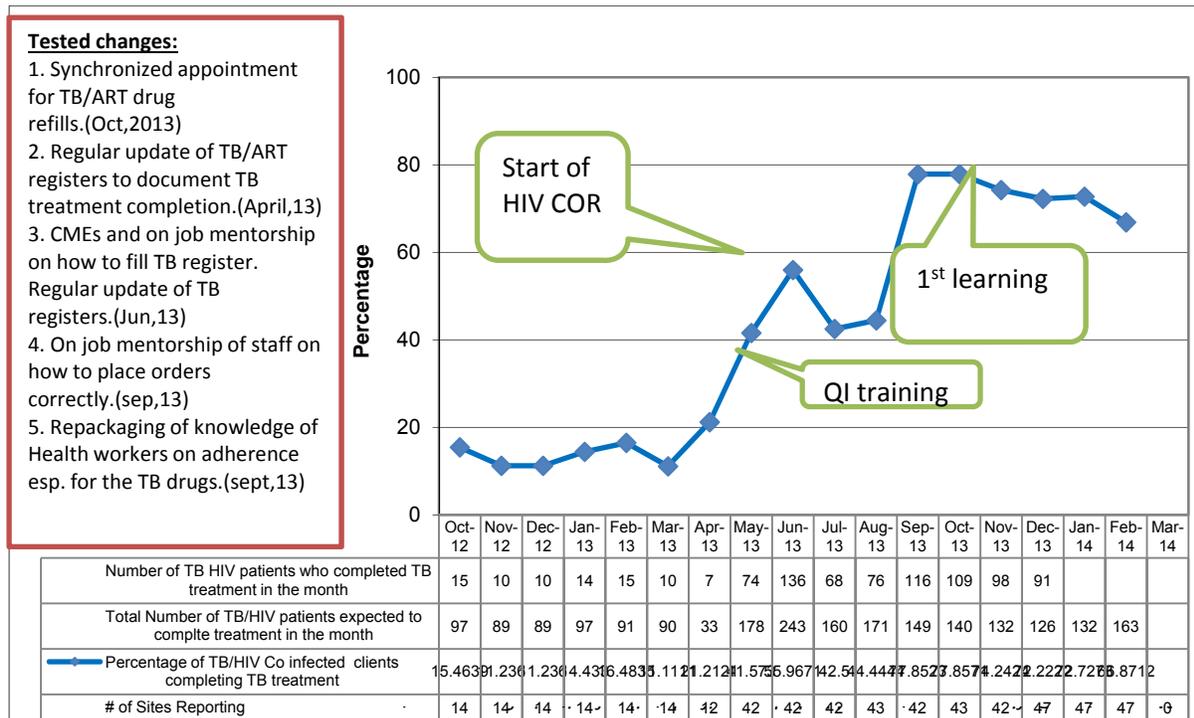


**Figure 36: Uganda: Percentage of HIV positive pre ART clients started on ART in a month (1-14 years) (Oct 2012 – March 2014)**

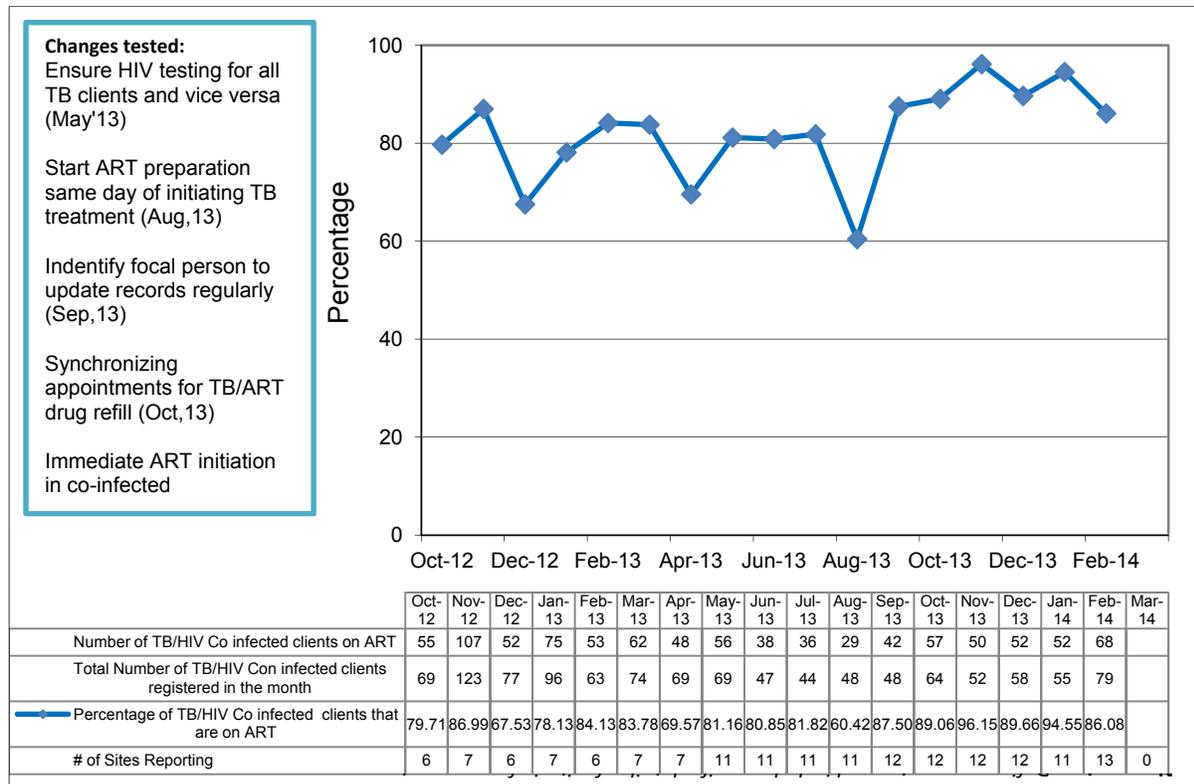


- **Retention on ART.**
  - Despite support provided to patients, failure to remain on ART still occurs. Issues of retention especially among the <14years are:
    - Focus being generalized across the ages, with little emphasis put on the under 14 years
    - Irregular attendance by the school going children
    - Lack of non-disclosure on why child has to attend the clinic regularly
    - Travel cost
    - Family making several visits to the health facility due to unsynchronized appointment dates
    - Dependency on the adults, grandparents for more support physical, material and financial
    - Changes in the caretakers (e.g. from mother/ parent to grandmother or uncle), causes a break in the continuity of care and information flow.
  - Changes tested include: Same appointment dates for different care services; pairing of Mother Baby HIV care cards so that mother and baby are seen on the same day; merging family clinic visit days with FSG days where families are seen on the same clinic day; and follow up of lost clients using the expert clients and VHTs.
  - Retention of children 0-14 years on ART has improved from 29% in October 2012 to 94.5% in November 2013.
- **Clinical Wellness.**
  - Health facilities have come up with the following changes to improve clinical wellness among clients on ART: Regular updating of the MOH tools in the ART clinic; engaging expert clients in health education and adherence counseling; and use of expert clients to assess for adherence
- **TB/HIV co management.**
  - TB/HIV care services are offered in all the HIV COR facilities, it was found that the care points for HIV and TB were different in most of the sites; as a result clients diagnosed with TB would not be linked to HIV care appropriately. Most of the co-infected clients were found to complete the TB treatment without ever starting on the ART drugs due to poor coordination and linkage between the two care points. The facilities have been able to put systems in place to establish this linkage.
- **TB treatment completion among TB/HIV co infected clients.**
  - During baseline assessment, we found that not all patients were completing treatment so improvement has been focused on closing this gap. See Figures 37-39.

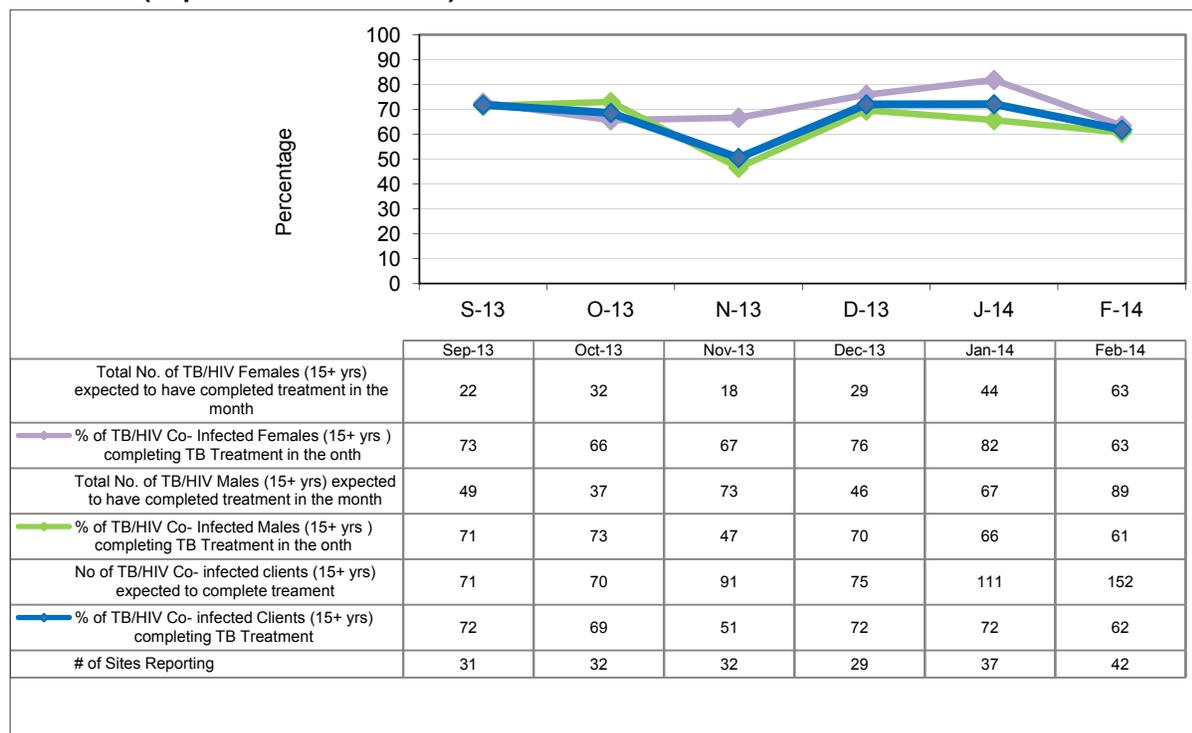
**Figure 37: Uganda: Percentage of TB/HIV Co-Infected clients completing TB treatment (Oct 2012 – March 2014)**



**Figure 38: Uganda: Percentage of TB/HIV co infected clients started on ART in 7 HIV COR special facilities (Jan 2013 - Feb 2014)**



**Figure 39: Uganda: Percent of TB/HIV Co-Infected Clients (15+ years) completing TB treatment in 42 sites (Sept 2013 – March 2014)**



- **Appointment keeping among HIV-positive pregnant mothers on option B+.**
  - HIV COR facilities strive towards elimination of MTCT of HIV has been boosted by offering one stop center for HIV-positive pregnant mothers as per MOH recommendation and establishing linkage with HIV clinic to update pre/ART registers.
  - Changes tested: Use of expert mothers to counsel others; Synchronizing FSG days with ANC clinic days; assign a particular date for HIV-positive pregnant mothers' visit.

**Activity 1b. Improve HIV care (Continuum of Response) - Community**

- **Identified the top 10 villages in Mitooma HC IV catchment (STAR SW region) where missed HIV visits commonly occurred.**
  - Data on HIV Appointments from 381 PLHIV clinic records was analyzed in order to identify villages where missed HIV appointments were concentrated. The total numbers of visits conducted over the 5-month period (June –October 2013) were 927 of which 29% were missed. A total of 32 villages out of 62 (where all missed appointments occurred) contributed to 80% of all missed visits. For demonstration, the top ten 10 villages were selected for QI intervention and will scale up to 22 through USG partners.
- **Conducted QI training for community teams in 10 villages in Mitooma district**
- **Conducted coaching sessions.**
  - Reporting tools to track community process indicators were developed, pretested and adopted. As a result, there was improvement in; i) the number of PLHIV followed up in the community for appointment reminders; ii) number of clients Lost-to-Follow up traced and referred back into care.
- **After PLHIV were linked to the community, follow up was conducted by VHTs and Community Support Agents (CSAs) through home visits or telephone calls to remind PLHIV of their HIV appointments and provide support (e.g., adherence counselling, psychosocial support as well linking them to existing CBOs for nutrition education and positive living). Changes implemented include facility based expert patients providing information on the existence and roles of community QI teams to PLHIV during health education sessions during HIV clinic days, as well as representatives of QI team members visiting the health facility on clinic**

days to provide sensitization have led to many more clients consenting to linkage, as well as follow up.

- **Results:** Out of all the 168 LTFU files reviewed at Kamuli General Hospital, 51 were from our 7 villages of intervention (30.3%). 43% of LTFU clients were located in the villages, 59% of these were referred back into care, while the remaining were identified as dead and self-transferred.

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

- **Conducted the first learning session for 3 sites in Mityana district.**
- **Carried out four coaching visits.**
  - Sites continued to work on improving the quality of records and reducing patients wait times. Since September 2013, these have improved from 78% of complete medical records to an average of 91% in December 2013. The percentage of clients on ART that wait less than 30 minutes between service points increased from 58% September 2013 to 88% in December 2013.

**Activity 1(d). Leadership collaborative**

**Accomplishments:**

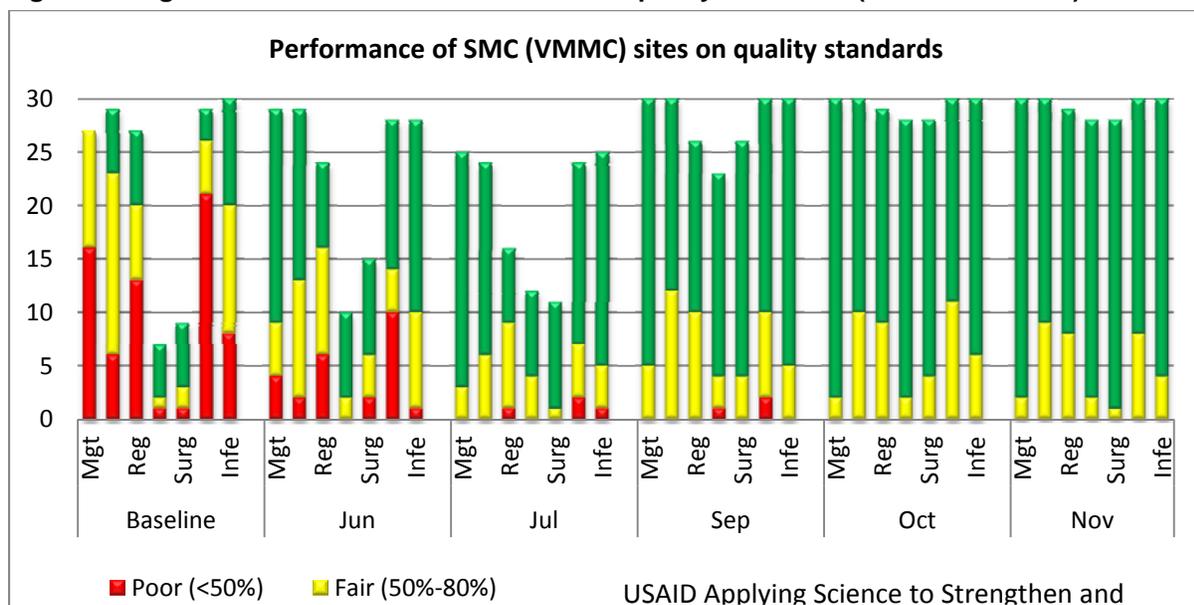
- **Conducted onsite and online coaching of all 12 health facilities in the leadership collaborative.**
  - The spread of QI concepts and formation of QI teams by the district leaders in Busia district has been done to 70% of health facilities using funds from SDS.

**Activity 2. Safe Male Circumcision (SMC)**

**Accomplishments:**

- **Conducted learning sessions.** A peer-to-peer learning session was conducted in November 2013. The main objective of conducting the learning session was to provide an opportunity for QI teams to share experiences and learn from each other and to harvest best practices to spread to other sites.
- **Results.** Figure 40 shows the performance of the sites on the MoH SMC Quality Standards. There is marked improvement in performance on all the standards at the 30 sites over time. Sites are now being supported to sustain the gains achieved.

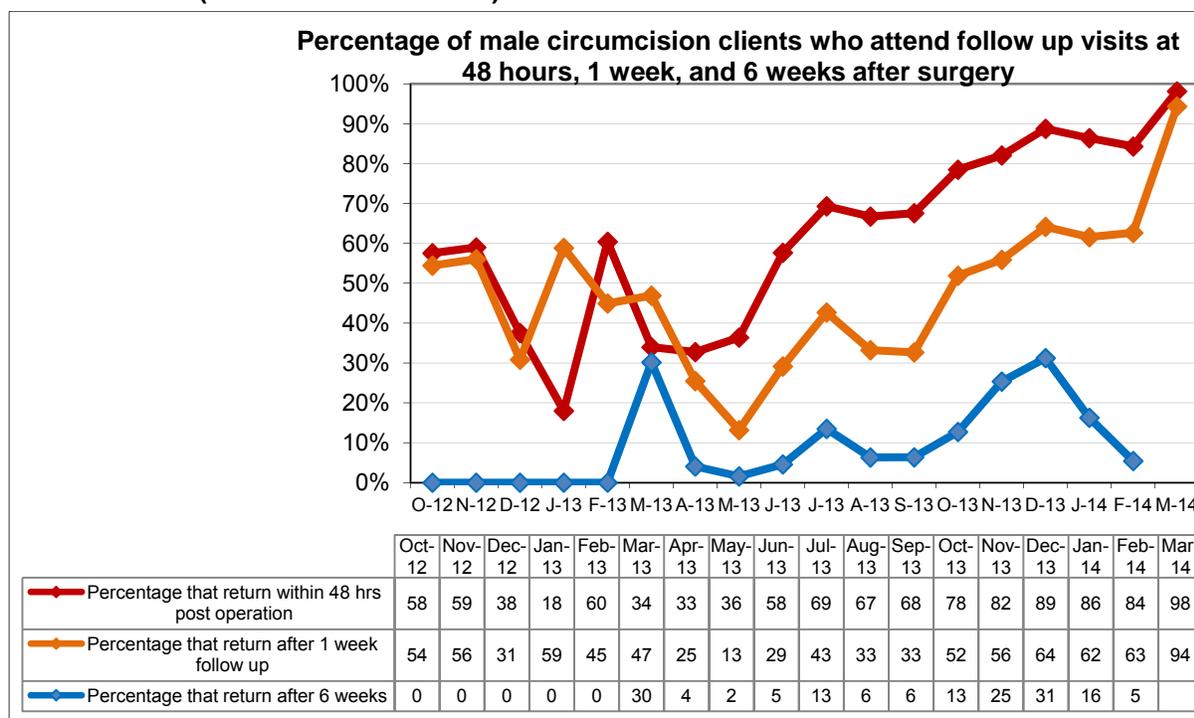
**Figure 40: Uganda: Performance of SMC sites on quality standards (June – Nov 2013)**



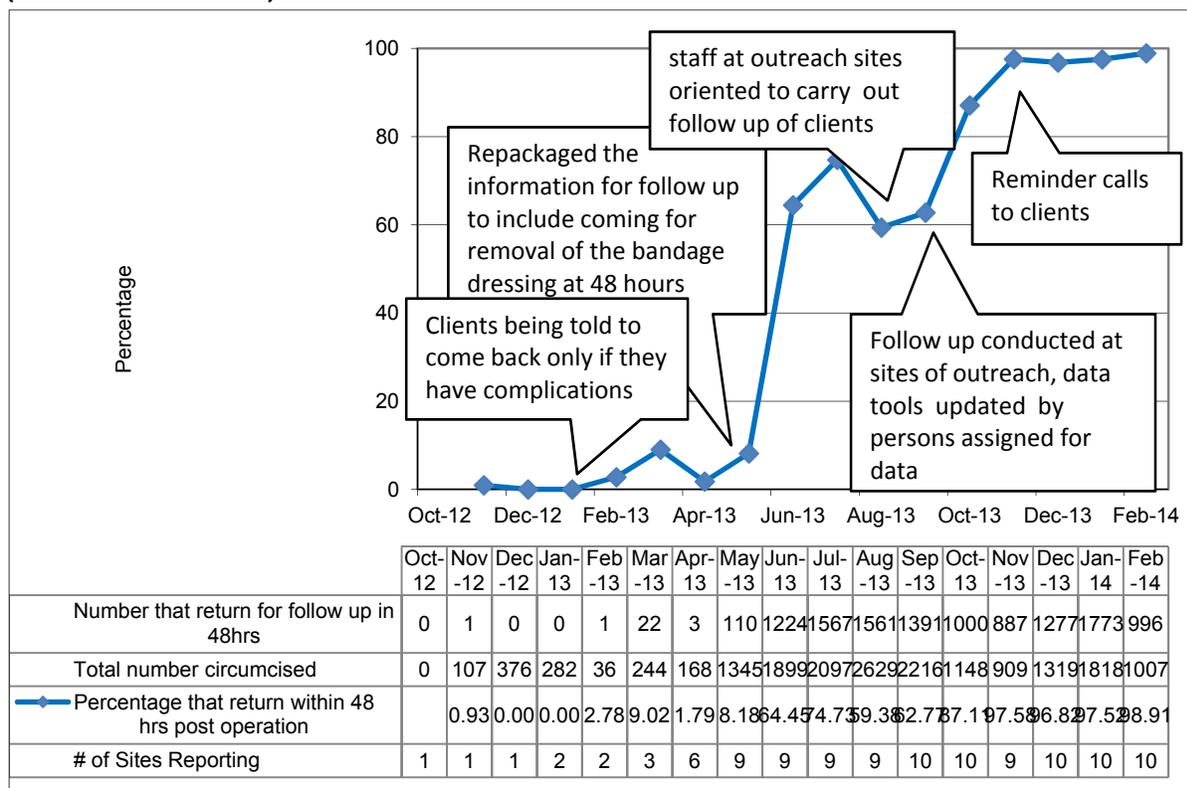
- **Participated in an External Quality Assessment.**

- An external quality assessment by an interagency PEPFAR team was conducted in November 2013. This was a follow on to the previous EQA of 2012. ASSIST participated in the EQA through working with IPs to address the gaps identified at the 2012 EQA. Preliminary results indicate that there has been marked improvement between the two EQAs.
- **Supported the National Safe Male Circumcision Task Force (NTF).**
  - As part of the technical support to MoH, USAID ASSIST supported MoH to convene the quarterly SMC NTF meeting on 25th February 2014 in order to provide oversight to the national program. The main items on the agenda were to discuss how to integrate the non-surgical (Prepex) methods of circumcision into the program.
- **Conducted coaching sessions.**
- **Client follow-up following circumcision.**
  - It is a requirement that clients are reviewed after circumcision. USAID ASSIST has been supporting improvement teams to changes to enable clients return for follow up. The graphs below the proportion of clients that returned for review at 29 health units.
  - As shown in Figure 41, a gradual improvement in the proportion of clients who return for review after circumcision has been noted. Prior to formation of improvement teams, there was no clear trend on the proportion that returns for review. However, the proportion that returns after 48 hour has stabilized above 80% while after seven days it has stabilized above 60%. Some of the changes that have led to this improvement are shown in Figure 42.

**Figure 41: Uganda: The proportion of clients that returned for review following circumcision, 29 health units (Oct 2012 – March 2014)**



**Figure 42: Northern Uganda: Percentage that return within 48 hours post operation, 10 sites (Oct 2012 – Feb 2014)**



- **Gender integration into safe male circumcision.**
  - The proportion of SMC clients that are educated about SMC together with their partners has improved. Aggregated data from 18 health units shows that by end of February 2014, 25% of the clients that had spouses attended health education with them. Before the start of the improvement activity, there were no clients attending with their spouses. Some of the changes include creating SMC clinics that have services for both males and females.

**Activity 3. Partnership for Free HIV survival**

**Achievements**

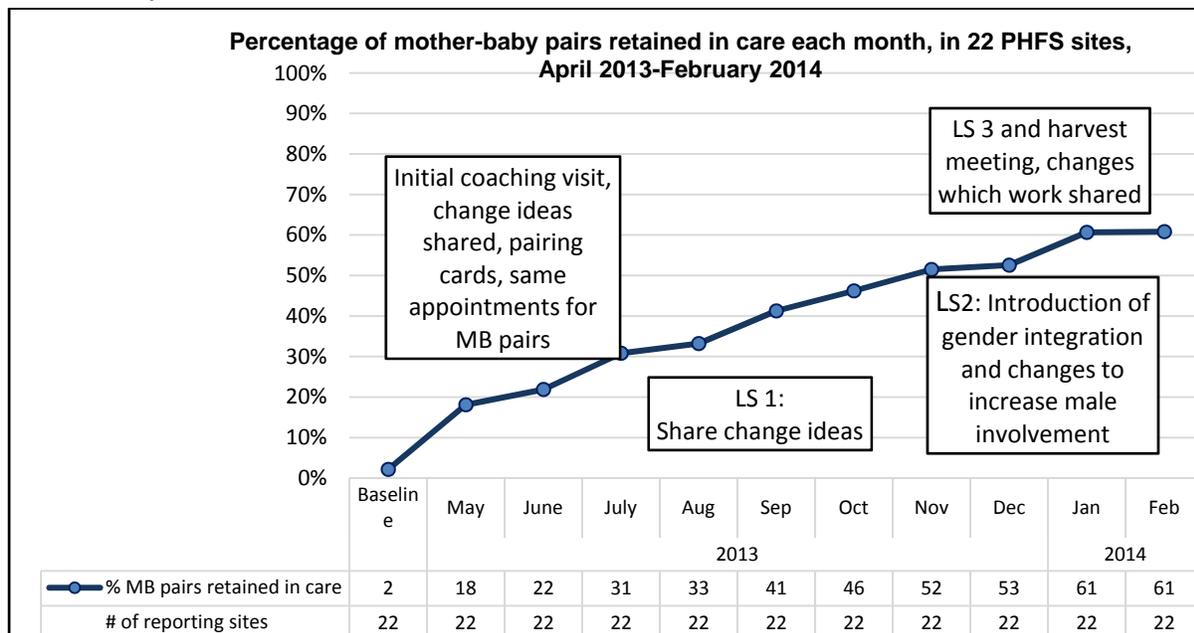
- **Hosted and participated in the PHFS regional meeting:** ASSIST prepared for and hosted the PHFS regional conference in Kampala, Uganda for 80 participants. The meeting was attended by country teams from Kenya and Tanzania, partners within the PHFS and MoH. The purpose was to review the implementation of the PHFS across countries, share lessons and address challenges.
- **Conducted coaching sessions.**
  - Conducted 4 joint monthly coaching visits to all 22 health facilities. Discussions focused on improving the special visits for mother-baby pairs where they receive additional services.
- **Conducted learning sessions:** Held two learning sessions for all 22 health facilities.
- **Conducted first harvest meeting:** the first harvest meeting was conducted in February 2014. The expected outcomes of the harvest meeting were as follows:
  - Identification of successful and unsuccessful changes and related evidence collated and evaluated by teams to identify teams’ “best advice” for new teams, including how-to-guide, for the learning areas of getting started, data quality, retention of mother-baby pairs and routine visits.
  - Identification of changes the sites have tested so far to improve special visits, retesting of HIV negative women and final HIV test for exposed babies, and development of action plans.
- **Facilitated a knowledge handover meeting:** In March 2014, spread activities were started in

the South Western region through a knowledge handover meeting. 4 teams from the demonstration phase and 13 additional health facilities in the spread phase were brought together to share and learn from the demonstration sites. The activity was jointly facilitated with SPRING and STAR SW.

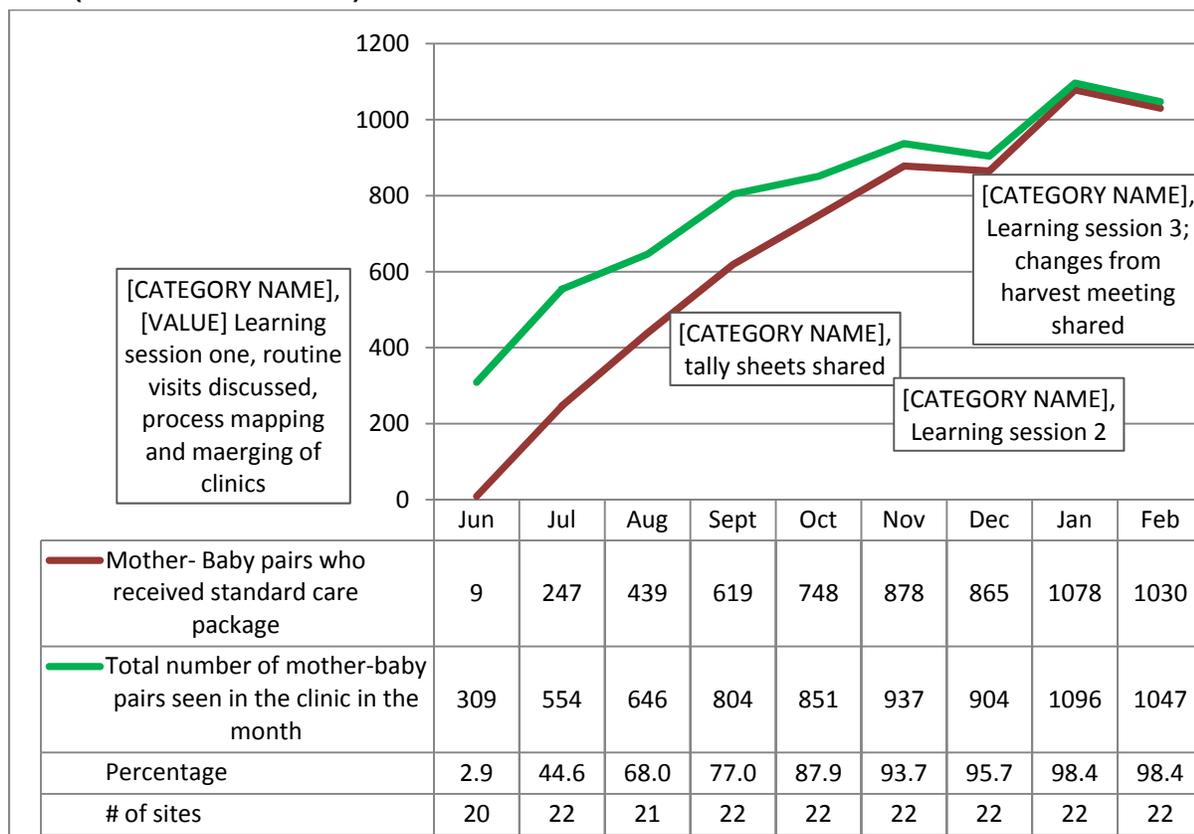
**Key Results:**

- **Improvement in data quality.**
  - Data completeness and accuracy continued to improve from 2.9% in April 2013 to 89.74% in November 2013. The improvement in data quality is attributed to: keeping the mothers’ and babies’ cards together, filling the cards out immediately, having someone review the cards and provide feedback on areas that have not been filled.
- **Lactating mothers initiated on ART.**
  - The percentage of mothers who were initiated improved from 23% in February to 100% in November 2013 in the reporting sites.
- **Mother-baby pairs who receive a standard package of care at routine visits each visit.**
  - As of February 2014, 98.4% of mother-baby pairs who came to the health facilities received a standard package of care. The standard package of care includes ART for the mother, cotrimoxazole or nevirapine for the baby, nutrition assesment for the pair, infant and young child feeding counselling and an appointment for the next visit.
  - Changes tested include: placing reminder notes on the wall to remind clinicians and midwives about the services and updating the cards; filling out mother and babies’ cards completely before the pairs leave the clinic; on job training of health workers and expert clients to provide services such as nutrition assessment using MUAC, infant and young child feeding guidelines; counter book/ form to keep a record of who received all the services; informing mothers about the services to expect; merging early infant diagnosis (EID) and ART clinics; and dispensing drugs in the same area where mother-baby pairs are seen.
- **Retention of mother-baby pairs in care.**
  - Retention of mother- baby pairs in care continued to improve from 52.6% in December 2013 to 60.8% in February 2014 (Figure 43). The proportion of mother-baby pairs receiving the standard package of services at routine visits improved from 2.9% in June 2013 to 98.4% in February 2014 (Figure 44).

**Figure 43: Uganda: Percentage of mother-baby pairs retained in care each month (April 2013 – March 2014)**

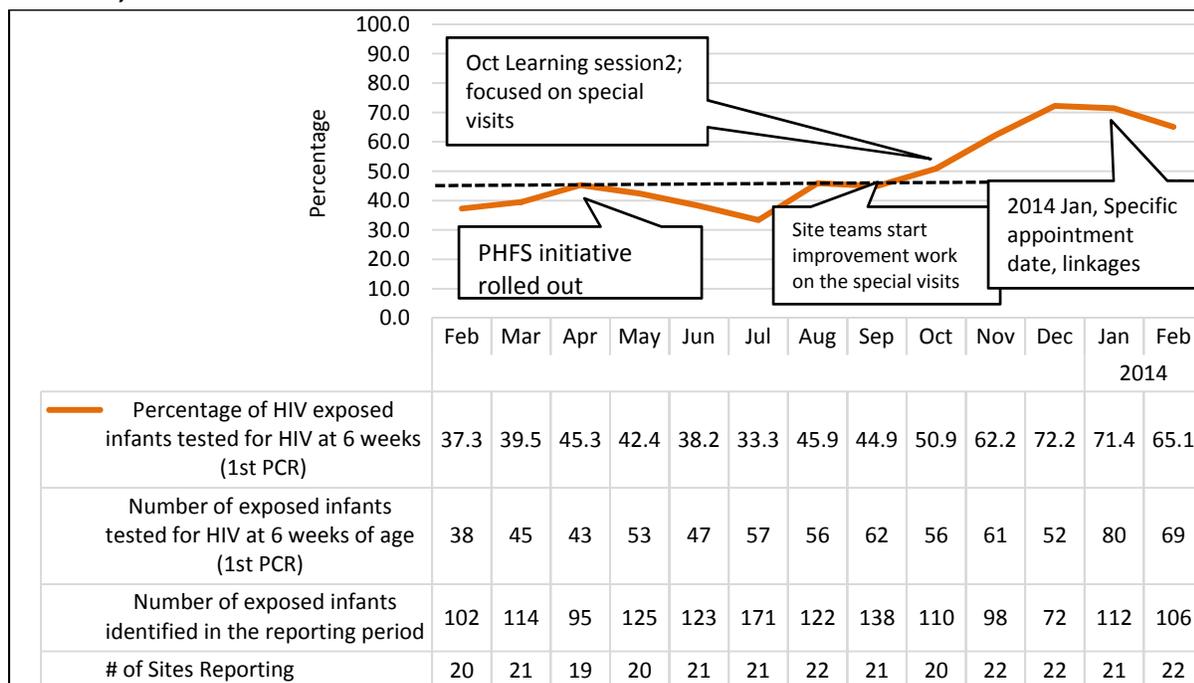


**Figure 44: Uganda: Mother-baby pairs receive a standard care package at routine visits, 22 sites (June 2013 – Feb 2014)**



- **Reported adherence to recommended IYCF practices.** The percentage of HIV exposed babies whose mothers reported to be adhering to the recommended IYCF practices (exclusive breastfeeding for the first 6 months of life, complementary feeding and continued breastfeeding from 6 months to 12 months of age) increased from 69.9% in May 2013 to 96.6% in February 2014. This improvement is attributed to a combination of factors including improved completeness and accuracy of the EID charts and the EID register.
- **First dried blood spot (DBS) test at 6 weeks of age for HIV exposed babies.** Figure 45 shows an increase in the percentage of identified exposed babies who got their first DBS at 6 weeks of age.

**Figure 45: Uganda: Percentage of exposed babies who get first DBS at 6 weeks (Feb 2013 – Feb 2014)**

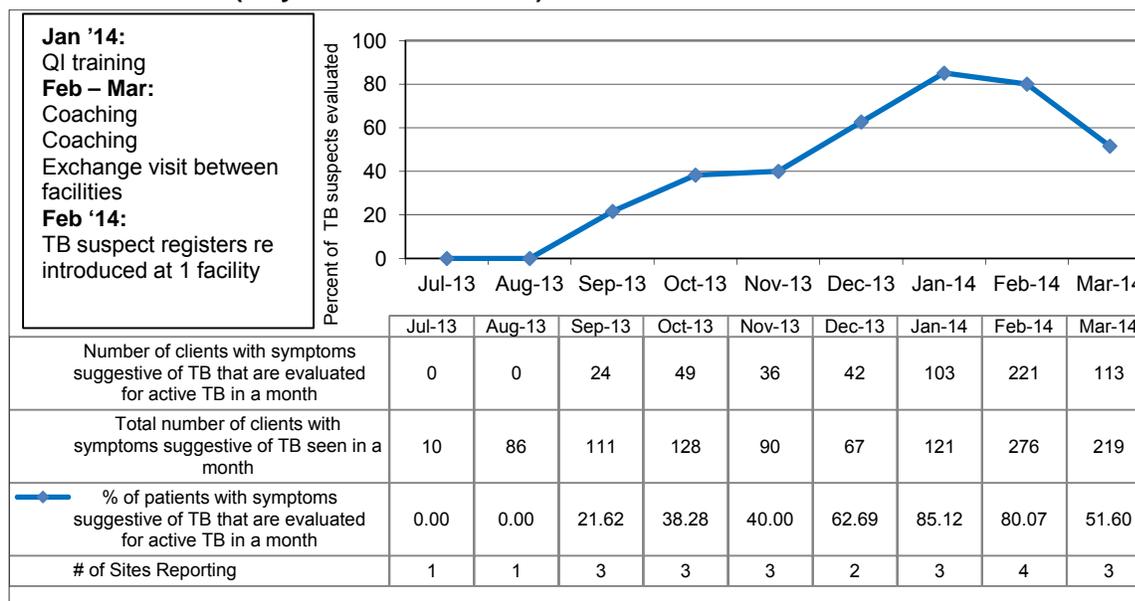


**Activity 4. Improve TB care**

**Accomplishments:**

- **Finalized baseline data collection.**
- **Conducted QI training for Kampala Capital City Authority (KCCA) based health care workers.**
  - In January 2014, ASSIST trained 25 KCCA staff from 6 health facilities and division offices in QI.
- **Conducted coaching session.**
  - Findings during the coaching included: Completion of action plans
    - Triage not routinely done for coughing patients (TB suspects). Most clinicians in OPD complain of long patient queues keeping them from triaging coughing patients
    - Intensified case finding (ICF) forms not widely used.
    - Most facilities that used the presumptive TB register do not update it regularly.
    - Most facilities had gaps in monitoring response to therapy.
    - No active surveillance for MDR TB.
  - During the coaching session, health workers were demonstrated to how to document within the R&R tools. At 2 facilities, an appointment register was introduced to keep track of their clients.
  - Facilities have had to identify a common place where the TB suspect register is to be placed within the TB clinic to encourage documentation. A linkage between the laboratories has been strengthened through holding several brainstorming meetings. The laboratory staff send the clients to the TB clinic first for registration in the TB suspect register and then go to the laboratory. Once the results have been received, they are sent to the TB clinic or back to the clinician. This has increased the number of patients investigated for TB using the right TB diagnostic algorithm.
  - Figure 46 shows improvement in the proportion of identified TB suspects that are being evaluated for active TB at six facilities in Kampala.

**Figure 46: Uganda: Percent of patients with unexplained cough that are evaluated for TB in 6 facilities in KCCA (July 2013 – March 2014)**



#### **Activity 5. Improve maternal, newborn and child health (MNCH)**

##### **Accomplishments:**

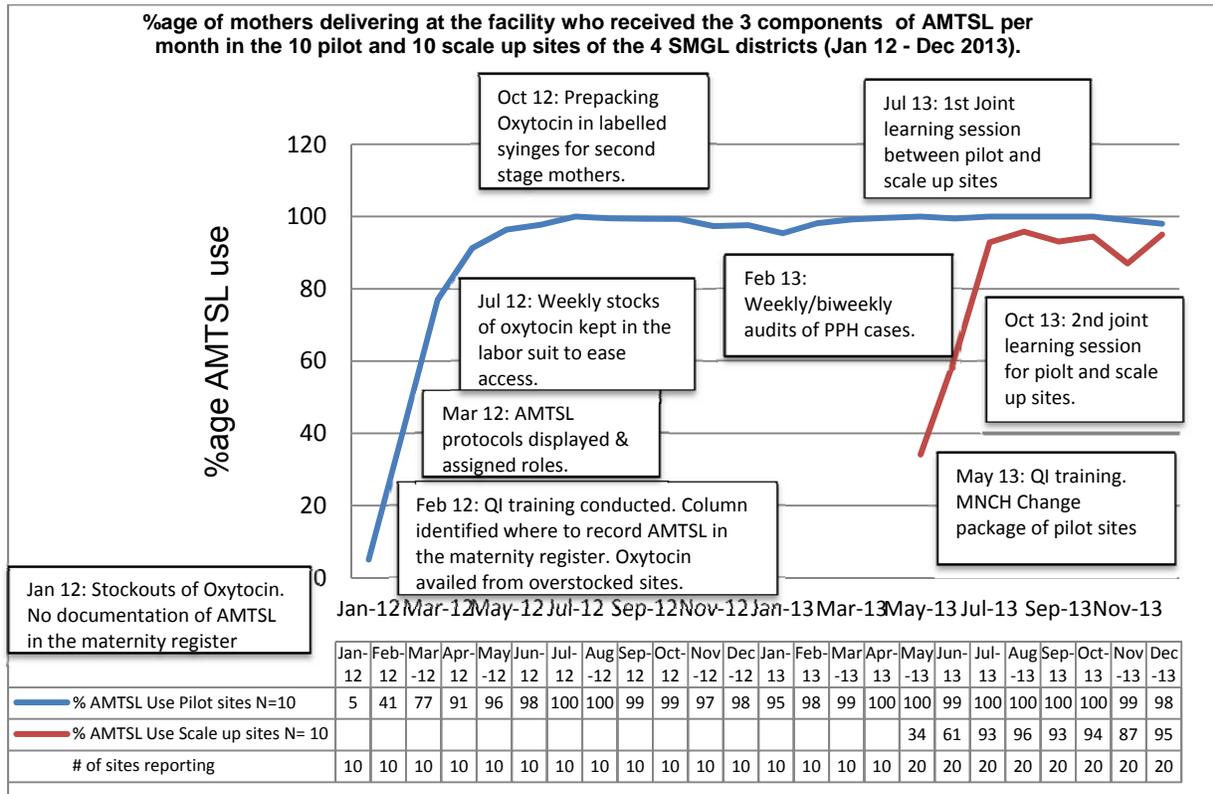
- **Provided support to Ministry of Health – national level.**
  - As part of health systems strengthening, the MOH was supported to review the Health Management Information System (HMIS) tools to integrate data entry points to measure newborn health quality indicators that will be used to monitor the quality of newborn health care services.
  - Technical support was also provided to the MOH to quantify national needs for Newborn Resuscitation and Training Equipment. A quantification was conducted for all government health facilities and medical training institutions. The quantification needs were submitted to the World Bank Health Systems Strengthening (HSS) Project for funding and subsequent procurement.
  - National-level Born-Too-Soon advocacy campaign was conducted to commemorate World Prematurity Day. The objective of the campaign was to raise more awareness of prematurity and its associated consequences if not addressed and to lobby and advocate for the use and scaling up of proven interventions that can help babies born prematurely survive.
- **Conducted a second joint learning session of 10 pilot and 10 scale up saving mothers, giving life (SMGL) sites.**
  - Conducted a second joint learning session for the 20 sites in the 4 SMGL districts implementing MNCH QI activities. Best practices were shared for each intervention area by the participants and a mini change package was shared at the end of the 3 day meeting.
- **Conducted coaching sessions.**
  - Emergency trays and special emergency packs for obstetric complications have been prepared in all the 20 labor units. These have improved the emergency preparedness and response.

##### **Results:**

- **Percentage of mothers delivering at the facility who received the 3 components of AMSTL improved.**
  - Changes tested include: Locally developed job aids on AMSTL use; assigning a focal person to monitor Oxytocin stocks in maternity; redistribution from overstocked sites in case of stock outs.

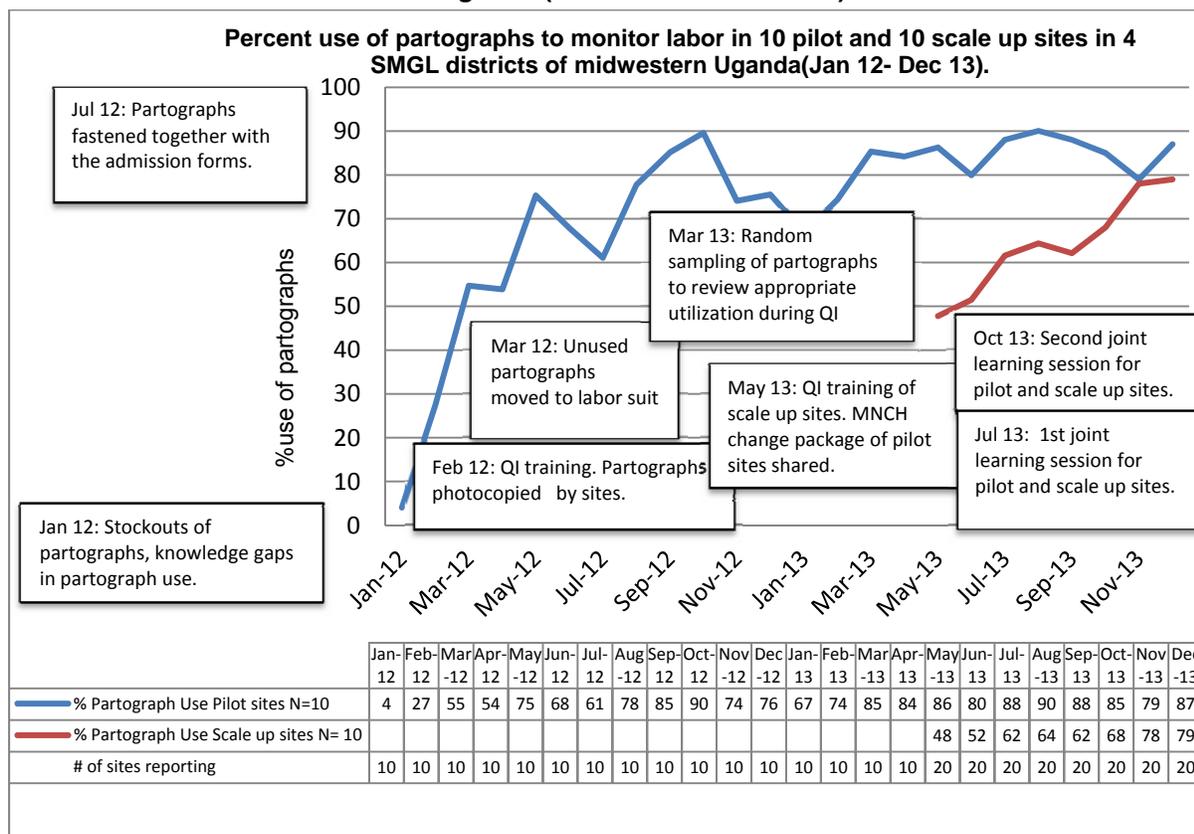
- Keeping weekly stocks of oxytocin in labor suit to ease access; mini change package from pilot sites shared with scale up sites during LS and coach visits.
- o Figure 47 shows that the 10 scale-up facilities have improved rapidly (95%) and about to attain a target in compliance to AMTSL use (98%). This has been through sharing what was learned works from the pilot facilities in improving AMTSL use through onsite coach visits and learning sessions.

**Figure 47: Uganda: Percentage of mothers delivering at the facility who received the 3 components of AMTSL (Jan 2012 – March 2014)**



- **Number of pregnancy induced hypertension cases.**
  - o Due to the increase in the number of pregnancy induced hypertension cases in the SMGL region, 17 out of 20 QI supported sites are routinely screening mothers at admission through blood pressure measurement and urine dipstick testing. The teams have also prepared special eclamptic packs to handle eclampsia emergencies. Blood pressure screening of mothers is currently at 80%. Urine dipstick testing is currently conducted on mothers whose blood pressure is >130/90mmHg due to inadequate supplies of urine dipsticks. Through the assessments, the teams have been able to identify mothers with pregnancy induced hypertension and managed them appropriately. There are fewer cases of maternal deaths due to eclampsia occurring in the QI supported health facilities.
- **Adherence to partograph use.**
  - o This has been institutionalized in all the 20 ASSIST facilities through photocopying/printing on site, partographs tendered and incorporated in the admission forms and daily/weekly review of client charts to check for utilization and completeness. Spread sites have improved faster and better than the pilot sites due to taking up of lessons learnt and institutionalizing them. Major challenge with partograph use is stock outs in some facilities where a budget is not allocated for printing/photocopying partographs. This is due to the lack of a national supply of partographs from the National medical stores (Figure 48).

**Figure 48: Uganda: Percent use of partographs to monitor labor, 10 pilot and 10 scale up sites in 4 SMGL districts of Midwestern Uganda (Jan 2012 – March 2014)**



- **Compliance to provision of a complete package of essential newborn care (ENC).**
  - A package of ENC (immediate and exclusive breastfeeding, cord care, eye care with tetracycline ointment, vitamin K 1 mg IM, immunization OPV, BCG and thermal protection (drying baby, cap and socks, blanket, room temperature, delaying bathing baby until after 24 hours) is provided before discharge to live newborns in the maternity wards recorded in the maternity register and at the back of the partograph. At discharge, these are checked by the staff discharging the newborn for each element supposed to be received. Mothers are educated on the thermal protection from the time of delivery up to discharge. There has been a challenge of stock outs of vitamin K and polio O& BCG vaccines in some districts at particular times. This sometimes affected the entire district for a period of 1 – 2 weeks.
- **Improving early detection and management of pre eclampsia and eclampsia.**
  - 10 Facilities have requisitioned urine dipsticks from the laboratories to the labor suite. All 20 facilities have requisitioned blood pressure machines from stores to the maternity department. Special emergency packs have been prepared in the labor suites to handle eclamptic emergencies.
- **Improving early detection and management of newborn asphyxia.**
  - Newborn asphyxia accounts for > 75% of newborn deaths in the four districts. This is due to the late arrivals of mothers at health facilities for delivery, lack of adequate and essential resuscitation equipment (right size of masks, bulb syringes, oxygen, suction machines, Neonathalie Kits). There is still a challenge of inadequate resuscitation equipment in health facilities like bulb syringes, suction machines, right size of masks and oxygen equipment.

**Activity 6. Integrate family planning into maternal newborn and child health**

**Accomplishments:**

- **Conducted second learning session.**

- Conducted second joint learning session for the 20 sites with the maternal and new born collaborative found in the 4 SMGL districts implementing QI activities.
- **Conducted two joint coaching visits with the District health teams to 18 SMGL sites.**
- The coaching visits focused on supporting the sites to come up with possible interventions to improve documentation and monitor performance, address the myths and misconceptions that were affecting FP use.
- **Conducted a baseline assessment.**

**Results:**

- Percentage of women receiving FP counselling in 15 sites increased from 23% in April 2013 to 55% by December 2013.

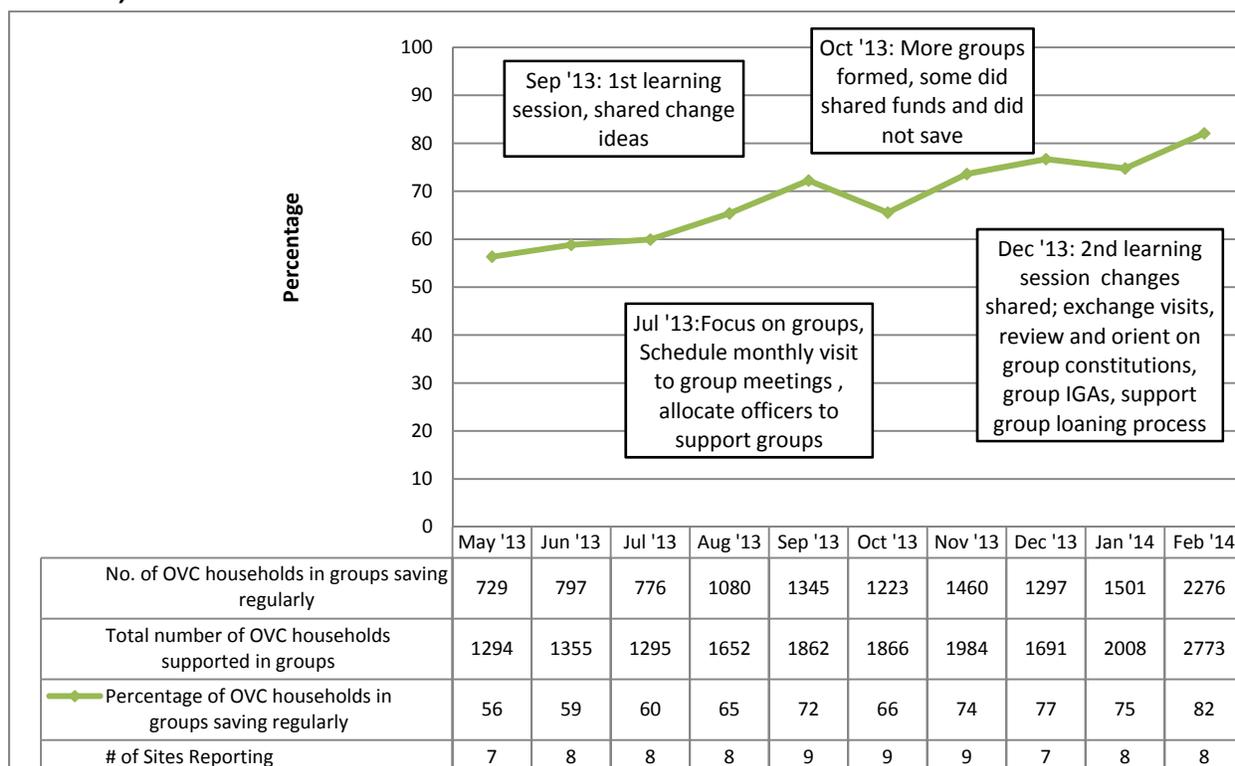
**Activity 7. Improve quality of Orphans and Vulnerable Children (OVC) services**

**Accomplishments:**

- **Conducted learning sessions.**
  - Teams that have met their targets were guided to select other areas for example; two teams (RUDFA and The Salvation Army) decided to work on improving sanitation among OVC households and other two teams (Agape and Kakinga CDC) selected improving vulnerable children who receive HIV counseling and testing.
  - The sub-county community development officers (CDOs) who have formed village child protection committees to improve community participation, ownership and management of vulnerable children at the village level share progress made and plans for scale up.
- **To improve regular school attendance the following changes were tested.**
  - Engaged vulnerable households to monitor and report their children's school attendance. For this change, some caregivers were not providing correct information so it was modified by assigning a caregiver to follow up 3 households and monitor school attendance for the children.
  - In Busia, The Salvation Army found out that many children left home but did not reach school; therefore they introduced a change of monitoring school attendance at the school through assigned teachers and community volunteers using specially designed school attendance sheets. Children not attending school are followed up through home visits and discussions held with parents to make plans to improve.
  - In Rukungiri, RUDFA tested use of interest free loan from social welfare fund in the village savings and loan associations (VSLA) to support caregivers purchase materials for children to attend school. The change worked at one VSLA group and was spread to other 6 groups.
- **To improve birth registration the following changes were implemented.**
  - The Salvation Army discussed the high cost of birth certificates as a hindrance for vulnerable households with sub-county and district officials. The sub-county and district authorities agreed to cost share so that vulnerable households would obtain birth registration certificates at 70% of the set fees. The Salvation Army paid birth certificates for 237 children (mainly one child per household) and advised care givers to obtain for the other children in their households.
  - Community dialogues have been held to inform caregivers on the importance of birth registration and the process of obtaining the certificates.
  - VSLA meetings have been used as an avenue to encourage member households to obtain birth registration certificates with some groups offering to buy for the most vulnerable children and providing interest free loans to members to pay for the registration certificates.
- **Household economic strengthening.**
  - To support vulnerable households improve their social economic status, OVC service providers have supported the formation of household economic strengthening (HES) groups provided with skills to work together, save money and generate capital for income generating activities. The service provider teams, improved follow up and support for the groups through monthly support focused on ensuring the HES groups improve monthly members meeting attendance, saving and other social challenges identified during their regular meetings.

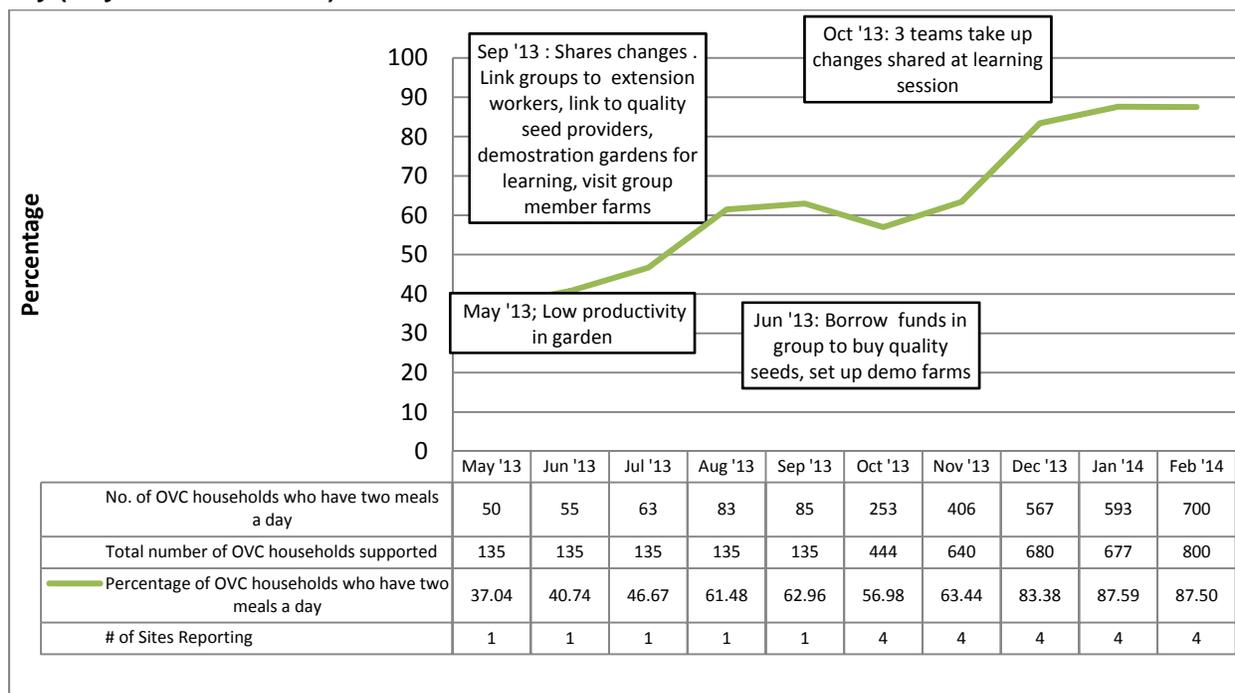
- By the end of February 2014, all the 11 sub-counties supported had formed a total of 26 village child protection committees of which 22 are functional. Across the committees, most of the children who were registered were out of school and parents reported that they needed support to have their children back to school. This was prioritized as an area for improvement by the committees and the village committees put in interventions to address this challenge.
- In January 2014, ASSIST conducted a baseline assessment at Naguru reception centre using ministry children (approved Home) regulation assessment toolkit. The assessment scored poorly in the areas of general child records and data management. The team was guided to form a quality improvement team that would be responsible for follow up of the improvement plan to address the identified gaps. Two coaching sessions were conducted in February and March 2014, focused on supporting the QI team to test changes. The team is working on to improve two areas, namely; Percentage of admitted children with complete records and percentage of children with known families resettled within six months of admission.
- **Results:**
  - Regular school attendance improved from 66% in October 2013 to 77% by November 2014 at three civil society organizations.
  - Teams have reported improvement in the number of households saving regularly as shown in Figure 49. Where teams have had challenges (for example transport to communities) with having field officers provide monthly support, they have oriented community resource persons to follow up the groups and provide guidance on how to identify challenges and address them.

**Figure 49: Uganda: Percentage of OVC households in groups saving regularly (May 2013 – Feb 2014)**



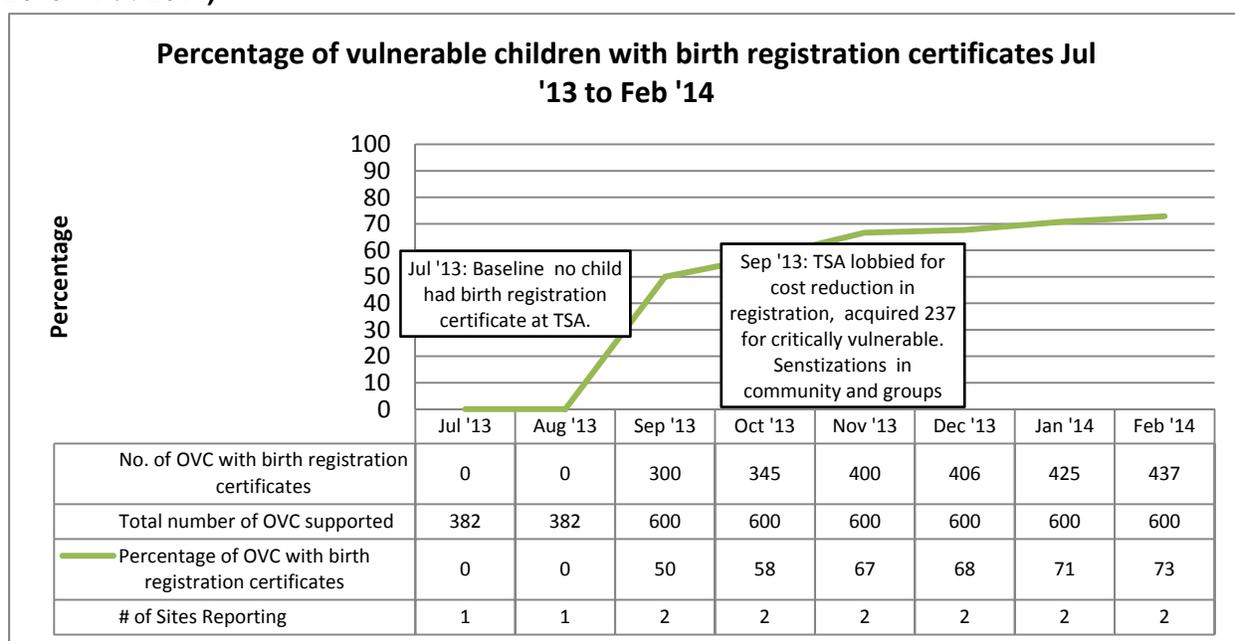
- The percentage of vulnerable households having two or more meals a day increased from 37% in May 2013 to 87% in February 2014 (Figure 50).

**Figure 50: Uganda: Percentage of vulnerable households who reported having two meals a day (May 2013 – Feb 2014)**



- The percentage of vulnerable children who have their birth registration increased from 0% in July 2013 to 74% in February 2014 (Figure 51).

**Figure 51: Uganda: Percentage of vulnerable children with birth registration certificates (July 2013 – Feb 2014)**



## How Do We Know We Are Improving?

### Improvement in Key Indicators:

Activity	Indicator	Baseline	Last value (month)
1. Safe Male Circumcision	<ul style="list-style-type: none"> <li>Percentage that experience moderate to severe adverse events</li> </ul>	Oct'12 (0.5%) N.B This was from 8 sites	0.6% (Feb'14)
	<ul style="list-style-type: none"> <li>Percentage that return within 48 hours post operation</li> </ul>	Oct'12 (58%) N.B This was from 4 sites	84% (Feb'14)
	<ul style="list-style-type: none"> <li>Percentage that return after 1 week follow-up</li> </ul>	Oct'12 (54%) N.B This was from 7 sites	63% (Feb 2014)
	<ul style="list-style-type: none"> <li>Percentage that return after 6 weeks</li> </ul>	Oct'12 (0%)	30% (Feb 2014)
2. Improve TB care	<ul style="list-style-type: none"> <li>TB case notification</li> </ul>	62.9% (Dec 2013)	80.7% (Feb 2014)
	<ul style="list-style-type: none"> <li>Percent of TB suspects sent for further evaluation</li> </ul>	0% (Dec 2013)	11.1% (Feb 2014)
	<ul style="list-style-type: none"> <li>Percent of TB retreatment cases that are sent for DST</li> </ul>	84% (Dec 2013)	70.4% (Feb 2014)
	<ul style="list-style-type: none"> <li>TB Treatment completion</li> </ul>	71% (Dec 2013)	43.9% (Feb 2014)
	<ul style="list-style-type: none"> <li>TB treatment response monitoring at 2, 5 and 8 months</li> </ul>	57.6% (Dec 2013)	69.7% (Feb 2014)
	<ul style="list-style-type: none"> <li>Percent of TB/HIV co-infected on ART</li> </ul>		
3. Improve maternal, newborn and child health	<ul style="list-style-type: none"> <li>Percentage of deliveries with compliance to Partogram use.</li> </ul>	Jan 12 (4%)	Mar 14 (86%)
	<ul style="list-style-type: none"> <li>Percentage of deliveries with compliance to AMTSL</li> </ul>	Jan 12 (5%)	Mar 14 (97%)
	<ul style="list-style-type: none"> <li>Percentage of deliveries developing PPH</li> </ul>	Jan 12 (0.3%)	Mar 14 (1%)
	<ul style="list-style-type: none"> <li>Percent of newborns who received a complete package of Essential newborn care.</li> </ul>	Jan 12(1%)	Mar 14 (88%)
	<ul style="list-style-type: none"> <li>Percentage of asphyxiated newborns who are successfully resuscitated</li> </ul>	Apr 13 (77%)	Mar 14 (86%)

### Directions for Q3 and Q4 FY14

HIV CoR	<ul style="list-style-type: none"> <li>Three joint onsite QI coaching visits to each of the 48 sites on a monthly basis including the two new private sites (Kinyara and Mehta) and light support to three sites supported by STAR SW, NuHITES and STAR E/EC</li> <li>Support facilities to implement projects</li> </ul>
HIV COR, treatment and support, Community	<ul style="list-style-type: none"> <li>Improve quality of services provided by QI teams by harmonising data collection tools and developing job aids for community QI teams. Feedback and partnership meetings to share progress through Joint Coaching and mentoring and Joint learning sessions</li> </ul>
Chronic care	<ul style="list-style-type: none"> <li>The objective for the next quarter is to guide sites synthesis what they have implemented since the start of the intervention</li> <li>Conduct coaching, a learning session, and plan for end line evaluation</li> </ul>

intervention	
SMC	<ul style="list-style-type: none"> <li>• Support to the original 30 intensely supported sites.</li> <li>• Scale up to 50 sites beginning in April 2014, USAID ASSIST will scale up intense support to 20 new sites making a total of 50 intensely supported sites.</li> <li>• Spread of best practices will be initiated to other 100 SMC sites next quarter. Technical support to MoH, UASID ASSIST will continue to support MoH to convene the quarterly oversight national task force meetings.</li> </ul>
PHFS	<ul style="list-style-type: none"> <li>• Knowledge hand over meetings in the eastern region and light support to spread sites in the south western region</li> <li>• Fourth learning session, next phase of harvest meeting and joint monthly coaching in 22 demonstration sites</li> </ul>
SMGL	<ul style="list-style-type: none"> <li>• Support the district and regional coaches to continue supporting the new scale up facilities in their districts through one joint quarterly visit to each of the 10 facilities.</li> <li>• Support the 20 facility quality improvement teams to document and update the changes tested to care processes in the documentation journals in preparation for the harvest meeting through on site coach visits.</li> <li>• Conduct a harvest meeting to document all changes tested and lessons learnt and develop a change package</li> </ul>
FP-MNCH	<ul style="list-style-type: none"> <li>• Conduct 2 coaching visit April and May 2014 in the 18 sites of the 4 SMGL districts.</li> <li>• Learning session in June and baseline assessment in the FP-HIV integration 18 ART clinics of the FP-MNCH participating sites.</li> </ul>
OVC	<ul style="list-style-type: none"> <li>• Hold a 4th learning session, harvest meeting and coaching</li> </ul>

## ASIA

### 1.16 India

#### Background

The USAID ASSIST Project started working in India in January 2013. The project is working in the six USAID-supported states to build improvement capability by enhancing the commitment and capability of leaders at the national, state and district levels to lead health care improvement. In addition, the project is working to develop the capacity to conduct improvement among health care workers and national, state, district, public and private facility, and community levels along the continuum of reproductive health, maternal, neonatal, child, and adolescent health (R-MNCH+A).

#### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Enhance the improvement capability in the Indian health system through conducting improvements in the “R-MNCH+A”	<ul style="list-style-type: none"> <li>• Improve care along the R-MNCH+A continuum in priority USAID districts</li> <li>• Develop the capacity to conduct improvement among health care workers at the community, facility, district, state and national level</li> </ul>	<p>USAID ASSIST is expected to work in: all 6 USAID-supported states, and all 30 of the USAID-supported districts, and one “block” in each of the selected districts:</p> <ul style="list-style-type: none"> <li>• Delhi: 2 districts, 2 blocks</li> <li>• Himachal Pradesh: 4 districts, 4 blocks</li> <li>• Punjab: 5 districts, 5 blocks</li> </ul>	x	

continuum in public and private entities	<ul style="list-style-type: none"> <li>Enhance commitment and capability of leaders at the community, facility, district, state and national level to lead health care improvement</li> </ul>	<ul style="list-style-type: none"> <li>Uttarakhand: 3 districts, 3 blocks</li> <li>Jharkhand: 11 districts, (staff placed in 6 districts)</li> <li>Haryana: 7 districts, 7 blocks</li> </ul> <p>Total expected number of facilities: 400-500</p> <p>Total expected population coverage: 3.5-4M</p>		
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## Key Activities, Accomplishments, and Results

### **Activity 1. Enhance the improvement capability in the Indian health system through conducting improvements in the “R-MNCH+A” continuum in public and private facilities**

**Improvement Goal:** Reduce maternal and child morbidity and mortality in high-priority districts in 6 states through improving process of delivery of health services and building a cadre of improvement professionals.

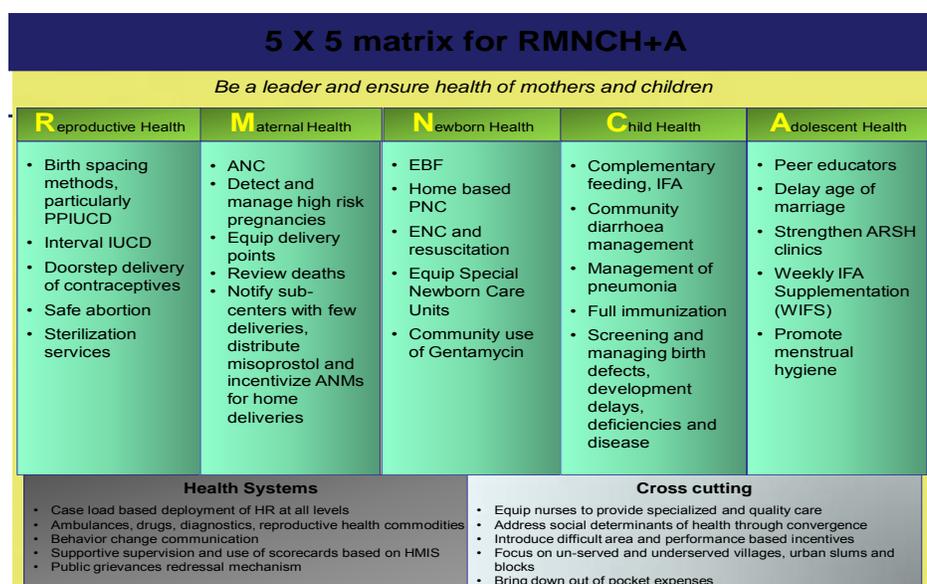
#### Improvement Aims:

- Reduce post partum hemorrhage by 50% in clinics supported by ASSIST in one year by improving primary prevention.
- Improve identification of high risk pregnancies by 100% in clinics and communities supported by ASSIST in 6 months by improving antenatal care.
- Improve institutional deliveries by 50% in districts with low institutional deliveries within one year.
- Improve immediate postnatal care by 50% in facilities where deliveries take place in high priority districts.

#### Accomplishments:

- Work in India began in Q1 with the relocation of ASSIST’s Project Director to Delhi. The focus during Q1 was setting up the administrative structure, recruiting staff (state coordinators, district improvement coordinators), meeting the key government and NGO partners and developing the project work plan. ASSIST is working with the government to help implement the RMNCH+A strategy. This strategy has 25 interventions (Figure 52).

**Figure 52: India: 5x5 matrix for RMNCH+A**

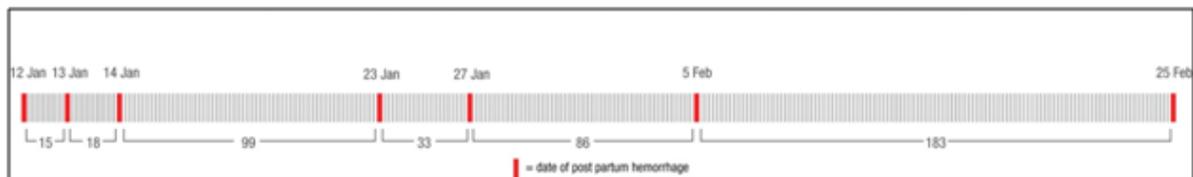


- After review of current evidence and Government priorities and consultation with experts, ASSIST India prioritized the following four areas for the first phase to focus on with an intention to reduce anemia, PPH and newborn deaths (Q1): (1) antenatal care, (2) delivery**

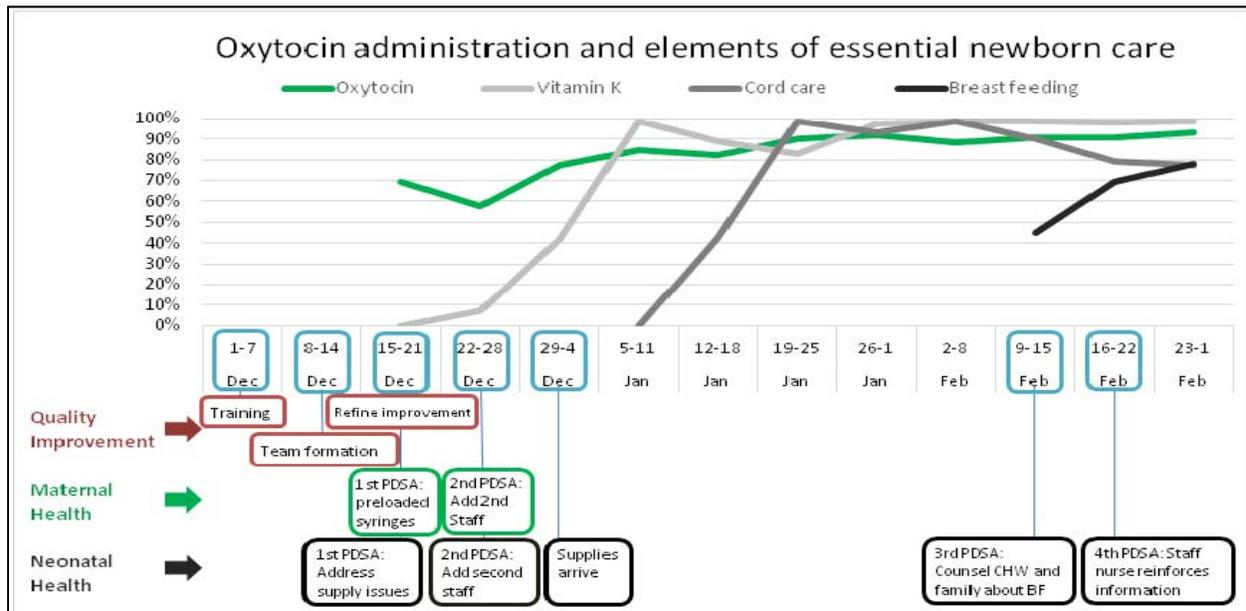
care, (3) immediate postpartum care, and (4) essential newborn care.

- **A list of indicators for baseline assessment, the data base and data collection tools were developed.** Staff were trained on QI and use of the data base. Using appropriate criteria one block was selected in each district in consultation with district officials. Each block has a Comprehensive Health Center (CHC), 3-4 Primary Health Centers (PHCs), and several sub centers.
  - Jharkhand State:
    - QI teams were established in 35 facilities.
    - District coordinators supported the development of District Action Planning process.
  - Haryana State:
    - QI teams were established in 33 selected health facilities.
    - District coordinators supported the development of District Action Planning process.
  - Punjab State:
    - QI teams were established in only 35 selected facilities.
    - District coordinators supported the development of District Action Planning process.
  - Himachal State:
    - QI teams were established in 16 selected health facilities.
    - District coordinators supported the development of District Action Planning process.
  - Uttarakhand State:
    - QI teams were established in 14 selected health facilities.
    - District coordinators supported the development of District Action Planning process.
  - Delhi Union Territory:
    - The formation of QI teams in 13 selected health facilities.
- **District coordinators supported the development of District Action Plans.**
- **Improvement work started in 146 facilities in 26 of 27 districts.** The final district will start after winter when the district becomes accessible and we can place a staff person there.
- **Successfully advocated for the inclusion of funding for quality assurance committees in the annual budgets in all states.** The amount is roughly \$30 000 - \$100 000 per annum per state. This includes dedicated staff for improvement and activity costs (meetings, trainings, onsite support).
- **Conducted improvement work in Godda Hospital:** Godda District Hospital is a 46-bed hospital serving a population of 1.3 million. It is staffed by 8 medical officers, 10 staff nurses, and 11 auxiliary nurse midwives. The labour and delivery room is staffed by 8 staff nurses and delivers approximately 12 women per day. As part of the government's RMNCH+A initiative, the hospital is striving to improve maternal and newborn care. The recently conducted gap analysis showed that there were some issues with labour and delivery. The hospital's initial focus was to reduce postpartum hemorrhage (PPH) by ensuring that all women receive oxytocin immediately after they deliver their babies and to ensure that all babies receive essential newborn care (ENC). Within three months they have seen a substantial decrease in PPH (Figure 53) and an increase in the number of neonates receiving the elements of ENC (Figure 54).

**Figure 53: India: Number of women who deliver between cases of post-partum hemorrhage (Jan – Feb 2014)**

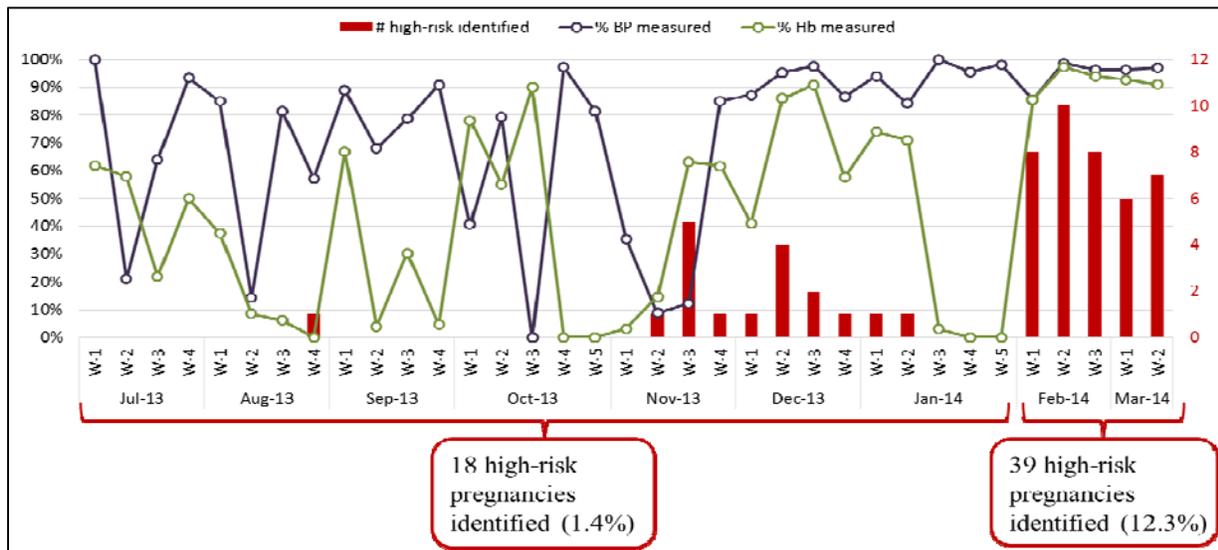


**Figure 54: India: Performance on oxytocin administration and elements of essential newborn care (Dec 2013 – Feb 2014)**



- Developing a system of care in the Mandi Antenatal Clinic:** The USAID ASSIST Project started work in Mandi as part of the RMNCH+A strategy in December 2013. The district coordinator for ASSIST worked with the team in the clinic to form a quality improvement team. After looking at their data, the team realized that their clinic was not doing a good job of identifying high-risk clients. When they analyzed their current system of providing care they found that staff were not clear about what services to provide to patients or who should do what. Because of this, the clinic was chaotic and not reliably providing standard care. For example, before the improvement team started working, the percentage of women receiving a hemoglobin test varied from 0 to 91% depending on the day, and most weeks no high-risk women were identified. With some simple changes the clinic was able to reliably provide routine care and to identify 8 times as many women with high risk conditions (Figure 55).

**Figure 55: India: Number of high-risk pregnancies detected and percentage of ANC consultations in which blood pressure (BP) and hemoglobin (Hb) were measured in Mani, Himachel Pradesh (July 2013 – March 2014)**



- Based on their analysis of the problem, the quality improvement team, supported by the ASSIST district coordinator implemented four main interventions:
  - On the job training about essential elements of ANC. The district improvement coordinator reviewed with the staff the government guidelines for ANC and helped make sure that all essential elements were included in their new system of care.
  - Defining roles. After clarifying the elements of care that needed to be provided the team assigned roles to staff describing who should perform which tasks and also clarified how patients should move between stations. The team started using the new system in the first week of February 2014.
  - Using standard government documentation tools. The district improvement coordinator shared with the team the Government of India ANC register which they had not previously been using. The team started using this in December 2013.
  - Counsel clients to return from lab. A major issue in the clinic was that patients had their haemoglobin and urine checked in the laboratory but did not bring the results back to the ANC clinic so laboratory tests were of no clinical use. To address this, the ANC recording staff started asking the women to return to the clinic with their lab test reports so that any additional actions could be taken

### Directions for Q3 and Q4 FY14

- Lead delegation of high-level government officials to the International Forum for Quality and Safety in Health Care and hold one-day meeting in Paris to discuss how to take lessons about improvement from the meeting, adapt them to India, and implement them.
- Investigate ways of involving the private sector in improvement work.
- Hold learning sessions in all states to bring teams together to share experiences of the first two months of improvement work.
- Conduct research on how community and family factors influence the ability of female community health workers to provide health care, to guide work with this important cadre of health workers.

## 1.17 Indonesia

### Background

Starting in January 2014, the USAID ASSIST Project began working with the University of Indonesia to conduct a mid-term and end-line evaluation to compare the quality of care provided in hospitals accredited by the Joint Commission International with hospitals accredited by the Indonesian Hospital Accreditation Commission. The baseline study was conducted under the HC) project in 2013. The midline phase of the study will be conducted in 2014 under the USAID ASSIST Project.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improve ment Activity	Activity
1. Hospital Accreditation Process Impact Evaluation (HAPIE)	HAPIE: Evaluating the quality of care provided in hospitals undergoing Joint Commission International (JCI) and KARS (Indonesian Hospital Accreditation Commission- <i>Komisi Akreditasi Rumah Sakit</i> ) accreditation in Indonesia (KARS)	9 hospitals have been selected in three provinces. 3: JCI accreditation 2: KARS Accreditation 4: later renewal of accreditation under KARS – not seeking accreditation until 2015		x

## Key Activities, Accomplishments, and Results

### Activity 1. Hospital Accreditation Process Impact Evaluation (HAPIE) Study - Midline

#### Accomplishments:

- **Contractual details were finalized with the Universitas Indonesia(UI) – Center for Family Welfare (UI-CFW) partners (Q1).** They prepared to organize the logistics for the pilot study using the tools that were modified according to the findings of the Baseline Assessment conducted under the HCI Project.
- **The protocol was prepared for submission to the UI for Institutional Review Board approval and was approved (Q1-Q2).**
- **Dr. Edward Broughton traveled to Indonesia from January 27 to February 7, 2014. The goals of the trip were to:**
  - Debrief with the data collection team on lessons learned from the baseline assessment
  - Begin health systems environmental analysis focusing on changes since October 2012
  - Begin planning for midline data collection in hospitals and revise the data collection tools
  - Perform training and capacity development for the data collection team from UI
  - Plan for piloting the data collection instruments and finalize the tools
- **While in Jakarta, Dr. Broughton met with Dr. Mohammed Shahjahan and Dr. Dewi Indriani from the WHO office of health system strengthening to present about the progress of the HAPIE study and the plans for the coming weeks and the overall strategy for completing the mid-line data collection.**
- **During the trip, Dr. Broughton and the team from UI – CFW traveled to Malang to visit Saiful Anwar Hospital to provide feedback as had been requested by the hospital administrators.** The same generalized presentation was delivered as it had been for several hospitals previously. The reaction was similar to that witnessed in other hospitals – some defensiveness and questioning the study methodology in domains in which the hospital demonstrated poor performance and a desire to be provided very specific guidance on what to do to improve performance.
- **Dr. Broughton traveled to Indonesia again from March 22 to April 5, 2014.** The goals of the March to April trip were to provide feedback to Sarang Hospital and Hasan Sadikin Hospital in Bandung and begin mid-line data collection in 3 of the 9 hospitals, review data collection instruments and data sheets for recording, and review qualitative data collection and begin preliminary analysis.
- **An in-depth debriefing about the data collection that had been ongoing in the hospital by the HAPIE/UI team took place.** It was reported that chart reviews were going well and that the process was being facilitated by the substantial help provided by the hospital staff. There were no substantive difficulties with the data collection and the instruments appeared to be working well. The four additional data collectors, two MDs and 2 Public Health graduates appeared well trained and were evidently engaged in their assigned tasks. They were also observed performing chart reviews the following day.

#### Directions for Q3 and Q4 FY14

- Data collection will be completed in all of the nine hospitals in the Q3 FY14. Data entry and cleaning will begin in this quarter also.

## EUROPE AND EURASIA

### 1.18 Georgia

#### Background

USAID ASSIST is working with the Ministry of Labour, Health and Social Affairs and other stakeholders in Georgia to address quality, consistency, and continuity of medical care; to improve access to and use of evidence-based medical information by physicians; and to enhance the availability of modern evidence-based treatments in one region. The project is supporting referral and primary care facilities to improve the quality of cardiovascular disease, asthma, pneumonia, and chronic obstructive lung disease prevention and treatment. We are also supporting private providers

and insurance schemes to adopt evidence-based clinical protocols.

## Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Improve quality, consistency and continuity of medical care in Georgia in a demonstration region	<ul style="list-style-type: none"> <li>• Improve timeliness, continuity, effectiveness, efficiency, patient-centeredness of provided services and their consistency with clinical guidelines through improvement collaborative approach</li> <li>• Strengthen capacity of medical providers to provide safe, timely, continuous, effective and efficient medical care</li> <li>• Improve awareness on quality improvement experiences countrywide</li> <li>• Strengthen HIS to support development of evidence-based decisions on improvement quality of medical care</li> <li>• Ensure equitable access to priority “best-buy” high impact medical services in IC regions</li> </ul>	<p>Demonstration of QI intervention to improve quality, consistency and continuity of care in one region (Imereti)</p> <p>Demonstration phase is taking place in 4 hospitals that recently have merged in 3 (out of 40), 4 polyclinics (out of 42) and 13 village doctors (out of 212) in Imereti (1 out of 11 regions of Georgia)</p> <p>This region has a population of 699,890</p>	x	

### Key Activities, Accomplishments, and Results (January – March 2014)

#### Activity 1. Improve quality, consistency and continuity of medical care in Georgia in a demonstration region

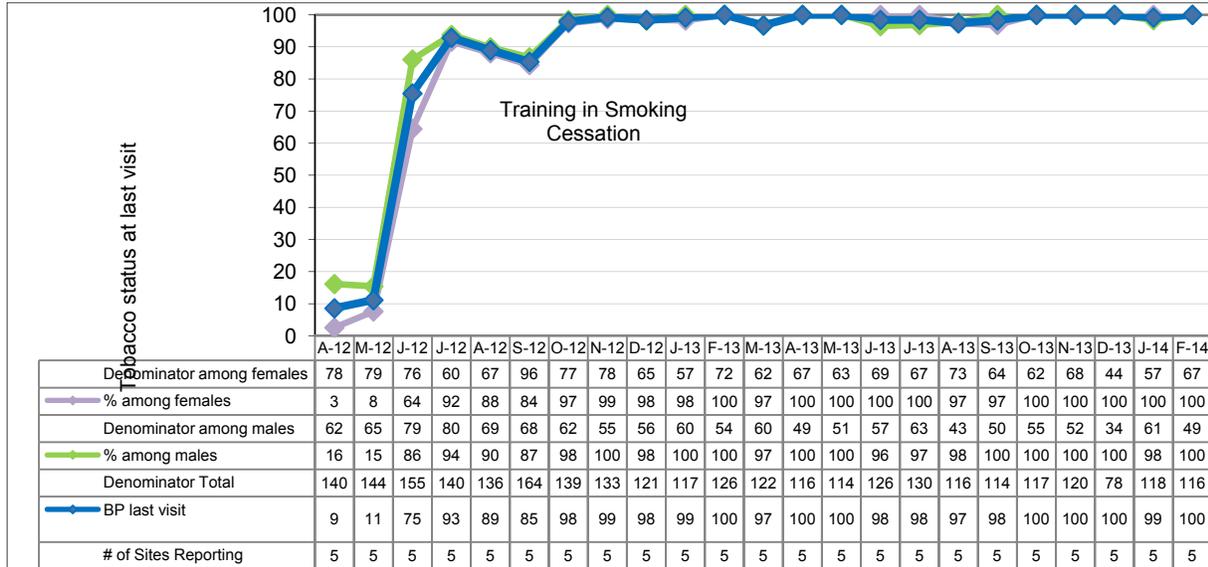
##### Accomplishments:

- **Integrated gender in quality improvement activities** with support of Dr. Taroub Harb Faramand (WI-HER, LLC). The project performed various steps to ensure that men and women in collaborative improvement facilities receive equal care. Specifically,
  - The project analyzed sex discrepancies in the baseline data from the “Assessment of effectiveness and cost-effectiveness of QI interventions” on cardiovascular disease risk factor screening and modification from medical chart review and patient exit interviews.
  - With support from Dr. Faramand at the 8th regional learning session, conducted on February 13-14, 2014 at Kutaisi National Medical Centre, the team oriented participants about gender issues and the importance to implement gender-sensitive interventions in quality improvement. Specifically, the project team presented sex-disaggregated data on Cardiovascular Disease (CVD) risk-factor screening and modification. Three sex-disaggregated datasets were presented to the learning session participants. At the learning session, facility Quality Improvement Teams discussed the core problems in four different chronic disease risk factor screening and modification areas (smoking, unhealthy diet, low level of physical activity and overweight; dislipidemia, hyperglycemia; and hypertension) and developed changes/interventions to close the gap in CVD risk-factor screening and modification practices between men and women.
  - The project disaggregated routine monitoring results of cardiovascular disease risk-factor screening and modification by sex from the beginning of Georgia HCI intervention.
- **Results:** Figure 56 shows improved documentation of tobacco status at last visit. The 20% gap which was evident during the first months of project interventions was closed after intensive discussions and trainings reinforcing the importance of screening and counseling all adult

patients regardless of their sex. Job aids and relevant chart insert forms also helped to close the gaps in tobacco screening and counseling practices between men and women.

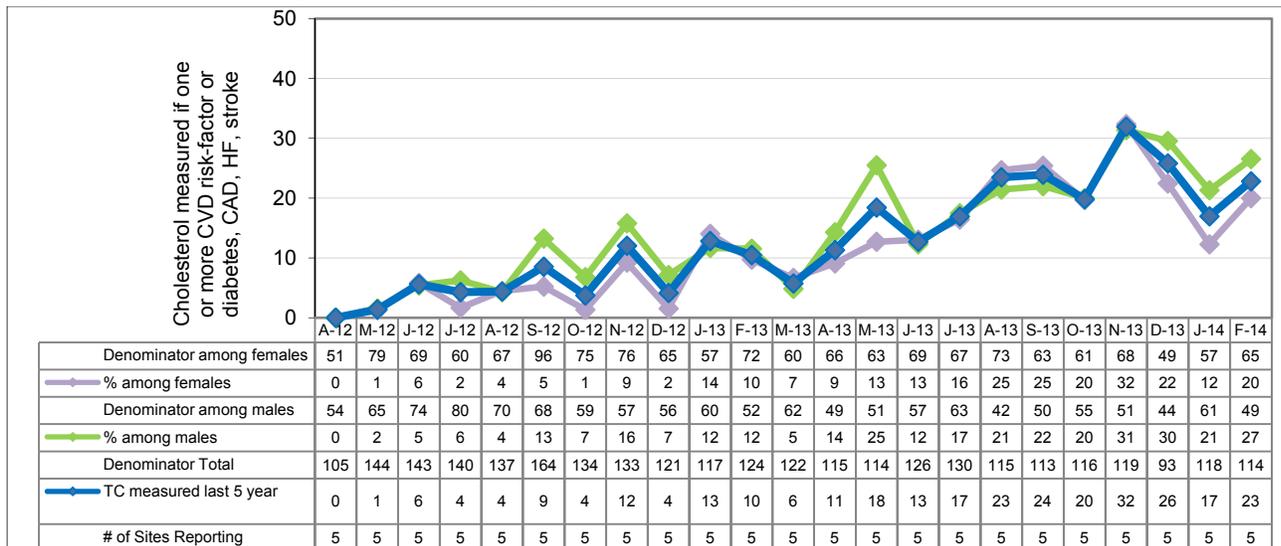
- o The results are consistent with baseline and end-line data for effectiveness and cost-effectiveness assessment and population surveys. At baseline only three charts contained tobacco status, at the end-line more than 90% charts of men and women contained documentation of tobacco status at the last visit.

**Figure 56: Imereti Region, Georgia: Tobacco status documentation disaggregated by sex at last visit in 3 polyclinics and 13 village solo practices, (April 2012-Feb 2014)**



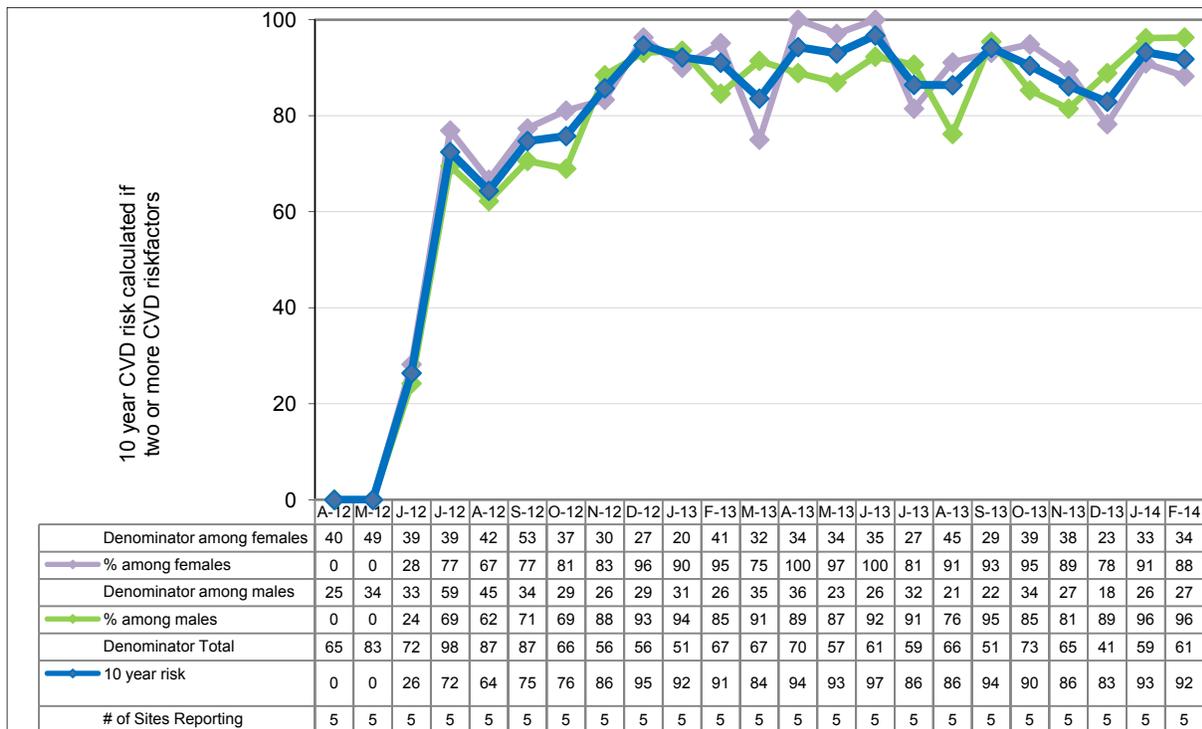
- Another modifiable cardiovascular disease risk factor, abnormal blood lipid levels remains unaddressed due to underutilization of its screening test. Even though the project was able to successfully advocate for inclusion of total cholesterol/blood lipid tests in most publicly funded programs, due to low public awareness of its significance the utilization of the lipid measurement remains low even in collaborative improvement facilities. Figure 57 shows a remaining gender gap in the above-mentioned indicator.

**Figure 57: Imereti Region, Georgia: Measurement of total Cholesterol disaggregated by sex, if one or more CVD factors or diabetes, coronary artery disease, heart failure or stroke in 3 polyclinics and 13 village solo practices, (April 2012 – Feb 2014)**



- Despite the fact that according to population survey (STEPS-2010) hypercholesterolemia is more prevalent in women (21%) than men (16%), routine monitoring results as well as facility baseline and end-line surveys demonstrate that more charts of men contain results of cholesterol measurement than of women (11% and 5% respectively at baseline and 45% and 38% respectively at end-line). At the same time patient surveys indicate that the prevalence of hypercholesterolemia diagnosis is moving towards the population level numbers. Noteworthy to mention is that there is no gender gap in prescription of the lipid measurement by medical care providers at all collaborative improvement facilities. This indicator reached and remains 100% in the last few months. As providers prescribe the tests, more patient/population awareness interventions are needed to improve the lipid measurement.
- Analysis of routine monitoring results revealed that the gender-specific gaps might be found even in the practices with more than 90% compliance. For example, in February 2014, calculation of 10 year CVD risk was 88% in female and 96% in male patients (Figure 58). The difference could be explained with providers' perception that the cardiovascular disease is more prevalent in men than in women. As this perception is currently not confirmed by modern scientific evidence, the Georgia team will initiate gender sensitive interventions to close the gap in women in this very important screening practice, considered as the best-buy by WHO.

**Figure 58: Imereti region, Georgia: Calculation of sex-disaggregated 10-year CVD risk in 3 polyclinics and 13 village solo practices, (April 2012 – Feb 2014)**



**Directions for Q3 and Q4 FY14**

- Provision of support to quality improvement teams of CI facilities in Imereti Region to test and implement changes in their care processes for CVD, asthma, COPD and RTI, support of integration of gender in quality improvement activities;
- Continue data analysis of effectiveness and cost-effectiveness assessment and working on preparation of publications in peer-reviewed journals;
- Support translation and spread of evidence-based medical information among Georgian physicians, including development of Hypertension Guidelines;
- Continue working on the CME modules.

## LATIN AMERICA

### 1.19 Haiti

#### Background

The USAID ASSIST Project was invited by USAID Haiti to provide technical assistance to the Haitian ministry, implementing partners, and the United States Government in Haiti, to improve the quality of services offered to vulnerable children and families affected by HIV. The project is a continuation of work accomplished under HCI which focused on building consensus among stakeholders on a set of minimum service standards at the point of service delivery. Over the past year, HCI supported formation of three departmental QI committees (North, West and Artibonite departments, training of coaches, revision and dissemination of OVC standards; and piloting of the service standards in nine sites in three out of ten departments. USAID Haiti has requested that ASSIST continue providing technical assistance to *Institut du Bien Etre Social and de la Recherche* (IBESR) an autonomous institution within the Ministry of Social Affairs, and implementing partners in the development and implementation of a plan to increase the distribution of the national service standards throughout all of Haiti and to develop strategies for overcoming critical barriers in the scale up and sustaining of effective high-impact interventions provided to vulnerable children and their families in Haiti.

#### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Build capacity of government and NGO partners to implement national service standards to improve quality of care for vulnerable children and their families	Improve the quality of OVC services & care through distribution of national service standards in six departments	Spread implementation of standards within 3 piloted departments: North, Artibonite, and West.  Initiate implementation in 3 additional departments, selection to be determined in collaboration with IBESR, USAID, and partners.	x	
	Develop strategies for identifying and overcoming critical barriers in the scale up and sustaining of effective high-impact interventions provided to vulnerable children and their families in Haiti.	One site in each of the three departments that participated in the piloting of the standards.		

#### Key Activities, Accomplishments, and Results

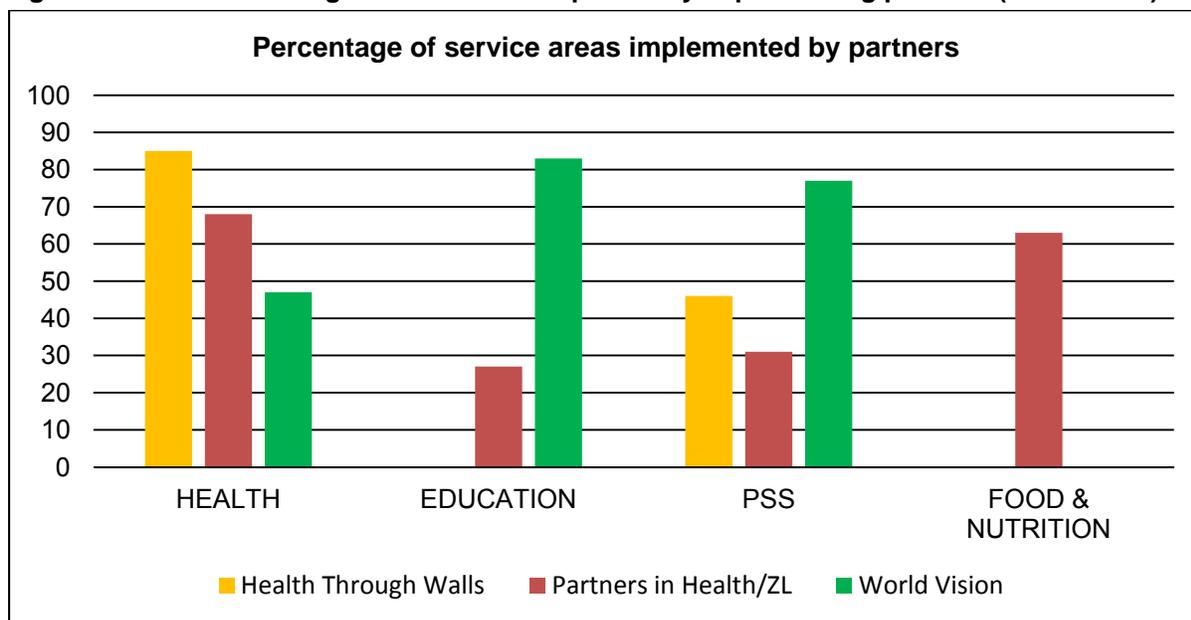
##### Activity 1. Build capacity of government and NGO partners to implement national service standards to improve quality of care for vulnerable children and their families

##### Accomplishments:

- **MoU signature** (February 2014): URC has signed a MoU with IBESR based on the technical support provided by URC and through the ASSIST Project. IBESR has taken advantage of this event to award a certificate of recognition to URC for its contribution to the Child Protection sector in Haiti.
- **ASSIST contributed to the review of the TOR of the Child Protection Group formed by IBESR in collaboration with all partners that signed the MoU** (Q2).
- **Held meetings with partners** (Q2). Several meetings were held separately with different stakeholders to discuss the implementation of the national guidelines and to choose the three new sites in three piloting departments and two new geographic departments.

- IBESR, USAID, Pathfinder, ASSIST, Caris Foundation, Handicap International, CRS, PIH/ZL, World Vision, Health Through Walls (HTW) are the partners will be collaborating in the implementation of the national guidelines.
- Grand'Anse and South were selected as new geographic departments while the sites to implement the national guidelines are located in Verretes, Titanyen, Montrouis, Cayes, Jeremie, Delmas and another in North department.
- **Conducted field visit in Verrettes** (March 2014). A field visit was conducted in Verrettes to meet the program team of the Hospital Durmasais Estime to discuss the terms to implement the national guidelines and to schedule a training session.
  - Five people including the program director, nurse in charge of nutrition, HIV/AIDS coordinator, social worker and the focal point of OVC for PIH attended this meeting conducted by the resident Advisor of ASSIST. A three day training session was scheduled on March 23 and April 8-9, 2014.
- **Conducted first training session** (March 2014) in Verrettes for the three sites in the two geographic departments.
  - Twelve people including focal points of Health through Walls, World Vision and PIH/ZL, IBESR representatives and the local team of Verretes Hospital were trained on the process for the guidelines implementation.
  - Quality dimensions, quality improvement methodology, team work, model for improvement and measurement including developing and tracking indicators were the topics covered to enable the staff of the partners to understand how the process works before approaching the national guidelines content and the strategies to implement and to disseminate them, as well as the QI tools.
  - After holding the first part of the training on the guidelines implementation, the staff from the Hospital Dumarsais Estime became very motivated to do the improvement work and the dissemination of the national guidelines in Verrettes.
- **Partners conducted self-assessments** (March 2014). PIH/ZL, Health through Walls and World Vision conducted self-assessment of their sites. Figure 59 shows the percentage of gap in each service area reported by PIH/ZL, Health Through Walls and World Vision. This self-assessment helped PIH/ZL and HTW understand the rate of key activities of standards they have to implement to improve the quality of services provided for orphans and vulnerable children. The self-assessment is ongoing because five other sites have yet to complete it.

**Figure 59: Haiti: Percentage of service areas piloted by implementing partners (March 2014)**



## Directions for Q3 and Q4 FY14

- Meet with national task team to develop QI strategy including indicators (April)
- Quarterly meetings with IBESR General Director's staff (May – June)
- Training on implementation and dissemination of the national guidelines for staff of IP (April – June)
- Coaches training/Departmental Committee meetings (June)
- Develop additional implementation tools (April – May)
- Launch the implementation of standards in five Departments (3 original, 2 new) (April – June)
- Data collection (April – June)

## 1.20 Nicaragua

### Background

Since January 2014, USAID ASSIST has been supporting the institutionalization of improvement methods and pre-service training in HIV services in the medical and nursing schools of eight public and private universities. The project is assisting in developing the skills of nursing and medical faculty to apply a teaching package for quality care. It is continuing the work with universities in Nicaragua begun under HCI in October 2012.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. To strengthen the teaching of HIV knowledge and skills for medical and nursing students through continuous quality improvement (CQI) and the use of the methodological designs included in the teaching package	Promote CQI in teaching by identifying gaps through HIV knowledge, attitude and practices (KAP) surveys among medicine students	8 universities: UNAN Managua, UNAN Leon, BICU, POLISAL, UPOLI, URACCAN, UCAN and UAM. Students: 1,495 Teachers: 50	x	
	Increase capabilities among universities' teachers in the use of assessment methodologies for medicine and nursing students	8 universities: UNAN Managua, UNAN Leon, BICU, POLISAL, UPOLI, URACCAN, UCAN and UAM. Students: 1,495 Teachers: 50		
2. To strengthen participation from associations of technical and professional workers in health services quality improvement in Nicaragua	Involve public health and medical associations in the management of information on HIV Transfer knowledge to medical associations of: MOH standards and protocols; the Teaching Package for skill development of HIV prevention and care; as well as best practices for quality improvement	Managua, with medical and public health associations		x

### Key Activities, Accomplishments, and Results

#### Activity 1. To strengthen the teaching of HIV knowledge and skills through CQI and the use of

## the methodological designs included in the teaching package

### Accomplishments:

- **Implemented KAP surveys at Bluefields Indian & Caribbean University (BICU), Politécnica de Nicaragua (UPOLI) and Universidad Nacional Autónoma de Nicaragua (UNAN León) to improve HIV knowledge, attitudes, and practices (KAP) among medicine and nursing senior year students.** Surveys were conducted at BICU among medical students previously trained in HIV Combination Prevention during workshops. Knowledge among these students was better compared with their counterparts in other universities. However, there was still a gap in knowledge of care for people with HIV. Surveys were conducted at UPOLI and UNAN Leon universities among senior year nursing students. Results were very similar in both universities. UPOLI students had not yet been trained in HIV since they recently started their academic year. UNAN Leon students previously received training on this topic but knowledge gaps persist, particularly on care for people with HIV (See Table 6).

**Table 6: Nicaragua: Average percentage of correct responses reached in KAP-HIV surveys by medical and nursing students (January 2014)**

Topic	Medicine BICU (n=12)	Nursing UPOLI (n=38)	Nursing UNAN León (n=28)
<b>General HIV knowledge</b>	<b>81</b>	<b>67</b>	<b>71</b>
Counseling principles (attitude)	100	46	73
Maternal child transmission of HIV	95	69	75
Risk factors for HIV	94	82	91
Transmission ways	94	88	90
Counseling principles (knowledge)	89	50	69
Human rights- stigma and discrimination	84	76	79
Antiretroviral therapy	82	58	71
Care for people with HIV (knowledge)	58	43	44
Care for people with HIV (attitude)	53	51	48

**Source:** KAP-HIV surveys conducted among senior year medical and nursing students.

- **Gaps in knowledge and attitudes were identified and analyzed**, including:
  - Some teachers have still not been trained on the teaching package’s methodological designs and therefore have not yet developed capabilities to implement them.
  - Some teachers work under contracts per hour and do not feel part of the university, thus dedicating less time to teaching and showing little interest, motivation and commitment to use the methodologies proposed in the teaching package.
  - The HIV topics are allocated little time within the medical and nursing students study programs.
- **Interventions implemented to overcome these challenges include reviewing content and the number of hours in the study programs at BICU, UNAN León, UPOLI and UNAN Managua.**
- **Nineteen BICU nursing and medicine teachers were trained on stigma and discrimination associated with HIV and sexual diversity.** The ASSIST Nicaragua team contributed to the successful institution of HIV, stigma, discrimination, and sexual diversity topics in study programs throughout the full curriculum. Training for the students was also conducted for those who participated in surveys, focused on the specific topics where knowledge gaps were found.
- **Revised and adjusted content and number of hours allocated to HIV topics in study programs for medicine and nursing in five universities.**
- **Developed competences among 222 medical graduates from UNAN Managua and 22 from UCAN.**
- **Increased capabilities among universities’ teachers in the use of assessment methodologies for medicine and nursing students.**

- As a product of analyzing KAP-HIV survey results, teachers were identified who had not been trained on the teaching package methodologies. The content regarding stigma, discrimination and sexual diversity is new and therefore teachers have not yet developed sufficient competences to teach students.

**Activity 2. To strengthen participation of professional associations in health services quality improvement in Nicaragua**

**Accomplishments:**

- **Established the first contact with members of the gynecology and obstetrics, pediatrics and public health medical societies to share objectives and action items of the project.**

**How Do We Know We Are Improving?**

**Improvement in Key Indicators:**

<b>Activity</b>	<b>Indicators</b>	<b>Baseline</b> (October – December 2013)	<b>Last value</b> (January – March 2014)
To strengthen the teaching of HIV knowledge and skills through CQI and the use of the methodological designs included in the teaching package	Number of surveys conducted among medicine students	217 completed out of 363 planned (60%)	294 completed out of 363 planned (81%)
	% of universities implementing rapid cycles	3 out of 6 visited (50%)	4 out of 7 visited (57%)
	Number of teachers per university applying methodological designs	49 out of 90 in the 6 universities visited (54%)	102 out of 120 in the 7 universities visited (85%)
	Number of students per university, trained and assessed using methodological designs	(0) Curriculum does not include HIV topics in this period.	222 of 500 (44%)
	Number of students trained in the new evidence for clinical care for people with HIV.	This activity is planned for implementation in the next quarter.	222 of 500 (44%)
	Number of teachers trained in the new evidence for clinical care for people with HIV.	This activity is planned for implementation in the next quarter.	19 of 50 (38%)

**Directions for Q3 and Q4 FY14:**

- Hold sessions with professionals from medical societies of public health, gynecology, obstetrics and pediatrics to introduce the teaching package and its usefulness, as well as to share the new WHO HIV guidelines.
- Complete the KAP-HIV surveys among medical and nursing students from URACCAN and POLISAL universities.
- Develop capabilities among teachers at UNAN Managua, UNAN Leon and UPOLI in the use and application of methodological designs contained in the teaching package specifically for stigma, discrimination, and sexual diversity.
- Follow up and technical assistance visits to universities to promote continuous quality improvement of teaching

## 2 Office of HIV/AIDS-Funded Activities

### 2.1 Community Health

#### Background

Community-based support can play an important role in improving uptake and retention of people living with HIV and AIDS (PLWHA) by strengthening the linkage between the community and health facility. Starting in January 2014, ASSIST began engaging the informal network of village community groups in Tanzania to extend the outreach system for PLWHA and to help health centers reduce loss to follow-up. This work builds on previous HCI work in the Muheza District of Tanga Region, Tanzania. In addition, ASSIST is building on the previous HCI demonstration collaborative project to improve performance of village health teams (VHT) in Uganda. ASSIST is working in Uganda to improve the performance of VHTs in identifying HIV patients, improve the quality of chronic care services for self-management at the community level, and to demonstrate the added impact of VHTs to chronic care services.

#### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Community support for HIV chronic care in Uganda	Utilize community system model: <ul style="list-style-type: none"> <li>To improve identification of PLWHA</li> <li>To improve clinical status through self- management of chronic conditions</li> <li>To improve the communication and feedback from health facility supervisor to VHT through mhealth</li> </ul>	Buikwe District, Uganda (one of 112 districts) Involving: 1/16 health facilities 10/475 Villages 20/950 VHTs	x	
2. Community linkages demonstration project , Tanzania	<ul style="list-style-type: none"> <li>Optimize linkages between the community and health facility to improve care and treatment services for PLWHA</li> </ul>	1 region/30 regions in Tanzania 1 Muheza district/8 districts in Tanga region 2 health centers/ 3 health centers in Muheza district 6 villages/12 villages in two health centers' catchment areas	x	

#### Key Activities, Accomplishments, and Results

##### Activity 1. Community support in Uganda

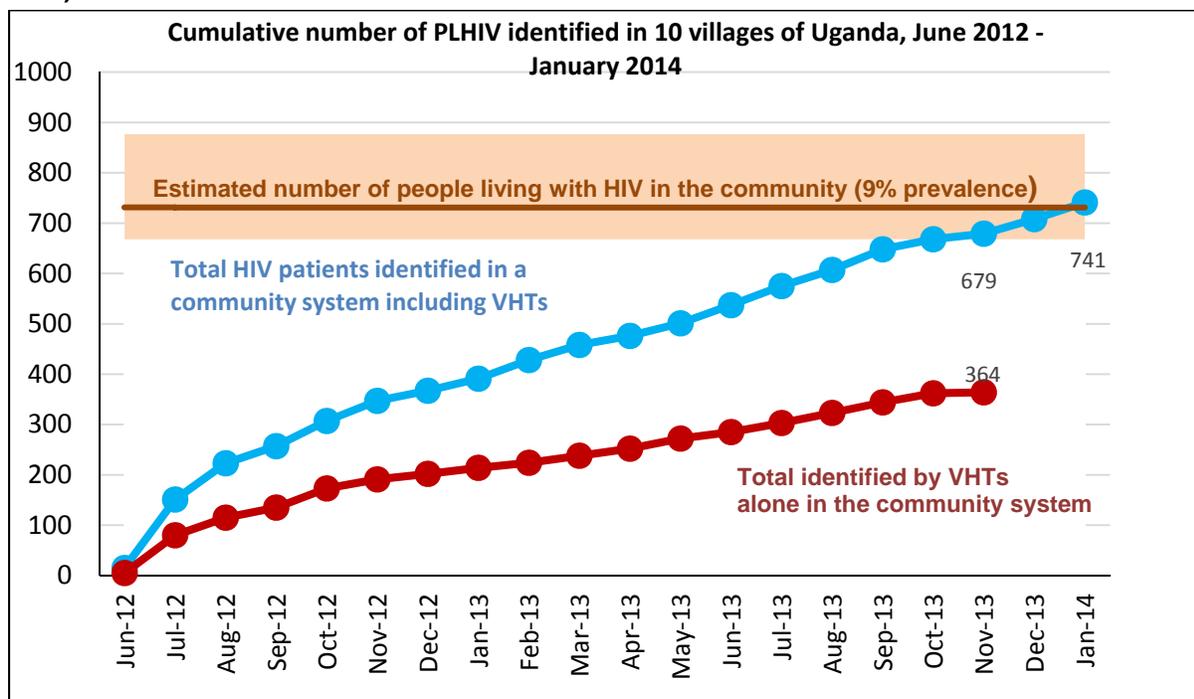
##### Accomplishments:

- **Conducted third learning session (Q1).** Conducted third learning session for the 10 villages in Buikwe district implementing chronic care activities. The learning session premised on sharing and harvesting changes that help identify PLWHA in the community, self management and improving clinical status. QI teams were oriented on the individual self management tool to help improve health goal setting and implementation. A total of 40 participants attended including Village Health Team members, community representatives, coaches, district and ASSIST staff.
- **Linked with existing community HIV services organizations (Q1).** Developed partnerships with two community HIV services organizations i.e. Mission for Community Development

(MICODE) and Health Initiatives Africa (HIA) to provide complementary HIV care services and linkages for support. Five QI teams are carrying out joint activities with the organizations which include HIV testing outreaches to help with identification of HIV clients, linking of HIV clients for educational and nutritional support and income generation activities. Through the partnership 77 community members received HIV testing of which 6 tested HIV positive and linked to the community QI teams.

- **Conducted coaching sessions in all 10 villages in Buikwe District.** Approximately 80 community representatives participated (January – February 2014). The coaches supported functioning of QI teams in each of the villages, identified performance gaps, introduced changes to address gaps, and monitored improvement.
  - Figure 60 highlights how support from the community system improved the performance of VHTs in identifying PLHIV in a village. The number of PLWHA identified in the community has increased from 708 to 767 (March 2014). Compared to the number of PLHIV expected to be mapped in 10 villages (N=731) we have achieved 5% beyond the target.

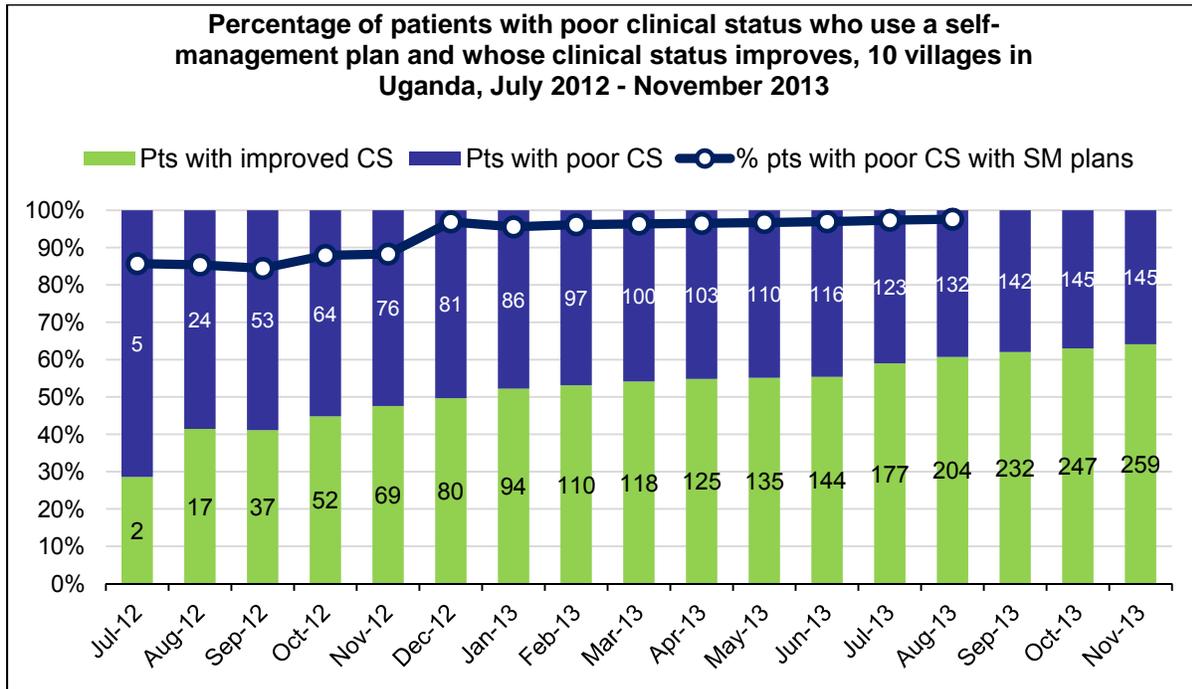
**Figure 60: Uganda: Cumulative number of PLWHA identified in 10 villages (June 2012 – Jan 2014)**



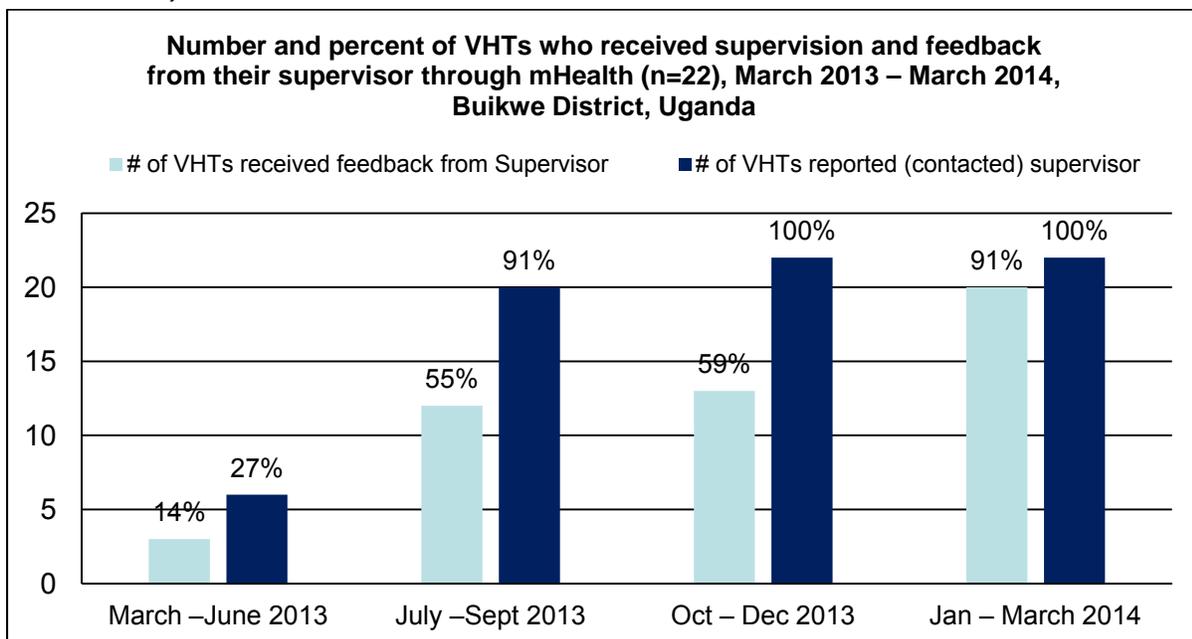
- Figure 61 shows that almost all PLWHA set a goal for self management of their poor clinical status. In November 2013, 64% of PLWHA who made a self-management plan were able to improve their clinical status. This can be explained by the introduction of the individual health goal setting tool which helped community teams keep a record of challenges faced by PLHIV, actions and progress. A record of the plan was maintained by individual community QI team members to serve as a reminder and plan for focused visits to PLWHA.
- **Conducted fourth learning session** for the 10 villages implementing chronic care activities (February 2014). A total of 35 participants attended. The learning session aimed at sharing experiences and harvesting tested changes to improve chronic care support for PLWHA. As a result, a draft change package was developed. The package highlights changes that help to map PLHIV in the community, support PLHIV self-management and use of mhealth technologies to improve VHT supervision.
- **Improved communication and feedback between VHTs and health facility supervisors through mhealth.** On a monthly basis, VHTs receive call-credit to call their health facility supervisors to receive feedback on their performance and learn new skills. Compared to the

previous quarter, the percentage of VHTs receiving feedback and supervision from their health facility supervisors improved from 59% to 91% (Figure 62). VHTs received feedback on tasks accomplished, quality of work, compliments, and learned new skills. As a result, VHTs demonstrated improvement in HIV care skills such as supporting client disclosure, referral and counselling.

**Figure 61: Uganda: Percentage of PLWHA developing self management plan to improve clinical status for PLHIV (July 2012 – Nov 2013)**



**Figure 62: Uganda: Feedback and supervision of VHT activities through mHealth (March 2013 – March 2014)**

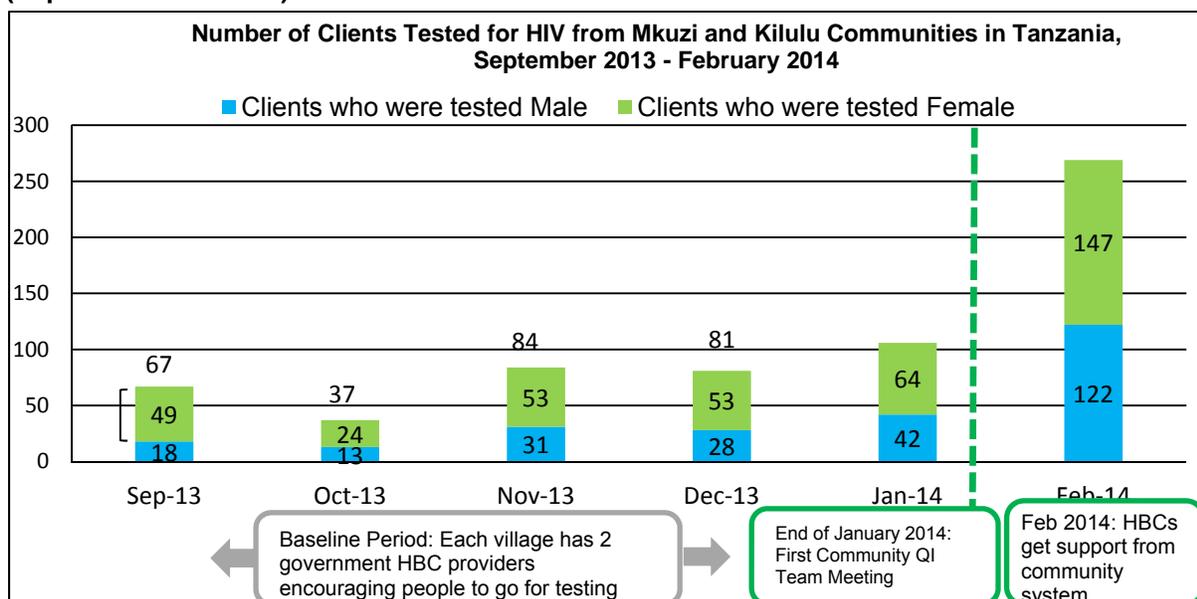


## Activity 2. Community Linkages Demonstration Project, Tanzania

### Accomplishments:

- **Health talks incorporated into community groups' meetings (Q2).** ASSIST worked with the HBCs and community coaches to identify community groups which were ready to incorporate health talks into their regular meetings. These groups were then given orientation to the community health system strengthening approach and now have incorporated health talks at their regular meetings. The ASSIST coordinator and the HBC provide coaching to both the CQI and community groups. The groups were also coached on how to receive and send health information clearly and correctly.
- **The ASSIST coordinator worked with HBC providers and community coaches to select community groups and community QI teams in five villages within the Kilulu and Mkuzi health center catchment area of Muheza district (Q2).** A total of 27 CGs and five CQI teams were selected in five villages. ASSIST selected a sixth village in Muheza district as a control village.
- **Coaches from health facilities conducted a one day orientation for 27 community groups and five community improvement teams about each member's role in creating awareness and collecting data of the number of eligible people for to test for HIV.**
- **During the first QI team meeting HBC providers proposed to focus on increasing the number of people tested for HIV since the data from the previous few months indicated that the number of people tested for HIV was low (January 2014).** The two HBC providers were not able to reach the remote and underserved people. Upon the request of HBC providers, the improvement team decided to increase the number of people tested for HIV testing in five villages. The community QI team decided to test the change idea that each member of the 27 community groups from the five villages urge their family members to go to the health facility for an HIV test for their own well being as well as for the good of the family. Figure 63 illustrates the number of people tested for HIV has increased significantly, from below 100 to above 200 people before and after the community group supported HBC providers (Jan – Feb 2014). The graph also clearly shows that the community groups' support not only increased the number of people tested for HIV, but it also increased the number of male partner tested for HIV. This result indicates that by engaging the family through the existing informal system in the village, more people can be reached effectively with health messages and services than by just using the government HBC providers

**Figure 63: Tanzania: Number of clients tested for HIV from Mkuzi and Kilulu Communities (Sept 2013 – Feb 2014)**



## How Do We Know We Are Improving?

### Improvement in Key Indicators:

Activity	Indicators	Baseline	Last value
Community Support in Uganda	% of VHTs who received monthly feedback from their supervisors	0% (August 2013)	90% (March 2014)
	#of identified by community groups and VHTs	05 (June 2012)	679 (Nov 2013)
	# PLWHA identified by VHTs alone	05 (June 2012)	364 (Nov 2013)
	% PLWHA who have improved clinical status	29% (July '12)	64% (Feb 2014)
Community Linkages Demonstration Project, Tanzania	# people tested for HIV	<100 (Sept 2013 – Jan 2014)	269 (Feb 2014)

### Directions for Q3 and Q4 FY14

#### Community Support, Uganda:

- No activities planned next quarter due to project close-out.

#### Community Linkages, Tanzania:

- Continue to promote HIV testing while also working on locating patients who are lost to follow-up and bring them back to facilities for treatment.

## 2.2 Health Workforce Development

### Background

The USAID ASSIST Project highlights health workforce development (HWD) as an essential component to improving quality of care. Integrated with strategies to improve clinical practices and streamline system processes, ASSIST applies innovative approaches to address the human factor as part of the project's quality improvement activities. The FY13 ASSIST HWD projects did not receive funding until March 2013, so they are continuing into FY14. ASSIST is waiting for approvals of the new FY14 ASSIST project plans. ASSIST's HWD work builds on activities carried out under HCI since 2007 in Niger, Tanzania, Uganda, Zambia, and Ethiopia and through global partnerships.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Global Health Workforce Alliance – Contribution and Participation	<ul style="list-style-type: none"> <li>• Participate and contribute to the 3<sup>rd</sup> Global Human Resources for Health Forum in Recife, Brazil, November 2013</li> </ul>	Global		x
2. Global: In-service Training	<ul style="list-style-type: none"> <li>• Raise awareness and increase application of practices that improve in-service training (IST) effectiveness, efficiency and sustainability</li> <li>• Facilitate the development of an evidence-informed national IST strategy in one country</li> </ul>	Global Country for assessment to be determined		x

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
3. Tanzania District Health Management Improvement	<ul style="list-style-type: none"> <li>• Improve performance of Regional (RHMT) and Council Health Management (CHMT) (district level) management teams</li> <li>• Improve district led support for, planning and coordination of improvements in HIV services in health facilities</li> <li>• Improve human resources management (orientation, new staff retention, follow up on vacant posts, performance appraisals)</li> <li>• Improve timely receipt and processing of supply orders</li> <li>• Improve accuracy, timeliness and accessibility of the Health Management Information System</li> </ul>	All 6 districts of Lindi Region. District management teams oversee and support 192 health facilities in the region	x	
4. Uganda Pharmaceutical Human Resources for Health (HRH)	<ul style="list-style-type: none"> <li>• Strengthen pharmaceutical human resources and develop core competencies to apply improvement approaches</li> <li>• Improve availability of medicines</li> <li>• Improve client retention, medicines use, adherence and outcomes</li> <li>• Improve availability of medicines</li> </ul>	3 districts: Bukedea, Jinja, Tororo  14 Health Centers	x	

### Key Activities, Accomplishments, and Results (January – March 2014)

We would like to applaud and acknowledge Allison Foster for her leadership of the Health Workforce Development Unit and portfolio under ASSIST. Her dedication, enthusiasm and efforts towards innovating solutions towards healthcare improvement and strengthening health workforce were exemplary and will be greatly missed. Tana Wuliji, Senior Improvement Advisor will be leading the Health Workforce Development unit as of April 2014.

#### Activity 1. Global Health Workforce Alliance (GHWA) – Contribution and Participation

##### Accomplishments:

- **Provided leadership with USAID and global partners to lead a double side session at the GHWA 3<sup>rd</sup> Global Forum on HRH to reach a commitment of stakeholders to harmonize support of community health providers (Q1).**
  - Ms. Allison Foster and Dr. Edward Broughton of the ASSIST team joined Kate Tulenko of IntraHealth co-authored one of three background papers toward developing consensus among ministries, donors, development agencies, and civil society in a commitment to harmonization of actions, accountability, and research.
  - As part of the side session, Ms. Foster presented the paper on “Monitoring and Accountability Framework for National Governments and Global Partners, in Developing, Implementing, and Managing CHW Programs.” Ms. Diana Frymus of USAID presented on “Knowledge Gaps and Needs-Based Research Agenda by 2015” with Ms. Maryse Kok of KIT. Dr. Shona Wynd of UNAIDS presented “A Framework for Partners’ Harmonized Support.” Other contributors to the session included ministry representatives from Mali, Kenya, Mozambique, Nicaragua, and India, along with the One Million CHW Campaign and World Vision. Exceeding the 60 person room capacity, the side session was attended by more than 100 people.
  - The commitment, entitled “The CHW Harmonization Commitment: Moving from Fragmentation to Synergy to Achieve Universal Health Coverage” was presented publically at the forum by Dr. Estelle Quain from USAID on November 12, 2013.

- Dr. Tana Wuliji of ASSIST, joined key partners in presenting a side session on health worker in-service training at the GHWA Third Global Forum on Human Resources for Health in Recife, Brazil in November 2013 – launching the Global Health Worker In-service Training Improvement Framework. This session was held in partnership with the International Training and Education Center for Health (I-TECH), Jhpiego, USAID, Capacity Plus, and the CDC-supported African Regulatory Collaborative, the ASSIST team addressed health worker IST, efficiency, and sustainability by examining and harvesting good practices and lessons learned. IST is on-the-job instruction designed to strengthen health worker competence and performance.
- **ASSIST and partners was accepted to present two sessions at the (Prince Mahidol Award Conference) PMAC global meeting in Bangkok, Thailand in January 2014, “Transformative learning for health equity”.**
  - Dr. Tana Wuliji partnered with Ms. Diana Frymus of USAID and others to lead a session on “Integrating improvement competencies as part of transformative pre-service education reform: building a frontline health workforce of change agents.”
  - Dr. Wuliji and Ms. Frymus also led a session on “Transformation across the Health Worker Continuum of Learning- strengthening coordination and collaboration between Pre-Service Education, Continuing Professional Development and In-service Training Systems.”
  - Some of the activities contributing to the PMAC sessions are discussed in the East Africa Region Section of the Report

### **Activity 2. Global: In-service Training**

#### **Accomplishments:**

- **Launched the Global Health Worker In-service Training Improvement Framework (Q1).**
  - Framework launched at the 3rd Global Human Resources for Health Forum at a side session held jointly with USAID, CDC, Jhpiego, CapacityPlus, and I-TECH.
  - Session brought together in-service training providers, program managers, funders, researchers and civil society. Through brief lightning talks, participants gained an understanding of each theme of the IST improvement framework and examples of resources, research findings and good practice examples. Participants were facilitated through knowledge cafes to network and share lessons learned.
- **Conducted literature review of IST coordination mechanisms (Q2)**
  - Coordinating IST at the national level has recently become a topic of focus in order to track IST efforts, to reduce duplication of IST training efforts, or to address unmet training needs. As such, this literature review was completed to determine, to date, what lessons could be drawn from IST coordination policies or programs in LMICs that provide a framework for improved coordination among all relevant IST partners in a country. A commentary is currently being prepared together with the ASSIST Swaziland and MOH Swaziland team for the IST Journal Series in the Human Resources for Health Journal calling attention to this issue and describing plans in Swaziland towards better IST coordination.

### **Activity 3. Tanzania District Health Management Improvement**

#### **Accomplishments:**

- **Led coaching session with CHMTs (November 2013). Objectives:**
  - Develop a tool, working with M/E team at ASSIST and the CHMTs to assess the maturation of the performance of the QI teams in their five priority function areas. The objective of this coaching session was to solicit input from the CHMT members on the questionnaire, and to have them complete the questionnaire. Administer questionnaires on what worked and what did not to contribute to the CHMT guide for District Health Manager Improvement.
  - Prepare teams for the February harvest meeting: Brief teams on the plan for the meeting and ask them to prepare input for guide and management maturity assessment
  - Collect and update most recent data on District Health Management indicators
- **The Tanzania District Management ended with a harvest meeting that brought together the six council health management teams (2-3 representatives from each team), several of the Lindi Regional Health Management team, and two facilities representatives (Q2).**

- During the two-day meeting, participants shared best practices that had been developed during the project, lessons learned from practicing the PDSA to solve problems and address gaps in their performance; plans for sustaining their achievements; plans for making further improvements, and suggestions for overcoming obstacles in the activity.
- Team members from ASSIST Uganda attended the harvest meeting to share some of the lessons learned in the Uganda pharmacy project, in which District Managers had applied improvement practices as part of their coaching facilities toward better practices and as a way to spread and sustain continued quality improvement.
- CHMT members contributed inputs to developing an assessment tool that could help district managers and improvement advisors see note progress in improving the performance in five management function domains. The CHMTs based their input on their own experience and determination of how to define levels of maturity in the quality of performance.
- CHMT members also contributed input to the development of a District Manager's Guide. This guide will be completed by the end of April, and will be used to support their colleagues in other districts of Tanzania.

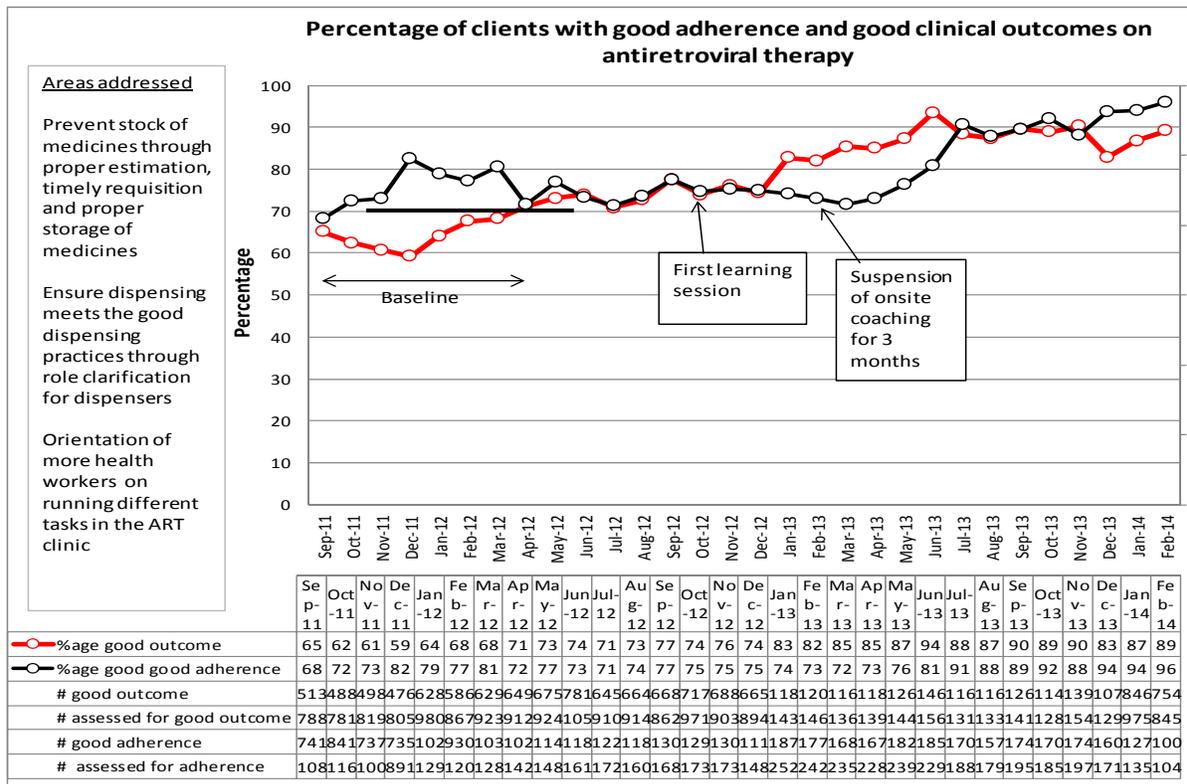
#### **Activity 4. Uganda Pharmaceutical HRH**

##### **Accomplishments:**

- **Conducted monthly onsite coaching.** Onsite coaching provided by district coaches at all 14 sites with a total of 56 coaching interactions over the last two quarters. The coaching involved supporting the teams to identify gaps in medicines requisition, storage, dispensing, adherence and appointment keeping. The visits were also used to build the competencies of health worker in improvement, particularly as there were changes in staff and new staff recruited at the start of 2014. A total of 370 health workers were reached during the first two quarters. The coaching in the first quarter mostly focused on addressing gaps in dispensing since this is an area that was identified to still be having gaps. The coaching visits in the second quarter focused on addressing data quality, improving the team's documentation journals and strengthening the functionality of the improvement teams.
- **Held coaches meeting, February 2014.**
  - Each of the district coaches was invited to the ASSIST office in Kampala to attend this meeting. The objectives of the meeting were to plan and develop tools for the upcoming learning session. Coaches reported that the revised coaching guide had greatly improved their performance especially by creating continuity between coaching visits since the previous tools were not adequately doing that.
- **Held second learning session, Mbale (March 2014).**
  - Attended by 72 participants that included representative from all the 14 health units, district health office, Ministry of Health headquarters, regional and ASSIST coaches. The District health Officers (DHOs) of Tororo and Bukedea attended in person.
  - All site participants sat in groups based on their health units and districts. With the support of coaches, they identified quality gaps they had and the changes they developed to deal with those identified gaps, as well as prepared presentations. Sites presented in a plenary and discussions were held. The discussions included changes for sites still having challenges and for those that were performing very well. In addition, they presented on how they are going to sustain the good performance. All sites developed action plans for improvement.
  - All the changes tested by all the teams were compiled into a single document, shared with all the teams for future reference. Some of the changes are summarized in the table above.
- **Exchanged lessons learnt with Tanzania District Management improvement collaborative (March 2014).** Two representatives from Uganda attended the District Health Management Improvement Collaborative Harvest meeting in Tanzania. The main objective was to share best practices and lesson learnt on improving district health management and HIV services provided by health facilities within the district. The Uganda teams made a presentation highlighting the work done to improve human resources in the pharmaceutical sector and how that links with clinical outcomes. Figure 64 shows the percentage of clients with good adherence as defined by the MoH. It shows a gradual increase from an average of less than 80% to an average of 90%. It shows that there has been a gradual improvement in the percentage of clients who experience

good clinical outcomes on ART from an average of 62% at baseline to an average 88% during this quarter.

**Figure 64: Uganda: Percentage of clients with good adherence to antiretroviral therapy and good clinical outcomes, 14 sites from Jinja, Bukedea and Tororo districts (Sept 2011 – Feb 2014)**



**How do we know we are improving?**

**Improvement in Key Indicators:**

Activity	Indicators	Baseline	Last value
Tanzania District Health Management Improvement	% of facilities that submitted supply orders on time to the CHMT	76% (March 2011)	94% (March 2014)
	% of district level reports that were processed and submitted to the region within two weeks of receipt from the facilities	71% (March 2011)	100% (March 2014)
	% of supply orders which were processed by the CHMT within two weeks of receipt and sent to the RHMT	91% (March 2011)	99% (March 2014)
	% of management team members that have clear and rationalized job descriptions	0% (March 2011)	100% (March 2014)

Activity	Indicators	Baseline	Last value
	% of newly recruited staff that received a technical orientation within two weeks of reporting	53% (March 2011)	71% (March 2014)
	% of newly recruited staff that are retained at 6 months	69% (March 2011)	89% (March 2014)
	% of CHMTs that have QI competencies (self-reported) according to a 11-point questionnaire	0% (March 2011)	75% (March 2014)
	% of health facilities applying improvement approaches to improve quality of health services (out of 192 facilities)	3% (March 2011) 10 facilities	13% (March 2014) 22 facilities <i>Data collected Annually</i>
Uganda Pharmaceutical HRH	Percentage of clients with good adherence to ART	72% (Apr 2012)	89% (Feb 2014)
	Percentage of clients with good clinical outcomes	71% (Apr 2012)	96% (Feb 2014)

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

### Background

USAID ASSIST HIV and AIDS prevention and treatment activities began in December 2012. The AIMGAPS and Chronic Care activities were previously funded under HCI and have continued under ASSIST with a prime focus of garnering packaging knowledge from ongoing demonstration projects. In addition, injection safety activities were also previously funded under HCI, and under ASSIST a new injection safety activity has started in Swaziland in FY14 along with an implementation study. Also under ASSIST since 2013, we are supporting an activity to improve the quality and safety of voluntary medical male circumcision in Uganda.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Assuring Infants and Mothers Get All PMTCT Services (AIMGAPS): Integration and Continuity of Care for PMTCT (Tanzania)	<ul style="list-style-type: none"> <li>Develop a change package for increasing access to PMTCT services.</li> </ul>	For global use Synthesis will include best practices from 11/176 PMTCT facilities in four districts of Iringa Region		x
	<ul style="list-style-type: none"> <li>Develop in-country capacity to support improving activities of PMTCT services</li> </ul>	Tanzania Iringa Region (4 of 4 districts in Iringa Region) with 26/70 Regional Health Management Team (RHMT) and Council Health Management (CHMT) members in the region		

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
2. Integrating quality improvement in Voluntary Medical Male Circumcision (VMMC)	<ul style="list-style-type: none"> <li>• Improve the ability of local officials and programmers to continuously monitor, evaluate, and improve their SMC/VMMC programs.</li> <li>• Increase our knowledge of how health systems should adapt to best accommodate and integrate SMC/VMMC programs</li> <li>• Increase uptake of SMC/VMMC through utilizing various changes including female partner involvement</li> </ul>	Uganda: Over 80 districts (out of 112) Intense support to be provided to 30 sites Light technical support to implementing partners at 3 sites per partner per quarter Support to the MoH	x	
3. Refined Chronic Care Model (CCM) Implementation & Impact Evaluation (Uganda)	<ul style="list-style-type: none"> <li>• To improve quality of care for people living with HIV through the implementation of an adapted, chronic care model. Improved care is measured using measurable patient outcomes and the ART framework which monitors closing the coverage, retention, and wellness gaps (Uganda)</li> <li>• To evaluate the impact of an adapted CCM model on quality of HIV/Chronic Care services and measurable patient outcomes</li> </ul>	6 facilities in two districts – Mityana (3 intervention sites) and Nakaseke (3 control sites) out of a total of 10 accredited ART health facilities in both districts	x	x
4. CCM Toolkit (including Expert Patient Guidance) - Uganda & Tanzania	<ul style="list-style-type: none"> <li>• Create a CCM toolkit that provides guidance for designing services to address the chronic nature of HIV and non-communicable conditions. This will provide a blueprint to be used in management HIV ,and other chronic conditions in different country programs</li> </ul>	N/A		x

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
5. Injection Safety (Swaziland)	<ul style="list-style-type: none"> <li>Apply QI principles to improve safe injection practices and reduce the incidence of unnecessary medical injections to reduce the transmission of HIV/AIDS, Hepatitis B &amp; C and other blood-borne pathogens.</li> <li>Research study to assess and evaluate current injection safety practices, and also issues of stigma and discrimination towards persons living with HIV (PLHIVs).</li> </ul>	Swaziland - 20 intervention sites in 4 regions: 11 hospitals, 1 health center, 5 public health units and 3 clinics.	X	X

### Key Activities, Accomplishments, and Results

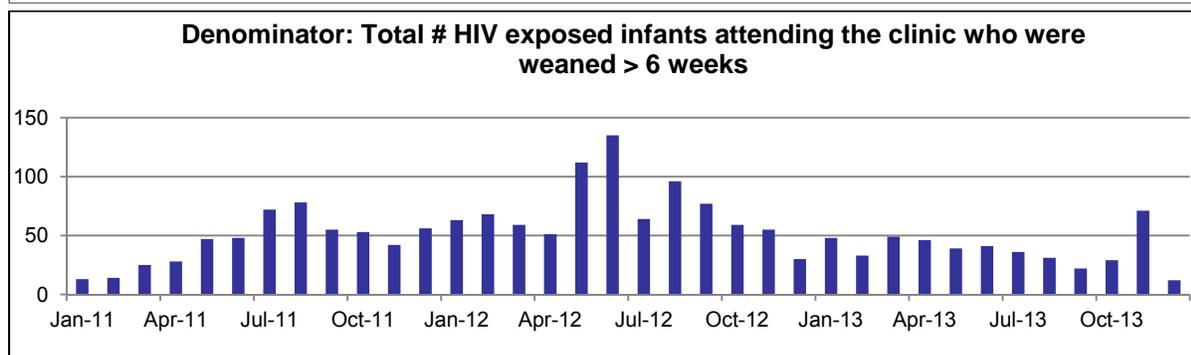
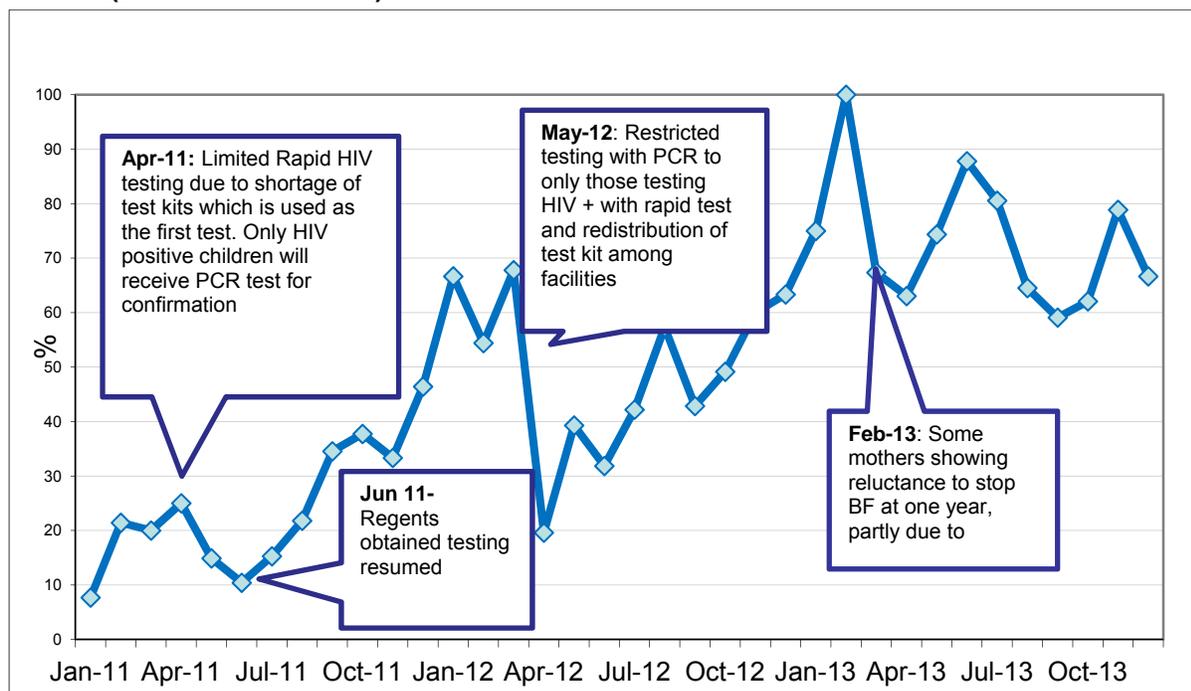
#### Activity 1. AIMGAPS: Integration and Continuity of Care for PMTCT (Tanzania)

##### Accomplishments:

- During the reporting period, AIMGAPS sites have transitioned to Option B+.** CHMTs have supported sites on documentation, data collection from new tools and ensuring ARVs availability. Data for all HIV positive pregnant and lactating mothers at Option B+ sites is entered to the database on weekly or monthly basis depending client load. Initially the Option B+ sites experienced shortage of ARVs, patients' cards (CTC1 and HIV Exposed Infant (HEI) cards). Responding to these shortages, CHMTs applied QI knowledge to address the shortages through:

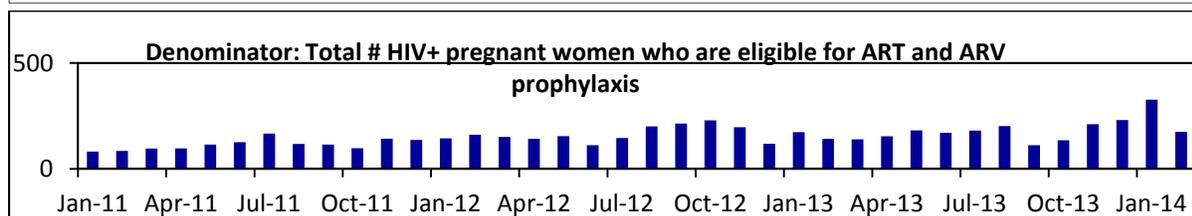
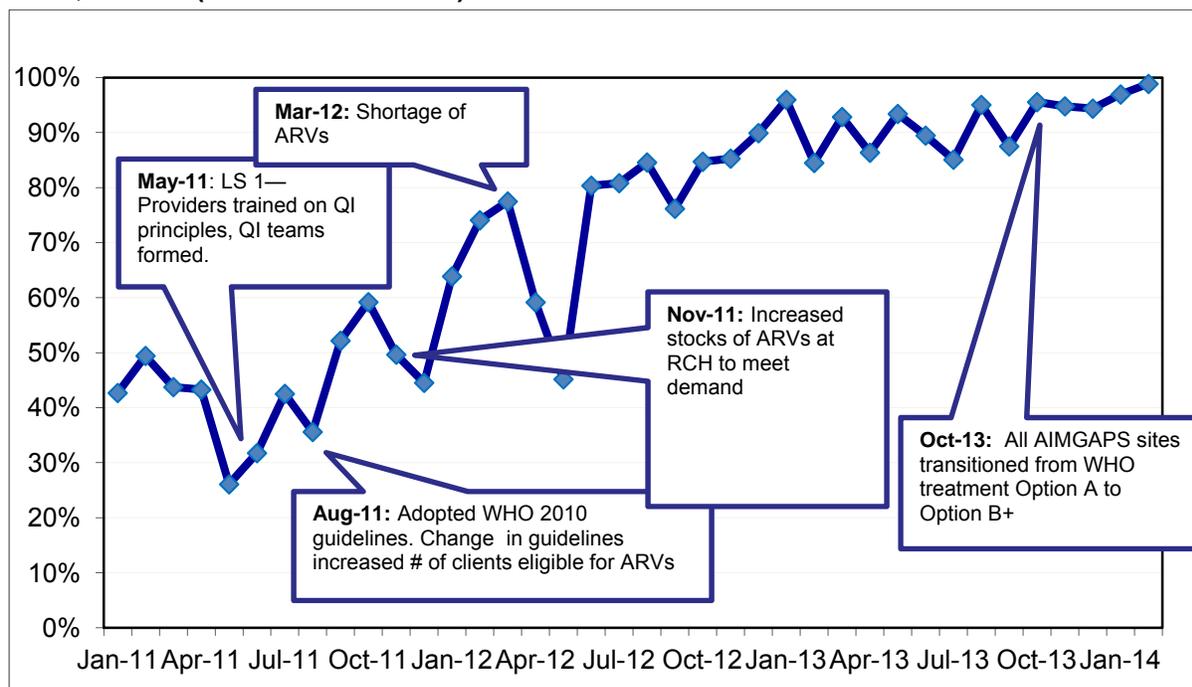
  - Redistribution ARVs supplied to sites that are not implementing B+ to sites implementing B+
  - Ordered additional stock of ARVs from Medical Stores department which were supplied and currently have enough stocks
  - Photocopied HEI and CTC1 Cards to ensure each child and mother has the card
- Facilities implementing community linkage, continued to support Community QI teams in two wards (Kihorogota and Nzihi) where at least one Community QI meeting was conducted for each village.** Definitive testing of HIV exposed infants has continued to remain around 60% (Figure 65). Facilities implementing the community component of AIMGAPS, continued to support community QI teams in two wards (Kihorogota and Nzihi), where at least one community QI meeting was conducted for each village.

**Figure 65: Iringa, Tanzania: Percentage HIV exposed infants receiving a confirmatory HIV test, 10 sites (Jan 2011 – Dec 2013)**



- Conducted endline assessment for AIMGAPS, Iringa Region (February 2014):** An end line assessment for the AIMGAPS study was conducted in four districts of the Iringa Region. Regional and District Reproductive and Child Health Coordinators participated in the activity. The assessment covered qualitative and quantitative components. The qualitative component focused on obtaining perspectives of services from clients, providers and community quality improvement teams. A total of 11 and 32 in-depth interviews were conducted with service providers and clients respectively. Members of community quality improvement teams from 11 villages implementing the community component of AIMGAPS were involved in focus group discussions to gain their insights on involving community groups to improve PMTCT service uptake and retention.
  - The quantitative component entailed retrospective data collection from 543 client records to determine services received by HIV positive women during ANC, labour and delivery, postnatal and child follow up. Treatment Option B+ for PMTCT was rolled out in all 11 AIMGAPS sites in October 2014. Figure 66 shows that the proportion of HIV positive women being initiated on life-long ART continued to increase last quarter, nearing 100%.

**Figure 66: Iringa, Tanzania: Percentage of HIV positive women started on or receiving ART or ARVs, 11 sites (Jan 2011 – Jan 2014)**



**Changes tested:**

- |  |   |
|--|---|
| 1. Storing ARV at RCH  | 2. Documentation at time of service provision   |
| 3. Keeping PMTCT care register at follow-up client care point. | 4. Keeping constant stock levels of ARTs at RCH |

**Activity 2. Integrating quality improvement in Voluntary Medical Male Circumcision**

**Accomplishments:**

- **Conducted coaching visits.** Teams led by ASSIST with representatives from the district health office (DHO) and the implementing partner (IP) conducted monthly on site coaching sessions at each of the 30 sites during the quarter. The purpose of these sessions was to provide ongoing support to the health unit quality improvement teams to identify and address emerging gaps within their SMC clinic. The coaching sessions served an additional purpose: To institutionalize improvement processes – through building coaching skills of the district team; and, to spread Improvement methodology- through building skills of staff from the healthcare facility and IPs.
- **Held 2nd Learning sessions.** A peer to peer learning session was conducted in November 2013. Four participants from each of the 30 SMC sites participated in the learning sessions. A representative from the district health office where the sites are located and a representative from the supporting implementing partners also attended the learning session. In addition, one learning session was held in Kampala, Uganda with representatives from USAID/W, CDC/Atlanta, CDC/Mozambique, CDC/Uganda, DoD, and OGAC attending the sessions in entirety or in parts.
- **Organized stakeholder meeting.** A stakeholder meeting with staff from the 10 implementing partners supported by ASSIST was organized. The purpose of this meeting was to review joint activities and plan for the next quarter. Staffs from the different IPs were able to share experiences and strategies for joint partner IP to IP collaboration, such as management of

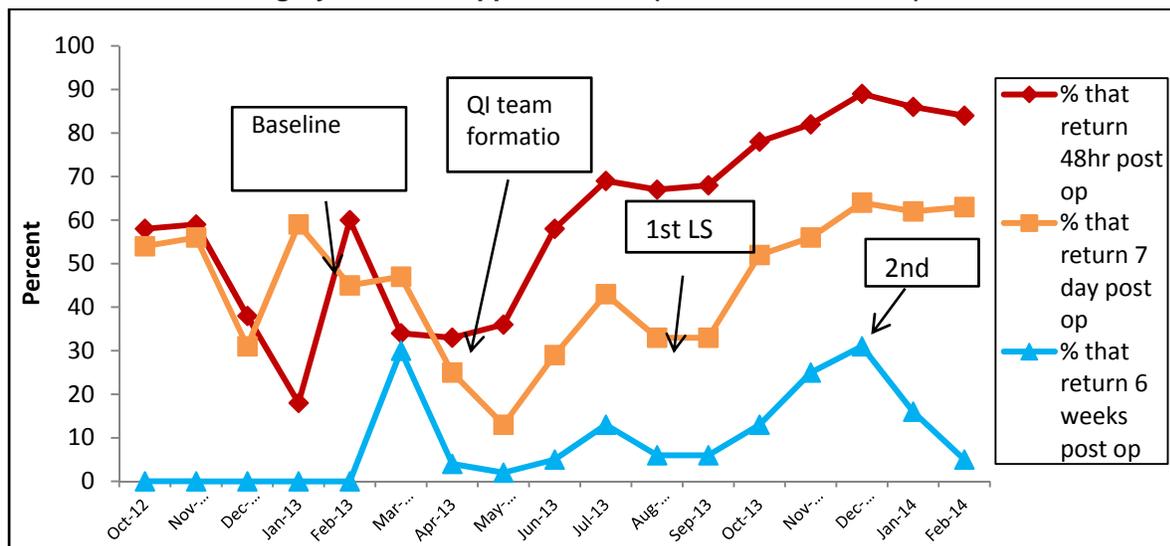
adverse events and client follow up.

- **Supported MoH to finalize SMC standard M&E tools.** The MoH SMC source documents and SMC standards tool kit were presented to Senior Management Committee at the MoH and approved as national tools. This was the final stage in the approval process of the tools. ASSIST participated in the orientation of staff from the AIDS Control Program (ACP) on use of the SMC M&E tools.
- **Supported the National Safe Male Circumcision Task Force (NTF).** As part of the technical support to MoH, USAID ASSIST supported the MoH to convene the quarterly SMC NTF meeting on 25th February 2014 in order to provide oversight to the national program. The meeting was attended by MoH staff; staff from the in country SMC PEPFAR Technical Working Group from the US Mission; representatives from WHO and representatives from USG funded SMC implementing partners. The main items on the agenda were to discuss how to integrate the non-surgical (Prepex) methods of circumcision into the program. A team to review the current tools and to integrate Prepex was formed. It was resolved that an IP supporting quality improvement should be a member of this team.
  - March 2014 - Conducted the third learning session for 10 sites based in the Eastern region of the country. A total of 61 participants attended the learning session including: four QI team representatives from each team, representatives from Ministry of Health, District Health Office, implementing partners and ASSIST. The teams shared experiences on changes they have tested to improve the quality of services provided.
- **Results: Improvement in SMC quality standards at all supported sites:** As shown in Figure 67, shows marked improvement in all the standards at the 30 sites over time. During the reporting period, all sites managed to move out of “red” in all the areas that were assessed. The proportion of sites that are still fair (yellow) in some areas is also on the decrease as there is more “green” and less “yellow” in the graph. Sites are now being supported to sustain the gains achieved.
- As shown in Figure 68, a gradual improvement in the proportion of clients who return for review after circumcision has been noted. Prior to formation of improvement teams, there was no clear trend on the proportion that returns for review. However, after the formation of the improvement teams, the proportion of patients returning after 48 hour has stabilized above 80% while after seven days it has stabilized above 60%. Some of the changes that have led to this improvement include the following: staff oriented on the importance of telling staff to return for follow up; designated person or area at the facility for follow up; register to document follow up; and reminder calls.

**Figure 67: VMMC/SMC Uganda Dashboard: Percent of standard that was met in 7 areas over time (April/May 2013 – Feb 2014)**

Health Unit IP Supporting Site District	Baseline						February 2014						
	Management systems	Supplies, equipment & environment	Registration group education and IEC	Individual counseling & HIV testing	Male circumcision surgical procedure	Monitoring & evaluation	Management systems	Supplies, equipment & environment	Registration group education and IEC	Individual counseling & HIV testing	Male circumcision surgical procedure	Monitoring & evaluation	Infection prevention
1	30	50	0			33	70	83	67	100	91	86	91
2	20	33	0			7	80	67	83			87	92
3	40	83	0			14	80	67	100			86	93
4	30	50	0			18	90	83	83	83	80	92	100
5	20	33	0			14	80	67	83	100	80	86	85
6	10	50				7	100	67	83	100	100	93	100
7	40	50	50			75	80	67	83	83	82	86	89
8	50	50	25			14	90	100	83	100	90	86	85
9	60	50	83	39	64	29	90	100	100	82	100	100	100
10	20	50	50			0	90	100	100	83	100	92	93
11	33	25	0			0	80	100	100	80	80	77	75
12	25	33	0				100	83	100	80	83	100	92
13	60	67	75	83	81	14	90	83	83	100	100	86	93
14	70	50	25			50	100	83	83	100	100	100	100
15	60	33	25			50	90	84	84	100	91	86	100
16	30	67	100			14	100	100	100	100	100	100	100
17	40	83	75	100	100	14	80	83	100	100	100	100	92
18	70	67	100	67	100	69	100	67	100	100	100	100	75
19	40	50	0			21	100	83	83	78	97	100	100
20	60	50	0			21	100	83	83	83	85	93	85
21	70	50	0			21	90	67	83	94	77	100	76
22	80	83	100			93	70	83	100	100	76	80	92
23	70	100	100	100	100	93	70	83	50	100	79	80	91
24	70	100	100	100	100	93	100	83	100	100	100	93	100
25	60	50	100			46	90	100	83	94	85	71	100
26	60	33	50			15	90	83	83	100	85	86	85
27	40	83	75	100	100	75	90	100	100	100	85	86	92
28	20	50			78	15	90	75	50	94	87	93	70
29	22	67	67		47	29	80	83	83	83	80	50	91
30	40	67				38	90	67	83	100	91	93	82

**Figure 68: Uganda: Percentage of Male SMC clients that return at 48 hours, 1 week (7 days) and 6 weeks after surgery, intense supported sites (Oct 2012 – Feb 2014)**

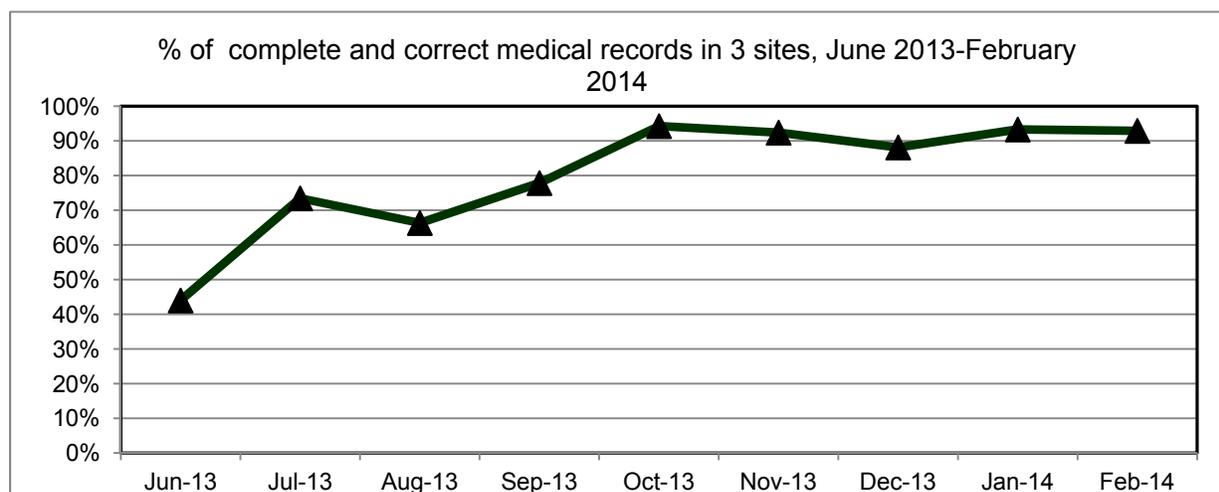


### **Activity 3. Refined Chronic Care Model Implementation & Impact Evaluation (Uganda)**

#### **Accomplishments:**

- **Teams continued to improve the quality of medical records, which was a focus for the previous quarter. First learning session held (October 2013).** Twenty seven participants attended including facilitators; 13 health workers from health facilities, three from the district health office, 2 from Mildmay Uganda (the implementing partners, and two from Buikwe district, where CCM was initially piloted. A team of 4 from USAID ASSIST, one MoH–AIDs control project staff and two regional coordinators facilitated the learning session. The objectives were to: 1) enable sites to share successful interventions, good practices and challenges noted during the last action period; 2) enable sites to synthesize best practices for implementing chronic care model for HIV care and learn from one another; 3) identify and document site level sustainable improvement changes that have led to improvement; and, 4) facilitate sites to develop action plans to help achieve site level improvement aims. At the end of the session, teams identified improvement aims to focus on during the quarter and developed a plan to achieve them which included ensuring that patients on ART remain in care and have better treatment outcomes.
- **Monthly coaching: The leaning session in October was followed by monthly coaching to support sites to achieve their improvement aims.**
  - October 2013 coaching focused on supporting sites to implement changes to ensure that at least 80% of patients on ART have better clinical outcomes. Focus was on strengthening TB /HIV co- management. Baseline data on TB HIV co management was collected and shared during the learning session so that teams could develop realistic plans to improve TB /HIV co- infection management.
  - November coaching focused on a review of data on CD4 and retention was done to ensure sites work towards 1) increasing the proportion of patients with stable or increasing CD4 count for the last 6 month and 2) decreasing the percentage of patients on ART that are lost to follow up
  - December coaching focused on follow up with action plans. Information on success stories about reducing wait time at Mityana and St. Padrepio was collected.
- **During Q2 interventions focused on:** 1) facilitating facility teams to synthesis through best practices and accelerating learning among site teams; 2) identifying and documenting site level sustainable improvement changes that have led to improvement including details of how they were implemented; and 3) planning and conducting an end line evaluation in the intervention and control districts.
- **Conducted 2<sup>nd</sup> learning session for 3 sites in the Mityana District involved in improving HIV chronic care (Feb 2014).** There were 27 participants, and the learning sessions was facilitated by staff from ASSIST, the Buikwe district that previously participated in the chronic care work under HCI and representatives from Mityana district’s District Health office. Sessions were organized in such a way that adequate time was allocated to discussing each improvement aim. Two facilitators were allocated to each session; one to chair, and the other to record changes implemented by sites including details of how they were tested.
- **Monthly coaching visits continued to the 3 sites in Mityana District.** Site teams were supported to use treatment guidelines and to support fellow staff that was not well acclimated to using treatment guidelines. During the same period, teams were encouraged to sustain changes to improve other improvement aims including: documentation, clinic efficiency and patients’ clinical outcomes. As a result of this initiative, the level of completeness and accuracy of medical, percentage of patients waiting less than 30 minutes between service points, and patients’ clinical outcomes improved further. During site visits, exchange visits between sites were done. One or two staff from one site was invited to move with the coaching team to share experiences and learn from the other site. During coaching meetings, teams shared the changes they implemented to achieve their improvement aims.
  - As the graphs in “How do we know we are improving” demonstrate, improvements in the below key indicators have been sustained.
  - Figure 69 shows chart completeness. At baseline, only 44% of charts were found to be accurately completed. This has since risen to 93%. Some of the changes tested can be seen in Table 7.

**Figure 69: Mityana District, Uganda: Percent of complete and correct medical records, 3 sites (June 2013 – Feb 2014)**



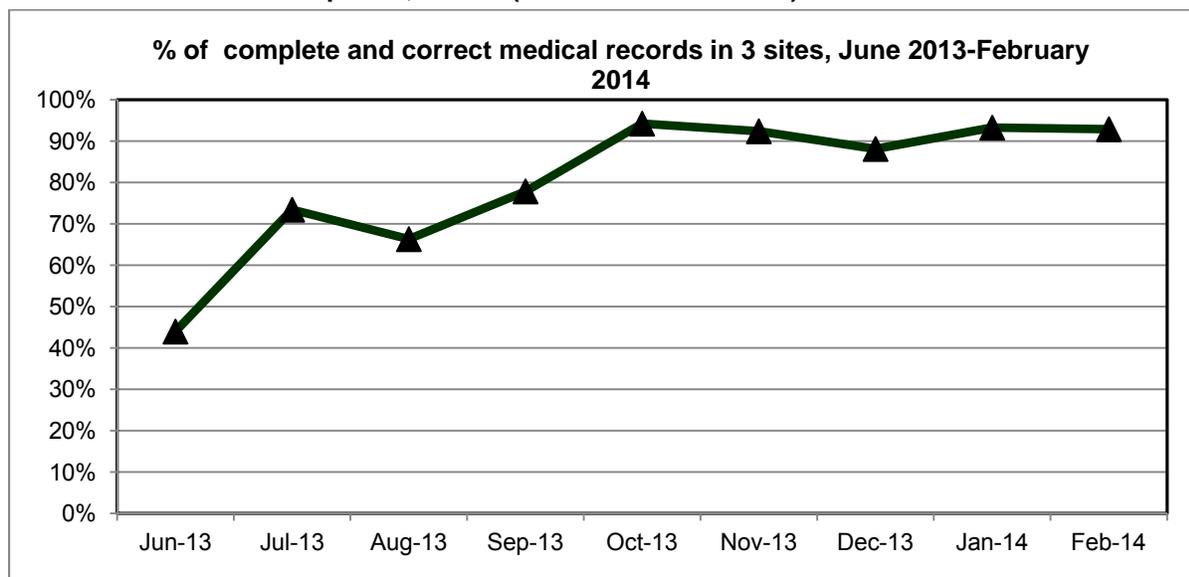
**Table 7: Uganda: Changes tested for refined Chronic Care Model implementation and impact evaluation**

Indicator	Increase % of complete and correct medical records (boxes on the ART / HIV care card)	
Gaps identified	Changes tested to address the gap	How to guide
Charts incorrectly filled in	On-job training on filling the charts	We got the health worker who was trained, knows how to fill the chart to teach and monitor others on how to fill the charts. At the end of a QI meeting, one staff is given a few minutes to teach others about how to fill in the card.
Incomplete records in the ART register	Separation of ART from pre-ART cards and update them	All the staff at the facility met and started sorting cards in the shelves, while one staff was responsible for re-arranging them into ART or Pre ART. After sorting, all the incomplete ART cards were separated and updated first relating to the information on the first page of the card, such as dates of initiation for duration on treatment.
	Assign a supervisor to regularly check a sample of cards for completeness with emphasis on CD4 count results	The clinician supervisor checks about 10 of the cards for patients that attended a clinic day. Gives feedback on wrongly filled in charts to respective staff that attended to the patient. At Mityana (returns the card as the clinic is running and corrections made) -A step was introduced to check for completeness of records in the flow of patients. This applies to all other medical records.
Staff not mentored on how to fill the ART cards	Formed a specific committee of 5 staff to update the register, orient staff, hold CMEs and check to ensure cards are well filled in	Held a meeting for all staff to brainstorm for solutions; the hospital picked 4 members; nurse, clinician, 2 data staff to update the register one is a supervisor for completeness of records. In the same meeting, staff was taken through filling out the ART card. At the hospital, staff selected Monday and Friday as specific days for updating the ART register.

Indicator	Increase % of complete and correct medical records (boxes on the ART / HIV care card)	
Clinicians forgetting to fill out the ART	Putting up reminders about filling the cards	Papers with written information are pinned on walls in the clinician rooms, directly in front of clinicians. Adherence was the main issue being forgotten. This notice is placed clearly in front of the clinician, hanged on the walls.

- As shown in Figure 70, the proportion of patients on ART waiting less than 30 minutes between service points has increased from 45% to 94%. Some of the tested included the following: triage/having nursing visits, starting clinic day earlier, assign expert patients to help in clinic with tasks such as weighing and registering patients, sorting ART cards, use of a client flow chart, and implementing an appointment book.

**Figure 70: Mityana District, Uganda: Percentage of clients on ART who wait less than 30 minutes between service points, 3 sites (June 2013 – Feb 2014)**



- As shown in Figure 71, the proportion of clients with clinical improvement has increased from 50% in April 2013 to 89% in February 2014. Inadequate or no assessment for opportunistic infections and incompleteness of TB register were identified as gaps by site teams. Changes tested included the following: use of intensified case finding (ICF) at the HIV clinic, and implementing regular CMEs on the TB/HIV co-management.
- Developed a document with changes implemented at the sites with details of how they were developed and wrote success stories written of how Mityana hospital implemented changes to reduce client wait times (Q2).

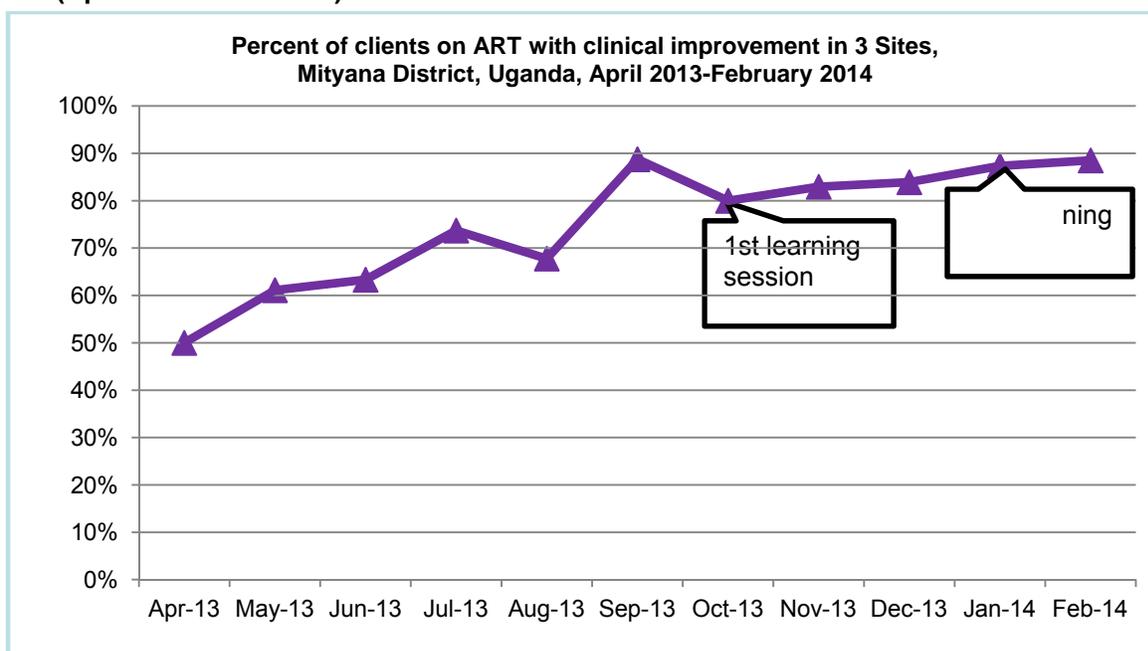
#### **Activity 4. Chronic Care Model Toolkit (including Expert Patient Guidance) - Uganda & Tanzania**

##### **Accomplishments:**

- **In preparation for developing the chronic care model tool kit, the coaching team worked with site teams to put changes in place to ensure detail on how they are tested is recorded (Q1).** An additional column in the site level documentation journal and coaching guide was added to record step by step of how changes are implemented. A collaborative level data base with a changes sheet was created so that indicator specific changes implemented by sites are documented.
- **Harvested changes implemented by the intervention sites in Mityana district (Q2).**
- **Made contributions to developing the expert patient guidance document. The second draft is under review (Q2).**

- Success story on improving clinic efficiency at Mityana hospital finalized (Q2).

**Figure 71: Mityana District, Uganda: Percent of clients on ART with clinical improvement, 3 sites (April 2013 – Feb 2014)**



#### **Activity 5: Improving injection safety and healthcare waste management**

##### **Accomplishments:**

- **With guidance for the MOH, USAID ASSIST identified intervention sites.** A meeting with the Deputy Director Public Health (MOH), who chairs the project steering committee in MOH and provides policy and strategic advice, suggested that in order to maximize the impact of the intervention we should focus on specific levels: hospital, health centres and Public Health Units (PHUs), leaving out clinics.
- **Collected qualitative data on injection-safety related stigma.** The data were collected over a period of 3 days from facilities spread around the country.

##### **How Do We Know We Are Improving?**

##### **Improvement in Key Indicators:**

Activity	Indicators	Baseline (Jan 2013)	Last value (Feb 2014)
Integrating quality improvement in VMMC	Proportion of clients counseled and tested for HIV during SMC	73%	88%
	Proportion of clients assessed for STI before surgery	81%	99%
	Proportion of circumcised clients with documented consent	83%	100%
	Proportion of clients experiencing adverse events following SMC	0.9%	0.6%
	Proportion of clients that return for 48 hour follow-up post-operatively	18%	84%

Integrating quality improvement in VMMC, continued	Proportion of clients that return for 7 day follow-up post operatively	59%	63%
	Proportion of clients that return for 6 weeks follow up post-operatively	0%	5%
	Proportion of clients attending group education with partners	0%	25%
	Proportion of clients having HCT with their partners	No data	100% (19 sites reporting March 2014)
Refined Chronic Care Model Implementation & Impact Evaluation (Uganda)	% of clients on ART seen in the past month who have shown clinical improvement	55%	89%
	% of complete and correct medical records (boxes)	44%	93%
	% clients on ART that wait less than 30 minutes between service points	45%	94%

### Directions for Q3 and Q4 FY14

#### **Activity 1. Assuring Infants and Mothers Get All PMTCT Services (AIMGAPS): Integration and Continuity of Care for PMTCT (Tanzania)**

- End line data analysis and report writing
- Revision of change ideas
- Compile elements of the AIMGAPS implementation tool kit
- Conduct a harvest meeting
- Convene a scale-up and planning meeting

#### **Activity 2. Integrating quality improvement in Voluntary Medical Male Circumcision**

- Support to the original 30 intensely supported sites to sustain the achieved gains.
- A third learning session will be convened
- Starting April 2014, USAID ASSIST will scale up intense support to 20 new sites

#### **Activity 3. Refined Chronic Care Model Implementation & Impact Evaluation (Uganda)**

- Complete end line evaluation data collection
- Compile, analyze data collected for the end line
- Start write up for the end line report including case studies
- Select coaches from Nakaseke district
- Conduct QI orientation for coaches and site teams
- Hand over and dissemination meeting for Mityana and Nakaseke districts respectively
- Conduct Monthly coaching in Nakaseke

#### **Activity 4. Chronic Care Model Toolkit (including Expert Patient Guidance) - Uganda & Tanzania**

- Expert patient guidance to be completed in the next quarter

#### **Activity 5. Improving Injection Safety and healthcare waste management**

- Establish quality improvement teams at implementing sites
- Implement improvement interventions in the 20 health facilities
- Provide QI coaches with training and coaching on injection safety , waste management and quality improvement
- Monthly data collection at implementing sites.
- Conduct periodic support supervision to implementing facilities.

## 2.4 Nutrition Assessment, Counseling and Support (NACS) and Partnership for HIV-Free Survival (PHFS)

### Background

Starting in FY14 and building on HCI's experience in supporting nutrition assessment counseling and support (NACS) services for HIV clients in Uganda and Kenya, USAID ASSIST is supporting clinics and communities in Malawi to improve nutrition care and to strengthen their systems to ensure high quality care is being delivered. USAID ASSIST is also supporting global technical leadership and learning related to reducing HIV transmission to exposed infants under the Partnership for HIV-Free Survival (PHFS) and NACS that draws on experiences funded under HCI since 2011.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Other Activity
1. Nutrition, Counseling, Support and Treatment Program (NCST) in Malawi	<ul style="list-style-type: none"> <li>Integrate nutrition services into HIV clinics to improve nutritional status of HIV clients (NACS)</li> </ul>	2 districts: Balaka and Karonga; 4 sites in each district for a total of 8 sites	x	
2. Quality improvement technical assistance to countries for the PHFS	<ul style="list-style-type: none"> <li>Reduce HIV transmission to exposed infants and reduce infant mortality by ensuring care is provided in line with 2010 WHO PMTCT guidelines</li> </ul>	Global Project – 5 countries (Uganda, Tanzania, Kenya, Lesotho, and Mozambique)	x	

### Key Activities, Accomplishments, and Results

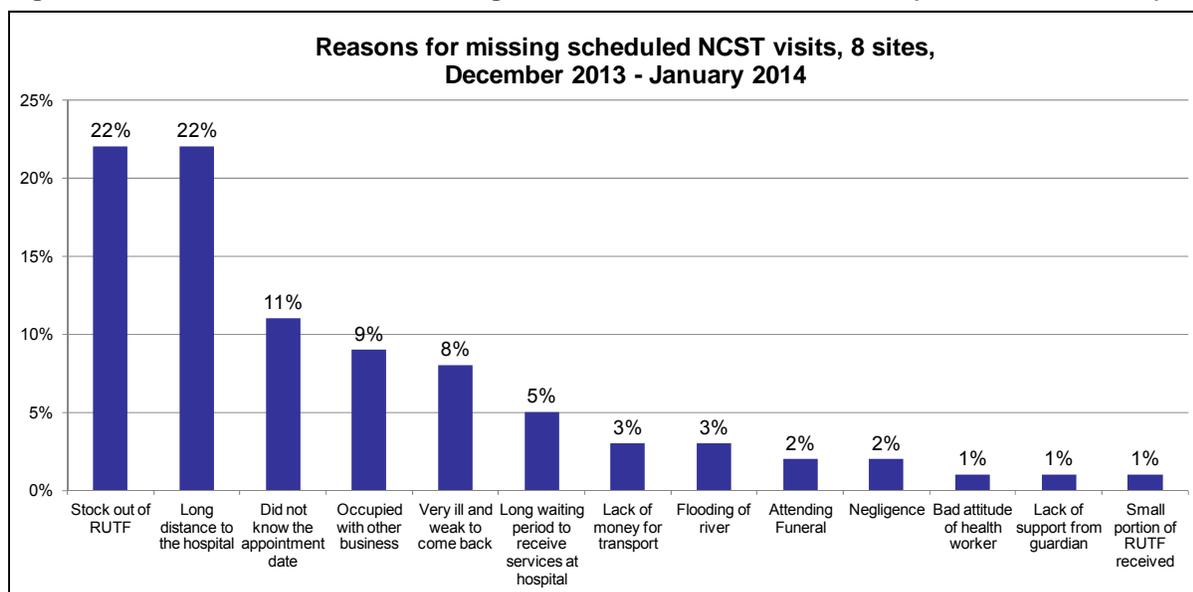
#### Activity 1. NCST Program in Malawi

##### Accomplishments:

- **Conducted learning sessions.**
  - On December 11 – 12, 2013 ASSIST conducted the second learning session for Karonga and Balaka QI teams to share progress of their improvement work. During the learning session, the teams shared what they have been learning about improving nutrition assessments, both in terms of successes and challenges, refresh the teams' skills in improvement, and discuss next steps in NACS in Malawi.
  - Most teams have achieved high levels of assessment (80% and higher). Therefore, during this learning session ASSIST staff asked QI teams to share their current data on default rates, that is patients in nutrition programs who have stopped coming for assessments. QI teams discussed improving measurement for default rates and then generated some initial ideas about why defaults occur.
  - The day before the learning session, a coaches' meeting was held to prepare for the learning session, discuss strengths and weaknesses in coaching and brainstorm ways to strengthen it.
- **Met with Clinton Health Access Initiative (CHAI).**
  - On December 6, 2013, ASSIST staff met with a representative of CHAI in Malawi to discuss opportunities for CHAI to provide ready-to-use therapeutic foods (RUTF) to the facilities involved in the NACS work. CHAI has included RUTF for adults in these facilities in their budget and is waiting to find out how much they will be able to procure.
- **Conducted coaching sessions**
  - January and February 2014: Conducted coaching sessions in all eight health facilities and focused on the following objectives:

- To review with the facility QI teams the improvement objectives developed on reducing defaulters and the indicators they are using to track the improvement aims
- To review with the teams the changes they have developed and tested to improve retention of patients in nutrition care
- To support and review data management and reporting with the facility QI teams
- To follow up on action points agreed during the last coaching sessions
- To provide support to district coaches in supporting teams of health workers to improve service delivery
- o During the coaching visit ASSIST, Ministry of Health and the Office of the President and Cabinet held a meeting with Balaka District QI coaches where a review of the coaches' support to sites and planning for the coaching sessions was done. It was interesting to note that the coaches requested funding from the District Health Management Team (DHMT) which they received and used for coaching sessions in the four sites.
- **Provided inputs to the Malawi NACS Guidelines currently supported by Food and Nutrition Technical Assistance III Project (FANTA).** The Ministry of Health recommended that QI should be incorporated into the Malawi NACS Guidelines. ASSIST has been providing technical guidance for the QI sections during the review process.
- **Worked with other partners to finalize the roadmap for incorporating NACS indicators into HMIS, HIV and TB monitoring and evaluation systems.**
- **Advocated for food supplies for malnourished clients identified in the eight sites supported by ASSIST. ASSIST identified and coordinated with CHAI to support eight sites.** In October 2013, ASSIST negotiated with CHAI to support the 8 sites with food supplies for managing the malnourished patients. During this time, CHAI was supporting the Malawi Community Management of Acute Malnutrition (CMAM) program that focuses on children only. CHAI had no plans to support the NACS program. ASSIST shared the results from the eight sites and highlighted the need for food supplies to support the program. ASSIST provided CHAI with projections for food supplies to support the 8 sites for one year. After a month of negotiations, CHAI was convinced of the need to support the 8 sites. In February and March 2014, CHAI began providing RUTF for severely malnourished clients and corn soya blend flour for moderately malnourished clients.
- **To understand why clients are missing appointments, the sites conducted a survey from December 2013 - January 2014.** The results from the survey in all eight sites are shown in Figure 72. The improvement teams are now testing changes targeted at the top three reasons.

**Figure 72: Malawi: Reasons for missing scheduled NCST visits, 8 sites, (Dec 2013-Jan 2014)**



## **Activity 2. Quality Improvement technical assistance to countries for PHFS**

### **Accomplishments:**

- **On October 29<sup>th</sup>, the ASSIST PHFS teams from Kenya, Tanzania and Uganda met for a regional PHFS meeting in Uganda to share progress and learning.**
- **Participated in monthly PHFS calls (Q1-2).**
- **Mozambique**
  - ASSIST Senior Advisor for Community travelled to three communities and identified community structures.
  - Hired Improvement Advisor.
  - Worked closely with global partners, implementing partners and community-based organizations.
- **Lesotho**
  - Since the November 2013 learning session, ASSIST staff travelled with Lesotho MOH PHFS/NACS Coordinator to all three districts to check on facility progress and coached facility and district staff on current performance and next steps.
  - Collected baseline performance data.
  - Hired, introduced and oriented new Chief of Party to PHFS work.
- **Uganda**
  - Conducted a February 2014 harvest meeting in Uganda. After this the team identified and documented the package of interventions that resulted in improvement for three areas:
    - Retaining mothers and babies in care: From 2.2% at baseline to 60.8% in March 2014.
    - Data quality: From 2.9% in April 2013 to 95.1% in February 2014.
    - Services for mother-baby pair routine visits: From 2.9% in June 2013 to 98.4% in February 2014.
- **Tanzania**
  - Tanzania held a PHFS National learning platform in March 2014.

### **How Do We Know We Are Improving?**

#### **Improvement in Key Indicators:**

<b>Activity</b>	<b>Indicators</b>	<b>Baseline</b>	<b>Last value</b>
Nutrition, Counseling, Support and Treatment Program (NCST) in Malawi	<p><b>Assessment:</b> Percentage of people assessed for nutrition in ART, PMTCT, TB with their Mid-Upper Arm Circumference (MUAC) and body mass index (BMI) recorded</p> <p><b>Defaulters:</b> Percent of clients defaulting from care</p>	45% Balaka 3% Karonga (Jan 2013) 43% Balaka 30% Karonga (Nov 2013)	100% Balaka 100% Karonga (March 2014) 40% Balaka 17% Karonga (March 2014)
Quality Improvement technical assistance to countries for the Partnership for HIV-Free Survival	Percentage of supported sites with 100% of HIV-positive mother-baby pairs retained into care at 18 months	Uganda: 2.2 % (April 2013) Kenya: 30% (Sept 2013) Tanzania: (July 2013) - Mbeya 13% - Mufindi 0% - Nzega 0%	Uganda: 60.8% (March 2014) Kenya: 43% (Jan 2014) Tanzania: (Jan 2014) - Mbeya 19% - Mufindi 15% - Nzega 31%

	Percent of completely & accurately filled EID care charts	Uganda: 2.9% (April 2013)	Uganda: 95.1% (Feb 2014)
	Percentage of HIV exposed infants alive and assessed for nutrition every month	Uganda:30% (May 2013) <i>Kenya:</i> <i>18% (Sept. 2013)</i>	Uganda: 98.8%(March 2014) <i>Kenya:</i> <i>36% (Jan 2014)</i>
	Percentage of HIV exposed infants below 6 months who are exclusively breastfed	Uganda: 87.5% (Oct 2013) Tanzania: (July 2013) - Mbeya 68% - Mufindi 64% - Nzega 77%	Uganda: 96.9% (Feb 2014) Tanzania: (Jan 2014) - Mbeya 85% - Mufindi 89% - Nzega 18%
	Percentage of mother-baby pairs receiving standard package of care	Uganda: 2.9% (June 2013)	Uganda: 98.4% (Feb 2014)

### Directions for Q3 and Q4 FY14

- **Malawi:**
  - Prepare and hold a learning session in April 2014.
  - Conduct a learning session preparatory meeting with the district coaches on April 2, 2014.
  - Work with MOH-Nutrition Unit and Office of the President and Cabinet-Department of Nutrition and HIV/AIDS to follow up on support for RUTF by MOH- Procurement department and NAC.
  - Prepare for QI training for eight new sites in Karonga and Balaka Districts. This includes conducting situation analysis visits to the new sites.
  - Work with other partners (FANTA, LIFT, WHO, MOH, etc.) to incorporate the key nutrition in HMIS, HIV and TB M&E tools.
- **Mozambique:**
  - First community learning sessions being held first week of May.
  - Follow-up coaching visits planned for May.
- **Lesotho:**
  - Second PHFS learning session planned for June.
- **Global Learning:**
  - Monthly ASSIST PHFS calls to share learning.

## 2.5 Vulnerable Children and Families

### Background

Building on the work of a regional initiative to improve the quality of orphans and vulnerable children programming known as “Care than Counts,” started under HCI in 2007, in October 2013, the USAID ASSIST Project is enhancing the technical and organizational capacity of the Regional Psychosocial Support Initiative (REPPSI) and the African Network for the Protection and Prevention of Child Abuse and Neglect (ANPPCAN) to provide a quality improvement approach to child protection services in Tanzania, Uganda, Swaziland, and Kenya.

## Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Africa Parenting Meeting	<ul style="list-style-type: none"> <li>Organize and conduct a meeting of Africa-based and international experts in the field of child-caregiver relationships to explore parenting programs that already exist in Africa and their successful/common elements components</li> </ul>	75/25 split between Africa-based and internationally-based attendees		X

## Key Activities, Accomplishments, and Results

### Activity 1. Africa Parenting Meeting

#### Accomplishments:

- USAID ASSIST organized and conducted a meeting of Africa-based and international experts in the field of child-caregiver relationships to explore parenting programs that already exist in Africa and their successful/common elements components** (Dec 11-13, 2013 in Cape Town, South Africa). This meeting was designed as an opportunity to convene PEPFAR Orphans and Vulnerable Children (OVC) Focal Points, international experts, and practitioners around how PEPFAR programs currently support activities to strengthen child-caregiver relationships and how these efforts might be expanded and improved to better address the multi-dimensional needs of vulnerable children and their families. Thirty-five experts from nine countries attended, including PEPFAR staff, local and international organizations, government staff, and ASSIST. To gather specific recommendations to address gaps in research, policy and programming around the issue of parenting, we used knowledge cafes and speed consulting. Hosting the meeting in South Africa allowed for enhanced participation among Africa-based practitioners who are already implementing parenting programs, and for PEPFAR and USAID to help inform evidence among African and other non-Western models about skillful parenting.
- Met with USAID TWG to discuss findings from meeting and recommendations for moving forward** (Q2). It was noted that a great deal is already happening around this topic in Africa, in USAID and non-USAID projects. There was interest in how to integrate parenting strategies in other technical areas such as microfinance.
- Produced final report distributed to participants and posted on USAID ASSIST website** (Q2). <https://www.usaidassist.org/resources/strengthening-child-caregiver-relationships-linking-evidence-and-practice>

#### Directions for Q3 and Q4 FY14

- No current funding

## 3 Cross Bureau-Funded Activities

### 3.1 Family Planning/Reproductive Health

#### Background

USAID ASSIST supports USAID Ending Preventable Child and Maternal Deaths (EPCMD) and USAID Population and Reproductive Health goals by strengthening system functions and quality of care to improve family planning (FP) services that can feasibly be integrated into routine maternal, neonatal, child health (MNCH) services in low-resource settings to reduce unmet need for FP and achieve Healthy Timing and Spacing of Pregnancy (HTSP). In Niger, the USAID ASSIST Project is working in close collaboration with the Niger Ministry of Health (MOH), managers and front-line

providers to promote healthy timing and spacing of pregnancy (HTSP) via improved integration of FP counseling and services into routine public and private sector MNCH services in the Niamey “Number 2” and Birnin Konni districts. In addition, through cross-bureau family planning funds, USAID ASSIST is testing and studying implementation approaches to support optimal use of the WHO Safe Childbirth Checklist (SCC) in a small sample of maternities in Mali and Senegal as part of the global WHO SCC Collaboration with a strong focus on the postpartum FP component of the checklist. Earlier versions of the SCC were developed and field-tested by HCI and partners. This work will contribute to greater understanding of the use of checklists to improve service delivery in low- and middle-income countries (LMICs). ASSIST is also supporting a greater focus on client-centeredness of care in FP services to improve client choice and continued adherence with FP methods of choice to reduce future unwanted pregnancies and secondary maternal and child morbidity and mortality.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Niger Postpartum Family Planning	<ul style="list-style-type: none"> <li>Achieve better health and social outcomes for women of reproductive age and their children and families by promoting HTSP with a focus on reducing unmet need for FP services during the early and extended post-partum period</li> </ul>	2 Districts: District N°2 in Niamey City (urban) and District of Birnin Konni (rural) in Tahoua region 18-20 facilities: 1 regional hospital maternity in Niamey; 1 district hospital in Konni; 8-10 primary care health centers/maternities (CSIs) in each district	x	
2. Postpartum FP as part of WHO Safe Childbirth Checklist implementation activity: Mali & Senegal	<ul style="list-style-type: none"> <li>Test and study implementation approaches to support optimal use of the WHO SCC in a small sample of maternities in Mali and Senegal</li> </ul>	Several pilot maternities in Mali and Senegal		x
3. Development & testing of FP Quality of Care Measures to support continuous improvement of FP service delivery	<ul style="list-style-type: none"> <li>To define and test more robust measures of quality of FP service delivery that can feasibly be integrated into routine facility and country HIS in low-resource settings</li> </ul>	Global		x
4. Development and country testing of FP client-centeredness of care conceptual framework	<ul style="list-style-type: none"> <li>To define aims and measures to support an explicit focus on client-centeredness of FP services, including country-level testing as part of country FP improvement work</li> </ul>	Global Mali (Mission-funded) Senegal (Cross-bureau FP funding)		x

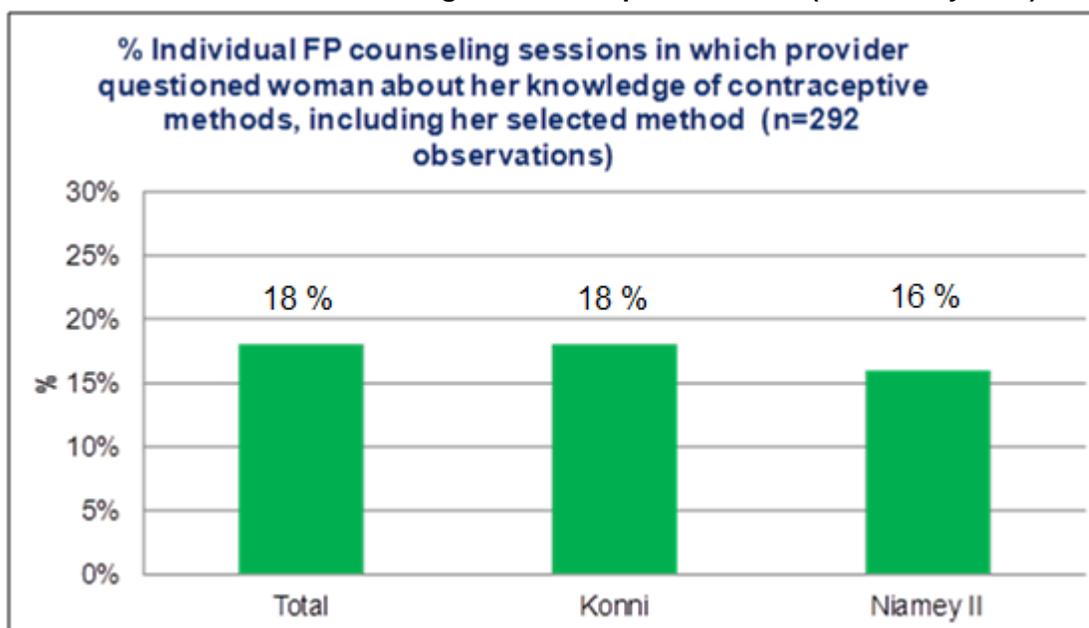
## Key Activities, Accomplishments, and Results

### Activity 1. Niger Postpartum Family Planning

#### Accomplishments:

- **Finalized baseline assessment and data analysis:** Data was collected from 28 primary and secondary health facilities in one rural (Konni) and one urban (Niamey II) district. Interviews were conducted with 28 facility managers; 292 health provider-client FP service delivery interactions were observed and 283 client exit interviews were conducted.
  - Results showed a great need for interventions to improve FP counseling, service provision, FP integration, supply management, competency and supervision. They also highlighted the need for community interventions targeted towards male partners/husbands. Selected results are shown in Figure 73. Given funding constraints, ASSIST will primarily focus on improving post-partum FP services in facilities in two districts, one rural and one urban.
- **Review of improvement content design in progress:** First draft developed in Q2 and currently under review by team.
- **Prepared materials for meetings on presentation of baseline results and quality improvement approaches for the 2 target districts (Niamey (urban) and Konni (rural)):** These materials included the baseline results, job aids and approaches for improving quality of PFP based on assessment results and inputs of local managers and providers.

**Figure 73: Niger: Percent of individual FP counseling sessions by region in which provider questioned woman about her knowledge of contraceptive methods (June – July 2013)**



### Activity 2: Integration of PFP into a WHO Safe Childbirth Checklist intervention in selected maternities: Mali & Senegal

#### Background:

The WHO Safe Childbirth Checklist (SCC) promotes routine delivery of high-impact evidence-based interventions at critical “pause points” that occur during every routine delivery: 1) upon admission of a woman in labor to a maternity, 2) at the time she begins to push (or prior to Cesarean delivery), 3) immediately after delivery, and 4) before discharge from the maternity. The 29-item bedside checklist includes a designated item on provision of postpartum FP as part of high-quality routine delivery and early postpartum care. To date, the SCC has not been evaluated or implemented in a sub-Saharan Francophone African country, although ASSIST and WHO Patient Safety believe that the SCC is likely to be a powerful adjunctive improvement tool in this setting. The close integration of maternal and newborn care best practices as part of routine childbirth phases (admission/labor, pushing,

immediate post-partum and post-partum) is likely to help support routine uptake of best practices including post-partum Family Planning services as a routine element of postpartum care.

**Objective of the Activity:**

To test and study implementation approaches to support optimal use of the WHO SCC as a tool for improvement in a small sample of maternities in Mali and Senegal as part of the global WHO Safe Childbirth Checklist Collaboration with a strong focus on the postpartum FP component of the checklist.

**Accomplishments:**

- **Contract signed with ASSIST partner WHO SDS for collaboration to support WHO SCC improvement work in Senegal and Mali.** Country visits planned to launch SCC improvement work in Mali and Senegal in May 2014.
- **Research protocol drafted to support WHO SCC implementation research, including PFP component, in Mali.**
- **Mission approval provided for Mali.** Country visit by Maina Boucar, Kathleen Hill and WHO representative to travel to Mali to work with Mali technical team, including new COP, in May 2014.
- **Mission and MOH approval provided for Senegal:** The Senegal MOH and USAID Mission approved a visit to Senegal in May 2014; MOH Director of MNCH highly engaged in planning for introduction of SCC activity in Senegal.

**Activity 3. Development & testing of FP Quality of Care Measures to support continuous improvement of FP service delivery**

**Accomplishments:**

- **Snapshot landscape review completed to assess established and needed tools related to:**
  - FP quality of care measures that can be integrated into routine information systems to support continuous improvement of FP services (including PFP services)
  - Review of available provider clinical decision support and patient counseling tools related to contraception management in women with special needs (older women, women with risk factors, women with co-morbid conditions)
  - Participated in the USAID-convened Community of Practice on Long-Acting Reversible Contraception (LARC) / Permanent Methods (PM) Community of Practice meeting held Jan 7 2014
- **Working draft of FP QoC indicators being finalized and tested in Mali and Niger;** will also be tested in Senegal as part of WHO SCC implementation work.

**Activity 4. Development of ASSIST FP client-centeredness of care conceptual framework for in-country testing and refinement of framework elements (per funding)**

**Accomplishments:**

- **Completed draft FP client-centered conceptual framework** (Sarah Smith leading framework development).
- **Developed initial set of assessment tools for assessment of individual and group FP counseling sessions.**
- **Focus group protocol tool developed to guide focus groups with FP clients and providers to guide client-centered improvement work as part of Mali PFP work.**

**How Do We Know We Are Improving?**

**Improvement in Key Indicators:**

- Indicators to be finalized after Mali/Senegal May 2014 visit.

**Directions for Q3 and Q4 FY14**

- Senegal and Mali country visit: May 2014 (Mali Mission approval received; Senegal Mission approval received)

## 3.2 Maternal, Newborn, and Child Health

### Background

USAID ASSIST supports governments and partners to adapt improvement approaches to continuously strengthen essential system functions to improve, scale up, and sustain high-impact evidence-based health care for leading causes of maternal, newborn, and child mortality. ASSIST cross-bureau funded activities focus on improving integrated, reliable and accessible delivery of maternal, newborn, child health (MNCH) best practices along all points of the antenatal care, intra- and post-partum, postnatal care and early childhood continuum and household to hospital continuum.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. WHO Safe Childbirth Checklist (SCC) Implementation Activity	To test and study implementation approaches to support optimal use of the WHO SCC in a small sample of maternities in Mali and Senegal as part of the global WHO Safe Childbirth Checklist Collaboration	Pilot maternities at different levels of the health system in Mali and Senegal		x
2. Latin America and Caribbean (LAC) Regional Newborn Alliance	Strengthen USAID-supported Kangaroo Mother Care (KMC) and Basic Newborn Resuscitation services	El Salvador, Nicaragua, Honduras, Guatemala and Ecuador		x
3. East, Central & Southern Africa (ECSA) Survive & Thrive Initiative (S&T)	To strengthen the capacity of the Regional Center for Quality in Health Care (RCQHC) to maximally support the ECSA regional Survive & Thrive Initiative with a focus on strengthening the competencies of participating members of regional and national Professional Associations (PAs) to fully participate in and help advance the objectives of the S&T regional maternal and neonatal health (MNH) initiative.	East, Central and Southern Africa region: Kenya, Uganda, Burundi, Zambia, Tanzania and Rwanda		x
4. Global Technical Leadership (GTL)	Promote widespread understanding of and uptake of modern improvement and health system strengthening approaches by governments and partners to build stronger health systems and achieve global, regional and country MNCH objectives	GTL		x
5. Support to Uganda National Newborn Program	Strengthen the MOH and National Newborn Steering Committee to support development and implementation of newborn national policies, including MOH stewardship role. Establish national newborn quality indicators as part of the National Health Information System	Uganda		x

### Key Activities, Accomplishments, and Results

#### Activity 1. WHO Safe Childbirth Checklist Implementation Activity

##### Accomplishments:

- **Contract signed with WHO Service Delivery and Safety Department to begin ASSIST-WHO SCC collaboration in Mali and Senegal.**

- **Detailed itinerary developed for travel to Senegal and Mali** (Maina Boucar & Kathleen Hill, May 17-30, 2014); **approval provided by USAID Missions in Senegal and Mali.**
- **Senegal MOH highly engaged and convening expert meeting to review Senegal SCC work during May visit.**
- **First draft Mali SCC research protocol completed** (with support of Astou Coly, ASSIST research team).

### **Activity 2. LAC Regional Newborn Alliance**

#### **Accomplishments:**

- **KMC Community of Practice (Q1):** First-ever Kangaroo Care LAC Forum successfully conducted, with participants from Ecuador, Guatemala, Dominican Republic, United States, El Salvador, Colombia, México, Brazil. Two sets of KMC indicators, one for preterm babies' care and another for a programmatic level were discussed. Internet-based community of practice proved to be a feasible means for knowledge management.
- **Participated in 1<sup>st</sup> LAC KMC Conference in Bogota, Colombia, organized by the Kangaroo Foundation (Q1).** At the invitation of the Kangaroo Foundation from Colombia, Ivone Gomez and Miguel Hinojosa from ASSIST-supported KMC programs from Nicaragua and Ecuador presented on the progress of KMC programs. This was an opportunity to promote the KMC Community of Practice with many LAC new countries and audiences.
- **ASSIST was invited to be part of the Global KMC Acceleration Group convened in Istanbul, October, 2013.**
- **The first- ever webinar on Kangaroo Mother Care was prepared together with Kangaroo Foundation from Colombia and the Neonatal Alliance;** and was broadcast live on April 22, 2014. Dr. Nathalie Charpak from the Colombia Kangaroo Foundation discussed potential future scenarios for a scale up of KMC in Latin America.
- **During Q2 the annual meeting was planned to take place in Bogota, in September 2014.** The Neonatal Alliance Annual meeting will have one full day on delegates planning activities of the Kangaroo Community of Practice. ASSIST is considering proposing the organization of a multi-country KMC Collaborative, with support and participation of the Alliance organizations members, such as the Mesoamerica 2015 project, UNICEF, PAHO, the Kangaroo Foundation, MCHIP and the LAC Regional Professional Associations.

### **Activity 3. East, Central & Southern Africa Survive & Thrive Initiative**

#### **Accomplishments:**

- **ASSIST led or co-led two work subgroups as part of the “Survive and Thrive” regional Global Development Alliance (a private public partnership with strong USAID engagement):**
  - To develop an internet-based regional MH Community of Practice (led by the RCQHC with ASSIST's support) to promote uptake of MNH best practices.
  - To strengthen Quality Improvement and clinical skills of Professional Associations participating in the Survive and Thrive regional initiative (led by RCQHC with ASSIST's support)
- **ASSIST is actively supporting the Regional Center for Quality Improvement's training for Professional Associations (PAs) on QI.** The first wave of training started with Uganda PAs. The expectation is that teams of professional association members will, with our support, use the knowledge acquired to conduct maternal and newborn care quality improvement projects in selected health facilities. The participants of the Integrated Maternal and Newborn Care training of trainers (ToT) are drawn from the Ministry of Health, Uganda National Clinical Officers Association (UNCOA), Association of Obstetricians and Gynaecologists of Uganda (AOGU), Uganda Nurses and Midwives Council (UNMC), Uganda National Association for Nurses and Midwives (UNANM), Uganda Paediatric Association (UPA), East Africa Paediatric Association (EAPA) and the East Central Southern Africa College of Nursing (ECSACON). Approximately 65 of those participating in the ToTs will be trained (drawn from 14 districts: Bugiri, Butaleja, Gulu, Iganga, Jinja, Kampala, Lira, Masaka, Mayuge, Mbale, Mbarara, Mitooma, Mukono and Soroti).

- Following the training, the master trainers will be expected to teach selected facility teams to apply principles and practices of QI and support them conduct quality improvement projects with logistical support from RCQHC and ECSA-HC. PA's trained staff will coach specific facilities introducing QI in newborn care.

#### **Activity 4. Global Technical Leadership**

##### **Accomplishments:**

- **WHO MNCH QoC Meeting, December 2013 Geneva;** ASSIST participation and presentation at meeting (Jim Heiby, AOR ASSIST; Kathleen Hill, Jorge Hermida).
  - In-depth discussion on global level MNCH quality advocacy indicators, categorized by maternal, newborn, child encompassing structural, process and outcome indicators.
  - In-depth discussion on using data/quality measures for continuous improvement and challenges around collection of quality-related data in front-line delivery settings in LMICs.
- **British Journal of Obstetrics and Gynecology (BJOG): Niger/Mali improvement case-study accepted for publication** in the Spring 2014 BJOG quality supplement.
- **ASSIST Newborn Resuscitation Quality Framework:** reviewed at annual UN Commission on
- **Newborn Resuscitation Quality/Systems Framework finalized.**
- **Presentation/ participation in Pre-Eclampsia/Eclampsia (PE/E) Technical Working Group meeting.**
- **Ongoing participation in technical working groups:** ICCM; HBB; UN Life-saving Commodities –Resuscitation and ACS; Inter-agency Newborn Health Indicators; Implementing Best Practices; Anemia Inter-disciplinary Task Force.

#### **Activity 5. Support to Uganda National Newborn Health Program**

##### **Accomplishments:**

- **URC's work in SMGL Initiative was acknowledged in USAID's SMGL Annual Report, with particular emphasis on quality of care improvement and on AMTSL (Q1).**
- **ASSIST actively supporting national the National Newborn Health program on:**
  - Introducing a QI approach into the MOH's Newborn Program activities.
  - Strengthening the National Newborn Steering Committee in its role of supporting and updating national policies, as well as working with the MOH on its stewardship role.
  - Establishing newborn national quality indicators and including those as part of the National Health Information System.
  - Developing a training approach aimed for national scale up, starting with the training of a cadre of national facilitators.
  - Strengthening national policies on: antenatal corticosteroids, prevention of newborn infection, postnatal care.

#### **Directions for Q3 and Q4 FY14**

- Prepare to fully launch WHO SCC implementation and research (Mali) activities in Senegal and Mali in collaboration with WHO Service Delivery and Safety (country visits May 18-30<sup>th</sup>, 2014)
- KMC Community of Practice: organize and conduct first LAC KMC webinar, with participation of Nathalie Charpak, Kangaroo Foundation Director, and/or Goldy Mazia, LAC Newborn Alliance Chairperson.
- Participate in WHO Every Mother Every Newborn (EMEN) Quality Improvement Initiative expert consultation (Geneva: April 29-30th).

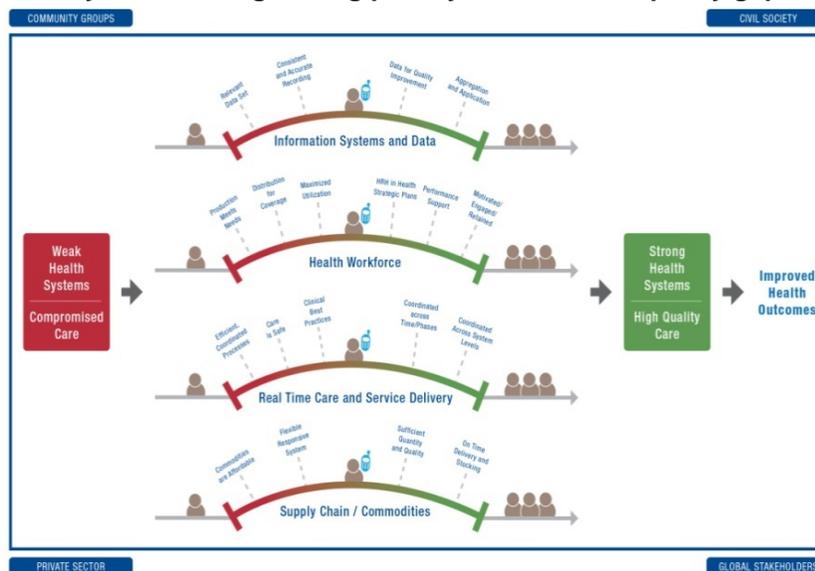
### **3.3 mHealth**

#### **Background**

In early 2014, ASSIST developed an mHealth Systems Strengthening Framework to guide consideration of mHealth and mHealth technologies that can best augment health systems strengthening (HSS) and quality improvement (QI) efforts to overcome common system and quality gaps in low- and middle-income countries. The ASSIST mHealth systems strengthening framework builds on a rich history of mHealth taxonomies and partner initiatives led by leaders in the mHealth field, including the WHO mHealth Technical Evidence Review Group, the mHealth Alliance, and the

mHealth Working Group. As depicted in Figure 74, the ASSIST mHealth systems framework examines use of mHealth technologies across four supply-side domains in which mHealth technologies may help overcome common system and quality gaps: 1) Service delivery/patient care; 2) health workforce; 3) supply chain and commodities; and 4) data and information systems. The framework intentionally focuses on the sub-national (i.e., regional/district) system although it is understood that local systems operate as part of broader national systems for which governance, financing and other functions are critical to overall system performance.

**Figure 74: mHealth Systems Strengthening priority domains and quality gaps**



**Program Overview**

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Global technical leadership: mHealth QI/HSS Framework & Associated Activities	<ul style="list-style-type: none"> <li>Define a framework characterizing system and quality constraints amenable to application of mHealth technologies as part of broader HSS and QI initiatives</li> <li>Explore evidence and expert opinion on mHealth HSS technologies used to improve care in low-resource settings</li> <li>Build consensus and uptake of mHealth technologies that can augment HSS and QI efforts to improve patient outcomes</li> <li>Test use of framework mHealth technologies as part of ASSIST country-level improvement work (per funding)</li> </ul>	NA		X

**Key Activities, Accomplishments, and Results**

**Activity 1. Global Technical Leadership: mHealth QI/HSS Framework & Associated Activities**

**Accomplishments:**

- Developed framework (Q1).** The mHealth Systems Strengthening Framework focuses on four health systems domains particularly relevant for district and sub-district health system performance within which quality improvement efforts may incorporate mHealth solutions to help strengthen systems and improve quality of care and services. The four domains are: Service Delivery, Data and Information Systems, Human Resources for Health/Workforce, and Essential

Commodities. For each domain, essential functions for the domain as well as common gaps in each function were defined through a literature review and interviews with expert informants. ASSIST team members also met with leading researchers in the mHealth field to promote alignment of the ASSIST mHealth framework with other mHealth implementation and research initiatives, including the WHO mHealth taxonomy initiative, known as the WHO mHealth Technical Evidence Review Group (mTERG).

- **ASSIST team members attended the annual mHealth summit**, where they strengthened linkages with leaders in the mHealth and eHealth fields and engaged in round table discussions during the mHealth Alliance technical working group meeting (Q1).
- **Convened mHealth meeting “Bridging the Gaps: Leveraging mHealth to Help Achieve Strong Systems and High Quality Care”** (January 31, 2014). Meeting convened 40 technology, public health and QI experts to review the ASSIST framework of mHealth technologies that can help bridge HRH, information, service delivery and commodities gaps to improve care and strengthen systems. The objectives of the meeting were to:
  - Review a working framework for selecting mHealth and mHealth solutions that can help bridge quality and systems gaps to improve health care in resource-limited settings
  - Build consensus on established, emerging, and needed mHealth/eHealth solutions that best address critical quality and systems gaps in low-resource settings
  - Identify areas of collaboration for implementation and research
- Discussion was interspersed with expert presentations. The meeting agenda and presentations may be accessed at: <https://www.usaidassist.org/content/bridging-gaps-leveraging-mehealth-achieve-strong-health-systems-and-high-quality-care-low>.
- **Technical report completed summarizing framework, evidence review and January meeting highlights**
- **ASSIST mHealth Technical brief developed** (Q2).
- **Presentation of ASSIST mHealth Systems Strengthening framework at QPI Global Technical meeting** (Q2).

#### **Directions for Q3 and Q4 FY14**

- Apply framework to test use of mHealth technologies as part of ASSIST country-level improvement work and research (per Mission and cross-bureau funding that may become available); three concept notes developed and submitted to OHS for consideration of funding (PMTCT, MNCH and CHW)
- Disseminate ASSIST mHealth technical report/framework.
- Present at and participate in the mHealth for Maternal Health meeting co-convened by the Maternal Health Task Force and the Harvard School of Public Health in April 2014.
- Present at an mHealth session at the CORE spring meeting.

### **3.4 Non-communicable Diseases**

#### **Background**

Non-communicable diseases (NCDs) are now the primary cause of death in all regions except Africa. USAID has recently developed a conceptual framework on NCDs and Injuries (NCDI's) that builds on USAID's existing platforms and investments in nutrition, MNCH, family planning, and infectious diseases (HIV/AIDS, TB and others) to outline principles of deeper engagement in NCDs. Among other principles, the USAID NCD conceptual framework emphasizes: complementarity with existing priorities; disease prevention and health promotion; low-cost, cost-effective, and evidence-based interventions; priority to activities that add value and can be easily integrated into existing programs and service-delivery platforms; and a multi-sectoral approach. In the last quarter, the USAID Office of Health Systems provided ASSIST with modest funding to help advance the principles outlined in the USAID NCDI conceptual framework. ASSIST (and its predecessor projects) have many years of experience implementing improvement work in the area of NCDs/chronic conditions including hypertension improvement work in Russia, integrated HIV/NCD services (Uganda, Tanzania), MNCH/NCD services (Ukraine), and CVD and asthma/COPD service delivery improvement at clinic and hospital level (Republic of Georgia). ASSIST will work closely with USAID OHS and Country Missions to define and advance activities that can contribute to and help advance the principles

outlined in the USAID NCDI conceptual framework.

## Program Overview

Activities <i>*pending mission approval</i>	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Support Kenya MOH to finalize a national NCD strategy	<ul style="list-style-type: none"> <li>Support the Kenya MOH to finalize its NCD national strategy including a monitoring framework</li> </ul>	N/A		x
2. Test integrated HIV/NCD service delivery platforms	<ul style="list-style-type: none"> <li>Support integrated NCD/HIV service delivery platforms in selected high-volume sites in Kenya (jointly leveraging Mission funding of HIV service delivery improvement work.)</li> </ul>	TBD		x

## Key Activities, Accomplishments, and Results

### Activity 1. Support Kenya MOH to finalize a national NCD strategy & Activity 2. Test integrated HIV/NCD service delivery platforms

#### Accomplishments:

- NCD concept note nearly finalized, including objectives
- Meeting held with USAID OHS and EE Bureau representatives in Washington, DC, to discuss the proposed scope of work
- Several meetings were held in Kenya with MOH NCD division and partners working in the area of NCDs by ASSIST Kenya team (Dr. Faith Mwangi-Powell, ASSIST Kenya COP; Dr. Subiri).
- Developed NCD and gender brief by WI-HER in collaboration with ASSIST staff

#### Directions for Q3 and Q4 FY14

- Finalize NCD concept note and share with USAID/OHS counterparts in DC (Adam Slote and Paul Holmes) and with USAID Mission for feedback, revisions and approval
- Plan country visit (Dr. Kathleen Hill) to discuss and finalize objectives and work plan with Kenya Mission and ASSIST Kenya team

## 4 Common Agenda Activities

### 4.1 Global Technical Leadership

#### Background

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 implementing partners and global health organizations to expand the application of improvement approaches. The project aims to serve as a conduit and catalyst for sharing, learning, and advancement in the field of improvement applied to various topics, including district management, human resources management, chronic care, gender equality, community-level services, local supply systems, knowledge management, and evaluation of improvement methods.

#### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Cross-cutting Activity
1. Increase application of	Expand the use of modern improvement approaches in USAID-assisted health care systems and by USAID	Global		x

improvement methods	cooperating agencies through global technical leadership for USAID's worldwide efforts to improve health care in developing countries			
2. Demonstrate results	Demonstrate the results of USAID's investment in health care quality improvement	Global		x
3. Build capacity in improvement	Support the development of improvement competencies in ASSIST staff, counterparts, and implementing partners	Global		x
4. Expand awareness of improvement methods	Increase awareness of ASSIST work and activities nationally, regionally, and globally outside of current circles of interaction	National Regional Global		x

## Key Activities, Accomplishments, and Results

### Activity 1. Expand the use of modern improvement methods

#### Accomplishments:

- Design teams identified and new templates created for documenting the design of each country program.** An innovation in the application of modern improvement methods through the ASSIST Project in the past six months was designation of "design teams" and development of a new "ASSIST design template" to be developed for each improvement activity. Chiefs of Party were asked to name the members of the design team for each improvement activity, to identify who would be contributing content expertise, local country content expertise, and improvement expertise. These teams are conferring, in person or virtually, to develop the content of each improvement activity and to finalize the aim statements and indicators to be used to measure achievement of aims. The product of the design team's work is a completed design template which outlines the goal and aims of the improvement activity, explains the phasing of the improvement work, describes the package of evidence-based interventions (technical content) that will be implemented through the improvement activity, and the process and outcome measures (indicators) that will be used to measure results. This report includes "improvement aims" for those countries that to date have finalized their improvement aims and indicators (India, Swaziland, Tanzania).
- Increased the extent to which gender was integrated into work plans.** In FY13, the proportion of countries collecting sex-disaggregated data was 86% (6/7), and 43% (3/7) of the FY13 country plans mentioned addressing gender-related barriers. WI-HER staff provided technical support to country teams during and following the September 2013 work planning meetings to integrate gender into country FY14 work plans. They reviewed drafts of work plans and held meetings and virtual consultations with country staff to help identify potential gender opportunities to focus on for the year and advised on how to incorporate gender. The impact of this assistance was a substantial increase in the proportion of country work plans with clear gender integration activities: Out of 19 countries with FY14 work plans, 15 countries (79%) addressed gender-related barriers in at least one activity in their improvement plans, an 84% increase from FY13.
- ASSIST Director Dr. M. Rashad Massoud and AOR Dr. Jim Heiby contributed significantly to the development of the *FY2014 PEPFAR Quality Strategy: Phase I: Institutionalization of Countries' Ability to Improve HIV Clinical Programs*.** The PEPFAR Quality Strategy was published in March 2014.
- Dr. Massoud was named co-chair of the "Quality Improvement and Regulation" working group of the Global Human Resources for Health (HRH) Strategy Task Team.** The working group is tasked with preparing a paper on strategies for improving health worker productivity and performance in the context of Universal Health Coverage (UHC), focusing on the roles of standards, quality improvement, and regulation.
- ASSIST convened new working group on quality of care in the context of Universal Health Coverage (UHC).** In March 2014, ASSIST convened with WHO, USAID Office of Health Systems and Office of HIV/AIDS, World Bank, PAHO, and Gates Foundation the initial meeting of the new working group, which is chaired by the WHO Service Delivery and Safety Department and seeks to define an action agenda for the partners to take forward to assure high quality UHC.

## **Activity 2. Demonstrate the results of USAID’s investment in improvement methods**

### **Accomplishments:**

- In the first half of FY14, project staff published one peer-reviewed article and had a second accepted for publication. The project published 11 case studies, two technical reports, 13 short reports, one improvement guide, and 10 annual reports (see Table 8).

**Table 8: USAID ASSIST Publications, October 2013-March 2014**

<b>Articles Accepted for Publication in Peer-Reviewed Journals</b>
Frymus D, Schaefer L, Wuliji T. “Improving the efficiency, effectiveness and sustainability of health worker in-service training: Closing the gaps between evidence, practice and outcomes.” Editor’s introduction to the five-article series published 1 October 2013 <i>Human Res Health</i> 2013, 11:51.
Boucar M, Hill K, Coly A, Djibrina S, Saley Z, Sangare K, Kamgang E. “Improving Post-partum Care for Mothers and Newborns in Niger and Mali: A Case Study of a Maternal and Newborn Improvement Program.” Submitted 30 November 2013 to <i>British J Obs Gyn</i> for BJOG “Improving Quality of Care for Maternal and Newborn Health” Supplement. Accepted for publication 1 March 2014.
<b>Case Studies (Date Published)</b>
Retention in care of HIV-exposed mother baby pairs in Kenya, <i>Case Study</i> (October 2013)
Integrating nutrition services in HIV and TB care in Karonga and Balaka Districts of Malawi. <i>Case Study</i> (December 2013)
Improving access to quality education in Nakanyanja Primary School in Mkata area in Mangochi District, Malawi. <i>Case Study</i> (December 2013)
Improving household food security in Mwanganya area through community involvement in Karonga District, Malawi. <i>Case Study</i> . (December 2013)
Successfully Providing Essential Newborn Care for Term and Premature Babies: A Midwife’s Perspective. <i>Case Study</i> (January 2014)
Organizing for obstetric emergencies: How Kabarole Hospital in Western Uganda is saving mothers’ lives. <i>Case Study</i> (January 2014)
Improving income-generating activities for vulnerable children and families at Agape Nyakibare Civil Society Organization. <i>Case Study</i> (January 2014)
A Fast Turn-around for Mengo Hospital: Improving the Quality of Safe Male Circumcision Services. <i>Case Study</i> (February 2014)
The first 3 months experience in improving labour and delivery care at Godda District Hospital, Jharkhand, India. <i>Case Study</i> (March 2014)
Improving retention of children in HIV treatment in Uganda. <i>Case Study</i> (March 2014)
The role of improvement teams in managing male circumcision-related adverse events: The experience of the mobile van clinic in Uganda. <i>Case Study</i> (March 2014)
<b>Technical and Research Reports (Date Published)</b>
Changes tested to improve quality of safe male circumcision services in Uganda. <i>Technical Report</i> . (November 2013)
Rapid Assessment of the Health Worker In-Service Training Situation in Ethiopia: Survey of Training Program Provider Practices and Key Informant Interviews (March 2014)
Strengthening Child-Caregiver Relationships: Linking Evidence and Practice. December 11 – 13, 2013. <i>Meeting Summary</i> . (March 2014)
<b>Flyers and Short Reports (Date Published)</b>
Linking HIV care and management of chronic non-communicable diseases. Experiences from Buikwe District, Uganda (2-page flyer) (October 2013)
Strengthening community systems to increase uptake and retention of PMTCT services in Tanzania (4-page flyer) (October 2013)
Applying the science of improvement to strengthen systems and improve health outcomes in Tanzania (4-page flyer) (November 2013)

USAID tackles the burden of non-communicable diseases in Europe and Eurasia Region (2-page flyer) (November 2013)
A Global Improvement Framework for Health worker in-service training: Guidance for improved Effectiveness, Efficiency and Sustainability (4-page flyer) (November 2013)
Applying Science to Strengthen and Improve Systems. Current Field Activities (2-page flyer) (December 2013)
Improving Alcohol and Tobacco Control during Pregnancy in Ukraine (2-page flyer, also published in Ukrainian) (January 2014)
Applying Science to Strengthen and Improve Systems. USAID ASSIST Project Five-year Cooperative Agreement in the USAID Office of Health Systems (4-page flyer) (January 2014)
Improving Health Worker Performance (2 page flyer) (February 2014)
Health Worker Engagement Study: Tanzania (2-page flyer) (February 2014)
Leveraging mHealth to Strengthen Health Systems and Improve Care ( 2-page flyer) (March 2014)
Rapid Assessment of the Health Worker In-Service Training Situation in Ethiopia: Survey of Training Program Provider Practices and Key Informant Interviews (2-page flyer) (March 2014)
Integrating Gender in Voluntary Medical Male Circumcision Programs to Improve Outcomes (4-page technical brief) (March 2014)
<b>Tools (Date Published)</b>
Guide for Applying Improvement Methods to Implement the National Standards for Improving the Quality of Life of Vulnerable Children in Nigeria (February 2014)
<b>Annual Reports (Date Published)</b>
ASSIST Annual Performance Monitoring Report, October 1, 2012 – September 30, 2013 (November 15, 2013)
USAID ASSIST Project. Documentation and Knowledge Management Report FY13 (December 2013)
USAID ASSIST Project. Research and Evaluation Report FY13 (December 2013)
USAID ASSIST Project. Burundi Annual Country Report FY13 (December 2013)
USAID ASSIST Project. Kenya Annual Country Report FY13 (December 2013)
USAID ASSIST Project. Malawi Annual Country Report FY13 (December 2013)
USAID ASSIST Project. Nigeria Annual Country Report FY13 (December 2013)
USAID ASSIST Project. Swaziland Annual Country Report FY13 (December 2013)
USAID ASSIST Project. Tanzania Annual Country Report FY13 (December 2013)
USAID ASSIST Project. Uganda Annual Country Report FY13 (December 2013)

- **Presentations on improvement methods and results made at regional and international conferences:** As shown in Table 9, in the first half of FY14, ASSIST staff participated in 14 regional and international conferences, delivering 47 presentations or sessions featuring ASSIST-related results and improvement methods.

**Table 9: USAID ASSIST Conference Presentations, October 2013 – March FY14**

Conference	ASSIST Staff Participation
<b>The United Republic of Tanzania Ministry of Health and Social Welfare National Family Planning Conference</b> October 9-11, 2013 Dar es Salaam, Tanzania	<ul style="list-style-type: none"> <li>• Yohana Miramweni made the oral presentation “Using improvement methods to meet the family planning needs of PLHIV in Manyara, Kilimanjaro and Morogoro regions, Tanzania”</li> <li>• Rose Burungi made the oral presentation “Integrating Family Planning into HIV/AIDS Services in Uganda”</li> <li>• Valeria Makatini of the Kwazulu-Natal Department of Health presented the poster, “Rethinking IUCD use as a contraceptive option in KwaZulu-Natal, South Africa” with support from ASSIST</li> </ul>
<b>ISQua’s 30<sup>th</sup> International Conference</b>	<ul style="list-style-type: none"> <li>• M. Rashad Massoud and Shawn Dick, together with Malcolm Daniel and Jason Leitch of NHS Scotland, led the skill-building workshop, “Applying a Reliable Design Framework to Improve Quality of Care for Your Patients”</li> </ul>

Conference	ASSIST Staff Participation
<p>October 13-16, 2013 Edinburgh, Scotland</p>	<ul style="list-style-type: none"> <li>• M. Rashad Massoud led the interactive session, “Improving at Scale in Low- and Middle-Income Economies” and also chaired the session “Quality and Safety in Transitional and Developing Countries”.</li> <li>• Isaac Chome Mwamuye made the oral presentation “Increasing the uptake of maternal health services of a rural community in Kenya by enhancing community-facility linkages”</li> <li>• Flora Nyagawa made the oral presentation “Improving Access to Health services for Most Vulnerable Children in Community Settings: A case of Bagamoyo district-Tanzania” and presented the poster “Let’s clean up this mess! A community-based strategy to improve food hygiene and sanitation at a highway travel stop: Lugono Experience, Morogoro Region, Tanzania” on behalf of Farida M. Mgunda and Carle Lyimo,</li> <li>• Kate Fatta made the oral presentation “Barriers and facilitators of institutionalization of quality improvement in Niger” on behalf of Maina Boucar</li> <li>• Rhea Bright made a short oral presentation “Strengthening community systems to increase uptake and retention of PMTCT services in Tanzania” and presented the posters “Working With Teams To Improve Quality of Prevention of Mother-to-Child Transmission of HIV Services: Successes Challenges and Lessons Learnt” on behalf of Elizabeth Hizza and “Comprehensive Counseling, Health Education and Support of HIV-positive Pregnant Women as a Factor to Improved Quality of Services to HIV Exposed Infants” on behalf of Monica Ngonyani</li> <li>• Pamela Marks made a short oral presentation “Transforming Health System for People Living with Chronic Conditions; What can be done in HIV Chronic Care, Tanzania Experience” on behalf of Joseph Kundy</li> <li>• John Byabagambi presented the poster “Functional improvement teams are positively associated with linkage of HIV-positive mothers into HIV care”</li> </ul>
<p><b>CORE Group Fall Meeting</b> October 16-17, 2013 Washington, DC</p>	<ul style="list-style-type: none"> <li>• Allison Annette Foster and Ram Shrestha presented on the HCI-developed CHW Program Decision-making Toolkit at a half-day pre-meeting workshop on Oct. 15: Decision-making support for developing and effectively managing CHW programs”</li> <li>• Ram Shrestha made a plenary presentation on the CHW experience in Nepal</li> <li>• Allison Annette Foster led a Power Breakfast Roundtable on “Hot Topics on CHWs”</li> <li>• Lani Marquez and Lenette Golding of CARE led a lunchtime Lunch Roundtable “I am, we are: A “share session” on how to stimulate a culture of learning in your organization”</li> <li>• Allison Annette Foster presented “Empowering Health Workers to Deliver Quality Care” in a panel with Concern Worldwide and IMA World Health</li> <li>• ASSIST had a resources tables where ASSIST and HCI publications, including the newly revised CHW AIM Toolkit, were distributed</li> </ul>
<p><b>American Evaluation Association</b> October 16-19, 2013 Washington, DC</p>	<ul style="list-style-type: none"> <li>• Edward Broughton delivered two half-day workshops: “Cost-effectiveness of health and human services programs” levels I and II</li> <li>• Edward Broughton gave a 45-minute “expert lecture”: “Do you really trust the numbers? Health data validity around the world”</li> <li>• Lynne Franco and Lani Marquez presented “Wrestling With the Data Beast - Developing an Approach to Using Quality Improvement Monitoring Data to Tell a Bigger Story”</li> </ul>
<p><b>Regional Conference on Health District</b> October 21-23, 2013 Saly, Senegal</p>	<ul style="list-style-type: none"> <li>• Maina Boucar made the oral presentation “Applying QI to Human resources management at the district level in Niger: A model for district health systems strengthening”</li> <li>• Martin Muhire made the oral presentation “Improving care for people with chronic conditions– A case study of changing health systems, Buikwe district, Uganda”</li> </ul>
<p><b>Regional Psychosocial Support Forum</b> October 29-31, 2013 Nairobi, Kenya</p>	<ul style="list-style-type: none"> <li>• Roselyn Were spoke on behalf of URC at the Tuesday opening session</li> <li>• Roselyn Were and Stanley Masamo led a QI workshop (Skill-building 2) on Wednesday</li> <li>• Diana Chamrad was a facilitator at a skill-building on standards (Skill-building 3) on Wednesday</li> <li>• Kate Fatta and Esther Kahinga led a skill-building session on knowledge</li> </ul>

Conference	ASSIST Staff Participation
	<p>management (Skill-building 4) on Wednesday</p> <ul style="list-style-type: none"> <li>Stanley Masamo presented in a special session on psychosocial services in Kenya (Special Session 2: Kenya's experience developing PSS Guidelines) on Wednesday</li> <li>Diana Chamrad moderated a panel on the Partnerships in Community Child Protection on Thursday</li> </ul>
<p><b>International Union on Tuberculosis and Lung Disease Conference</b> October 30- November 3, 2013 Paris, France</p>	<p>ASSIST Swaziland three posters on work funded by ASSIST:</p> <ul style="list-style-type: none"> <li>"TB screening and mapping of miners and examiners in Swaziland" by S. Haumba; N. Mdluli; M. Calnan; T. Dlamini; V. Jele</li> <li>"MDR-TB treatment outcomes among HIV-infected and HIV non-infected patients in Swaziland: A review of routinely collected data" by N. Mdluli</li> <li>"Drug resistance profile of patients with pulmonary tuberculosis in Swaziland" by C. Mlambo; S. Haumba; M. Calnan; G. Maphalala; J. Manjengwa; T. Zananwe; J. Ongole; T. Dlamini</li> </ul>
<p><b>American Public Health Association (APHA) Annual Meeting</b> November 2-6, 2013 Boston, MA</p>	<ul style="list-style-type: none"> <li>Rhea Bright made the oral presentation "Transitioning to the WHO 2010 PMTCT and Infant Feeding Guidelines at the local level: Identifying and addressing operational challenges in Tanzania."</li> </ul>
<p><b>Third National Quality Improvement Forum on Health Care</b> November 26-28, 2013 Dar es Salaam, Tanzania</p>	<ul style="list-style-type: none"> <li>Rashad Massoud delivered a keynote address "Quality Improvement to Address Health Systems Strengthening"</li> <li>Flora Nyagawa made two oral presentations: "Involvement of most vulnerable children in responding to improving their health services" and "Optimising linkages between the community and health facilities to improve care and treatment of PLHIV in Tanzania"</li> <li>Joseph Kundy made the oral presentation "Exploring the relationship between engagement and performance of health workers delivering HIV services in Tanzania"</li> <li>Yohana Mkiramweni made the oral presentation "Using improvement methods to meet the family planning needs of PLHIV in Manyara, Kilimanjaro and Morogoro regions, Tanzania"</li> <li>Stella Mwita presented two posters: "Instituting data quality protocol to verify quality of data within CTC and RCH services within ASSIST Project" and "Preparedness for Option B+ in districts supported by partnership for HIV Free Survival in Tanzania"</li> <li>Elizabeth Hizza presented the poster "Can communities contribute to improving service uptake? Community PMTCT experience in Iringa District Council"</li> <li>ASSIST sponsored a resources table at the conference</li> <li>Following the conference, Dr. Massoud delivered a separate "Grand Rounds" address on "The Science of Improvement"</li> </ul>
<p><b>Third Global Forum on Human Resources for Health</b> November 11-13, 2013 Recife, Brazil</p>	<ul style="list-style-type: none"> <li>Allison Annette Foster presented "Monitoring and Accountability Framework for National Governments and Global Partners, in Developing, Implementing, and Managing CHW Programs" at the USAID-led session, "SE4-SE5: Strengthening the role of Community Health Workers in Achieving Universal Healthcare Coverage: Moving from Fragmentation to Synergy"</li> <li>Tana Wuliji led and presented at the side event "SE30: Improving health worker in-service training effectiveness, efficiency and sustainability: Harvesting good practices and lessons learnt"</li> </ul>
<p><b>European Ministerial Conference on Prevention and Control of NCDs</b> December 3-4 2013 Ashgabat, Turkmenistan</p>	<ul style="list-style-type: none"> <li>Tamar Chitashvili attended as part of a three-member official delegation from Georgia.</li> </ul>
<p><b>5th Quality Management</b></p>	<ul style="list-style-type: none"> <li>M. Rashad Massoud gave a keynote address at the conference, "Improving Health Care"</li> </ul>

Conference	ASSIST Staff Participation
<b>Conference at Arab Health Week</b> , January 27-29, 2014, Dubai, United Arab Emirates	<ul style="list-style-type: none"> <li>Dr. Massoud also made the presentation, “Designing improvement for local ownership, great results, and learning”</li> </ul>
<b>2014 Prince Mahidol Award Conference</b> , 27-31 January 2014, Bangkok, Thailand	<ul style="list-style-type: none"> <li>ASSIST supported USAID and CDC in convening a three-hour side session on “Strengthening the Continuum of Learning” which looked at both pre-service and in-service training and featured the in-service training improvement framework</li> <li>ASSIST, USAID, WHO and the Uganda-based Regional Center for Quality of Health Care convened a 90-minute session on “Integrating Improvement Competencies into Pre-service Education”</li> </ul>
<b>Global Health Mini-University</b> , March 7, 2014, Washington, DC	<ul style="list-style-type: none"> <li>Ram Shrestha and Rhea Bright presented the interactive session, “The Strength of the Community - A foundation for healthcare delivery”</li> </ul>

- Technical briefings conducted by ASSIST staff during the October 2013-March 2014 period:**
  - ASSIST Director M. Rashad Massoud conducted a webinar on scale-up sponsored by the International Society for Quality in Health Care (ISQua) on Oct. 1.
  - ASSIST convened the meeting “Bridging the Gaps: Leveraging m/eHealth to Achieve Strong Health Systems and High Quality Care in Low-Resource Settings” in Washington, DC on January 31, 2014.
  - On February 5 and March 13, 2014, Dr. Massoud led seminars for PEPFAR staff on “The Science of Improvement and Supporting Field Application of the PEPFAR Quality Strategy.”
  - On February 18, 2014, M. Rashad Massoud, Allison Foster, Edward Broughton, and Sarah Smith Lunsford participated in the day-long seminar sponsored by ASSIST, Capacity Plus and the World Bank on “Supporting Country-Led Efforts to Recruit and Retain Health Workers and Improve Their Productivity.”
  - On February 19, 2014, Dr. Edward Broughton led a webinar on the cost-effectiveness of medical care in low-resource settings for the International Center for AIDS Care and Treatment Programs (ICAP) at Columbia University’s Mailman School of Public Health. A recording of the webinar is available at: <http://columbiauniversitymsph.adobeconnect.com/p99y9ab17s6/>.
  - On March 12, 2014, Dr. Massoud conducted a seminar at the World Bank on improving health care.
  - On March 14, 2014, Dr. Kathleen Hill and Dr. Jorge Hermida presented at MCHIP on ASSIST’s work on improving the diagnosis and management of pre-eclampsia and eclampsia in Niger and Mali.
  - On March 18, 2014, Dr. Diana Chamrad participated in the USAID/OHA webinar, “Creating Partnerships in Community Child Protection and Quality Improvement.”

**Activity 3. Support the development of improvement competencies in ASSIST staff, counterparts, and partners**

**Accomplishments:**

- Improvement competency development:** Using field support funding from several countries, ASSIST is developing a set of competency-based learning modules on improvement. This activity will utilize the best of what we have learned from application of improvement science in lower and middle-income countries, the state-of-the-art in improvement science, and the state-of-the-art in adult learning science to develop a set of competency-based learning modules that can be used to build the competencies of staff, counterparts and implementing partners. The modules will be based on the competency framework ASSIST supported the Regional Center for Quality in Health Care (RCQHC) to develop. Each module will include guides for learners and trainers, materials, exercises, and references designed and packaged in a way to optimize learning effectiveness and efficiency. An expert in instructional design (Dr. Julie Dirksen) was identified to work with Tana Wuliji and Kim Stover to develop the modules. During the second quarter, a general structure for the learning modules was started.
- Gender integration training and coaching:** Dr. Taroub Faramand, President of WI-HER, led

training sessions on gender integration in improvement in Uganda (March 2014) and Georgia (February 2014).

#### **Activity 4. Increase awareness of project work and accomplishments**

##### **Accomplishments:**

- **Launch of the ASSIST Facebook page:** In concert with the launch of the project website, the USAID ASSIST Project Facebook page was launched on March 18 at <http://www.facebook.com/USAIDASSISTProject>.
- **Outreach to other gender integration groups:** Elizabeth Romanoff Silva represented the USAID ASSIST Project in two gender-related working groups during the second quarter of FY14. She also participated in two CORE Group Social and Behavior Change (SBC) working group meetings and shared learnings from USAID ASSIST gender-related behavior change strategies and activities.
- **Manage Jim Heiby's QI Book Project:** ASSIST AOR Jim Heiby began a project to author a book of case studies on quality improvement in low- and middle-income country health systems to capture decades of experiences from USAID-supported projects to improve health care quality using improvement methodology. Given the project's tight timeline, Rashad Massoud recommended that Jim work with a member of the ASSIST team for support. Feza Kikaya was selected to serve as the project manager on behalf of ASSIST to coordinate communications, meetings, and inputs. In early March, a questionnaire was developed and disseminated widely in order to allow quality improvement practitioners the opportunity to suggest potential cases based on specific themes related to improving care in resource-constrained settings. This initial "call" for improvement stories yielded 52 submissions from contributors representing various organizations and regional expertise.

##### **Planned Activities for Q3 and Q4 FY14**

- Plan and hold regional content design meeting for vulnerable children and families work June 30-July 3 in Nairobi and begin planning PMTCT/HIV regional content design meeting.
- ASSIST will be actively involved in the official launch of the PEPFAR Quality Strategy in June 2014.
- Continue active participation in the UHC quality working group, the 2015 WHO Global Report on Quality and Safety, the Global Human Resources for Health (HRH) Strategy Task Team the "Quality Improvement and Regulation" working group, and the "Every Mother Every Newborn" quality initiative.
- Develop and begin field testing the improvement competency learning module structure, content and materials.
- Provide gender integration technical support to India, Tanzania, Ukraine, and Uganda.
- Present on ASSIST results and improvement methods at the Throughout the Reproductive Life Course Technical Meeting, the mHealth for Maternal Health: Bridging the Gaps technical meeting, the International Forum on Quality and Safety in Health Care, the CORE Group Spring Global Health Practitioner Conference, and the American Evaluation Association Summer Institute.
- Launch a Spanish webinar series for newborn care topics
- Dr. Edward Broughton will conduct a webinar on the cost-effectiveness of improving medical services in resource-poor settings sponsored by the International Society for Quality in Health Care (May 21)

## **4.2 Knowledge Management**

### **Background**

Building on the experiences of HCI's knowledge management system and web portal, USAID ASSIST is supporting harvesting what we are learning from the implementation, evaluation, and research work we do at the country level. Through our knowledge management (KM) work, we integrate learning across countries, and make that learning available through web portals and in face-to-face events, in a wide variety of formats, including case studies, blog, improvement stories, technical reports, tools, and e-Learning. In addition, recognizing the value added of considering

gender in improvement projects, ASSIST is emphasizing gender integration as a key area of learning on how to make improvement activities more effective and supporting country teams to integrate gender considerations wherever relevant in facility- and community-level improvement efforts.

## Program Overview

Activities	What are we trying to accomplish?	Improvement Activity	Cross-cutting Activity
1. Continuously refine the KM strategy for ASSIST	<ul style="list-style-type: none"> <li>Conduct studies to evaluate and inform ongoing enhancements to the ASSIST KM system; monitor usage statistics for the ASSIST web portal and social media; submit annual KM and documentation reports to USAID</li> <li>Coordinate annual work plan development and manage Quarterly Review Meeting (QRM) reporting and semi-annual and annual reporting to USAID</li> </ul>		x
2. Manage a knowledge portal for improvement evidence and information	<ul style="list-style-type: none"> <li>Launch and operate the ASSIST knowledge portal at <a href="https://usaidassist.org">https://usaidassist.org</a></li> <li>Support country teams to operate local websites (India, Ecuador, Uganda)</li> <li>Publish blogs, technical reports, and other knowledge products highlighting key learning coming out of ASSIST-supported activities</li> <li>Elicit and search out relevant content from ASSIST partners, other USAID cooperating agencies, and other technical organizations, including case studies</li> <li>Conduct webinars and discussion forums, including partnering with other organizations to house such activities on other websites</li> </ul>		x
3. Document improvement knowledge and learning from activities supported by the USAID ASSIST Project	<ul style="list-style-type: none"> <li>Assist country and technical teams to define key learning questions and develop systems to document and synthesize that learning as knowledge products and make it available to others</li> <li>Support country teams in applying KM approaches to connect implementers and generate and document key learning from improvement activities</li> <li>Support country and HQ teams in integrating gender considerations in the planning and implementation of improvement activities</li> <li>Support country teams in making key learning and improvement information available on the ASSIST web portal using multiple media</li> <li>Support ASSIST country teams in creating local knowledge repositories</li> </ul>		x
4. Promote the use of improvement knowledge	<ul style="list-style-type: none"> <li>Exploit social media channels to promote ASSIST knowledge products and the application of improvement approaches</li> <li>Develop communities of practice on the ASSIST web portal</li> <li>Disseminate resources from the ASSIST web portal to country and technical teams</li> </ul>		x

## Key Activities, Accomplishments, and Results

### Activity 1. Continuously refine the KM strategy for ASSIST

#### Accomplishments:

- Designed the first study to measure the added value of KM methods to spread learning from improvement.** To evaluate the effectiveness of ASSIST knowledge management activities, we proposed to USAID Uganda a research study to measure the added value and costs of applying deliberate knowledge management strategies as part of the scale-up of improvements in safe male circumcision (SMC) care to new facilities and districts in the last quarter of FY14. The study will

compare improvements in care and uptake of specific change ideas in spread sites with and without deliberate knowledge transfer/handover strategies of varying intensity. Through such evaluative research, we expect to measure the cost-effectiveness of knowledge management strategies in the Ugandan health sector. The study, managed by ASSIST Uganda and the ASSIST Research & Evaluation team, is also supported by KM research experts from Johns Hopkins University Center for Communication Programs (JHU CCP). In March, the SMC-KM study was approved by URC's Institutional Review Board (IRB) and submitted to the Makerere University IRB.

- **Began market research in Uganda on the demand for improvement information:** In March, JHU-CCP's Uganda office began conducting structured interviews with Ministry of Health (MOH) and implementing partner representatives for preferences and interest in formats and topics for improvement knowledge in Uganda. The market research is studying the following: (1) current information needs in health care and OVC improvement knowledge tailored to Uganda, (2) design, format and delivery preferences for print and digital resources, (3) access to print and digital health resources, (4) needs for knowledge exchange forums, and (5) existing knowledge capacity, resources, and tools in order to identify gaps. .

## **Activity 2. Manage a knowledge portal for improvement evidence and information**

### **Accomplishments:**

- **Launch of the ASSIST knowledge portal (<https://www.usaidassist.org>):** With support from JHU CCP in Baltimore, the ASSIST web portal went live on March 18, 2014 with many new features not found on the HCI Portal. The ASSIST Blogs (<https://www.usaidassist.org/blog>) offer a less formal platform for sharing insights and key learning about improving care and systems than do formal publications. The Events section (<https://www.usaidassist.org/events>) gives us a place to highlight national and international events and post materials such as presentation PDFs or handouts from conferences and meetings in which ASSIST staff participate. The Original Research database (<https://www.usaidassist.org/original-research>) can be filtered by research method. The Improvement Science section (<https://www.usaidassist.org/topics/improvement-science>) includes new summary descriptions of skills to support improvement (<https://www.usaidassist.org/resources/improvement-skills>) and techniques for measuring improvement (<https://www.usaidassist.org/resources/measuring-improvement>), coaching/supportive supervision (<https://www.usaidassist.org/resources/support-improvement-coachingsupportive-supervision>), documenting learning (<https://www.usaidassist.org/resources/documenting-learning>), synthesizing learning (<https://www.usaidassist.org/resources/synthesizing-learning>), and sharing learning (<https://www.usaidassist.org/resources/sharing-learning>). The Resources section (<https://www.usaidassist.org/resources>) offers more possibilities for filtered search of all resources on the site, while the Topics pages (<https://www.usaidassist.org/topics>) highlight all resources, blogs and events related to the focus topics of the site: Community Health; Gender; HIV and AIDS; Family Planning and Reproductive Health, Health Workforce Development, HIV and AIDS, Innovative Technologies, Maternal Newborn and Child Health; Nutrition; and Vulnerable Children and Families. We have also created a French content page (<https://>



[www.usaidassist.org/french](http://www.usaidassist.org/french)) to concentrate all French-language resources in one place.

- **Resources transferred from [www.hciproject.org](http://www.hciproject.org):** All of the publications and improvement reports that formerly were on the HCI website are now available on the ASSIST website. The Improvement Database from the HCI website has been renamed as a repository of Improvement Stories (<https://www.usaidassist.org/content/improvement-stories>). A redirect function was put in place on March 20 to redirect anyone going to a URL with hciproject.org to the ASSIST website. The [www.hciproject.org](http://www.hciproject.org) site has been closed.

### **Activity 3. Document improvement knowledge and learning from activities supported by the USAID ASSIST Project**

#### **Accomplishments:**

- **Provided technical assistance in KM to field teams in Tanzania, Kenya, Uganda, Malawi, and India to strengthen staff capacity in KM and assist technical teams to incorporate KM approaches in their work.** These ASSIST field teams were also supported to identify knowledge products that synthesize key learning from improvement activities. In October 2013, Lani Marquez spent a week in Tanzania to orient ASSIST technical staff to knowledge management concepts and how they apply to their work, particularly in the development of knowledge and communication products that will support the spread of improved care processes. In November, Lani Marquez and Kate Fatta conducted a two-and-a-half-day KM training for the entire 20-person ASSIST country team in Kenya to develop their understanding of knowledge management concepts and techniques and how they apply to their work, including defining learning questions, obtaining and summarizing knowledge from improvement activities, creating knowledge assets and products that present the key learning from improvement activities to guide others, and designing effective knowledge transfer processes. In November, Lani Marquez spent a week in Uganda, helping the ASSIST team leadership to define the main elements of a strategy for meeting the project's knowledge management and learning objectives, including research and evaluation activities, in response to MOH and USAID priorities. In December, Kate Fatta traveled to Malawi to provide the ASSIST staff with KM support. Ms. Fatta assisted the Resident Advisor and Improvement Advisor for NACS to plan an interactive Learning Session that included storytelling, poster presentations, Liberating Structures' 1-2-4-All technique, and a game to reinforce QI principles. In December, Sidhartha Deka spent two weeks in India working with ASSIST country staff to plan for its first year KM strategy and to plan the design of an internal ASSIST India web-based toolkit that will be a one-stop resource for state-based and district-based staff to access QI-related materials and knowledge products. Mr. Deka conducted a half-day training session on KM for the six State Improvement Coordinators, two District Improvement Coordinators, and Delhi-based technical staff.
- **Technical assistance in gender integration provided to Georgia and Ukraine.** Dr. Taroub Faramand of WI-HER traveled to Georgia in February 2014 to provide technical assistance to integrate gender into the non-communicable diseases (NCD) improvement work. Dr. Faramand led a training session on gender integration in NCD improvement at the 8<sup>th</sup> learning session in Kutaisi and developed recommendations to integrate gender in NCD improvement activities in Georgia. In late March, Dr. Faramand traveled to Uganda to provide gender integration technical support to the ASSIST Uganda program. She led four training sessions on gender integration in improvement: one learning session on integrating gender in the SMC project and three coaching sessions on how to integrate gender, identify gender-related barriers, and address challenges in quality improvement. Dr. Faramand also designed one Continuum of Response package of actions based on HIV status and sex and another based on prevention strategies for gender-related barriers to accessing care and treatment and designed a male involvement intervention in PHFS.
- **Gender Integration Country Profiles developed for all USAID ASSIST Funded Countries.** WI-HER gender and KM specialist Elizabeth Silva developed gender integration profiles to capture what is known about how each country is integrating gender into each activity it is undertaking and how field offices are following through on their gender integration strategies written in their yearly country work plans. The country profiles track the extent to which countries are reporting sex-disaggregated and gender-sensitive indicators, what changes to test related to

gender have been identified and implemented, and the results of those changes and will be used to monitor overall project accomplishments in integrating gender considerations in all country programs.

- **Development of new OVC improvement materials and case studies for Nigeria:** During the second quarter of FY14, Kate Fatta, Diana Chamrad, Kim Stover, and URC's media department provided extensive virtual support to the ASSIST Nigeria team to develop a series of technical products to complement the National Standards for Improving the Quality of Life of Vulnerable Children in Nigeria. These products included a Guide for Applying Improvement Methods to Implement the Standards, a job aid/simple-text version of the standards for community groups, four state-level case studies on the piloting of the standards, and an improvement team journal.

#### **Activity 4. Promote the use of improvement knowledge through the ASSIST KM system**

##### **Accomplishments:**

- **The Salud Materno Infantil Spanish language website continued to attract new members to its communities of practice on Kangaroo Mother Care (KMC) and Helping Babies Breathe and held its first moderated discussion forum** on "appropriate indicators for management and continuous improvement of KMC services". The discuss forum was held on the [www.maternoinfantil.org](http://www.maternoinfantil.org) website during 9-19 December 2013, with over 100 participants.
- **Introduced KM concepts based on ASSIST's experience to participants in the Regional Psychosocial Support Forum**, held in Nairobi in October 2013. Ms. Fatta led the two-hour participatory session, which was designed to engage participants in applying KM techniques and was attended by about 25 forum participants.
- **Supported the USAID OVC team to apply KM approaches to the design of its regional parenting meeting.** In December, ASSIST hosted a meeting on behalf of PEPFAR to capture experiences and guidance from orphans and vulnerable children parenting programs in Africa. KM concepts and techniques were taken into consideration in the design of this two-day meeting held in Cape Town, South Africa. In order to capture the experiences of people working in parenting programs, the meeting was designed with a number of KM techniques, including two knowledge cafés to elicit participants' ideas around successful practices and recommendations for PEPFAR. Participants also shared gaps in policy, research, and implementation of parenting programs in a rapid consulting session. In feedback gathered from participants, many cited the interactive sessions as their favorite, saying they learned much more by talking with other participants and also realized they knew more about parenting programs than they had initially thought.
- **Launched the ASSIST Facebook page at <https://www.facebook.com/USAIDASSISTProject>:** In conjunction with the soft-launch of the ASSIST Knowledge Portal, the project's Facebook presence was fully transitioned to its new social media page during the latter part of the quarter. The ASSIST Facebook page, which had been populated with content over the past few months, was officially published for public viewing on March 17, 2014. Followers of the HCI Facebook page were encouraged to "like" the new page to remain informed of project news, highlights, and opportunities for shared learning.
- **Provided support for country-level social media.** Another key activity in the past quarter was assisting ASSIST countries with their social media pages. Ms. Feza Kikaya worked with Ms. Esther Kahinga to strategize on promoting the ASSIST Kenya Facebook page. Current activities include creating a customized banner for the country page that will then parallel the country's soon-to-be-launched Twitter page.
- **Increased engagement on the ASSIST Twitter page:** During the quarter, the ASSIST Twitter page gained many followers as a result of live-tweeting by staff and partners at various meetings, as well as due to the addition of the ASSIST Uganda team to the Twittersphere. As of April 17, the ASSIST Twitter page amassed 599 total followers.
- **Launched ASSIST Uganda Twitter page:** The ASSIST Uganda team launched their country-specific Twitter page (@USAID\_ASSISTUg) in early January 2014. As a result of the team's successful efforts, other countries such as Kenya expressed interest in launching their own Twitter pages.

## Directions for Q3 and Q4 FY14

- JHU-CCP will wrap up interviews with respondents from implementing partners and MOH in May and will present findings to the URC Uganda office, the MOH, and USAID in June.
- Carry out in-depth usability testing for the ASSIST website with a sample of users.
- Interactive session on ASSIST's use of KM concepts and techniques to "improve improvement work" at the International Forum on Quality and Safety in Health Care in Paris (April 10, 2014).
- Use social media to promote ASSIST presence at the International Forum on Quality and Safety in Health Care, World Health Worker Week, key global health days, and other major events as appropriate. Coordinate these efforts with blogs featured on the ASSIST Knowledge Portal.
- Provide social media support and guidance to Kenya, Uganda, Swaziland and other teams invested in promoting their activities through country-specific Facebook and/or Twitter pages.
- Expand ASSIST's Facebook reach by purchasing ads targeted to specific audiences based on key global health events. Measure these efforts using Sprout Social to determine utility; adjust social media strategy accordingly.

## 4.3 Research and Evaluation

### Background

Through USAID ASSIST, the research and evaluation (R&E) unit is providing technical assistance and guidance on country-led research and syntheses of learning across country- and centrally funded projects on several improvement topics including the validity of improvement-indicator data, sustainability and institutionalization, spread, and economic analysis. The R&E unit is working to disseminate knowledge generated by these studies through web-published reports, peer-reviewed journal articles, and presentations at relevant international meetings to encourage wider adoption of improvements methods.

### Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Validation of 25% of improvement indicators	<ul style="list-style-type: none"> <li>• Demonstrate that data reported by the ASSIST project are accurate, reliable and relevant</li> </ul>	No less than 25% of total number of country reported indicators with completed validity assessment		x
2. Collecting data from control groups for 10% of indicators	<ul style="list-style-type: none"> <li>• Demonstrate the attributable impact of ASSIST interventions on improvement indicators</li> </ul>	Comparison reports on no less than 10% of country-reported indicators		x
3. Evaluating design of improvement activities for lower and middle income countries	<ul style="list-style-type: none"> <li>• Advance learning in improvement science in low and middle income countries</li> </ul>	Every ASSIST country program		x
4. Evaluation of methods and approaches for effective design and implementation of scale-up	<ul style="list-style-type: none"> <li>• Advance global knowledge on scale up of improvement interventions</li> </ul>	Selected ASSIST country programs with scale up activities		x

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
5. Economic analysis of improvement activities	<ul style="list-style-type: none"> <li>Advance global learning on comparative advantage and economic efficiency of QI activities</li> </ul>	At least one economic analysis (may be basic cost report to full cost-effectiveness analysis) for every ASSIST country with an improvement program		x
6. Sustaining improvements and institutionalizing the capacity to continuously improve	<ul style="list-style-type: none"> <li>Contribute to global learning on sustaining and institutionalizing improvement methods to ensure sustainability beyond the life of the Project</li> </ul>	At least two studies on sustainability and institutionalization of improvement after direct involvement of the project has ceased		x
7. Generating learning from multi-country studies	<ul style="list-style-type: none"> <li>Advance knowledge on improvement intervention and how they work in different settings</li> </ul>	At least one study that either combines or compares and contrasts improvement interventions and their effects in more than one country		x
8. Capacity building for research and support to country programs	<ul style="list-style-type: none"> <li>Build research and data management capacity of HCI staff</li> </ul>	Every ASSIST country program		x

Ongoing ASSIST studies are listed in Table 10.

**Table 10: List of ASSIST Studies**

	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. Study planned for FY15	HIV & AIDS
2	Burundi	Factors associated with HIV testing among male partners of pregnant women	Improving Care	Verbal national ethics approval received. Awaiting official notice to begin data collection	HIV & AIDS
3	Mali	Impact of anemia community collaborative intervention in Mali	Design of Improvement Activities	Concept paper developed	MNCH
4	Mali	Institutionalization of improvement in Mali	Institutionalization	Planning	MNCH
5	Mali	WHO Safe Birth Checklist implementation study	Design of Improvement	Concept paper developed	MNCH

	Country	Study	Research Area	Status	Program Area
			Activities		
6	Nigeria	Validation of OVC data at the community level	Validation	Planning	OVC
7	Swaziland	Validation of new diagnostic technologies for pediatric TB cases	Improving Care	Protocol in review with Swaziland IRB	TB
8	Swaziland	Injection Safety, Waste Management Practices and Related Stigma and Discrimination in Swaziland: A national assessment, exploratory study, and evaluation	Improving Care	Baseline data collection complete. Analysis begun.	HIV & AIDS
9	Tanzania	Factors associated with missed appointments among ART clients in Morogoro Region	Improving Care	Protocol and tools drafted	HIV & AIDS
10	Tanzania	A qualitative evaluation of "Assuring Infants and Mothers Get All PMTCT Services" (AIMGAPS)	Design of Improvement Activities	Endline data collected	HIV & AIDS
11	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	Endline data collection complete; amendment to protocol submitted to IRB	HIV & AIDS
12	Uganda	Improving the quality of safe male circumcision in Uganda: An evaluation and qualitative exploration	Improving Care	Data collection	HIV & AIDS
13	Uganda	Impact of Community-based Quality Improvement on Retention and Adherence	Design of Improvement Activities	Delayed until FY15	HIV & AIDS
14	Uganda	Integration of Family Planning into HIV Care: A Cost-Effectiveness Analysis	Design of Improvement Activities	Planning	HIV & AIDS
15	Uganda	The effectiveness and efficiency of integrated service delivery to HIV-positive mothers and their babies in Uganda	Design of Improvement Activities	Approved by Makerere IRB. Awaiting National Council approval	HIV & AIDS
16	Uganda	Safe Male Circumcision Knowledge Management (SMaCKM)	Design of Improvement Activities	Protocol in review with Makerere IRB	HIV & AIDS
17	Uganda	Uganda OVC	Design of Improvement Activities	Delayed until FY15	OVC
18	Ukraine	Improving Alcohol and Tobacco Control during Pregnancy in Ukraine	Design of Improvement Activities	Protocol drafted	MNCH

	Country	Study	Research Area	Status	Program Area
19	Multi-Country Africa	Building Partnership: Experiences from the Partnerships in Community Child Protection in Africa	Design of Improvement Activities	Writing	OVC

## Key Activities, Accomplishments, and Results

### Activity 1. Validation of 25% of improvement indicators

#### Accomplishments:

- **Dr. Edward Broughton accompanied Charles Kimani and Prisca Muange (URC) to Muthane North Health Facility in Nairobi, Kenya, a unit where the USAID ASSIST Project is providing technical assistance to APHIA Nairobi / Coastal, the implementing partner, to improve HIV care and treatment.** This served as a fact-finding mission and pilot test of the data validation tools. It was found that there were significant issues with the validity of the data being collected and reported by the facility teams to the district health office. These data are then entered into the electronic health information system and are the used and aggregated for reporting at higher levels in the health system.
- **Following the visit, a validation data collection tool was developed and the Kenya country team has worked to get buy-in from implementing partners to use these tools for routine data validation going forward.** The first rounds of data collection for validation are planned for April and it is expected that there will be further reporting on these in the coming quarter.
- **In Uganda, Dr. Broughton met with the M&E country team to discuss how to go about the validation of improvement data for all of the improvement activities.** The process was begun to define what the total number of indicators that are being reported for improvement activities are across all programs underway in the country.

### Activity 2. Collecting data from control groups for 10% of indicators

#### Accomplishments:

- **In conjunction with the exercise to obtain data for validation (see Activity 1 above), plans were made with implementing partners to collect data on the same six indicators of service performance in sites in which they are working without the support of the ASSIST Project.** The same tool will be used for data collection. This activity is also planned for Kenya in the coming quarter.

### Activity 3. Evaluating design of improvement activities for lower and middle income countries

#### Accomplishments:

- During the first half of FY14, ASSIST completed a protocol and data collection tools for a study in Burundi on **“Factors associated with HIV testing among male partners of pregnant women”** and submitted them to the local IRB in Burundi for approval. ASSIST received verbal approval for the study. Once official written approval is granted, ASSIST will begin data collection. Dr. Astou Coly plans to travel to Burundi to provide TA for pre-test activities, data collectors training, and the launch of data collection.
- ASSIST completed baseline data collection and began analysis for a study on **“Injection Safety, Waste Management Practices and Related Stigma and Discrimination in Swaziland: A national assessment, exploratory study, and evaluation.”** In preparation for collecting this data, ASSIST conducted virtual/live trainings for data collectors in Swaziland on qualitative data collection and research ethics. Ms. Rhea Bright provided the live component of the training in Swaziland and Dr. Sarah Smith provided virtual training from Bethesda.
- ASSIST completed endline data collection for **“A qualitative evaluation of ‘Assuring Infants and Mothers Get All PMTCT Services’ (AIMGAPS).”** In preparation for collecting this data, ASSIST conducted virtual/live trainings for data collectors in Tanzania on qualitative data collection and research ethics. Ms. Rhea Bright provided the live component of the training in Tanzania and Dr. Sarah Smith provided virtual training from Bethesda. 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. Under the ASSIST Project, an AIMGAPS implementation toolkit will be produced on how to use quality improvement methods to improve the uptake, retention and quality of PMTCT services that can be applied in-country and globally.

- ASSIST completed endline data collection for a study on **“The effectiveness and efficiency of applying the chronic care model to clients with HIV in Uganda: A non-randomized controlled evaluation.”** Additionally, ASSIST submitted an amendment to the study protocol to the URC IRB for approval. This amendment seeks approval to continue the study for an additional year and to document outcomes as the intervention is spread to the control sites.
  - ASSIST is implementing a follow-up to the chronic care improvement intervention implemented by HCI in Buikwe from October 2010 to October 2012. Under ASSIST, the chronic care model is being 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.
  - Quantitative data has primarily been collected from client medical records. The 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.
  - This study also includes a smaller component focusing on the activation or engagement of clients in the management of their condition. We are following a cohort of clients to assess and document any changes in their ability to self-manage. A smaller cohort of 50 clients from the intervention and control districts (for a total of 100) were randomly selected to participate.
- ASSIST completed baseline and qualitative data collection for a study on **“Improving the quality of safe male circumcision in Uganda: An evaluation and qualitative exploration.”** ASSIST is 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 safe male circumcision (SMC), and improve follow up at 48 hours and at 7 days. After the intervention, the 10 implementing partners will then scale up improvements to other facilities that they support. ASSIST has worked with the implementing partners to conduct a facility-level assessment of the 30 facilities using the SMC Quality Standards Tool. 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.
- ASSIST submitted a protocol for a study of **Safe Male Circumcision Knowledge Management (SMaCKM) in Uganda** for ethical approval by the Makerere University IRB in Uganda. ASSIST is working in Uganda to spread the improvement of safe medical circumcision in Uganda using knowledge management methods. This study, which will be conducted in 15 sites in partnership with JHU-CCP, will use a three-armed comparison, with sites randomly assigned to one of the following arms: simple handover of written materials; handover of written materials with an in-person handover meeting; and handover of written materials with an in-person handover meeting and follow-up coaching from a DHO/IP. Data collection by observations of delivery of care will include: pre- and post-op interaction with patient, the handover meeting, and coaching visits
- ASSIST completed a protocol and tools for a study of **“Factors associated with missed appointments among ART clients in Morogoro Region”** in Tanzania. This study seeks to explore individual factors and gender dynamics contributing to loss to follow-up among clients from HIV care and treatment clinics services in Morogoro, Tanzania. Information will be collected from ART clients, and key information from clients and providers. Findings will inform the development of a package of best practices to promote retention among PLHIV clients.
- The WHO Patient Safety Program launched the Safe Childbirth Checklist Collaboration in 2012 as a platform for organizations to work with WHO to study the implementation and usefulness of the Checklist in diverse health-care settings with a focus on implementation research questions

related to 1) acceptability, feasibility, and usability of the Checklist; 2) mechanisms and resources that facilitate or hinder use of the Checklist, including cost issues, staffing, training, timing, organizational impact, related procedures, etc.; 3) barriers, success factors and conditions to facilitate its scaling-up in settings of varying complexity, organizational and safety cultures, and socio-economic level. The lessons learned and experiences gained through the projects participating in the Collaboration will inform the development of the necessary implementation tools and materials which will accompany the Safe Childbirth Checklist upon its public release. **As part of the WHO Safe Childbirth Checklist Collaboration, ASSIST proposes to conduct a study in Mali.** The research questions and study design will be finalized after further discussions with WHO.

- **The USAID Mission in Uganda requested that ASSIST implement its planned study on OVC activities in Uganda in FY15 rather than FY14.** ASSIST will prepare a protocol and tools for this study for IRB submission in FY14, but will plan data collection to begin in FY15.
- ASSIST analyzed data for and began writing a paper on **“Building Partnership: Experiences from the Partnerships in Community Child Protection in Africa.”**

#### **Activity 4. Evaluation of methods and approaches for effective design and implementation of scale-up**

##### **Accomplishments:**

- During the first half of FY14, ASSIST submitted a research protocol and tools for a prospective pre-post mixed methods study on **“The effectiveness and efficiency of integrated service delivery to HIV-positive mothers and their babies in Uganda”** to the Makerere University IRB in Uganda. ASSIST received ethical approval from Makerere University and we are awaiting final approval from the National Council. Data collection for the study is planned to begin next quarter.
  - 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. In 2014, ASSIST-Uganda will begin spreading the best practices identified in this demonstration phase to an additional 87 facilities across the country. Currently, services for HIV-positive women and their babies tend to be provided at ART clinics and post-natal clinics, requiring mothers to attend both clinics. In an effort to improve retention of mother-baby pairs in care there has been a movement toward merging service delivery so mother-baby pairs can receive care at the same time or strengthening the linkages between post-natal and ART services to ensure mothers and their babies receive the necessary services.
  - The objective of this study is to evaluate these different modes of service delivery among the 87 spread facilities with particular attention to infant feeding and retention into care of mother-baby pairs.

#### **Activity 5. Economic analysis of improvement activities**

##### **Accomplishments:**

- **End line data collection has been completed for a study of the effectiveness and efficiency of implementing the chronic care model in Uganda.** There has been regular communication between HQ and the Uganda country team for organizing and executing these activities.

#### **Activity 6: Sustaining improvements and institutionalizing the capacity to continuously improve**

##### **Accomplishments:**

- **ASSIST began planning a study on institutionalization of improvement in Mali.** ASSIST is planning a longitudinal study to monitor signs of institutionalization of quality improvement over time as well as to assess barriers to and facilitators of institutionalization. The protocol and tools for this study are being developed for IRB submission.

#### **Activity 7: Generating learning from multi-country research**

##### **Accomplishments:**

- **A review of literature on the cost-effectiveness of improvement interventions in low and middle income settings was initiated.** Details of the protocol for the desk review will be available in the next quarter.

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

##### **Accomplishments:**

- While in Kenya, Dr. Broughton presented on the definitions of validity and how the data validation exercise was being done in other country programs. This was part of the wider discussion of data management for improvement I the project.
- **When in Uganda, Dr. Broughton presented on difference-in-difference analysis for program evaluation.** The presentation was done for those involved in data collection, entry and other aspects of the SMaCKM study and chronic care program evaluation in Nakaseke and Mityana. Dr. Broughton also reviewed the statistical analysis that will be an important part of the evaluation of the chronic care study with Martin Muhire, the Improvement Advisor most responsible for managing the study on the ground. Dr. Broughton also met with the finance and administration staff to clarify what cost data are required for the economic analysis of the chronic care model.
- **Dr. Sarah Smith Lunsford conducted virtual training on qualitative interviewing for the Uganda safe male circumcision data collection.**
- **Simon Hildebeitel traveled to India to support development of project indicators and data collection tools, and to design an indicator data system for the project using Excel databases.** He also provided training on data presentation.

#### **Activity 9. Disseminate knowledge gained through ASSIST R&E activities**

##### **Accomplishments:**

- **Dr. Broughton attended the BMJ International Forum on Quality and Safety in Paris to present on performing cost-effectiveness analyses on improvement activities.** The session was attended by about 200 delegates.

##### **Directions for Q3 and Q4 FY14**

- Swaziland injection safety: complete analysis of assessment data and qualitative data and write up findings
- Complete data collection for “Factors associated with HIV testing among male partners of pregnant women” in Burundi
- Begin data collection for “The effectiveness and efficiency of integrated service delivery to HIV-positive mothers and their babies in Uganda”
- Publish additional R&E material to the new USAID ASSIST website, including study summaries and blog posts
- Develop study on institutionalization of improvement in Mali
- Develop protocol for WHO safe birth checklist implementation study
- Finalize partnership for child protection in Africa paper
- Analysis and begin writing up circumcision study

## **5 Obstacles and Remedies**

### **Obstacles**

There remain some funding issues for ASSIST. Overall, additional obligations have been made by various missions and bureaus. Planning for specific missions is difficult as future funding is unknown or said to have been obligated but has still not reached the ASSIST agreement via a formal obligation. This results in confusion between mission and ASSIST field staff. In addition to the missions, there is still pending core funding that ASSIST is waiting for which is reported to be imminent. The core-funded work supports a portfolio of personnel and multi-year activities that are adversely affected by these gaps in funding. Technical directors at USAID and ASSIST staff are frustrated by the resulting delays.

## Remedies

Please expedite the obligation of funding actions that are pending. Please communicate to the bureaus and missions that delays will result in damages to the technical progress of work as well as relationships with MOHs and partners on the ground.

## 6 Analysis and Explanation Costs

Costs to date have been below expectations. Past delays in funding were the main cause of the lower than expected levels of spending. However, new obligations were awarded in February and March 2014 which significantly increased the funding for specific countries and/or activities. This will result in an increase in future spending as the funds shall be programmed and activities strengthened or expanded as planned. Unfortunately, these additional obligations will not translate in an uptick for all activities, but only those that received funding. ASSIST staff shall plan accordingly and attempt to keep all activities moving forward until future obligations are made.

## 7 Performance Monitoring Plan

The table below summarizes progress through March 2014 on key indicators in the ASSIST performance monitoring plan.

**Table 11: Progress on USAID ASSIST Project performance monitoring indicators, April 2014**

Project Management						
#	Indicator	Baseline	End of Project Target	Progress as of September 2013	Progress as of March 2014	Data Source/ Collection methods
1	# of Annual Work Plans submitted on-time to the AOR (cumulative)	0	5	1	2	Transmission of deliverable to the AOR
2	# of Annual Project Reports submitted on-time to the AOR (cumulative)	0	5	NA	1	Transmission of deliverable to the AOR
3	Gender Framework submitted within 90 calendar days of the cooperative agreement effective date	0	1	1	1	Transmission of deliverable to the AOR
4	# of Annual Research and Evaluation Reports submitted on-time to the AOR (cumulative)	0	5	NA	1	Transmission of deliverable to the AOR
5	# of quarterly financial reports submitted on-time to the AOR (cumulative)	0	20	4	6	Transmission of deliverable to the AOR
6	# of Semi-annual Performance Monitoring Reports submitted on-time to the AOR (cumulative)	0	10	1	2	Transmission of deliverable to the AOR
7	Final Report of the cooperative agreement submitted on-time to the	0	1	NA	NA	Transmission of deliverable to the AOR

	AOR					
<b>Documentation and Knowledge Management</b>						
#	Indicator	Baseline	End of Project Target	Progress as of September 2013	Progress as of March 2014	Data Source [Benchmark]
1	Knowledge Management Plan submitted within 90 calendar days of the cooperative agreement effective date	0	1	1	1	Transmission of deliverable to the AOR
2	# of Documentation and Knowledge Management Reports submitted to AOR (cumulative)	0	5	NA	1	Transmission of deliverable to the AOR
3	Design of ASSIST Knowledge Portal submitted to AOR for approval	-	1	1	1	Written approval by AOR [Benchmark: completed in year 1]
4	# of country case studies (cumulative)	0	30	2	13	[Benchmark: 20 completed by the end of year 3]
5	# of research and evaluation studies examining the KM system as a whole or components (cumulative)	0	4	0	2 in planning	[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 (cumulative)	0	100%	79% (11/14)	58% (11/19)	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)	42% (8/19)	Country program quarterly and annual reporting; special surveys
8	Average # of knowledge products developed per country (cumulative)	TBD	3	0.6 (8/14)	1.47 (28/19)	Country program quarterly and annual reporting

9	% of assisted countries with local repository of improvement knowledge (cumulative)	0%	Baseline + 25%	0%	0%	Country program quarterly and annual reporting
10	# of communities of practice supported on the ASSIST knowledge portal (cumulative)	0	3	0	0	HQ quarterly and annual reporting
11	# of virtual learning events supported by the ASSIST KM system (cumulative)	0	3	0	2	HQ quarterly and annual reporting
<b>Global Technical Leadership</b>						
#	Indicator	Baseline	Target	Progress as of September 2013	Progress as of March 2014	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 (cumulative)	0	10	0	2	Publication or acceptance for publication
2	# of assisted countries with national health care improvement policies and strategies (cumulative)	3	Baseline + 5 = 8	4	4	Country program quarterly and annual reporting
3	# presentations given by ASSIST staff at global health technical conferences (cumulative)	0	25	31	78	HQ and country quarterly and annual reporting
<b>Field Operations</b>						
#	Indicator	Baseline	Target	Progress as of October 2013	Progress as of March 2014	Data Source/ Collection methods
1	% of integrated country design plans signed by country and USAID stakeholders (per	0	100%	100% (6/6)	64% (13/19)	Country Improvement Plan signed

	year)					
2	% of annual country reports submitted on-time	NA	100%	NA	100%	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	7/7 (100%)	Review of annual country reports
4	% of country-reported indicators externally validated	NA	25% of reported indicators	3 country studies underway	3 country studies and one validation activity 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%	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)	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%	26% (5/19)	Accounting records
8	% of integrated country design plans that address relevant gender-related barriers	NA	30%	43% (3/7)	79% (15/18)	Review of integrated country design plans





**USAID APPLYING SCIENCE TO STRENGTHEN  
AND IMPROVE SYSTEMS PROJECT**

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