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TECHNICAL REPORT

Tanzania-Kenya knowledge exchange for the Partnership for HIV-Free Survival:

Reflections and recommendations

MAY 2016

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

Cover photo:

Teams from Kenya and Tanzania engage in small group discussion.
Photograph by Sidhartha Deka, CCP.

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May 2016

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DISCLAIMER

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TABLE OF CONTENTS

Acronyms ii
Glossary of Terms ii
EXECUTIVE SUMMARY iii
I. BACKGROUND 1
II. KEY LEARNING: HIGHLIGHTS 2
A. Stakeholder Engagement 2
B. Role of the Community 4
C. Care Delivery 5
D. Institutionalization and Scale-up 8
E. Learning and Action 8
III. OVERVIEW OF EXCHANGE: VALUE 10
A. Methods 10
B. Anticipated Value to PHFS At-large 11
APPENDICES 13
Appendix A: High-level Agenda 13
Appendix B: Kenya Mother-Baby Pair Register 14

Acronyms

ANC	Antenatal care
ART	Antiretroviral therapy
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
CCHP	Comprehensive Council Health Plans
CHMT	Council Health Management Teams
CHW	Community health worker
EMTCT	Elimination of mother-to-child transmission
LTFU	Loss to follow-up
MOH	Ministry of Health
NACS	Nutrition assessment, counseling, and support
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHFS	Partnership for HIV-Free Survival
PMTCT	Prevention of mother-to-child transmission
PNC	Postnatal care
QI	Quality improvement
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization

Glossary of Terms

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

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

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

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

EXECUTIVE SUMMARY

Introduction

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

Overview of the Exchange: What and How

A mixed-method agenda was created to provide ample opportunities for shared learning. Day one consisted of interactive peer-to-peer learning activities, including team sharing of data and progress. Day two consisted of site visits where participants observed on-site data review during site-level quality improvement team meetings, observed peer mentor coaching/teaching, and met with site-level teams to discuss data and changes being made to improve clinic and community engagement practices. Days three and four consisted of reflection on the site visits, multiple breakout discussions on key learning topics, group actions for knowledge sharing and application of learning, and final reporting back on learning and subsequent actions each country team would take to apply ideas and knowledge gained moving forward.

Key Learning: Highlights

Key learning was harvested from exchange sessions, video interviews, one-on-one conversations, reporting back, and individual evaluations. Five areas of learning were identified by meeting organizers before the meeting and were confirmed on day one as key topics for discussion: 1) Stakeholder engagement, 2) role of the community, 3) care delivery, 4) institutionalization, and 5) scale-up. The two country delegations also mapped out how they would apply this learning after the meeting.

Value of Exchange

The exchange enabled direct peer-to-peer learning which was highly valued by participants. Trust-building among all participants was fostered, and as a result, representatives from both country teams were transparent about their gaps, experiences, and areas that need improvement, leading to a deeper exchange that often is not possible during large multi-country meetings.

The content shared during this visit will provide the participating teams with: 1) Ideas on how to involve and engage community members, 2) evidence-based change ideas for keeping mother-baby pairs in care and ensuring integration of nutrition assessment, counseling, and support across the continuum that they can adapt and test, 3) lessons for sustaining stakeholder involvement, and 4) advice and emerging ideas on institutionalization and scale-up.

Recommendations for Future Exchanges

Participants noted four main recommendations for others to consider when planning similar knowledge exchanges:

1) Consider where each team is in their implementation journey when deciding what type of agenda would allow for maximum cross learning to happen,
2) Be flexible and allow the agenda to alter and change to match participants' learning needs, as areas of interest will always arise once open conversations and connections start to happen,
3) Recognize and account for any potential language issues ahead of time, and
4) Factor in time for individuals and then teams to process learning and turn learning into action for post-meeting application.

I. BACKGROUND

The Partnership for HIV-Free Survival (PHFS) is a six-country (Kenya, Lesotho, Mozambique, South Africa, Tanzania, and Uganda) initiative, conceived by the World Health Organization (WHO) and the United States President's Emergency Plan for AIDS Relief (PEPFAR) with design support from the Institute for Healthcare Improvement (IHI), to assist the countries with their current national efforts to eliminate mother-to-child to transmission of HIV/AIDS along with improving maternal, infant care, and nutrition support through effective implementation of the WHO 2013 *Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection* using quality improvement (QI) and collaborative learning methods. The initiative focuses on antenatal and postnatal care and nutrition of mothers and infants in high HIV-burden countries with the ultimate goal of increasing HIV-free survival. Improvement work supported under the PHFS focused on four steps in the care cascade: 1) retention of mother-baby pairs in care; 2) ensuring all mother-baby pairs receive all recommended services, including nutrition assessment, counseling, and support (NACS); 3) mother-baby pair HIV status is known; and 4) optimal antiretroviral coverage for the mother-baby pair.

As part of the PHFS, knowledge exchange visits have been arranged to share effective implementation strategies/practices between country teams and programmatic challenges and how they are overcome. Organized by the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project with specific support from the IHI and Johns Hopkins Center for Communications Program (CCP), this knowledge exchange was held between PHFS participating country representatives from the national, district, and site levels as well as other implementing partners from Tanzania and Kenya. The exchange took place July 14–17, 2015 in Mbeya Town, Tanzania. The visit also created additional lessons learned and action steps for upcoming exchange visits between other participating PHFS countries.

A. Planning

Planning for the exchange started approximately two months prior to the exchange. Tanzania was chosen to host the exchange visit because of highly engaged national leaders from the Ministry of Health (MOH) and active involvement of several partners. Tanzania was also chosen so that both teams could observe what has been implemented in one of the pilot districts in the country for the previous 22 months. The PHFS demonstration in Tanzania had shown progressive improvement in the focus areas of retention, HIV testing, and ART coverage, as well as in nutrition and community involvement. Each team's learning needs were solicited in advance via telephone and email conversations, and a set series of topics were formulated for discussion ahead of time. Given that both teams were at similar stages of implementation and that the number of participants at this exchange would be kept to less than 16, an open agenda (rather than structured interactions) was designed to provide a wide block of time on a specific topic where the two groups would have sufficient time and space to direct the conversation.

Ample opportunities for knowledge exchange and shared learning were provided by facilitators. Refer to **Appendix A** for a high-level agenda for the four-day knowledge exchange.

II. KEY LEARNING: HIGHLIGHTS

Through discussions prior to the meeting and through an interactive opening exercise on day one, teams identified five main areas of interest for discussion: 1) Stakeholder engagement, 2) role of the community, 3) care delivery, 4) institutionalization and scale-up, and 5) learning and action.

A modified affinity diagram exercise or a "field trip around the room" was used to collect, identify, and prioritize individuals' specific questions—what they wanted to learn more about within each topic. After participants were guided through top areas identified for learning, they were asked to identify what they (or someone they knew) could teach or share on any of the questions noted.

Participants discuss expectations they generated for the knowledge exchange. *Photo by Sidhartha Deka, CCP.*

This exercise guided facilitators to organize discussions and match learning needs to knowledge assets in the room. Mixed methods were used to create opportunities for dialogue, eliciting questions and devising a list of ideas or actions based on learning. Large and small group circles were used to maximize participation from all present. Key takeaways, insights, ideas, and greatest lessons learned were harvested and culled from these exchange sessions, video interviews, one-on-one conversations, reporting back, and, at the end of the exchange, via individual evaluations. Learning highlights from the five main topics of discussion are summarized in the sections below.

A. Stakeholder Engagement

Teams discussed how they collaborated with stakeholders and partners at all levels: national, district, local, and community; what roles the various partners played (or didn't play) in the partnership to improve PMTCT care using QI approaches; strategies for sustaining work once partners leave; and ideas on advocating for other stakeholders' involvement in using QI methods to improve PMTCT care. Given its high level of stakeholder engagement, Tanzania led the discussion on this topic. Tanzania shared how they engage stakeholders within their National Learning Platform (a collaborative workshop held for multiple stakeholders engaging key staff in each of the three districts). The National Learning Platform is an opportunity to highlight activities to strengthen and improve the PMTCT pathway, emerging data, and changes tested and to share lessons, address challenges, and build skills in QI. Representatives from the MOH and ASSIST in Kenya added their experiences to the conversations.

A champion's critical role

Tanzania has a clear national-level champion who pioneers, promotes, and influences others at national level to ensure the PHFS agenda is followed through in all conversations and meetings. Read more about its National Learning Platform here: https://www.usaidassist.org/blog/enabling-knowledge-and-experience-sharing-among-health-care-providers-through-multi-facility

The following steps for engaging stakeholders emerged from the discussion:

1. **Ensure a proper introduction to the work is provided:** Explain what PHFS is, how it builds on current national programming and strengthens existing systems and priorities; ensure partners know they are there to support MOH's leadership and ownership of this work to improve PMTCT.

2. **Communicate to all that the PHFS was established as *a way*** to strengthen what is there, helping countries to achieve what they are setting out to do already (within their national PMTCT plans).
3. **Involve all stakeholders (if possible) from the very beginning in design and launch:** Ensure stakeholders are present and participate in the first meeting launching the partnership to improve PMTCT and that they have input into the design of how this partnership and related improvement activities will be implemented. Such engagement will ensure ownership, ongoing sustainability, and necessary accountability from the start. Create and adhere to a set protocol that will guide implementation and be a benchmark of progress and technical implementation of activities.
4. **Identify a national level champion (supporter and promoter of this work and the QI process)**, through key support from the MOH as the leader of the partnership so as to ensure that results are recognized and scaled up through ownership that has been created from the start.
5. **Show results:** Results from key processes and any early emerging outcome data are powerful leverage to engage and build will; use existing data/results of any demonstration work in your or other countries to illustrate potential impact of using a QI approach to improve PMTCT services. This could help garner national-level champions and interest in starting/spreading and/or sustaining this work moving forward.
6. **Build relationships with all stakeholders:** Take the time to build trust from the very beginning by creating an ongoing forum for discussions among stakeholders. In Tanzania, this was achieved through the monthly national steering committee meetings attended by all partners and the annual PHFS National Learning Platform.
7. **Align with key decision-makers' high priority issues and planned roll-outs**: For example, the Tanzania PHFS launch was aligned with the roll-out of Option B+. Kenya piggy-backed activities to the First Lady's launch of the Beyond Zero program, a key spotlight across the country that had already gathered key decision-makers together to help mothers and children overcome challenges they face with HIV.
8. **Convene learning sessions/platforms for sharing at various levels**: Hold a few at national level to gain wider buy-in, and invite many and all stakeholders regardless of whether they are part of group of PHFS implementing partners.
9. **Ensure an all-inclusive approach**: Involve all project managers as well as relevant community members from the start – always invite them to any meeting or event discussing the partnership to improve PMTCT; invite all stakeholders to meetings, learning sessions, and activities that are focused on improving PMTCT maintain their engagement.
10. **Advocate for QI as part of existing PMTCT work plans, not separate**: Seek continued funding for PHFS activities from PMTCT funding/budgets (i.e., build QI activities into PMTCT work plans). Promoting PHFS as a method to accelerate learning and collaborative work to improve PMTCT is important to ensure continued support for QI in PMTCT budgets.

During the discussion session, several additional questions were posed and discussed, providing further insight on stakeholder ownership and engagement:

Tanzania question: What are the key factors in Kenya to ensure stakeholders are engaging fully and without conflict in PHFS activities in health services?

Kenya response: Kenya gathers stakeholders within large forums on a quarterly basis. Different working groups meet monthly to ensure consistency and constant presence. Based on the experience and challenges they faced (having minimal implementing partner support and noting that PHFS-designated activities were not in facility work plans), the Kenya team emphasized that anyone looking to gain buy-in must understand what specific actions will be needed for facilities to support activities using a QI approach to improve PMTCT. For example, they noted in Kenya that facilities support activities that are clearly indicated in their facility work plan. Therefore, unless QI collaborative activities to improve PMTCT (e.g., the use of QI teams, data-driven approaches to identify areas in need of improvement, setting targets for achieving improved results, and gathering together periodically with other clinics to learn from

each other) are within these work plans, they will not be implemented (whether partner support is present or not).

Kenya question: How did Tanzania achieve national level ownership?

Tanzania response: The PHFS initiative was introduced not as a standalone or new project but as activities to strengthen the existing PMTCT system, with focus on areas that had minimal attention (nutrition and postnatal care steps in the PMTCT pathway). The rapid formation of a steering committee, comprised of multiple stakeholders including the National PMTCT coordinator and USAID focal point, was crucial. These two key stakeholders must be part of initial steering committee discussions in order to channel their commitments and advocate for funding (e.g., existing PMTCT funds). A common monitoring and evaluation framework should be developed, and partners should be committed to a protocol to develop an initiative. The steering committee should make a plan for reporting and funding issues.

B. Role of the Community

Throughout the learning exchange, the role of the community was a main discussion thread woven into most other topics discussed. As the Tanzania team was known to have deep involvement of community members in their approach to improve PMTCT, they described the various ways community members are engaged in their PHFS work.

From the start: Community as partners

Tanzania had an eye towards understanding how critical it was to involve and link with community members and existing community structures right from the very start of PHFS. For example, the inclusion of peer mothers as key members of the health care team, providing support, care, and education to pregnant women and mothers and participating on facility QI teams, analyzing data and contributing ideas and solutions side by side facility staff.

Tanzania has had a high level of engagement of Council Health Management Teams (CHMTs). The CHMTs of the three pilot districts were fully involved and led the activities that incorporated communities as partners. From the start, in Nzega District, the CHMT took ownership of PHFS and extended the use of QI approaches to improve PMTCT into already existing structures. For example, they tapped into existing community health worker (CHW) and peer mentor programs and added QI activities to their existing routine. Pregnant women are matched with a peer mentor and CHW during antenatal care (ANC). Through a previously established mobile health (mhealth) tracing program, CHWs use existing cell phones and free airtime to call mothers who need follow-up for missing postnatal appointments and link them back to the facility. As another example, community forums, village meetings, and existing HIV and health days held in the community are used to advocate and promote the presence of fathers to accompany mother-baby pairs to key postnatal care (PNC) visits (in addition to accompanying pregnant women for ANC visits). Local radio campaigns coupled with dramas at the village level depict the importance of male involvement in a woman's care. The use of peer mentor mothers is particularly effective for the PHFS work to improve PMTCT care, including NACS and keeping mother-baby pairs in care. Mentor mothers actively teach, support, and train other mothers in nutrition (including coaching them to set up hand washing stations and grow their own vegetables), HIV, and caring for and keeping their baby HIV-free through one-on-one mentoring and through monthly social groups for mothers. These social groups, in addition to providing health and nutrition education, also provide access to business seed funds. Data on keeping mother-baby pairs in care and reducing transmission rates are attributed to this enhanced community involvement in PHFS. Specifically, the 80-90% retention of mother-baby pairs in Mbeya District has been attributed to peer mother and CHW support, tracking, and follow-up.

To further understand lessons learned and emerging ideas from both teams on the role of the community in using QI approaches to improve PMTCT, participants were split into smaller groups to discuss questions posed earlier on the topic, sharing insights from their current work and brainstorming together. A summary of key questions and ideas that emerged from these conversations are presented below:

What are additional ways to involve community members?

- Sensitize community leaders about what PHFS is trying to accomplish (improving PMTCT care and keeping mother-baby pairs healthy and alive) and the important role of the community in finding lost mothers and bringing them back into care.

- Invite and involve community members, CHWs, and health workers to participate in ward development committee meetings and orient the committee members about the importance of mother-baby pairs staying in care.

How can we best motivate the community to participate in QI activities to improve PMTCT services?

- Update communities about new issues as they arise (e.g., explain right from the start the QI approach being used to improve PMTCT services and keep them informed as work progresses).
- Promote the benefits of involvement (e.g., improving the system from their perspective - to ensure the provision of timely and quality services when they access facilities so patients have a good experience) and highlight the need for their involvement to convey what it is they want and need.
- Community health workers can encourage community members themselves to use their resources and community groups (e.g., youth groups) to help promote the continued and regular use of ART, encourage mothers to ensure they are routinely visiting the clinic for their own and their baby's care, and help to find mothers in the community that are not coming back for care at the clinics. They can also provide moral support for income-generation activities and nutrition counseling.
- Invite them to participate in different education events, such as street drama, to spread PMTCT related-messages (e.g., nutrition and exclusive breastfeeding actions and reasons why) to their community.
- Involve them in facility meetings, quality improvement teams, and other existing forums; ensure they are updated on the services available and ways to participate in improving them.

How do we ensure community participation is sustainable?

- Involve communities (leaders and key stakeholders) in annual health planning activities at the facility level.
- Sensitize community leaders to incorporate improvement activities for EMTCT/PMTCT within council comprehensive annual plans.
- Encourage community health workers to form or participate in community-based organizations (civil society organizations and income-generating activities) to have health representation and collaboration.
- Involve community leaders in budget development (PMTCT budgeting and planning).

C. Care Delivery

The group split in two during a simultaneous break-out session, choosing one of two care delivery topics to discuss: "Keeping pregnant women and mother-baby pairs in care (retention) and minimizing loss to follow-up (LTFU)" or "nutrition assessment, counseling and support from ANC to PNC." Groups discussed current processes for each of these areas in their respective facilities/countries, ideas being tested to improve both areas, lessons learned, challenges, and actions to take forward. A summary of key questions discussed and learning highlights from each group follow.

What's so exciting about a mother-baby pair registry tool?

Kenya's testing of a new streamlined mother-baby pair register could help uncover and allow teams to address multiple barriers across the postnatal pathway. By knowing who should be in care (and isn't), what care services they are getting (or aren't…especially nutrition care and services), clinic staff are one step closer to having key data/information at hand to improve care and keep mothers and babies in care. (See **Appendix B** for the Kenya mother-baby pair register.)

1. Keeping pregnant women and mother-baby pairs in care and LTFU

What are some challenges one or both countries face with keeping mother-baby pairs in care?

- The heavy documentation workload for staff, e.g., multiple registers to be filled in, can be time-consuming, tedious, and lead to mistakes as systems for collecting and tracking data are often inefficient.

- Keeping mother-baby pairs in care after 12 months of care – the percent of pairs that continue in care past this point drops significantly in both countries.
- The migration of mother-baby pairs to neighboring or alternate sites is very common, and it is challenging to track these pairs to ensure they continue to get the care needed.
- Limited adherence counseling on the day of initiation (done once on the day of the diagnosis instead of three times before initiation as is done for other clients) limits repeated information and multiple opportunities to reinforce messages, tasks, and understanding.

What change ideas have been successful in keeping mother-baby pairs in care?

- Integrating all services for the mother and baby into one room and done at the same visit.
- Stapling the mother's and baby's care cards together.
- Using an appointment or block scheduling system for mother and child together.
- Using appointment and tracking registers at all sites to identify those not coming in as soon as possible.
- Linking peer mentor mothers and CHWs at facilities to work together as a team to teach, build relationships with. and work with mothers.
- Having peer mentor mothers promote and support mothers to seek routine care and to provide same day tracking of missed appointments for mother and child.

What are some of the key lessons learned?

- Community outreach, mHealth used for tracking/education, clinic reorganizations of services (e.g., to integrate NACS early on and rearrange steps so testing or NACS services happen first), and other interventions are important to use concurrently to reach mothers at different times to ensure the mother-baby pair stays in care.
- Providing consistent and persistent health education to clients at every touch point (e.g., same information about adherence and breastfeeding) provides reinforcement and multiple opportunities to learn and engrain this information into memory. It also ensures information is not missed if provided at every entry.
- Using peer mentors and other community health workers at facilities to assist with routine care and tracking of those lost to care can widen the care team to include critical community members, who bring fresh perspectives to improvement work. They also enhance the comfort of mothers by providing peer support and task shift so clinical staff can focus on needed clinical skills (among other things).
- Using QI methods has improved follow-up of mother-baby pairs as new ideas have been generated from staff and the community, tested to see if they work, and adapted based on how effective they are at improving follow-up care.
- Identifying treatment supporters immediately after enrollment into care to help women be encouraged and supported right from the start is critical.

2. NACS from ANC to PNC

Key learning from the NACS discussion group centered around the immense impact PHFS has had on integrating NACS into routine MNCH services and elevating its importance into care and tracking systems. Additional highlights from the discussion are listed below:

What were some of the initial challenges and on-going barriers faced related to NACS?

- At the system level, nutrition services were seen as separate from other health services in both countries before this initiative started.
- There was no clear monitoring and evaluation for nutrition from site level to district to regional to national. Prior to the PHFS initiative, no data tools for nutrition were used, and minimal indicators for nutrition were being tracked, collected, and reported. This led to no (or still limited) demand for NACS data at district or higher levels, as it was not part of routine reporting.
- At the site level, teams did not have the equipment (anthropometric tools such as measuring tapes, length and height boards, and weighing scales) for measurement and therapeutic food to provide to clients when needed.

- There was limited capability to provide NACS at facilities as health workers had no prior training.
- Availability of supplemental food (especially once donor-funded partners phase out) was extremely limited.

How were challenges addressed to integrate NACS into routine MNCH services?

- Nutritionists have been introduced at district levels as part of national efforts by MOH to support the agenda for nutrition and mainstream ideas around nutrition in Tanzania.
- Efforts are being made to introduce NACS indicators and regular reporting into the routine data collection and reporting cycle.
- Nutrition education and training have been incorporated into on-the-job training, continuing medical education, and within various training curriculum for multiple different cadres of health care workers (clinical officers, nurses, and other system staff) so that these services can be provided by all rather than relying solely on the nutritionists. CHWs also are provided with NACS training as part of their overall package of training.
- Initiatives in Mbeya District in Tanzania to teach mothers how to build a home garden as well as how to build a hand washing station for home health and hygiene have provided hands-on learning and educational opportunities for mothers while at the facility. This emphasizes the importance of nutrition and shows mothers how they can be in control. Mothers are taught by peer mentor mothers to create their own source of food to supplement maternal nutrition.

Community garden used to supplement maternal nutrition, Igawilo Hospital. *Photo by Sidhartha Deka, CCP.*

What are some of the key lessons learned?

- The introduction of nutritionists into decision-making roles/meetings helped in mainstreaming NACS into MNCH in Mbeya and Nzega districts in Tanzania. The latter had no district nutritionist prior to PHFS initiation of PMTCT, NACS, and QI activities.
- Improvement methods and associated approaches/methods brought about necessary commitment and will by health care workers to ensure that NACS is part of the PMTCT program and routine activities at site level.
- Overall system-level advocacy is needed to mainstream NACS into routine MNCH services; nutrition should be integrated in multiple care delivery areas.
- The technical leadership by the Tanzania Food and Nutrition Centre (TFNC) working with FANTA/FHI 360 has enabled capacity building in all three of the PHFS focal districts in Tanzania and facilitated support for the implementation of nutrition activities. This has been through trainings of health workers, follow-up of nutrition tools, and working together with USAID to purchase ready-to-use therapeutic foods in Nzega District specifically and to follow up this issue in the other two districts.

One noted area of learning that was discussed across both groups and highlighted throughout the exchange was the development and successful introduction of a mother-baby pair register (see **Appendix B**) that was tested and is now being used in the PHFS demonstration sites in Kenya. The register was highlighted as a way to better track and keep mother-baby pairs in care and ensure the provision of the necessary package of routine services. Additionally, the register was highlighted as a way to integrate NACS into routine care as key NACS indicators are included and tracked via this register. The register also fills a critical demand for a tool to collect 24-month retention and outcomes of pairs as this is tracked on a national level but currently is not tracked at the clinic level via their current registers. A column was added to this new mother-baby pair register to track the pair at their 24-month visit. At the time of this writing, the register is being reviewed by the Ministry of Health to be spread country-wide.

D. Institutionalization and Scale-up

Institutionalization and scale-up were discussed together in a break-out group discussion. Topics discussed included: specific processes to increase institutionalization; how to integrate evidence-based PMTCT interventions, changes made in care and delivery, and the QI approach into national plans; and ideas and action plans for sustaining changes and quality of care. Key ideas and suggestions from both teams to others for institutionalizing and scaling up the QI approach and evidence-based changes to improve PMTCT from ANC to PNC were culled and are listed below.

1. Institutionalization

- Explore ways to integrate QI training into existing training (clinical, orientation, refreshers, etc.) and pre-service education system. For example: In Kenya, in lieu of learning sessions, an introduction to QI for PMTCT activities will be included in training packages at training institutions, as part of pre-service training, and within other existing structures so health care workers will gain these skills as part of routine training (not just at learning sessions, thus, transferring skill development directly into existing structures).
- Explore ways to create local ownership by involving and instilling ownership by the government at all levels from the beginning of any initiative to improve clinic services, care, and health. In Tanzania, they incorporated evidence-based interventions to improve PMTCT that were discovered during the PHFS demonstration phase into budgets of the Comprehensive Council Health Plans (CCHPs), which are then funded by government-based resources. In Kenya, they will be working to incorporate proven interventions into the Kwale County-wide plan.
- Sensitize leaders/health managers (middle-level and high-level systems leaders) on QI early on and continuously.
- Create policies and systems to sustain changes proven to improve processes at the clinic level; for example, document this new way of working and consider having health worker performance appraisals contain a section that assesses worker's continuation of this new way of working.

2. Scale-up

- Document changes that worked into a package for others to learn using the following steps: 1) Note the problem; 2) provide a summary of change ideas and the intervention; 3) note how these were implemented (who was involved, what specific steps they entailed) so others can duplicate it at their site; 4) show the evidence (data) of how the changes improved the problem identified.
- Create ways to scale-up PHFS (changes that led to evidence-based improvements along the PMTCT pathway *and* the use of QI approaches) that use minimum resources and empower local staff.
  For example, Tanzania is scaling up from 30 PHFS sites to 90 sites across three regions. As part of the scale-up, each PHFS prototype site will support two new sites. Each week, two local health workers from prototype sites visit scale-up sites to help introduce improvement or ways to improve PMTCT care and services (empowering health workers to train others and feel ownership).
- Ensure stakeholder lobbying and advocacy activities, which consist of highlighting data and results from demonstration sites, are part of the plans for scale-up and ensure that proven interventions to improve PMTCT are highlighted and integrated into other programs/activities.

E. Learning and Action

On the final day of the exchange, facilitators led a group debrief and recap on discussions from the week. A final "Learning and Action" session allowed the Kenya and Tanzania participants to debrief within their country teams about key learning and map out plans for application of new knowledge post-meeting. After a group brainstorming, teams came together to share their learning and plans for action that included key lessons/ideas learned and how they will apply learning across each main topic area of discussion. Below is a summary of these plans.

Kenya PHFS team noted the following learning and actions to be applied:

- Stakeholder engagement
  - The team will share results with partners during stakeholder forums (held quarterly) to highlight the evidence of what changes are working and subsequent improvement in results.

    - Given the evidence of strong results by engaging community members, the team plans to lobby for partners to support a community component of PMTCT work (currently there is a gap in community support from existing partners).

- Care and delivery
    - They plan to customize the mother-baby appointment register based on learning at the exchange and test it in four facilities.
    - They will put more emphasis on PNC indicators in existing data tools.
    - The team will share with facility-level QI teams the idea of encouraging mothers to bring their children for immunizations (instead of other relatives or caregivers).
    - They will propose to provide airtime and transport for community health volunteers for follow-up and make it a policy so health facilities include it in their budget.

- Role of community
    - The will request community health volunteers to draw a map of their catchment area, including what services may be needed, and update regularly.
    - They plan to share data they have gathered on PMTCT and effects of this focused improvement work with the Community Strategy focal point person, Public Health Officers, Community Health Extension Workers, community health volunteers, and other cadres.
    - They will seek to involve the Kwale County First Lady to develop a fund for PHFS activities including paying mentor mothers.

- Institutionalization and scale-up
    - The team will ensure that proven interventions for improving PMTCT are incorporated into county, sub-county, and facility work plans (these are already in the five-year strategic work plan for Kwale County).

Tanzania PHFS team noted the following learning and actions to be applied:

- Stakeholder engagement
    - They plan to involve all stakeholders from all sectors by sensitizing all levels about activities to improve PMTCT care, including the QI approach
    - They will enlist influential people to come to sites - through the Regional Commissioner, invite the Tanzanian First Lady to the sites to further showcase their work and lessons learned.

- Care and delivery
    - They learned from Kenya how to link CHWs to the HIV-positive mother on the same day of enrollment to ensure that mother is kept in care. They plan to do this and involve the peer mother to take personal information such as address on the same day.
    - At all intake points, they will have heath care providers responsible for taking detailed physical addresses (asking more details as to what streets or landmarks women live near) to provide more accurate ways to trace mothers later that have not returned for care (LTFU).
    - They learned that Kenya hosts a celebration for mother-baby pairs to recognize and congratulate mothers when the baby turns two and is HIV-free. This celebration is held at the clinic where other mothers and pregnant women can take part and learn through example that if they follow the right steps at the right time in their ART regimen, get the information they need on exclusive breastfeeding (including how long to breastfeed), and ensure their baby gets tested, they too can give birth and keep their baby HIV-free. They plan to test this out in Mbeya District.

- Role of community
    - They aim to increase community buy-in and help create community ownership of their local facilities by sharing all financial information and information about the functioning of the facility (including activities) with the community. They will display this on note boards at facilities.

- Institutionalization
    - They learned from Kenya how to advocate for PHFS-inspired activities to improve PMTCT at all system levels (only done now in a few regions); They will include the QI approach and activities to improve PMTCT from ANC to PNC in annual work plans and CCHPs.

III. OVERVIEW OF EXCHANGE: VALUE

A. Methods

The methods used during this peer exchange created space for open, mixed discussions, small group brainstorming and building on each other's ideas, direct observation of work processes and improvement practices (QI team meeting with data review, group discussion, and analysis of data on-site), and time to process what was observed and heard.

Opportunities to share and celebrate

Seeing the presentation with all data and annotated changes made the Tanzania team realize how far they had come. It is important to have opportunities for the larger team to come together to see the results of their work.

The open-ended topical discussion sessions with pointed questions for small group processing allowed for flexibility to adjust the discussion as new learning and ideas emerged. Small group brainstorms provided time for individuals to process what they were learning and discuss ideas in their common language, giving individuals increased ability to be comfortable with participation. Methods used also ensured that cross-team "pollination" of ideas occurred, allowing new knowledge to be created together by mixing up discussion groups and topics. Ideas were expanded, added to, and analyzed together. Teams were given time to regroup at the end of the meeting, creating an immediate space to formalize ideas on how to apply this new knowledge into their work on the ground.

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

- *"How to involve community and how to link the HIV mother in the first day of the identification."*
- *"Stakeholder engagement/involvement from the beginning from top (MOH) to all levels such as the community."*
- *"Knowing how Kenya succeeded to lobby and develop a reporting tool and how Kenya scaled up activity to many facilities."*

The knowledge exchange was a valuable opportunity to promote peer-to-peer learning, something all PHFS country teams noted they wanted opportunities for across the initiative. Since both groups had already started to build relationships previously, open and honest sharing took place. Further trust building between all participants was fostered, and as a result, representatives from both country teams were transparent about their gaps, experiences, and areas that need improvement, leading to a deeper exchange that often is not possible during large multi-country meetings. The field visit brought some perspective to the participants from Kenya and Tanzanian partners on the health system support behind building community linkages. Participants noted their appreciation for learning about how key community change agents identified pregnant mothers in the community and then proceeded to keep the mother-baby pair in care.

When asked what their key takeaways and eye-opening moments were during the exchange, teams noted the following as value-added learning highlights.

Value of strengthening documentation

Strengthened documentation through Kenya's mother-baby register not only reduces workload for facility staff but also provides an opportunity to celebrate those mothers whose babies have been documented in the register to be HIV-free at the age of two.

Kenya's learning highlights:

- Sharing PHFS results in different forums among other partners or other key stakeholders was something Kenya had never thought about doing.
- The emphasis placed in Tanzania on transfer training and training of trainers was eye-opening as well as seeing district coaching happening consistently without relying on partner support.
- The government support and recognition of community health workers as a new cadre of worker.

- The level of community engagement and use of peer mothers for keeping mother-baby pairs in care was quite remarkable.
- The partner coordination, respect, and teamwork to move PHFS forward collaboratively in Tanzania was so evident.

Learning highlights as noted by one participant

"Learning how Kenya succeeded to lobby and develop a reporting tool, and how Kenya scaled up this activity to many facilities, how strong community-to-facility linkages is in Mbeya."

Tanzania's learning highlights:

- Political commitment from the start is critically important (from PHFS launch or even before during pre-launch conversations).
- Multiple-method interventions are important (community, mHealth) to ensure retention (keeping mother-baby pairs in care).
- Involving stakeholders from the start to ensure they are accountable for commitments to activities.
- Leveraging other sources of funding, especially important when PHFS funding is no longer available.
- The ability of Kenya to make their mother-baby register into a formal tool.
- Impressive to learn how much Kenya has been able to accomplish.

One of the most valuable activities teams noted as the highlight of the week was the day-long series of site visits to the Mbeya Council (district) health office, Igawilo Hospital (district hospital), and a health center (teams split into two groups to visit two separate centers simultaneously to keep the group size manageable). Groups learned about processes of care at the different facilities, noting and watching how peer mentors conduct NACS intake of mother and baby pairs and how they teach mothers to set up home water stations and grow gardens. Site nurses/QI team members at the hospital and at each health center walked the group though a data review and analysis of key PHFS indicators being tracked, as well as problems/challenges faced and change ideas being tested to improve performance and address problems. Peer mentors (also members of the QI team) shared their community data tracking tool, which is integrated into the facility-system and how they are active members of the facility QI work and team. They described their involvement and work with mothers at the health center and through community visits. Post-visit, teams reflected and shared the following learning highlights:

- The deep engagement, commitment, and connection with community peer mentors and CHWs was strong and evident at the sites.
- The connections between the peer mentors, CHWs, and facility staff and between peer mentors, CHWs, and patients are equally strong - they are the glue to forming strong facility-community links.
- Ownership of the PHFS work (QI methods and data) by facility staff, community workers, and peer mentors is very strong; their presentations demonstrated keen knowledge and understanding of QI language, approach, and data.
- The high uptake of NACS at all levels was evident.

Lastly, one of the members of the Tanzania team that was working in a neighboring district noted that participating in this site visit in this neighboring district was extremely valuable to be able to see first-hand what they had only heard about in past meetings and discussions. The power of site visits was not only strong for cross-country exchange, but also for in-country learning.

B. Anticipated Value to PHFS At-large

This type of visit contributes to the PHFS global learning goal as the above-mentioned lessons and shared content offer insights for all teams to learn from at any stage. The visit created space for rapid extraction of quantitative and qualitative data for learning, identified successful changes to processes being tested, and allowed individuals to reflect together on progress, barriers, and ideas for forward

movement. Joint learning accelerates progress toward team aims as teams come away not only with a host of ideas and insights related to technical content but also feeling supported, proud of accomplishments to date, and having a renewed sense of commitment and a host of ideas and plans to implement.

The exchange also amplified the intersection of roles of multiple stakeholders within the health system and its importance to institutionalizing evidence-based practices to improve PMTCT that were learned from PHFS into national PMTCT programs. When asked about lessons learned during this exchange, one participant noted: stakeholder engagement/involvement "*from the top (MOH) to all levels…brings ownership*."

The content shared during this visit will provide the remaining teams with: 1) Ideas on how to involve and engage community members, 2) evidence-based change ideas that they can adapt and test for keeping mother-baby pairs in care and ensuring NACS integration across the continuum, 3) lessons for sustaining stakeholder involvement, and 4) advice and emerging ideas on institutionalization and scale-up.

IV. RECOMMENDATIONS FOR FUTURE EXCHANGES

As teams think about hosting other cross-country or in-county knowledge exchanges, the following suggestions should be kept in mind. These are based on what worked (or didn't) from feedback from facilitators and participants. Additional insights on preparing for exchanges can be found in the report on the Uganda-Lesotho PHFS knowledge exchange.

1) Consider where each team is in their implementation journey when deciding what type of agenda would be appropriate for maximum cross learning to happen. For example, decide if teams would benefit from loosely structured open-ended discussion sessions versus specifically targeted topic sessions or a hybrid of both.

2) Be flexible and allow changes to the agenda as you go, since areas of interest will always arise once open conversations and connections start to happen; be sure to get agreement at the beginning from both teams to ensure they are comfortable with this flexibility. Identify any topics or sessions that they do not want to alter or miss.

3) Recognize any potential language issues ahead of time; know which languages each team and also individual members of each team are most comfortable using. Recognize that while a common second language may exist (e.g., English or Swahili), not every individual may be at the same level of proficiency; adjust sessions and group discussions as needed to ensure conversations can happen in a common language that allows for maximum discussion and analysis.

4) Factor in time for individuals and then teams to process new knowledge gained and turn learning into action for post-meeting application. Build in team time so teams together can discuss what it is they are hearing from the other team and how it can apply to their work.

V. APPENDICES

Appendix A: High-level Agenda

TUESDAY JULY 14

Time	Session Topic
Morning	Welcome, introductions and briefing on the agenda
	Understanding the areas of focus for exchange, mapping key questions and topics to discuss
	Overview of the PHFS Global, PHFS Tanzania, PHFS Kenya
Afternoon	Stakeholder engagement discussion (large group)
	Site visit prep

WEDNESDAY JULY 15

Time	Session Topic
All Day	Travel to Sites

THURSDAY JULY 16

Time	Session Topic
Morning	Large group debrief (with small group processing) and review of site visits
	Care delivery discussion (two small group discussions, concurrent)
Afternoon	Discussion Group 1: Community involvement
	Discussion Group 2: Institutionalization and scale-up

FRIDAY JULY 17

Date/time	Session Topic
Morning	Learning and action planning (small group brainstorming in teams)
	Large group report back
	Conclusions and wrap-up

Appendix B: Kenya Mother-Baby Pair Register

Serial No.	Date of Enrolment	Unique Number	Name					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	COMMENTS
1.			Mother:	LNMP		Physical Address		WHO Stage																														
								Cd4 Count/Viral Load																														
								Ca Cervix Screening																														
								Family Planning																														
								Cotrimoxazole prophylaxis																														
				EDD																																		
						Mobile Number		ART Regimen																														
								HB																														
						Height		MUAC																														
								Weight																														
				HIV Status of Partner				BMI																														
								Vitamin A																														
								Nutritional Counseling/ Support Offered																														
						Blood Group		Tetanus Toxoid																														
								IPT																														
								Ferrous Sulphate/Folate																														
								Cotrimoxazole prohylaxis																														
								Date of next appointment (mother and baby)																														
			Infant:	Birth Weight				Immunizations																														
								Vitamin A suppliments																														
								Vitamin A suppliments																														
								Cotrimoxazole prohylaxis																														
								Prophylactic ART																														
				Mode of Delivery				Feeding Option																														
								Height																														
								Weight																														
								Muac																														
				Place of delivery		Hospital	Home	1st PCR																														
								HIV test at 9 months																														
				Date of Birth				HIV test at 18 months (confirmatory PCR if necessary)																														

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