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COLLABORATE.LEARN.ADAPT. CASE COMPETITION CASE STORY TEMPLATE



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CASE COMPETITION

Collaborating, learning, and adapting (CLA) have long been a part of USAID’s work. USAID staff and implementing partners have always sought ways to better understand the development process and USAID’s contribution to it, to collaborate in order to speed and deepen results, to share the successes and lessons of USAID’s initiatives, and to institute improvements to programs and operations. Through this case competition, USAID and its LEARN mechanism seek to capture and share the stories of those efforts.

The [CLA Case Competition](#) is open to all types of individuals and organizations working with USAID, from any country. Participants will have the opportunity to promote their work and contribute to good practice that advances our understanding of collaborating, learning, and adapting in action.

Before submitting your entry, please carefully read the Guidelines and Judging & Prizes information and Writing Tips for case stories available on USAID Learning Lab at usaidlearninglab.org/cla-case-competition.

Use the case story template below to help you develop your submission, following the guiding questions. Although some questions may not be applicable to your case, please try to respond as completely as possible. Also make sure you do not exceed the maximum word limit for each question, although you are free to write less. Save your story as a Word file.

To submit your case story, click on the ‘Submit Entry’ button, complete the Author Information section of the online form, and upload your story and any supporting materials in the spaces provided. Check the Release checkbox, complete the Captcha, and click the save button to submit your case story before the deadline of August 31, 2015 at 5pm EDT. For any questions, please contact submissions@usaidlearninglab.org.

Case Title *Health Workers at the Forefront of Improving Medical Male Circumcision (10 word limit)

What is the general context in which the story takes place? * (250 word limit)

Set the scene by providing some background details about the country and/or activity context. Was the CLA activity part of a larger project, mechanism or initiative? Who were some of the key stakeholders involved?

We describe the effort taken by health units to integrate continuous quality improvement (CQI) in voluntary medical male circumcision (VMMC, also known as safe male circumcision or SMC) in Uganda’s program. Thirty multilevel health units, both public and private not for profit, implementing SMC, received technical support from the USAID Applying Science to Strengthen and Improve Systems project (ASSIST) to simultaneously test changes to address gaps in their SMC service delivery. This was a pilot intervention to improve the quality of the male circumcision program in Uganda following an assessment that showed quality gaps in the program. The activity was implemented with support from USAID Uganda, the Ministry of Health (MOH), 10 implementing partners (IPs) (8 USAID and 2 DOD) and the corresponding district health office that the health units reported to. The CQI intervention had an important learning and adapting component: teams would test changes to improve



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SMC in their unit and share what they learned with other units at learning sessions that brought together representatives from all the units, together with project, MOH, district health office, and IP staff.

What was the main challenge/opportunity you were addressing with this CLA approach or activity? * (500 word limit)

What prompted your team/organization to undertake this activity or implement this approach? Was there a particular opportunity for new or improved collaboration, learning, and/or adapting? Or was there a problem or pain point you were trying to solve?

The World Health Organization (WHO) recommended VMMC as part of HIV prevention strategies in 2007. Uganda officially added it to comprehensive HIV prevention strategies in 2010 when it developed a policy to guide its implementation. In the policy, the MOH clearly indicated that quality of the program would be one of the pillars of the service. To further drive the quality agenda, minimum standards of procedure were issued by the MOH in 2011. However, along the way, there was loss of focus on the quality aspect as evidenced by the findings of an external quality assessment of the program that was conducted by an interagency PEPFAR team in late 2012. Generally the assessment found that there were no systematic efforts at the health unit level to integrate quality improvement in SMC service delivery, and health units whose level of service delivery was in severe contravention of the WHO guidance were requested to suspend the service until the identified gaps were addressed. However, the findings of this assessment did not go down well with some IPs and health facilities. They complained that the assessment tool that was used to conduct the assessment was not consistent with other existing guidelines and protocols of the MOH and required very high standards which could not be met by health units in Uganda. USAID ASSIST was requested to provide technical support to the MOH, 10 SMC IPs and health units to address the gaps. Although USAID ASSIST had expertise in providing CQI approaches to address health system gaps, we had never done this in the area of SMC. We embarked on the learning process with health units, IPs and the MOH to save Uganda's SMC program.

Describe the CLA approach or activity employed * (600 word limit)

What were the objectives or anticipated outcomes of the CLA initiative? What were the main strategies, tools, or methodologies used to carry out this approach or activity? Was it something new, or did you amend/improve an existing process or activity to promote stronger collaborating, learning, and/or adapting? Was it a one-off action, ongoing, or recurring over time? Who was involved?

Our main objective was to set up a site-level system that was health worker-led to continuously identify gaps in SMC service delivery and then develop local solutions to address these gaps. To begin, we convened several consultative meetings with the MOH, IPs and representatives of the health units to agree on the course of action. One of the very first challenges we had to address was the development of an assessment tool that was agreeable to all the parties without compromising on the quality standards stipulated by WHO. A team led by the MOH went through the process of adapting the PEPFAR assessment tool to align it to other existing MOH guidelines and protocols.

Owing to the fact that the 10 IPs had more than 150 sites which could not all be supported by USAID ASSIST, we requested each IP to identify three health units that would act as learning sites from which best practices would be spread to the rest of the SMC sites. The plan was that USAID ASSIST, the IP and district health office staff would jointly work together in the three sites and then the IP and district health office staff would spread the learning to the rest of their sites. Baseline assessments were conducted by a team consisting of a representative from the MOH, ASSIST, IP and the site team to establish the level of performance in the 30 sites. The assessment revealed that teams faced similar gaps, and the majority of sites were not familiar with use of the CQI approach. Four representatives from each site were invited to attend a three-day training focused on how to identify gaps, identify possible solutions, test these solutions to confirm if they addressed the gaps, and then implement the successful solutions.



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Teams were supported to form improvement teams that would spearhead the process of addressing the gaps. They received monthly onsite coaching from ASSIST, MOH and IP staff during which they would be supported to refine their changes, understand the effect of the changes in terms of addressing the gaps and more staff would be oriented on use of the CQI approach. Representatives from each of the 30 sites were invited to attend peer-to-peer learning sessions held every 3-5 months during which each team was given an opportunity to share their work. Good and poor performing teams would be identified and requested to share what had enabled them to perform well or what challenges they were facing. The teams performing well on specific indicators supported the poor performing teams to quickly spread learning. At the end of the second learning session, we compiled all the best practices that had emerged into one document [Changes tested to improve Quality of Safe male Circumcision Services in Uganda](#) which was shared with all 30 teams to further spread learning. We also organized site exchange visits in which we took participants from either a poor-performing site to a good-performing site or vice versa to support one another and experience what the other team was doing. This was done for a few selected teams that specifically had challenges. After one and a half years of providing onsite coaching and three learning sessions, we organized a harvest meeting in which we systematically put together changes that had yielded positive results at most of the sites into [A Guide to Improving the Quality of Safe Male Circumcision](#). The guide was written in a way that would make it easier for sites that were not part of the collaborative to understand what the 30 teams had done and adapt.

Were there any special considerations during implementation (e.g., necessary resources or enabling factors)? * (500 word limit)

Describe the critical success factors or particular implementation challenges. Did you need any special tools or skills? What type of resources (e.g., financial and/or non-financial) were required? Were there any conditions or factors (e.g., leadership buy-in) that contributed to or inhibited implementation?

The findings of the external assessment took everyone by surprise and complicated the start of the interventions. Notably, some stakeholders wanted to take quick action to respond basing on the fact that matters of quality cannot be delayed while others wanted to go into a lengthy planning phase to address the gaps. This called for compromises in both groups. Luckily, there was strong leadership from the MOH and USAID that greatly enabled us to come to a consensus where we had disagreements. We endeavored to ensure that we create a harmonious working relationship with all IPs. We conducted regular meetings in which we openly discussed any challenges and these further strengthened the working relationship. Not only did these meetings improve our relationship with the IPs, but they also improved the relationship between the IPs themselves. For example we had received complaints between some IPs regarding intrusion into each other's catchment areas and follow-up of clients with adverse events. The good relations between all the parties created a very good learning environment that enabled us to quickly turn around for better the quality of the program.

Creating an environment that promotes inter-health facility, inter-IP and inter-country learning was also critical for the success of the program. The site exchange visits, peer-to-peer learning sessions and stakeholder engagement promoted in-country learning. We developed several knowledge products that greatly promoted inter-country learning: [VMMC Continuous Quality Improvement \(CQI\) Resources](#) including case studies, blogs, webinars, technical reports, peer reviewed manuscripts, and quality improvement tools which we have shared with other USAID ASSIST countries and are open to members of the public. We also created a VMMC ASSIST online community of practice which is only open to USAID ASSIST staff in all countries in which we share updates, discuss challenges and progress.

What have been the outcomes, results, or impacts of the activity or approach to date? * (300 word limit)

Have you been able to qualitatively track or measure any outcomes, results, or impacts of the activity or approach thus far? What have you seen? Did you use any particular M&E methodology? If you do not yet have any noticeable outcomes or results, what are you doing to monitor the value provided by the approach or activity?

The approach has spread from 30 sites to now 165 sites in Uganda and has now been introduced by ASSIST in other countries through learning, collaborating and adapting to the local context. In Uganda, the work done in the first 30 sites led to the development of standardized national tools and indicators for monitoring the quality of services which have since been integrated into the national health information management system. We have



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shared our experience with other countries and to date South Africa, Malawi and Tanzania have started similar programs to integrate CQI in their VMMC programs. Based on the work done in Uganda, PEPFAR VMMC technical working group has recommended that all VMMC programs integrate CQI in their programs.

We have developed tools such as a performance dashboard which has been adapted by all SMC sites in Uganda and other ASSIST-supported countries as a tool for monitoring the quality of male circumcision. We also have developed an onsite coaching guide to support coaches to provide onsite support. All these tools started as pilot tools in the 30 sites but have now been taken on by all SMC sites in Uganda and adapted by other countries.

What were the most important lessons learned? * (300 word limit)

How will your organization use this experience moving forward? If others wanted to implement a similar approach or activity, is there anything they should consider? What worked or did not work?

One of the best lessons we have learned is consulting widely and involvement of key stakeholders during planning and implementation. In the process of learning and adapting, one should be open to as many ideas as possible as this promotes the buy-in of key stakeholders, making implementation smooth. We have also learned in activities that have multiple stakeholders, it is important to have clear roles and responsibilities for each stakeholder and to have a clear understanding of the objectives of the activity. Clear objectives serve as the binding factor when disagreements tend to emerge and keep everyone focused.

At the start of the intervention as USAID ASSIST, we only knew how to apply the CQI approach but we did not know the actual changes needed to improve care. We have learned that when frontline service providers are given proper guidance, they know the interventions that can best improve the services they offer. It is important not to impose on them external interventions but rather create an environment conducive for learning, exploring and innovating. We have also learned that it is important to help health workers understand what we are trying to achieve and not just focus on how to get the result. This is important for sustainability of good practices. We are currently focusing our efforts on spreading learning to as many sites in Uganda and passing on coaching skills to public officials and district ownership. In doing this we are using health workers from the pilot sites to share experiences focusing on what did and did not work for them.

Any other critical information you'd like to share? (250 word limit)

Use this optional space to provide any additional information not already included.

Through this activity we are also trying to learn about the cost-effectiveness of different methods of spreading learning from the SMC improvement activities. We are currently tracking the effects on SMC service quality of transferring learning through written products (i.e., distribution to new sites of A Guide to Improving the Quality of Safe Male Circumcision), a two-day face-to-face knowledge handover meeting that brought together representatives from new sites and from demonstrate sites to discuss the content of the guide, and following up with on-site coaching visits. We expect the results to be available at the end of 2015.