Knowledge Management Needs Assessment of East, Central, and Southern Africa Health Community (ECSA-HC) Member States

October 2016
# Contents

Acknowledgments .................................................................................................................................................. iii

Acronyms ............................................................................................................................................................. iv

Executive Summary ............................................................................................................................................... v

Introduction .......................................................................................................................................................... 1

  Background ....................................................................................................................................................... 1
  Methods ............................................................................................................................................................. 2
  Participants ....................................................................................................................................................... 2

Findings .................................................................................................................................................................. 2

  Participant Background ................................................................................................................................... 2
  Knowledge Management at ECSA-HC ............................................................................................................... 4
  Partnerships and Professional Networks ......................................................................................................... 7
  Communication .................................................................................................................................................. 9

Information Technology ..................................................................................................................................... 11

ECSA-HC’s Role and Contributions ...................................................................................................................... 12

Health Ministers’ Resolutions ............................................................................................................................. 17

Vision for Knowledge Management at ECSA-HC .............................................................................................. 19

Recommendations and Conclusions ................................................................................................................... 20
Acknowledgments

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The K4Health Project is supported by USAID and led by Johns Hopkins Center for Communication Programs (CCP) in conjunction with FHI 360, IntraHealth International, and Management Sciences for Health.

The three-year project (April 2013 to October 2016) is supported by the U.S. Agency for International Development (USAID) and is a partnership between three organizations: USAID’s Kenya and East Africa mission; the East, Central, and Southern Africa Health Community (ECSA-HC); and the East Africa Community.
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>CCP</td>
<td>Johns Hopkins Center for Communication Programs</td>
</tr>
<tr>
<td>DHIS</td>
<td>district health information system</td>
</tr>
<tr>
<td>ECSA-HC</td>
<td>East, Central, and Southern Africa Health Community</td>
</tr>
<tr>
<td>HMIS</td>
<td>health management information system</td>
</tr>
<tr>
<td>IT</td>
<td>information technology</td>
</tr>
<tr>
<td>K4Health</td>
<td>Knowledge for Health project</td>
</tr>
<tr>
<td>KM</td>
<td>knowledge management</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>monitoring and evaluation</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>U.S. President's Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>USAID</td>
<td>U.S. Agency for International Development</td>
</tr>
</tbody>
</table>
Executive Summary

Introduction
The K4Health East Africa Field Project works to improve the exchange of information, experiences, tools, research, and knowledge concerning health service delivery among governments and stakeholders in East and Central Africa.

The K4Health Project, in collaboration with the ECSA-HC Secretariat, conducted a knowledge management baseline assessment of ECSA-HC in August 2015. Findings from the assessment emphasized the need to further develop the culture of knowledge management among the ECSA-HC member states. A needs assessment was therefore conducted in June 2016 to (1) understand the knowledge management capacity and level of effectiveness and efficiency when sharing health knowledge and (2) identify health information needs among ECSA-EC member states. This report summarizes the findings from the needs assessment.

Methods
The needs assessment used key informant interviews as its sole method. Each key informant interview took approximately 45 minutes to conduct and was audio recorded for note-taking purposes. A team, consisting of two ECSA-HC members and one staff person from the Johns Hopkins Center for Communication Programs (CCP), facilitated data collection in six member states between June 12 and June 26, 2016. The assessment covered various topics including understanding and use of knowledge management, knowledge sharing, and access to and use of information. The qualitative data was transcribed and analyzed by the K4Health research team and the data collection team. The findings were analyzed using a combination of manual coding and coding in a qualitative software program (Atlas.ti) to identify main themes and subthemes. A non-research determination was received from the Johns Hopkins University Institutional Review Board.

Participants
Participants were from six ECSA-HC member states: Lesotho, Malawi, Mauritius, Swaziland, Tanzania, and Zambia. The selection of these countries was done in consultation with the Director General of ECSA-HC. All participants were over 18 years of age. To recruit participants, the research team used convenience sampling and worked with a contact person for each member state. A total of 68 people participated in the interviews: Lesotho (n=10), Malawi (n=11), Mauritius (n=11), Swaziland (n=12), Tanzania (n=12), and Zambia (n=10).
Findings

Participant background
Participants largely represented two positions: directors (31%) and program managers (32%). The most common job responsibilities included coordination, oversight, development, and implementation. The majority of the participants held a master’s degree or higher (e.g., doctorate or medical degree).

Knowledge management at ECSA-HC
When asked what KM means to them, many participants provided general descriptions mentioning the linkages between data, information, and knowledge. Those common definitions typically covered the following KM processes: generating, acquiring, organizing, sharing, and disseminating. The majority of participants had never received any formal training in knowledge management; however, some noted that they had attended courses, trainings, and/or workshops that included KM components. Many participants recognized the positive contributions that KM can make to the goal of improving health outcomes in the region and noted that KM responsibilities were an integral part of their scope of work, although such roles and responsibilities were not directly specified in their job descriptions. Participants defined KM champions largely in one of two ways: (1) people who practice and promote KM principles or (2) people who are experts and have extensive knowledge in a particular health subject or profession.

Partnerships and professional networks
The World Health Organization, United Nations agencies, USAID, U.S. Centers for Disease Control and Prevention, ICAP, Institute of Health Management, and the Southern African Development Community were mentioned multiple times as existing or global KM partners that would be strategic for ECSA-HC’s knowledge management efforts.

Communication between ECSA-HC and member states
The majority of participants indicated that they had not communicated with ECSA-HC member states in the last six months. The majority of participants felt that they have access to the information they need to do their job. Many participants mentioned that they use the internet to access the information they need. Several mentioned that with the use of internet and email, the ability to access information has improved over the last several years. The majority of participants indicated that they regularly meet in person to share, disseminate, and promote success stories, lessons learned, or best practices.

Information technology
Participants were asked how their organizations use IT to manage and maintain knowledge information, data, and facilitate the sharing and exchange of knowledge. More than half reported using (or attempting to use) online databases or data management programs/software, such as DHIS 2 (district health information system), SmartCare, and HMIS (health management information systems).

ECSA-HC’s role in the region
Recognition of ECSA-HC among the various member states was divided between participants who were aware of ECSA-HC and their work, participants who had heard of ECSA-HC but were not able to
elaborate on their work, and participants who had never heard of ECSA-HC. When asked how ECSA-HC contributed to the goal of improving health outcomes in the region, several participants noted that ECSA-HC contributes by bringing together the different member states to learn from one another. Many participants mentioned the Health Ministers’ Conference and the Best Practices Forum as examples, and suggested that ECSA-HC should help member states increase interaction and communication among themselves and also with ECSA-HC by effectively coordinating and being a “KM champion” for the region. The majority of participants had not received technical guidance or support from ECSA-HC or other ECSA-HC member states within the last six months. Similarly, the majority of the respondents had never requested information or technical guidance from ECSA-HC. Although many of the participants had heard of ECSA-HC’s knowledge management initiatives (except in Mauritius where almost all participants were unaware of such initiatives), about half of them said they did not truly understand the benefits yet and thought that eventually it would be understood by the staff of the ECSA-HC member states.

**Health ministry resolutions**

Overall, the majority of participants were aware of the Health Ministers’ Conference and the passing of resolutions. However, a substantial proportion of participants had not heard of the resolutions. The majority of participants were not aware as to whether the resolutions were being implemented in their country and how.

**Vision for knowledge management at ECSA-HC**

Many of the respondents mentioned that they would like to see ECSA-HC provide general KM technical assistance or capacity-strengthening services to the member states in the next two years. The focus of these services differed from country to country but included KM awareness and sensitization, organizational structure, human resources, and KM tools.

**Recommendations and Conclusions**

This KM assessment resulted in a number of key findings and recommendations that the ECSA-HC Secretariat may consider useful in order to increase the effective use of KM approaches among its member states.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Key findings</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visibility</td>
<td>The Best Practices Forum and Health Ministers’ Conference are frequently mentioned as major KM events.</td>
<td>Continue using these events as a priority avenue to increase the visibility of ECSA-HC, demonstrate its relevance to the region, and make known what it currently does and what technical assistance it can offer to member states. Consider offering special technical/consultative sessions focusing on these matters during the events.</td>
</tr>
<tr>
<td>KM capacity strengthening</td>
<td>Formal KM training is not offered to member states and KM understanding</td>
<td>ECSA-HC Secretariat is best positioned to provide technical assistance to member states</td>
</tr>
<tr>
<td>Themes</td>
<td>Key findings</td>
<td>Recommendation</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Health information sharing</td>
<td>There is a clear interest among member states in receiving updated health information from the ECSA-HC Secretariat and to strengthen communication and exchange of information with member states and between ECSA-EC member states.</td>
<td>Prioritize the health areas and routinely provide updated health information to member states. Consider updating the ECSA-HC website with current information and resources and availability of relevant information that member states can easily access.</td>
</tr>
<tr>
<td>Health Ministers’ Conference resolutions</td>
<td>Implementation of Health Ministers’ Conference resolutions is not consistent and member states need more guidance.</td>
<td>There is a need to communicate and follow up with member states on the Health Ministers’ Conference resolutions so they can be incorporated into the respective member states’ annual work plans for implementation. Consider including monitoring of the implementation of the Health Ministers’ Conference resolutions.</td>
</tr>
<tr>
<td>Focal person</td>
<td>There is a need to appoint ECSA-HC focal persons in member states to communicate effectively about ECSA-HC and the expertise it can offer to member states.</td>
<td>The focal persons for ECSA-HC in member states should preferably be at the managerial level and can effectively communicate and create awareness about ECSA-HC’s work in the member states. Consider conducting knowledge mapping exercise and reviewing technical and managerial expertise to identify appropriate focus persons.</td>
</tr>
</tbody>
</table>
Introduction

Background

The K4Health East Africa Field Project is implemented in partnership with three organizations: USAID’s East Africa Mission; the East, Central and Southern Africa Health Community; and the East Africa Community over a three-year period between April 2013 and October 2016. The K4Health Project is led by Johns Hopkins Center for Communication Programs (CCP) in conjunction with FHI 360, IntraHealth International, and Management Sciences for Health. The goal of the project is to improve the exchange of information, experiences, tools, research, and knowledge concerning health service delivery among governments and stakeholders in East and Central Africa. Specifically, USAID’s East Africa Mission is engaging CCP’s K4Health project to strengthen knowledge management capacity among its partners to: (1) improve collaboration, sharing, and learning; (2) scale up high-impact practices; (3) reduce duplication of effort; and (4) improve the quality of health systems across countries in the region.

K4Health, in collaboration with the ECSA-HC Secretariat, conducted a knowledge management baseline assessment in August 2015. Findings from the assessment emphasized the need to further develop the culture of knowledge management among the ECSA-HC member states. A needs assessment was therefore conducted in June 2016 to (1) understand the knowledge management capacity and level of effectiveness and efficiency when sharing health knowledge and (2) identify health information needs among ECSA-EC member states.

ECSA-HC is a regional intergovernmental health organization that fosters and promotes regional cooperation in health among member states. Member states of the ECSA-HC include Kenya, Lesotho, Malawi, Mauritius, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. ECSA-HC was established in 1974 to foster and strengthen regional cooperation and capacity to address the health needs of the member states.

Through partnerships with diverse institutions, ECSA-HC’s activities also spread to other countries in Africa to address common health challenges facing the region. ECSA-HC works within countries to promote efficiency and effectiveness of health services through cooperation, collaboration, research, capacity strengthening, policy development, and advocacy. The ECSA-HC Secretariat supports countries in four program clusters: (1) family health and infectious diseases; (2) KM and M&E; (3) health systems services development and capacity development and noncommunicable diseases; and (4) food security and nutrition. The KM and M&E cluster is responsible for information sharing, updating ECSA-HC’s website content, and capacity development of member states in knowledge management.

Based on ECSA-HC’s overarching mandate, the organization seeks to be a leader in health in the region. Being the only intergovernmental organization in the region that focuses on health, ECSA-HC is well positioned to be the knowledge hub for the region and has embraced KM as one of the key strategies to achieve its organizational objectives.
Methods

The needs assessment relied solely on key informant interviews. Each key informant interview took approximately 45 minutes to conduct and was audio recorded for note-taking purposes. A team, consisting of two ECSA-HC members and one CCP staff person, facilitated data collection in six member states between June 12 and June 26, 2016. The assessment covered various topics including understanding and use of KM, knowledge sharing, and access to and use of information.

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Findings

Participant Background

This section describes participants' demographic characteristics including job type and education level.

Participants largely represented two types of jobs: directors and program managers. About one-third of participants reported having a job title of program manager (32%; n=22) while almost another third of participants were directors (31%; n=21). The remaining job categories consisted of researcher/evaluator (10%; n=7), technical advisor (7%; n=5), service provider/clinician (6%; n=5), administrative staff (4%; n=3), and policy maker (3%; n=2). Of the total 68 participants, 4 did not respond as to their job type (6%).
Table 1: Participant Job Type by Country

<table>
<thead>
<tr>
<th></th>
<th>Tanzania</th>
<th>Lesotho</th>
<th>Malawi</th>
<th>Mauritius</th>
<th>Swaziland</th>
<th>Zambia</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Manager</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Director</td>
<td>8</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Researcher/Evaluator</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Technical Advisor</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Service Provider/</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Clinician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Maker</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Administrative Staff</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12</td>
<td>10</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>10</td>
<td>68</td>
</tr>
</tbody>
</table>

Given that the majority of participants were program managers or directors, the most common job responsibilities included coordination, oversight, development, and implementation. Other common responsibilities included research, monitoring and evaluation, communication, and planning. In terms of the area of work, participants indicated that they worked on a variety of health issues such as HIV/AIDS, infectious disease, noncommunicable disease, and reproductive health. Of the 68 participants, 45 noted their level of education in the interview, with the majority having a master’s degree (43%; n=29). Table 2 shows the participants’ level of education by country.

Table 2: Participant Education Level by Country

<table>
<thead>
<tr>
<th></th>
<th>Tanzania</th>
<th>Lesotho</th>
<th>Malawi</th>
<th>Mauritius</th>
<th>Swaziland</th>
<th>Zambia</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor’s</td>
<td>0</td>
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<td>0</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Master’s</td>
<td>6</td>
<td>1</td>
<td>9</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>29</td>
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<tr>
<td>PhD</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
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<tr>
<td>MD</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Master’s and MD</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>8</td>
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<td>23</td>
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<tr>
<td><strong>Total</strong></td>
<td>12</td>
<td>10</td>
<td>11</td>
<td>11</td>
<td>12</td>
<td>10</td>
<td>68</td>
</tr>
</tbody>
</table>
Knowledge Management at ECSA-HC

This section covers how participants defined what KM meant to them, KM trainings, their explanations of how KM can contribute to their work, and KM responsibilities among staff. Participants also shared their vision for KM and what support or resources would be needed to nurture a culture of KM at ECSA-HC and among member states.

Defining Knowledge Management

When asked what KM means to them, many participants provided general descriptions mentioning the linkage between data, information, and knowledge. Those common definitions typically covered the following KM processes: generating, acquiring, organizing, sharing, and disseminating. For example, one participant remarked:

*Knowledge management is a process of gathering information or data if you like and being able to package that data and share that data or information with different audiences.*

—Participant from Zambia

Some of the participants (notably, those from Tanzania) described knowledge management on a personal level, noting the importance of having knowledge relevant to day-to-day work. Other participants (notably, those from Lesotho) viewed KM as an important internal function contributing to skill development and capacity strengthening at the organizational level, as illustrated in this quote:

*Knowledge management will have to do with whether people have enough capacity to execute their jobs they are doing at work. Capacity in terms of training, in terms of executing whatever duties they are assigned to do.*

—Participant from Lesotho

Furthermore, some participants (notably, those from Malawi) appeared to be more audience-focused and emphasized the purpose of knowledge management as it relates to decision-making, policy, service delivery, and program interventions:

*Knowledge management is utilization of whatever evidence that might arise…and translating it into actionable points for the better service delivery of health services within the country.*

—Participant from Malawi

Participants also recognized the role that knowledge management can play in making research findings accessible. They mentioned that KM can enhance the production and dissemination of best practices, and evidence-based or scientific knowledge in a variety of health areas including HIV/AIDS, reproductive health, infectious diseases, and noncommunicable diseases. For example, one participant exclaimed:

*Especially dealing with HIV, there is always new information, there is new guidelines that are being developed so it’s a question of being able to harness that information and then contextualize it and be able to disseminate that information to all the players that take part in a particular field.*

—Participant from Zambia
Knowledge Management Trainings

The majority of participants had never received any formal knowledge management training; however, some noted that they had attended courses, trainings, and workshops that included KM components. Of those who had received KM training, the majority were from Zambia. Organizations reported to offer such KM trainings included Dignitas International, CCP, and the University of Malawi. When participants were asked if they would like to receive training in knowledge management, almost all responded affirmatively. A few participants commented that they would also like KM trainings to be available for junior staff, senior management, and decision makers. One participant remarked:

Not only for myself. My directors and program managers [too] because I think capacity for that knowledge management has to be spread all over so that we don’t rely on one department.

—Participant from Lesotho

Some participants mentioned specific KM needs that they would like training on, including packaging material for different audiences, the translation of knowledge or data to policy and action, and to generally understand benefits of applying KM in the health sector. One participant explained:

The weakness I think we have is data translation or interpretation of data to policy, to materials that policy makers can use . . . How are we actually interpreting data to make sense for policy makers getting that information and use it for action rather than telling the policy makers prevalence was 17% and we put full stop there? That doesn’t make any sense to the policy makers.

—Participant from Tanzania

Knowledge Management Contributions

Participants noted that KM can help them share current policies and programmatic experiences from different countries and learn from each other, as they shared similar health challenges (e.g., HIV/AIDS, tuberculosis, malaria, etc.). However, the magnitude of those problems, prevalence, and the level of achievements made toward reducing morbidity or mortality may greatly differ. Several participants pointed out that KM can also support countries to monitor and reach national and global targets such as the United Nations Sustainable Development Goals. For example, one participant noted:

It is critical for us to have really strong knowledge management because it will get us examples and best practices which other people have gone through so that we can duplicate and get the same results in our setting.

—Participant from Tanzania

In terms of describing the role of KM for fulfilling job responsibilities, many participants noted the contributions of KM in the area of coordination, planning, monitoring, and evaluation, and emphasized the importance of having access to timely, accurate, and evidence-based information as shown in the following quote:
Knowledge management is very crucial because if you have evidence-based information, you will be in a better position to make good decisions for effective implementation of activities.

—Participant from Malawi

Knowledge Management Use

Most participants noted that KM responsibilities were an integral part of their scope of work although such roles and responsibilities were not directly specified in their job descriptions. Many participants felt that their program management tasks were closely linked to knowledge management, and elaborated upon their coordination, communication, training, research, monitoring, and evaluation roles as examples of using KM. For example, one participant stated:

I have to coordinate the program, everyone who is under the program understand what they are doing and also feedback to them on the overall running of the program. My primary assignment is to make sure that the project is timely implemented so that we are meeting the set targets according to those who fund us and according to our own strategic plan. I am also responsible for the capacity building of districts which we fulfill through supervision; we get to understand what is wrong and what is not wrong, where are the gaps? And based on that, we usually come back and plan interventions that are going to address those identified gaps during supervision.

—Participant from Lesotho

Another respondent noted:

It’s my responsibility to reach out to knowledge or information as it is becoming available. And then in collaboration with colleagues, we look at the country context and are able to translate or adapt that knowledge to the country context and then be in a position to put it in a package that we can use for training, a package that can be used as guidance to the implementers on the ground.

—Participant from Zambia

Some of the participants mentioned strategic planning and policy formulation as their KM-related roles and emphasized the importance of transferring knowledge, such as health guidance, to the various levels of health systems including the community level, as shown through this quote:

We have a very big responsibility on knowledge management. I will take the example of the standard guideline. It’s something which has to be used by the health care provider or sometimes some other people on the low level. So by managing, I have to make sure that—even not only myself at the office level... that knowledge is trickling down to the low level or to the health care provider level where they are solely responsible for provision of health services to other people.

—Participant from Tanzania

Knowledge Management Champions

Participants largely defined KM champions in one of two ways: people who practice and promote KM principles or people who are experts and have extensive knowledge in a particular health subject or profession. Many participants also noted that a KM champion needs to be a good leader, listener,
communicator, and advocate who supports knowledge sharing and dissemination. For example, one participant noted:

A knowledge management champion is the one who largely advocates the information or research results and should be utilized for development of policies and interventions . . . (in my agency), we have a research sector and the head of the research is likely the champion.

—Participant from Malawi

Another participant noted:

A champion . . . I would look for someone who is influential and someone who is at a level of making decisions and someone who is well informed of the goals of the ministry. Someone who understand knowledge management which is the basic part. Someone who understands that there are all levels from data collection to decision-making.

—Participant from Swaziland

When asked whether there was a knowledge management champion in each respective country or organization, several participants referred to themselves. A few participants also thought that everyone should be a KM champion. Finally, a few participants stated there were no current KM champions as shown through the following quote:

No, I don’t see [KM champions], because not that they are not there or people are not capable, I think people are just too busy multitasking, too much due to the issues of not enough human resources. But if, say, there were someone who just do knowledge management, I think that would work.

—Participant from Swaziland

Partnerships and Professional Networks

When asked if they knew of existing regional or global KM partners that would be strategic for ECSA-HC’s knowledge management efforts, more than half of the participants provided examples (Table 3). World Health Organization, United Nations agencies, USAID, U.S. Centers for Disease Control and Prevention, ICAP, Institute of Health Management, and Southern African Development Community were mentioned multiple times. A few participants also commented it might be helpful to partner with universities, PEPFAR partners, and other ministries. One participant noted:

I would say we need to—ECSA needs to sensitize itself in the country, working with the people already in the position. And again for other ministries, I would suggest we involve even the education because it’s where we capture—they have our young ones who need the information and also probably to impart the health issues in the country.

—Participant from Swaziland
Table 3: Organizations Mentioned as Potential KM Partners for ECSA-HC

<table>
<thead>
<tr>
<th>African Institute for Development Policy</th>
<th>Jhpiego</th>
</tr>
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<tbody>
<tr>
<td>African Union</td>
<td>K4Health</td>
</tr>
<tr>
<td>Central Statistics Office (Swaziland)</td>
<td>National AIDS Council, Swaziland</td>
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<tr>
<td>Communication for Health Support</td>
<td>Professional Development Management (South Africa)</td>
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<tr>
<td>DHIS Network</td>
<td>Southern African Development Community</td>
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<tr>
<td>Dignitas International</td>
<td>Special Programme for Tropical Disease Research (Global Health Network, South Africa regional office)</td>
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<tr>
<td>Global Plan for Elimination of Mother-to-Child Transmission</td>
<td>U.K. Department of International Development</td>
</tr>
<tr>
<td>Health Communication Capacity Collaborative</td>
<td>United Nations agencies (UNFPA, UNICEF, etc.)</td>
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<tr>
<td>ICAP</td>
<td>University Research Co., LLC</td>
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<tr>
<td>Institute for Health Economics</td>
<td>U.S. Agency for International Development</td>
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<tr>
<td>Institute of Health Management</td>
<td>U.S. Centers for Disease Control and Prevention</td>
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<tr>
<td>International Federation of Health Information Management</td>
<td>UONGOZI Institute</td>
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<tr>
<td>International Organization for Immigration</td>
<td>World Health Organization</td>
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<tr>
<td>Johns Hopkins Bloomberg School of Public Health</td>
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</tbody>
</table>

The majority of participants indicated that they are part of or have previously participated in global professional networks. Participation in a global professional network varied widely by country (Table 4). For example, all participants from Lesotho and over 80% of the participants in Malawi and Zambia responded that they were part of a network, compared with only a few participants from Mauritius.

Table 3: Participation in Global Professional Networks

<table>
<thead>
<tr>
<th>Country</th>
<th>Total number of participants asked about participation in a global professional network</th>
<th>Total number of participants who responded affirmatively</th>
<th>Percentage of participants (by country) who have participated in a global professional network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesotho</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Malawi</td>
<td>11</td>
<td>9</td>
<td>82%</td>
</tr>
<tr>
<td>Mauritius</td>
<td>12</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>Swaziland</td>
<td>9</td>
<td>7</td>
<td>78%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>12</td>
<td>8</td>
<td>67%</td>
</tr>
<tr>
<td>Zambia</td>
<td>10</td>
<td>8</td>
<td>80%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>58</td>
<td>38</td>
<td>66%</td>
</tr>
</tbody>
</table>
Most participants provided examples of global professional networks, but some also provided examples of regional networks, including Building Children’s Nursing for Africa, African Cancer Network, and Asian Bioethics Association. Participants also mentioned local university networks and national networks, including the Tanzania Dental Association and Tanzania Public Health Association. Some participants provided examples of networks featuring online platforms or a social media component. Online platforms included the Disaster Management and Mitigation Unit (hosted through a United Nations platform), Devex, Global South-South Learning Forum, and Springboard for Health Communication Professionals.

Communication

This section covers how staff communicate internally and externally, including how information is accessed, shared, and communicated between ECSA-HC and the member states.

Communication Between ECSA-HC and Member States

The majority of participants indicated that they had not communicated with ECSA-HC member states in the last six months. Of the few participants who had communicated with member states recently, the communication was most often related to meetings or other initiatives/projects. Only two participants, both from Tanzania, remarked that communication with other member states was very frequent.

Similarly, the majority of participants had not communicated with the ECSA-HC Secretariat in the last six months. A few participants said they had communicated with the Secretariat, but most communication was in regard to singular events, such as a meeting or summit.

Given that most participants had not been in recent communication with ECSA-HC or other member states, only a few provided insights about the flow of communication across programs and projects between ECSA-HC and member states. One participant from Zambia commented that the flow of information is much less than the period between 2000 and 2009, partially because of programs scaling back due to financial challenges.

A few participants also noted that while their personal communication with ECSA-HC or member states might not be frequent, there may be coordinators within the ministry who are responsible for communicating with regional bodies and initiatives.

Most participants thought that email was the most common, useful, and effective form of communication for ECSA-HC and more generally.

For email, it’s timely and accurate. For letters, you might miss a letter two or three weeks before the events . . . Because for last month, I missed one of the meetings which was very important in Arusha because I got the letter late.

—Participant from Tanzania
Some participants also mentioned that phone, face-to-face meetings, formal letters, and communication via WhatsApp were common. A handful of participants noted that face-to-face meetings were most useful. Some also suggested video-conferencing, social media platforms, and chat sessions as most useful.

**Accessing Information**

The majority of participants felt they had access to the information they needed to do their job. Many participants used the internet to access the information they need. Several mentioned that with the use of internet and email, the ability to access information has improved over the last several years. Several participants used websites to access and store information related to their work. Several participants referred to their ministry websites as places where they access information, but noted that the websites may not be regularly updated or information is hard to find. A few participants mentioned visiting the ECSA-HC website to access information relevant to their work including information regarding the Health Ministers’ Conference resolutions and tuberculosis (TB) documents.

A few participants mentioned internal databases to store information at their ministerial level. They noted, however, that this information is often not available to the public and is available only at varying levels to staff depending on their level of access. A few participants noted that they use HMIS, HMIS 2, and DHIS 2 to access and store information as well. Several participants discussed using private databases to store patient-related information.

Several participants mentioned that each department is in charge of collecting and storing their own data. This often posed challenges and delays given that officers were not able to access information from the other districts without requesting the information directly from the department.

A few participants mentioned difficulty in accessing information and data from other member countries. Staff turnover was also mentioned as a barrier to accessing information. For example, one participant stated:

> We haven't heard anything from ECSA-HC because our head of the department changed, she retired. She was the one connecting us with ECSA-HC. She retired and then I think there was lost communication.

—Participant from Lesotho

**Sharing Information**

The majority of participants said they regularly meet in person to share, disseminate, and promote success stories, lessons learned, or best practices. For example, several participants from Tanzania mentioned the annual stakeholder’s meeting, and many participants from Lesotho mentioned the joint annual reviews. These annual meetings were typically held at the national or headquarters level, and included senior management, key stakeholders, partners, and technical experts. At the regional and district levels, participants seemed to meet more frequently (e.g., monthly or quarterly) with local leaders and counselors to review monitoring data and evaluate program progress. Several participants, mostly from Mauritius, mentioned in-person workshops on specific focus areas—nursing, TB, malaria, and HIV/AIDS—as a common venue for information sharing. Participants from various countries also felt
that regional and international conferences provide a good opportunity to share best practices and learn from each other.

For disseminating program information, many participants indicated that their organizations or ministry offices had a website that was open to the general public. Several participants expressed their preference for using internet and electronic technologies (e.g., email, social media, video sharing). However, some mentioned constant connectivity problems. For example, one participant said:

> Internet is a challenge [because] the connection is poor . . . if there was a reliable source of internet, that would help a lot.

—Participant from Malawi

In addition to in-person and electronic information sharing, some participants regularly compiled written reports (e.g., annual reports, data briefs) and disseminated hard copies as needed.

**Information Technology**

This section covers participants’ use of different software and programs for knowledge management, organizational website status, and challenges related to information technology.

Participants were asked how their organizations use IT to manage and maintain knowledge information, data, and facilitate the sharing and exchange of knowledge. More than half reported using (or attempting to use) online databases or data management programs/software, such as DHIS 2 (district health information system), SmartCare, and HMIS (health management information system). Five participants, three of whom were from Mauritius, said that eHealth systems were being implemented or piloted within their respective countries’ ministry.

While describing IT as it relates to communication channels, some participants mentioned the potential of platforms such as WhatsApp to create professional networks and to provide technical assistance. For example, one participant provided an example of how databases and mobile technology can add to surveillance improvement:

> Rapid reporting to improve surveillance—this is where we have empowered our health facilities, particularly in areas where we are earmarking for malaria elimination. We want to make sure that we treat every case of malaria. We have empowered communities with mobile phones and the CHWs [community health workers] are able to use the phones to send info on stocks of malaria medicines.

—Participant from Zambia

Many participants’ organizations had websites, but there were reported challenges with maintaining updated information, uploading information due to “red tape” ministerial protocols, and non-functional websites. Participants also mentioned other IT challenges, including intermittent internet connectivity, ineffective database management capabilities, and an inability to retrieve updated information. A few participants said they required substantial IT support or equipment.
Many participants needed various types of IT-related support. They were typically concerned about lack of access to computers, new software, and reliable internet connection. They also wanted support for secure IT equipment to facilitate an electronic document repository and to share and disseminate information in the region. A few of them elaborated further on the need for creating a central repository or platform. For example:

IT would be very critical . . . if we could have a dedicated platform where we can keep all the documents that we have produced as a unit, and of course as a department, . . . that would go a long way in improving the way we share information from our side.

—Participant from Malawi

Some participants also recognized the potential of IT to enhance personal connection and specifically indicated that they would like to receive support to establish teleconference facilities.

**ECSA-HC’s Role and Contributions**

This section discusses how participants viewed the role of ECSA-HC in East, Central and Southern Africa and how it has influenced health outcomes in the region.

**ECSA-HC’s Role**

Recognition of ECSA-HC among the various member states was divided—some participants were aware of ECSA-HC and their work, some had heard of ECSA-HC but were not able to elaborate on their work, and some had never heard of ECSA-HC.

Among the participants who knew very little about ECSA-HC, the exposure they had was from participating in a meeting or training or from reading a report in which ECSA-HC was mentioned. For the participants who had never heard of ECSA-HC, they were unable to attest to how ECSA-HC had contributed to health outcomes in the region. For these individuals, the interview was their first exposure to ECSA-HC and ECSA-HC’s work. For example, one participant stated:

Two years I have been at my job. I still don’t know your [ECSA-HC’s] work. It’s an area that needs to improve.

—Participant from Lesotho

One participant assumed they were not the only ones who were unaware of ECSA-HC’s work:

I am not the only one not knowing about ECSA-HC, yet this is such a big body which is supposed to actually be giving us direction on a regular basis.

—Participant from Swaziland
ECSA-HC’s Contribution to Health Outcomes

When asked how ECSA-HC contributed to the goal of improving health outcomes in the region, several participants noted that ECSA-HC contributes by bringing together the different member states to learn from one another. Many participants mentioned the Health Ministers’ Conference and the Best Practices Forum as examples. Participants noted that they learn at the forum and it is a place where information is shared across countries. For example, one participant said:

*I think they contribute a lot by having these professional meetings or conferences where people are invited. These professional give their experience in their country, what they are doing, and what are good practices and what are not. I think in that way I can say they contribute a lot.*

—Participant from Tanzania

Another participant noted:

*I have attended, I think, two ECSA Health Minister Meetings. I think the bringing together of different countries to share the knowledge is appropriate; sometimes there is something Malawi is doing good or maybe Zambia is doing good. You might learn from each other so I find it a bit helpful.*

—Participant from Malawi

Another participant called ECSA-HC a communication champion, stating:

*ECSA Secretariat is doing a very good job because, for instance, in terms of communications, they are very champions on communications. They link between countries. They make sure that people within these countries, they meet during meetings, they are open to talk, they are open to contribute and I think it also contributes toward ECSA’s development as well.*

—Participant from Tanzania

A few participants noted that ECSA-HC is an overall good initiative and contributes to improved health in the region through the support that it provides to member countries. A few participants noted that ECSA-HC has contributed to health outcomes through various trainings, curriculum development, the sharing of information and ECSA-HC’s wealth of knowledge. For example, one participant noted:

*ECSA provides training to enhance skills of program officers so that they are able to use those skills to actually plan well or plan better to evaluate and monitor and evaluate in a better way.*

—Participant from Zambia

Several participants also named specific health programs that ECSA-HC works on including family planning, neglected tropical diseases, sexual and reproductive health, TB, and HIV/AIDS. For example, one participant noted:

*ECSA is contributing very much in many sectors. HIV, mother-to-child [transmission], maternal well-being of people, and also wellness of health care centers.*

—Participant from Mauritius
One participant partially dedicated their success in certain health indicators to ECSA-HC’s support:

> Actually our indicators of family planning, ANC [antenatal care], delivery in facility, PMTCT [prevention of mother-to-child transmission of HIV] coverage of course has increased in this country and this is because of the assistance partly from ECSA and other organizations.

—Participant from Lesotho

A few also noted ECSA-HC’s contribution in the development of guidelines, protocols, and strategies. Some participants elaborated to say ECSA-HC contributes by bringing countries together and helping member states advocate for policies. One participant noted:

> ECSA helps us with the information that we need to help us advocate or lobby for some of the things we need in countries.

—Participant from Swaziland

Another participant explained:

> ECSA as a regional body has been involved in standardizing states and helping member states to be able to translate some of the global strategies into regional strategies and provide guidance to member states to be able to translate that on a local level.

—Participant from Zambia

When discussing how ECSA-HC contributes to the health outcomes in the region, several participants asked that ECSA-HC do more to connect, coordinate, and promote knowledge exchange between the member states. A few participants made comments that they feel as though they should be benefitting more from ECSA-HC than they currently are. For example, one participant noted:

> Some of us are left behind. We are lagging behind. . . . Involve some of us who are not there and find out why we are not there because maybe they [ECSA-EC] assume that we are part of the group, yet some of us are not and even don’t know that they exist. Maybe we were left out by mistake. I think we need a revival.

—Participant from Swaziland

Many participants noted that they would like to see improved communication with ECSA-HC. For example, one participant noted:

> I am really interested in working with ECSA because I know their mandate and very interested in hooking up somehow because there is a lot we can do together and a lot we can get from them.

—Participant from Swaziland

To improve communication with ECSA-HC, a few participants recommended appointing a country focal person and the need to include lower-level staff rather than the Permanent Secretary level in
communication, as information often does not trickle down from upper management. Staff turnover and lack of knowledge on how to contact ECSA-HC were mentioned as barriers to communication.

Additionally, a few participants noted that while ECSA-HC requests information (mainly M&E information from member countries), the member countries often do not receive the final products from with the information they submitted. A few mentioned that after they submit the data, they do not hear back from ECSA-HC in terms of follow-up or additional information. For example, one participant stated:

*I know ECSA collects reports from all countries, the member states. M&E reports and perhaps they compile it to come up with one report, but I never saw the output from the reports they are collecting from countries. So, I don’t know how they contribute [to health outcomes in the region].*

—Participant from Tanzania

On the same note, several participants also noted that they wanted ECSA-HC to share more health information about the region and the member countries with them. For example, one participant stated:

*They need to be more vigilant in making sure that we are updated on new things.*

—Participant from Swaziland

Other suggestions were to support member states with capacity strengthening in knowledge sharing and message development.

**Member State Contributions to Health Outcomes in the Region**

A few member states (Tanzania, Lesotho, and Mauritius) were asked how their country specifically contributed to health outcomes in the region. Participants from Tanzania felt they contributed to health outcomes in the region by working on responsibilities that had been agreed upon by the region and by submitting country-specific information to ECSA-HC when it was requested. One participant from Lesotho noted that they had contributed to health outcomes in the region by sharing their routine monitoring and resource-mapping information. Participants from Mauritius explained that they had contributed and can continue to contribute through the exchange of information, policies, and sharing of experiences specifically in regard to hypertension, diabetes, and obesity.

**ECSA-HC’s Role in Nurturing Knowledge Sharing in the Region**

Participants made comments on the role of ECSA-HC in nurturing a knowledge-sharing culture in the region. They suggested ECSA-HC help member states increase interaction and communication among themselves and also with ECSA-HC by effectively coordinating and being a “KM champion” for the region.

Furthermore, several participants noted the need for having a focal person dedicated for specific technical areas such as HIV/AIDS and TB, as well as KM in each country to foster a knowledge-sharing culture:
We need to have a dedicated personnel for promotion and education and of course designing those critical messages such that they reach the communities. Educating the communities is what we need so that we can be able to bridge the current performance gaps that we see.

—Participant from Lesotho

Technical Assistance Provided by ECSA-HC

The majority of participants had not received technical guidance or support from ECSA-HC or other ECSA-HC member states within the last six months. Similarly, the majority of the respondents had never requested information or technical guidance from ECSA-HC. A few participants stated that they were not aware of technical guidance provided by ECSA-HC but that others in their office might be more aware. Among the few that did receive technical guidance or support, they mentioned receiving guidance on TB, asking questions about regional initiatives they were implementing, and information on the assistance provided by ECSA-HC under the World Bank.

Among those who said they received technical guidance or support from other ECSA-HC member states, Uganda was mentioned a few times. One participant from Tanzania reflected that staff from Uganda traveled to Tanzania because they “wanted to establish a malaria center in Uganda so they were seeking some information.” Another participant from Malawi explained that staff from Uganda “came here to do an assessment for our labs so that we are able to work well with the nation’s reference lab in Uganda.” Another participant noted that they facilitate travel among the ECSA-HC member states but they do it themselves, without the support of ECSA-HC.

Several participants mentioned receiving technical guidance and support from other organizations, mainly the World Health Organization and Southern African Development Community. The World Health Organization was referenced several times as providing global technical guidance and health information, providing general oversight to programs, and connecting participants to what they need.

Awareness of ECSA-HC’s KM Initiatives and Approaches

Although many of the participants had heard of ECSA-HC’s knowledge management initiatives (except for Mauritius where almost all of them were unaware of such initiatives), about half said they did not truly understand the benefits yet and thought that eventually it would be acknowledged by the staff of the ECSA-HC member states. For example, one participant noted:

I think, since I didn’t know much about [the initiative], meaning maybe in terms of advocacy, there is need for it to be more informative so that people know who they are.

—Participant from Zambia

In terms of the use of KM approaches by ECSA-HC, participants mentioned that ECSA-HC has facilitated communication and information sharing between the member states. Some participants provided specific examples, such as forums, workshops, and training opportunities, including the Best Practices Forum and technical working group meetings. A few participants noted improvements in recent years as shown through the following quote:
We have been capacitated in different forums by ECSA, we learned best practices from other countries, neighboring countries; we are now starting to implement those best practices in the country. We have improved, since I came here in 2009 the indicators especially on family planning because they were focusing mainly, most of the advocacy we have done was focusing on improving coverage of family planning, we have increased our coverage and the unmet need has gone down. So ECSA has contributed to that a lot.

—Participant from Lesotho

Some participants expressed that they would like ECSA-HC to continue strengthening KM in the region by providing funding, technical expertise, and progress monitoring:

ECSA source some funds for these meetings; what I have seen most of the times, they source funds for these meetings for the people to come up with resolutions . . . However, possibly maybe there is complacency among countries to implement the same. So possibly if ECSA could have a monitoring mechanism to try and see if indeed—not really policing but monitoring in the sense of advising countries as well—if they are indeed achieving the resolutions and that possibly might be trying to motivate countries to align their plans, either yearly plans or strategic plans, to achieving whatever the resolutions recommend.

—Participant from Malawi

Health Ministers’ Resolutions

Awareness of Health Ministers’ Resolutions

Overall, the majority of participants were aware of the Health Ministers’ Conference and the passing of resolutions. However, a substantial proportion of participants had not heard of the resolutions. Of those who were aware of the resolutions, the majority were not able to articulate a specific resolution. When discussing why they had not heard of the resolutions or why they were not able to provide an example, several participants noted barriers regarding the exchange of information.

Several participants also noted that there was a focal person who might have more information on the resolutions or who attended the meetings and assigned tasks related to the resolutions. A few participants noted that the resolutions were reported out during routine management meetings. One participant explained the sharing process as:

We disseminate the report to the senior management. The minister shares with the senior management meeting every Tuesday and we meet in the boardroom. We share resolutions from each and every meeting, so for instance in this ECSA we would share the resolutions. Then once we have shared in that meeting, then program officers or directors are given specific areas to follow up.

—Participant from Zambia
Implementation of Health Ministers’ Resolutions

The majority of participants were not aware if the resolutions were being implemented in their country and how. For example, one participant noted:

*I have heard about those resolutions but I feel it’s not well communicated especially to the people who are supposed to be seen responding to the resolutions.*

—Participant from Swaziland

Another participant noted:

*The general impression that I have is that many of them are not implemented. We just come up with resolutions but then there is no follow-up.*

—Participant from Mauritius

Despite this, several participants were able to provide examples of how the resolutions were being implemented in their country. For example, one participant noted:

*A lot of them [the resolutions] form the basis of what we include in our strategic documents.*

—Participant from Zambia

Another participant noted that resolutions are taken into consideration when developing plans:

*Countries agreed that they would work toward making sure that no woman dies toward giving birth, so we adopted that in Swaziland and we had to come up with a strategy or action plan.*

—Participant from Swaziland

The resolutions that participants said were being implemented by the country related to newborn health, HIV/TB, HIV/AIDS, reproductive health, tobacco, family planning, maternal health, quality M&E frameworks, availability of medicine, and TB in the mines.

Of those who were asked if they received support from ECSA-HC in terms of implementing the resolutions, only a few participants stated that they received support. The support included technical and financial support to attend relevant meetings and support from country offices.
Vision for Knowledge Management at ECSA-HC

This section describes participants’ vision for ECSA-HC’s KM initiative within the next two years. Many of the respondents mentioned they would like to see ECSA-HC provide general knowledge management technical assistance or capacity-strengthening services to the member states. The focus of these services differed from country to country but included knowledge management awareness/sensitization, organizational structure, human resources, and KM tools. For example, one participant noted:

*I think for me it first has to start with orienting us on knowledge management. So that is the point of departure, so that at least once you have taught us now how to be professors, then we can go and lecture the same teachings so that we teach others how to fish, how to become professors.*

—Participant from Lesotho

Several participants also mentioned that they would like to see ECSA-HC play a coordinator role. This role was often mentioned in the context of other regional bodies such as the Southern African Development Community, implementing partners, and between non-health development sectors. For example, one participant mentioned:

*We should now start to talk of ECSA Standards of Care going beyond the country borders because I think issues of shortage are similar in ECSA. Our challenges, the conditions that we are handling like malaria, pneumonia, they are similar in ECSA so it’s also possible to create standards of care in ECSA. And then we start to monitor each and everyone who are members, are nurses and then we start to monitor, aware of professional way of doing things learning from each other.*

—Participant from Malawi

A few participants also mentioned the need for ECSA-HC to improve their visibility as noted by this participant:

*(ECSA should) start identifying one or two people from the ECSA to represent the Secretariat or somebody who will represent you [ECSA] so that you [ECSA] are not only visible for knowledge management but other uses also. Also these people can tell the Secretariat, look, we have done this successfully in increasing physical activities we have success in reducing prevalence in hypertension and would you like us to come and share our experiences?*

—Participant from Mauritius

Participants also expressed the need for capacity strengthening through training, mentorship, expert consultation, and technical meetings/workshops in a variety of subject areas. For example, noting the importance of having access to reliable and up-to-date data that can be used for decision-making and programing, they suggested specific topics including data analysis and visualization. A few participants mentioned the desire to build skills to write funding applications. Noting that KM was a new concept, several participants noted they would like training on KM concepts and approaches.
Recommendations and Conclusions

It is important to note that some of the challenges that ECSA-HC has faced (e.g., staffing, funding, etc.) would naturally impact their ability to reach out to members, provide technical assistance, or promote their work effectively. Also when participants noted they were unaware of ECSA-HC communication and activity implementation, because permanent secretaries are often the target audience for communication and key participants in face-to-face events, it is possible that they do not share information down about ECSA-HC to others.

This KM assessment resulted in a number of key findings and recommendations that the ECSA-HC Secretariat may consider useful in order to increase the effective use of KM approaches among its member states.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Key findings</th>
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<tbody>
<tr>
<td>Visibility</td>
<td>The Best Practices Forum and Health Ministers’ Conference are frequently</td>
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<tr>
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<td>mentioned as major KM events.</td>
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<td></td>
<td>Continue using these events as a priority avenue to increase the visibility</td>
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<td></td>
<td>of ECSA-HC, demonstrate its relevance to the region, and make known what it</td>
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<td></td>
<td>currently does and what technical assistance it can offer to member states.</td>
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<td></td>
<td>Consider offering special technical/consultative sessions focusing on these</td>
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<td>matters during the events.</td>
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<tr>
<td>KM capacity strengthening</td>
<td>Formal KM training is not offered to member states and KM understanding</td>
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<td></td>
<td>and skills vary.</td>
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<tr>
<td></td>
<td>ECSA-HC Secretariat is best positioned to provide technical assistance to</td>
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<td>member states to strengthen KM capacity of member states on KM.</td>
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<td></td>
<td>Promote KM training resources readily available (e.g., K4Health’s eLearning</td>
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<td></td>
<td>and toolkits) to member states, and consider organizing in-country training</td>
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<td>sessions if feasible.</td>
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<tr>
<td>Health information sharing</td>
<td>There is a clear interest among member states in receiving updated health</td>
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<td></td>
<td>information from the ECSA-HC Secretariat and to strengthen communication and</td>
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<td>exchange of information with member states and between ECSA-EC member states.</td>
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<td>Prioritize the health areas and routinely provide updated health information</td>
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<td>to member states.</td>
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<td></td>
<td>Consider updating the ECSA-HC website with current information and resources</td>
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<td>and availability of relevant information that member states can easily access.</td>
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<tr>
<td>Health Ministers’ Conference</td>
<td>Implementation of Health Ministers’ Conference resolutions is not consistent</td>
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<tr>
<td>resolutions</td>
<td>and member states need more guidance.</td>
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<td></td>
<td>There is a need to communicate and follow up with member states on the Health</td>
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<tr>
<td>Themes</td>
<td>Key findings</td>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>Focal person</td>
<td>There is a need to appoint ECSA-HC focal persons in member states to</td>
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<tr>
<td></td>
<td>communicate effectively about ECSA-HC and the expertise it can offer to member states.</td>
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