UNITED REPUBLIC OF TANZANIA
Ministry of Health and Social-Welfare

National Guidelines for Quality Improvement of HIV and AIDS Services

National AIDS Control Programme
(NACP)

FOREWORD

Efforts by the Government of Tanzania to improve health services in the country date back to the post-independence era and have resulted in a substantial increase in the number of health facilities, associated with an intensified training of human resource to run them. The scale up of efforts to provide improved access to health services was constrained by the economic slump of the 1980s and this compromised efforts in providing quality health services. In 1993, the Ministry of Health and Social Welfare (MOHSW), embarked on the Health Sector Reforms (HSRs), aiming at improving the quality of the services provided at health facilities, and developed in 2004 the Tanzania Quality Improvement Framework (TQIF), as a guiding document for quality improvement in health service provision. Realizing the scope of the quality improvement for the different components of health service provision, the TQIF encourages stakeholders to develop initiatives, focusing on their respective area of interest, but working within the national framework to improve quality of the services that are provided.

Translating the TQIF into action has been hampered by many system's constraints including the burden of the HIV and AIDS epidemic that struck the country in 1983. This epidemic had a number of system's effects, affecting the quality of service delivery, including, among others, overstretching the health workforce. In recognition of the need to improve the quality of services, many stakeholders have been undertaking initiatives, geared towards improving the quality of services at facility level. Much of the impetus for this initiative has focused on improving the availability of quality HIV and AIDS services in the country.

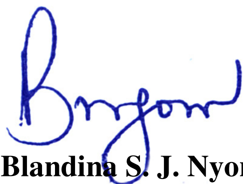
QI initiatives that have been implemented by regions with support from implementing partners, have so far used different approaches in design, processes, monitoring and reporting structures. In this context, the MOHSW acknowledged the need for having a systematic and harmonized approach to the design, planning and implementation of QI activities across the whole range of HIV and AIDS interventions. To achieve this, QI guidelines based on strategies and actions, stipulated in the TQIF, has been developed, to ensure that QI in HIV and AIDS interventions is implemented in a harmonized manner.

The national QI guidelines have been developed, taking into account the current context on the ground and the future health sector plans, as stipulated in the Health Sector Strategic Plan (HSSP) III – July 2009 to June 2015. These guidelines are expected to maintain a conscious mind among health workers, on the importance of quality in all HIV and AIDS interventions, as we embark on providing universal access to prevention, care and treatment. The guidelines will be useful to all health workers in the field, including those at facility and policy making levels. They are also designed to assist both mentors and supervisors of health workers in the field, to ensure a continuum of quality of HIV and AIDS services in the health care delivery system.

The National QI Guidelines for HIV and AIDS Services are arranged into seven sections. The first section provides background information, regarding HIV and AIDS services in Tanzania. The second section presents the rationale of having these guidelines. Section three explains the objective, target audience and content of the guidelines. The quality improvement concepts and definitions feature in section four, while section five presents the QI approaches used for HIV and AIDS and other health services in Tanzania. The sixth section covers specific roles and responsibilities for each level of health care. Section seven is about the actual implementation of QI at national, regional, district and health facility level, taking core QI activities into account. Section seven also contains a log-frame, outlining the implementation of activities at all levels. Its appendices have a list of operational HIV and AIDS guidelines, and the specific tools that have been developed, to facilitate QI implementation.

The operationalization of these guidelines uses a framework consisting of five key QI functions, as well as implementation of roles and responsibilities that are specified for each level of service provision. The components of the framework include: assessment of health facilities; service provision accompanied with use of- and compliance with HIV and AIDS guidelines, for specific interventions and improvement of services using 5-S and Improvement Collaborative approaches that include supportive supervision; mentorship; monitoring and evaluation. It is expected that, management structures at national, regional, council and facility levels, guided by their roles and responsibilities, will make this framework a reality as will be measured by the improvement in coverage, retention of patients/clients, treatment outcomes and crosscutting issues.

The MOHSW urges all stakeholders providing HIV and AIDS services, to use these guidelines consistently and to be free to offer critical comments for improving future editions of this document.



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The development of the National Guidelines for Quality Improvement of HIV and AIDS services, that define quality improvement processes and outlines roles and responsibilities of key players, is an important step in harmonizing and structuring the Quality Improvement for HIV and AIDS interventions in the health sector in Tanzania. The development of these guidelines, is a culmination of the efforts by the National AIDS Control Programme (NACP), to develop a uniform approach to addressing Quality Improvement (QI) activities that are related to HIV and AIDS services in Tanzania. The guidelines also reflect the various QI efforts, as already implemented by partner organizations and other stakeholders. It is anticipated that the use of these guidelines will lead to a unified approach in improving quality of HIV and AIDS interventions in Tanzania.

The process of developing the National QI guidelines has been facilitated by the NACP, in collaboration with various institutions, who provided technical and financial support to this endeavor. The Ministry would like to thank PharmAccess International (PAI) and University Research Company (URC), for the overall technical and financial support.

Our appreciation and thanks, also go to the World Health Organization (WHO), Family Health International (FHI), Japan International Cooperation Agency (JICA), Benjamin William Mkapa HIV and AIDS Foundation (B-MAF), Management Science for Health (MSH), Muhimbili University of Health and Allied Sciences (MUHAS), Regional and Council Health Management Teams (R/CHMT), Regional Implementing Partners and health facilities, that participated in the consultations or review of these guidelines.

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ANNEX 1: LIST OF HIV & AIDS INTERVENTION SPECIFIC GUIDELINES CURRENTLY IN USE *30*

LIST OF ACRONYMS

AIDS	-	Acquired Immuno Deficiency Syndrome
AMSTL	-	Active Management of Third Stage of Labour
ANCs	-	Antenatal Clinics
ART	-	Anti Retroviral Therapy
ARVs		Antiretroviral drugs
CBOs	-	Community Based Organizations
CCHPs	-	Comprehensive Council Health Plans
CHMT	-	Council Health Management Team
CQI	-	Continuous Quality Improvement
CQIT	-	Council Quality Improvement Team
CQI-TQM	-	Continuous Quality Improvement -Total Quality Management
CRHPs	-	Comprehensive Regional Health Plans
DACC	-	District AIDS Control Coordinator
DMO	-	District Medical Officer
EPI	-	Expanded Program on Immunization
FBOs	-	Faith Based Organizations
GPA	-	Global Program on AIDS
HBC	-	Home Based Care
HBCT	-	Home Based Counseling and Testing
HF	-	Health Facility
HIV	-	Human Immunodeficiency Virus
HSHAS	-	Health Sector HIV and AIDS Strategy for Tanzania
HSHSP	-	Health Sector HIV AIDS Strategic Plan
IEC	-	Information Education and Communication
IPOs	-	Implementing Partner Organizations
IPs	-	Implementing Partners
LGA	-	Local Government Authority
M&E	-	Monitoring and Evaluation
MoH	-	Ministry of Health
MOHSW	-	Ministry of Health and Social Welfare
MTP	-	Medium Term Plan
NACP	-	National AIDS Control Program
NQIT	-	National Quality Improvement Team
NCTP	-	National Care and Treatment Plan
NGO	-	Non Governmental Organization
NMSF	-	National Multi-sectoral Strategic Framework
OIs	-	Opportunistic Infections
PBAs	-	Performance Based Contractual Agreements
PDSA	-	Plan Do Study Act
PITC	-	Provider Initiated Testing and Counseling
PLHIV	-	People Living with HIV and AIDS
PMTCT	-	Prevention of Mather To Child Transmission
QA	-	Quality Assurance
QI	-	Quality Improvement
RACC	-	Regional AIDS Control Coordinator

RHMTs	-	Regional Health Management Teams
RIP	-	Regional Implementing Partner
RMO	-	Regional Medical Officer
RQIT	-	Regional Quality Improvement Team
STIs	-	Sexually Transmitted Infections
TACAIDS	-	Tanzania Commission for AIDS
TB	-	Tuberculosis
ToR	-	Terms of Reference
ToT	-	Training of Trainers
TQIF	-	Tanzania Quality Improvement Framework
TQM	-	Total Quality Management
TWG	-	Technical Working Group
VCT	-	Voluntary Counseling and Testing
WHO	-	World Health Organization
ZTCs	-	Zonal Training Centers

SECTION 1

1.0 BACKGROUND

1.1 The National HIV/AIDS Response

Tanzania, being one of the Sub-Saharan countries most affected by the HIV and AIDS epidemic, has been taking a number of control measures since the first AIDS case was detected back in 1983. The first institutional mechanism in responding to the HIV and AIDS epidemic was the establishment of a task force by the Ministry of Health to implement a Short Term Plan in 1985. In 1988, the Ministry of Health established the National AIDS Control Programme (NACP) to coordinate the National Response and took responsibility for the formulation and implementation of the three Medium Term Plans (MTPs I-III) leading up to 2002. Through the Global Program on AIDS (GPA) based at the World Health Organization (WHO) headquarters in Geneva and the international community, Tanzania was able to mobilize resources to implement most of the strategic plans and interventions contained in the MTPs.

During MTP-I (1987-1992), the main focus was to intensify the social mobilization processes at community level (decentralization), through education campaigns on the epidemic. During this time, Regional and District AIDS Control Coordinators (RACC and DACC) were appointed to assist the Regional and Council Health Management Team (RHMT and CHMT) under the leadership of the Regional and District Medical Officers (RMOs and DMOs) respectively, to champion the response at these levels.

Simultaneously, health workers were trained on various aspects of HIV disease, including its transmission and prevention in order to educate the general public. Within a short time, a number of Community Based Organizations (CBOs) and Non-governmental Organizations (NGOs) as well as a few non-public health sectors became involved in the fight against the HIV epidemic. This was the beginning of multisectoral collaboration in the national response to the epidemic that became more intensified during MTP II-III between 1992 and 2002. By the end of 2002 more than 500 NGOs and CBOs were implementing HIV and AIDS activities in the country in partnership with the government. Throughout this period, developing countries affected by the pandemic were assisted by the international community under the leadership of GPA, to design country specific strategic plans.

1.2 Introduction to early HIV and AIDS Services

In the health sector, main HIV and AIDS intervention activities in the early years of the epidemic and for the entire period of MTP I-III (1987-2002) included:

- Health education to the general public using various Information Education and Communication (IEC) approaches
- Training of health workers in specific skills such as management of Sexually Transmitted Infections (STI), laboratory tests, counseling and communication for behavior change

- Procurement and distribution of commodities and supplies including condoms
- Printing and distribution of IEC materials
- Development of guidelines and dissemination for various interventions
- Disease monitoring and surveillance (establishment of sentinel sites, data collection, analysis and reporting)
- Screening of donated blood and Antenatal Clinic (ANC) attendees for HIV and syphilis for both routine and surveillance purposes
- Syndromic management of STIs
- Procurement and distribution of drugs for treating STIs

During this period, most activities conducted were preventive in nature. As such, very little change could be seen in most health facilities since services offered did not differ from the existing routine health services except in scope and linkage to HIV and AIDS. Following scientific advances in development of antiretroviral drugs (ARVs) and a global initiative to provide ARV at subsidized cost, the focus of HIV and AIDS interventions shifted from being predominantly preventive to include care and treatment.

Realizing this paradigm shift, two main national strategic approaches were developed at the beginning of 2003 namely: the Health Sector HIV and AIDS Strategy for Tanzania 2003 - 2006[1] (HSHAS) under the leadership of Ministry of Health (MOH) and the National Multi-sectoral Strategic Framework on HIV and AIDS[2] (NMSF) spearheaded by the Tanzania Commission for AIDS (TACAIDS). These strategies signified important departure from the previous approaches, with NACP focusing on health and medical issues of the epidemic, while TACAIDS provided a framework for other players in the multisectoral response to develop their own sectoral strategies.

Currently, TACAIDS is implementing a second five-year National Multisectoral Strategic Framework on HIV and AIDS (NMSF 2008 – 2012) from which the MOHSW has developed a second Health Sector HIV and AIDS Strategic Plan (HSHSP 2008 - 2012) both focusing on universal access to prevention, care, treatment and support.

1.3 The National HIV Care and Treatment Plan

A paradigm shift occurred in 2003 at the time of developing the first Health Sector Strategy for HIV and AIDS (2003-2006) with a major focus on care and treatment for people living with HIV and AIDS (PLHIV). By this time only about 2,000 PLHIV were receiving ARV drugs from private health facilities. None of the public sector health facilities were providing ARV drugs. Based on this MOH developed a full fledged National Care and Treatment Plan (NCTP) for the five years[3] (2003 to 2008). The plan aimed at providing ARV drugs to as many eligible PLHAs as possible, starting with an initial target of 400,000 by the end of 2008.

[1] Health Sector HIV and AIDS Strategy for Tanzania. Ministry of Health 2003
[2] National Multi-sectoral Strategic Framework. TACAIDS 2003
[3] National Care and Treatment Plan 2003 - 2008. Ministry of Health 2003

This required massive training of almost the entire health workforce into management of AIDS patients using Anti Retroviral Therapy (ART) and development and review of guidelines related to HIV care and treatment.

In order for facilities, (public, faith-based and private) to initiate ART services they had to meet minimum standards and criteria, set by NACP. Assessment criteria and tools were developed to ascertain readiness of Health Facilities (HFs) to provide ART. Minimum criteria among others included:

- At least 3 staff trained on HIV care and treatment
- Space for patient clinical consultation and counseling
- Essential laboratory services
- Storage facility for drugs and commodities
- Availability of guidelines for the management of HIV and AIDS patients

It was expected that a HF that met minimum criteria during assessment would proceed to provide HIV care and treatment services and those not meeting criteria will be encouraged to implement an improvement plan based on each assessment. However, virtually all of the HFs assessed did not meet the criteria set. Given the urgent need for scaling up ART, 36 hospitals started providing ARV drugs in 2004, gradually increasing to over 200 hospitals by the end 2006. Scaling up to primary level HFs has resulted into more than 527 health centres and dispensaries currently providing ART in the country. Involvement of primary health facilities in the provision of HIV and AIDS care and treatment services has contributed much to the increase in numbers of PHLHIV enrolled in care and treatment as more than 470,000 are currently registered for HIV care and more than half of them (234,000) have commenced treatment with ARVs.

The involvement of primary health facilities in the provision of HIV and AIDS care and treatment is a strategic decision by the MOHSW to improve access particularly in rural areas where distance to the district hospital is a critical factor influencing availability of service. In realization of constraints affecting provision of quality services in such facilities, formal certification has been deferred until completion and implementation of the new QI guidelines and consequent revision of nationally agreed standards and criteria. Currently, the most important criterion for ART initiation is the availability of trained staff on ART management in addition to improvement of physical infrastructure at the health facility level.

1.4 Current HIV Care Treatment and Support Services

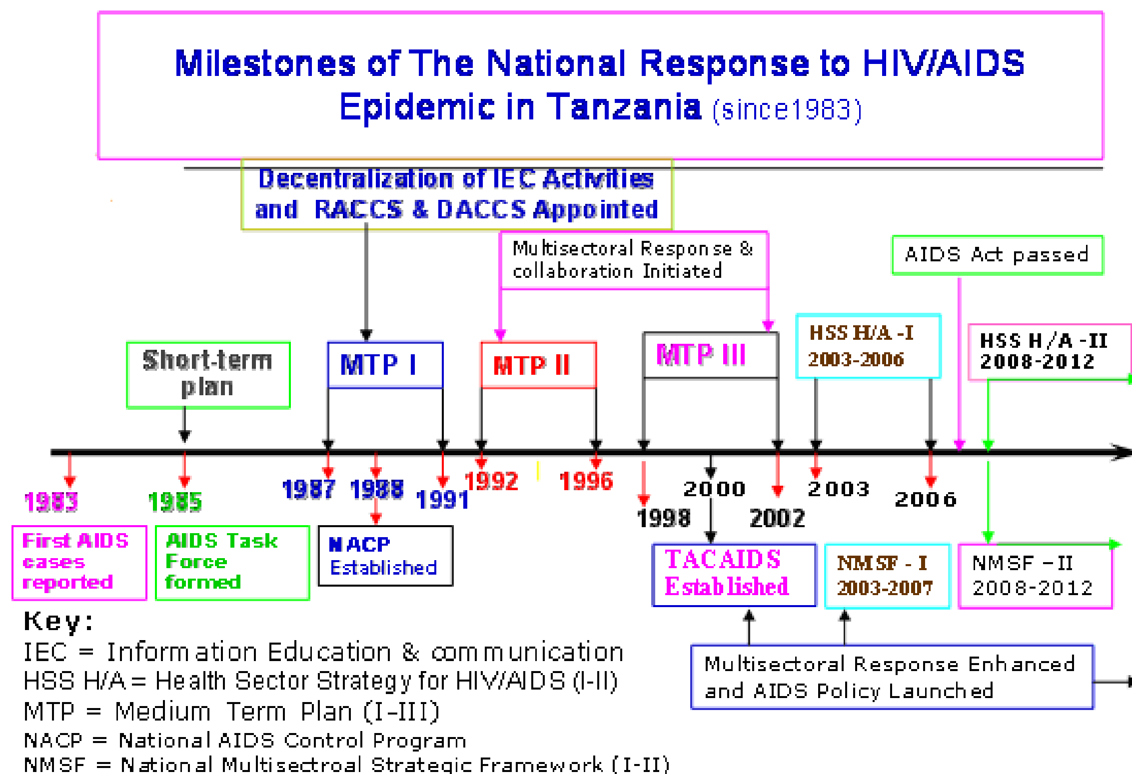
In HSHSP – II, the main focus is on universal access to HIV prevention, care, treatment and support, reflected in the following range of interventions:

- STI management
- ART access
- Prevention of Mother To Child Transmission of HIV (PMTCT) services

- HIV testing and counseling; Voluntary Counseling and Testing (VCT), Provider-Initiated Counseling (PITC) and Home-Based Counseling and Testing (HBCT) services
- Laboratory services both for diagnostic, monitoring of patients on ART and surveillance purposes
- Safe blood transfusion services
- Infection prevention and control in health care delivery setting – including prevention of nosocomial infections
- Home Based Care (HBC) services
- Health education for promoting service utilization (including condom use) through HFs, community and mass media.

Figure 1 below illustrates the historical background of the national response as it grew up from the health sector leadership (end of the MTP-III in 2002) to the time of the establishment of TACAIDS under the Prime Minister's Office in 2000. The figure also shows times when HSHS-I and HSHSP-II, NMSF-I and II were launched as well as the passing by the parliament of the HIV and AIDS Act 2008.

Figure I: History of the HIV and AIDS National Response in Tanzania (1983 to date)



SECTION 2

2.0 RATIONALE

The National Health Policy aims at providing quality health services to all people of Tanzania. In realizing this commitment, there has been considerable expansion of health services since independence and initiation of Health Sector Reforms (HSR) and Health Sector HIV and AIDS Strategic Plans (HSHSP). The implementation of HSHS I 2003 – 2006 resulted in a rapid scale up of the delivery of HIV and AIDS interventions in all the four thematic areas of the health sector response, namely: Prevention, Care and Treatment, Cross-cutting issues and Health Systems Strengthening. Efforts to scale up HIV and AIDS services will be sustained during implementation of HSHSP II (2008-2012).

One of the three goals of the HSHSP–II is to improve the quality of HIV and AIDS interventions aimed at the general public, PLHIV, health care providers and other vulnerable populations[4]. However, the health sector is facing a critical shortage of human resources. This deficiency has weakened the health care delivery to the extent of compromising the quality of its services. Within the health sector response to the HIV and AIDS epidemic, emergence of new interventions and the urgent need to scale-up aiming at mitigating its impact has resulted in concerns regarding the quality of services.

Recently, the Ministry of Health and Social Welfare (MOHSW) developed the Tanzania Quality Improvement Framework (TQIF)[5] with the purpose of encouraging the health workers at all levels and other stakeholders in the sector to develop a culture of quality in healthcare provision. The Framework also outlines critical steps to be considered in improving and institutionalizing quality of healthcare in the country using available resources. Despite these efforts, the system to improve, monitor and report on the quality of health services provided has not been well operationalized.

Based on the context described above and the need to improve and harmonize efforts, the MOHSW through NACP has decided to develop Quality Improvement (QI) guidelines for HIV and AIDS Prevention, Care, Treatment and Support Services based on TQIF. Quality services will contribute positively to customer satisfaction, improved health seeking behaviour, subsequent adherence and reduction of stigma by health care workers and users. All of these are key a to successful HIV and AIDS intervention.

[4] Health Sector HIV and AIDS Strategic Plan II 2008 – 2012, Ministry of Health and Social Welfare, February 2009.
[5] Tanzania Quality Improvement Framework, Ministry of Health and Social Welfare, September 2004

SECTION 3

3.0 OBJECTIVE, TARGET AUDIENCE AND CONTENT OF THE QUALITY IMPROVEMENT GUIDELINES

3.1 Objective of the QI Guidelines

The objective of the QI guidelines for HIV and AIDS Prevention, Care, Treatment and Support services is to provide guidance on how to improve the quality of HIV and AIDS services in the health sector in Tanzania. It incorporates fundamental QI concepts contained in the TQIF and draws experience from HIV and AIDS implementing partners at national and international levels as well as field-based experience from the Tanzanian context. Core characteristics of the QI guidelines for HIV and AIDS services include:

- Policy formulation and coordination roles for the National level
- Decentralization of implementation
- Provision of training by Zonal Training Centres (ZTCs)
- RHMT playing a leading role in coordination of QI activities in regions and districts
- Involvement of regional Implementing Partner Organizations (IPOs) and other stakeholders in supporting Quality Improvement of HIV and AIDS care, treatment and support services

3.2 Development of the Guidelines

These guidelines is a result of consultative and collaborative efforts in designing and implementing HIV and AIDS quality improvement strategies, organized and managed by MOHSW through NACP with relevant partners. The guidelines draws experience from the NACP baseline assessment of health facilities, supportive supervision, monitoring and evaluation of HIV and AIDS services in Tanzania and a field test of the proposed quality improvement approach as applied in Tanga and Morogoro regions. It also includes a review of published and unpublished documents on QI. In addition, the development process included recommendations from MOHSW representatives, HIV and AIDS implementing partners, RHMT, CHMT and health care workers at different levels of health care as well as from PLHIV.

3.3 Target Audience

The QI guidelines are intended to be used by: MOHSW/NACP policy makers, planners, RHMT, IPO, CHMT, program managers, teaching/academic institutions, partners in public, private, FBO, NGOs involved in HIV and AIDS service provision, health care providers and clients.

SECTION 4

4.0 QUALITY IMPROVEMENT CONCEPTS AND DEFINITIONS

4.1 Preamble

The systems-based framework defines health care as a system composed of health structures and processes of care which result in consequent outcomes. Structural component refers to organizational factors that define the health system under which care is provided, e.g. personnel, equipment, drug supply and buildings. On the other hand, processes of care involve interactions between users and the health care structure; in essence, what is done to or with users. Outcome refers to consequences of interaction between individuals and the health care system. It should be noted that structure as well as processes may influence outcome, indirectly or directly; for instance, a patient may die from HIV disease either because ART is not available (structure) or because her HIV test is misinterpreted (process).

4.2 Definitions

4.2.1 Quality care can be defined as accessible and effective care that is delivered in compliance with evidence-based standards and meets clients' needs[6,7]. Evidence-based standards define for both health workers and clients what constitutes quality care, and have been associated with improved health outcomes.

4.2.2 Quality Assurance (QA) is the process of verifying or determining whether products or services meet or exceed clients' expectations and put measures to ensure quality is maintained. In healthcare settings QA has been referring to a set of activities carried out following set standards of work, monitors implementation and improves performance so that the service provided is as effective as possible.

4.2.3 Quality improvement (QI) is a systematic process of assessing performance of a health system and its services, identifying gaps and causes, and introducing measures to improve quality and monitoring the impact. QI uses scientific principles and tools to understand and address system deficiencies in order to produce efficient and effective healthcare delivery processes through redesign.

4.2.4 Quality control is a process employed to ensure a certain level of quality in a product or service. Quality control involves verification of certain characteristics of a product or service to identify products or services that do not meet specified standards and once identified production could be stopped temporarily or entirely.

QA and QI have been used interchangeably

[6] Berwick, D. *A primer on leading the improvement of systems.* Brit Med J, 1996. 312: 619–622.
[7] Campbell SM, Roland MO, Buetow SA. *Defining quality of care.* Soc Sci Med, 2000. 51(11):1611-25.

4.3 Why Quality Improvement?

Evidence-based standards[8] and guidelines already exist and new ones are rapidly emerging for most of the world's health priorities. However, it has been widely shown that providers routinely comply with only a small proportion of guidelines, despite standards-based training. For example, a low-cost evidence-based package of three simple steps known as active management of third stage labor (AMTSL) has been shown to reduce postpartum hemorrhage, the leading cause of maternal mortality worldwide, by over 50%[9]. Yet AMTSL is not practiced in many HFs in Tanzania and where practiced, quality problems in terms of storage conditions for drugs limit its effectiveness. Improving quality for more complex health care problems, such as HIV and AIDS, requires a systematic process to understand causes of problems and based on these develop and implement solutions.

4.4 Principles of quality improvement

Modern quality improvement (QI) approaches based on five principles have been shown to improve processes of care, even within weak health systems that face severe material and human resource constraints. These principles are:

4.4.1 Focus on the client needs: health care services need to be comprehensive and broad enough to meet all common needs and expectations of the clients and community as they occur. Services that do not meet clients' needs fail as patients increasingly want explanation and discussion about their symptoms and like to be involved in decisions about their management. To be comprehensive, HIV and AIDS services available to clients and community at large should include the whole range of interventions such as prevention, care, treatment and support.

4.4.2 Understanding work as systems and processes: Services offered in HF should be viewed as a product of interactions of interdependent parts of a system made up of three components: input, process and output. In designing and implementing QI activities a system view (inputs, processes and outputs) should be considered and avoid fragmented approach in improving quality.

4.4.3 Teamwork: Improving quality of the system requires that people working in different parts of that system to work in a coordinated manner and focusing on realization of the same main goal. Therefore involvement and participation of the people and creating a common understanding is key. Having an effective teamwork requires leadership, participation of team members in analyzing system deficiencies, agreeing on changes to be made and meeting regularly to evaluate progress.

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[8] Mfinanga G. S. et al. Health facility-based Active Management of the Third Stage of Labor: findings from a national survey in Tanzania. Health Research Policy and Systems 2009, 7:6

[9] Prendiville WJ, JE Harding, DR Elbourne, GM Stirrat. The Bristol third stage trial: active versus physiological management of the third stage of labour. Brit Med J, 1988. 297:1295–1300.

4.4.4 Focus on the use of data: Data is needed to analyze processes, identify gaps, and measure performance. Changes can then be tested and the resulting data analyzed to verify that the changes have actually led to improvements. In implementing QI it is important to measure components of system. Quality of input (*also known as structure*) can be measured by looking at resources such as the quality of personnel, drugs, supplies, and physical resources. The quality of processes can be measured by addressing the key procedures involved in patient/client care such diagnostic, therapeutic and patient care procedures and protocols. Outcomes measures include infection rates, morbidity and mortality rates as well as client or healthcare provider satisfaction.

4.4.5 Communication and feedback: Communication is the ability to build a relationship of trust, understanding and empathy with the client and to show humanism, sensitivity and responsiveness. Communication occurs at several levels of interaction (client / provider; health system / community; provider / management and between providers) within the health care system. Effective communication is essential for ensuring quality services and client satisfaction. Barriers to communication such as language used, channel used to convey message and message content can affect the quality of service.

SECTION 5

5.0 THE QUALITY IMPROVEMENT MODEL

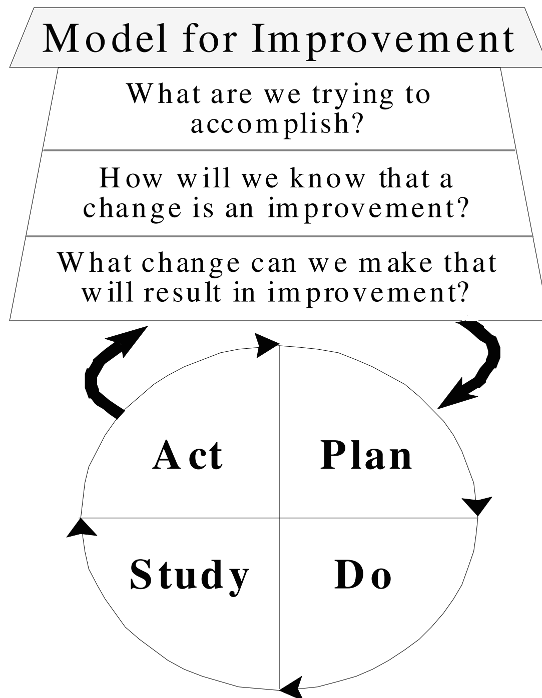
5.1 PDSA cycle

Improvement comes from the application of knowledge in making changes in response to three fundamental questions[10]:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in an improvement?

These three questions provide the basis for making any sort of improvement through trial and learning, the use of data and the design of effective changes. To facilitate the development of tests and implementation of changes, the Plan, Do, Study and Act (PDSA) framework will be applied. The cycle begins with a plan and ends with an action based on the learning gained from the Plan, Do and Study phases of the cycle. The three questions and the PDSA cycle combined will form the basis of a model for improvement (figure 2). The model is applicable for both simple and sophisticated situations and applied efforts may differ depending on the complexity of the product or process to be improved.

Figure 2. The PDSA Cycle



Quality Improvement works by addressing processes of care within health systems. "Every system is perfectly designed to achieve the results it achieves"[11]. The emphasis on systems is central to QI since poorly designed systems generate inefficiency, waste, poor health care quality and negative health outcomes.

QI methods deliberately tackle a range of quality problems among the many inter-related parts of a system. Key system functions are analyzed to identify unnecessary, redundant, or missing parts.

[10] Langley, G., et al., The Improvement Guide: A practical Approach to Enhancing Organizational Performance. 1996: Jossy-Bass

Based on analysis of the current system, a QI team hypothesizes and tests changes in the organization of care that may result in improved quality and efficiency. Increasing efficiency within a system by promoting only effective activities and ceasing all unnecessary, wasteful, and potentially harmful activities can yield important quality benefits and cost savings (see Box 1 for an example of PDSA cycle).

Box 1. Example of using the PDSA Cycle

The PDSA cycle is a simple way to help local teams answer the three fundamental questions when they introduce a new activity, using an effective method to learn and assess changes in their own settings. In the case of HIV and AIDS, the PDSA cycle can be used to test or adapt best practices and new approaches and to spread them when they work. For example, after a health care team clarifies what it wants to accomplish (its aim) and develops measures to monitor its progress, it completes a PDSA cycle:

Plan: Health care teams plan for a change.
Their plan addresses the following issues:

- What change do they want to test in this cycle;
- What questions need to be answered about the change;
- Who will be involved;
- Where will the plan be implemented;
- When will the plan be implemented;
- What data need to be collected?

Do: Health care teams test the change on a small scale:

- They document problems and unexpected observations
- Begin analysis of data collected

Study: Health care teams observe the results:

- Complete an analysis of the data
- Compare results with initial goals
- Summarize what they have learnt

Act: Health care teams make decisions which may be either of the following:

- Abandoning the change due to undesirable results
- Refining the change by going back to the planning stage
- Implementing the change and institutionalize

5.2 Quality Improvement Approaches

The design and context in which QI programs are implemented, as well as the methods used to carry out the changes, matter greatly. The evaluation of QI approaches to decide which one is the best poses substantial challenges given the multitude of changes occurring simultaneously during implementation as well as the existence of concurrent external and internal stimuli to improve care. There is little research assessing the effectiveness of one or more hospital or national quality strategies. The lack of evidence is largely a result of the difficulties of evaluating this type of intervention and of proving that the results are due to the strategy and not to other changes.

In sum, no quality improvement strategy can be recommended over another on the basis of evidence of effectiveness, ease of implementation or costs. From what is known, no quality improvement program is superior and real sustainable improvement might require implementation of some aspects of several approaches be it together or consecutively. Improvement experts agree that "one size fits all" does not apply to improvement approaches. Rather context and available evidence should guide the choice of improvement approach to be used.

The PDSA model for improvement described in section 5 can be implemented using different approaches. Currently in the Tanzanian context two QI approaches are being applied for improving health care services: The 5-S and the Improvement Collaborative Approach.

5.1.1 Five-S (5-S) as an entry point for overall health system Quality Improvement

Five-S is a management tool, used as a basic, fundamental and systematic approach for productivity, quality and safety improvement in all types of organizations. It is a philosophy and a way of organizing and managing the workspace and work flow with the intent to improve efficiency of work by eliminating waste, improving flow and reducing process unreasonableness.

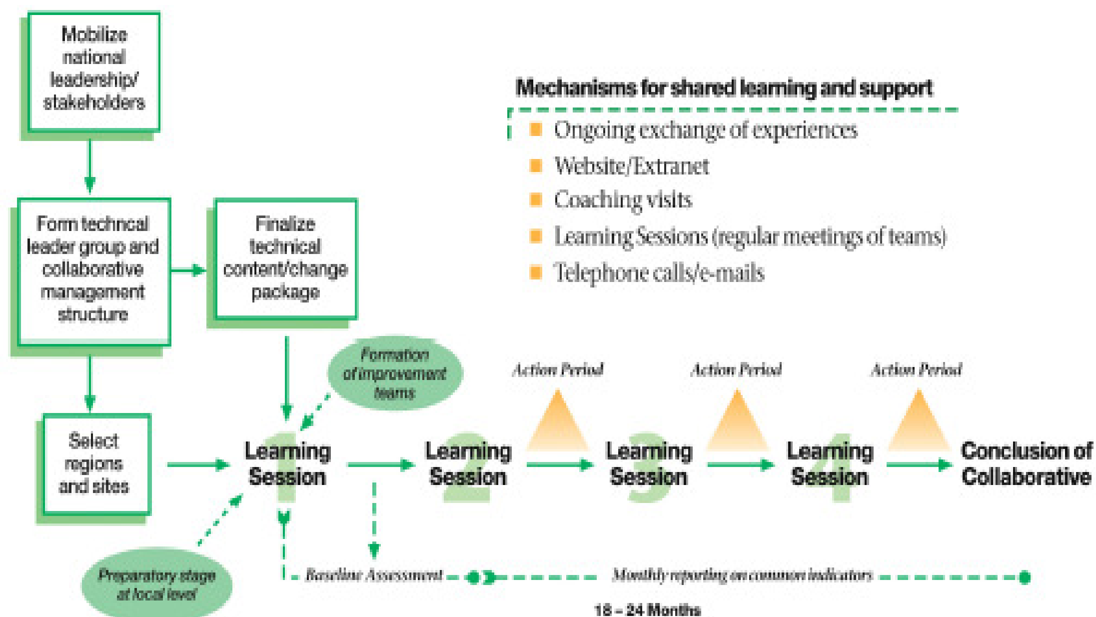
Improvement of work processes often is sustained only for a while, and workers drift back to old habits while managers lose determination and perseverance. 5-S in contrast involves all staff members in establishing new disciplines so that they become the new norms of the organization i.e. by internalization of concepts. Five–S is an abbreviation for five terms presented below:

- **Sort** to remove unused stuff from your working place
- **Set** is to organize all necessary items in proper order for easy services provision
- **Shine** is to maintain high standards of cleanness
- **Standardize** to set up the Sort, Set, and Shine as norms in every section of health facility
- **Sustain** is to train and maintain discipline of the health care workers engaged

5.1.2 Improvement Collaborative Approach

An Improvement Collaborative is an organized network of a large number of sites (e.g. districts, facilities or communities) that work together for a limited period of time, usually 9 to 24 months, to rapidly achieve significant (often dramatic) improvements in a focused topic area through shared learning and intentional spread methods. The approach uses the rapid team problem solving approach during the action periods which tailors the problem solving process to the situation at hand and minimizes activities just to ones necessary to make improvements (the PDSA model is described in section 5).

During learning sessions teams receive updates on the technical content and evidence based standards of the problem identified and develop common improvement indicators. In between learning sessions, teams go into action periods to analyze processes of care and design process changes to implement evidence based standards with the help of the coaches/mentors. The supervisors act as coaches and Quality Improvement experts. At the learning sessions, teams exchange results and learn about the changes. If a team is stuck, they can learn from another team that found something that worked and they feel the competition to keep up with the other teams. These elements of sharing, competition and rapid follow-up, help maintain energy and momentum. A particular strength is that peer to peer learning, as occurs during the learning sessions, is often more powerful than top down technical assistance.



5.3 Framework for Improving the Quality of HIV and AIDS services in Tanzania

Since it is almost impossible to improve something that has not been defined, the QI model described above demands responding to the question: "What are we trying to improve?" before engaging in any sort of improvement work. In the context of HIV and AIDS in Tanzania it is prudent that all stakeholders involved understand what constitutes Quality Improvement for harmonized and equitable provision of services. In the Tanzanian context major areas of emphasis for QI have been outlined in HSHSP – II as summarized below:

- **Coverage/Access:** ensuring that PLHIV have access to all available HIV and AIDS interventions. Currently there is inadequate coverage in:
  - HIV testing and counseling
  - PMTCT, STI management and Tuberculosis (TB) screening
  - ART initiation, clinical patient monitoring and follow up
  - Management of opportunistic infections
  - Home Based Care (HBC) services
  - Infection prevention and control in health care delivery settings (including prevention of nosocomial infections)
  - Health education for promoting service utilization (including condom use) through HFs, community and mass media
- **Retention:** of PLHIV in various HIV and AIDS interventions as required by the continuum of care model.
  - In HIV care and treatment as well as TB treatment programs
  - PMTCT clients (mothers and exposed infants)
- **Outcome:** achieving desirable health outcomes as a consequence of HIV and AIDS interventions. These outcomes include reduction in morbidity and mortality, resumption of normal functioning, weight gain, reduction of opportunistic infections, HIV negative babies born by HIV positive mothers, reduction in viral load and rise in CD4 count.
- **Cross cutting issues: i**n order to ensure improved coverage, retention and outcomes as outlined above, cross cutting issues listed below need to be considered for effective implementation of QI efforts for HIV and AIDS interventions.
  - Harmonization and coordination of implementation
  - Operationalization of guidelines
  - Availability, storage, maintenance and service of supplies and equipment
  - Record and reporting system
  - Quality of laboratory services
  - Production of IEC materials

To address above challenges and for sustainable improvements, concerted efforts by all health sector stakeholders and compliance to intervention-specific guidelines is required.

SECTION 6

6.0 ROLES AND RESPONSIBILITIES

Health services in Tanzania are organized in four levels: National, Regional, District and Facility level. National and regional levels, the MOHSW and Regional Administrations are involved in policy, coordination and guidance, while district, council authorities and facility levels are responsible for direct implementation of the QI strategy. Each level has a critical role in ensuring efficient and effective running of the QI program. This section describes the level specific roles and responsibilities to be undertaken in the implementation of guidelines

6.1 National level

The MoHSW aims at a rapid rollout of Care and Treatment services to those in need, hand in hand with quality assurance. As implementing partners are increasingly introducing QI approaches for HIV and AIDS services, coordination becomes important to ensure uniformity, which calls for formulation of national policy guidelines. The following are roles and responsibilities of MOHSW:

Box 2: Roles and responsibilities of MOHSW in QI of HIV/AIDS service provision:

- Set QI policies and standards based on available evidence and best practices
- Develop guidelines for all core interventions with clear targets and monitoring indicators
- Develop a QI coordination mechanism and monitoring and evaluation system and supportive supervision tools
- Mobilize financial and technical resources for QI implementation
- Develop and update the tools that are linked with the QI guidelines: measurements/assessment, supportive supervision, mentoring and M&E
- Identify training needs on QI and develop an appropriate capacity building programme.
- Disseminate QI guidelines and tools to regions and relevant stakeholders
- Prepare the respective QI training curricula for the national ToTs, ZTC and RQIT/CHMT
- Provide regular technical support to regions in improving the quality of HIV and AIDS services and coordination and monitoring of its implementation
- In collaboration with National, Referral and Specialized hospitals provided support and coordination to regional hospitals in terms of provision of specialized laboratory testing, clinical mentoring and disseminating evidence based management of HIV and AIDS
- Initiate, monitor and audit the performance based contractual agreements (PBAs) made between IPOs and RHMTs for initiating and sustaining the QI
- Develop and update the QI guidelines through lessons learned and available evidence

6.2 Regional level

At the regional level, the RHMT and HIV and AIDS Implementing Partner Organizations (IPOs) will work together on QI activities in their Region. The RHMT, being the Government arm, will provide leadership to all stakeholders in QI activities connected to policy, coordination, advocacy and communication. The RHMT in collaboration with relevant stakeholders will accomplish the following QI tasks:

Box 3: Roles and responsibilities of RHMT in QI of HIV and AIDS service provision:

- Establish the regional QI team (RQIT), based on agreed eligibility criteria and specific Terms of Reference (ToR)
- Coordinate and provide leadership in the implementation of the QI guidelines in the region
- Provide linkage between MOHSW, Local Government Authorities (LGAs) and relevant stakeholders in QI activities for HIV
- Mobilize key stakeholders to join implementation of the QI guidelines at regional and district levels
- Monitor and supervise performance of districts on priority QI targets and indicators
- Provide regular technical support to districts in implementation of the QI guidelines
- Receive district reports, aggregate and analyze for decision making, planning and management purposes
- Submit reports to national level and share with relevant stakeholders
- Ensure integration of QI activities for HIV and AIDS into all Comprehensive Regional Health Plans (CRHP)
- Distribute and enforce the use of HIV and AIDS intervention guidelines in the districts

6.2.1 Roles of regional hospital

The regional hospital being the referral level within the region will provide:

Box 4: Roles of regional hospital

- Clinical services to inpatients and outpatients referred to by district hospitals
- Curative specialist services in the region
- Expert and technical support to district, faith-based and private hospitals as well as primary health facilities on HIV and AIDS services
- Representative health professionals to join the RQIT and the QI implementation, in particular the clinical mentoring component

6.3 District level

Implementation of the health care policy has been decentralized to Local Government Authorities (LGAs). The day to day implementation of health services including QI is therefore the responsibility of CHMTs. In this regard, Councils have responsibility of ensuring availability of adequate resources for provision of quality health services. The following are specific responsibilities of CHMTs in relation to QI activities:

Box 5: Roles and responsibilities CHMT:

- Establish Council QI team with terms of reference and initiate QI processes within the district
- Implement HIV and AIDS QI activities in line with QI guidelines at the district level
- Provide a link between CHMT and RHMT, implementing partners, District Hospital and other health facilities on QI activities for HIVAIDS services
- In collaboration with in-charges of health facilities, facilitate identification and training of QI teams at facility level
- Strengthen procurement systems to ensure uninterrupted supply of HIV and AIDS commodities
- Provide technical support to Hospitals, and Primary Health Facilities (PHFs) on HIV and AIDS QI related activities in public, faith-based and private facilities
- Conduct supportive supervision, mentoring and coaching to hospitals, PHFs in the district on QI activities
- Oversee QI implementation in the district by conducting review meetings regularly with all health facilities and relevant partners in the district
- Ensure functioning of the existing system for data collection, analysis, reporting and utilization in all facilities
- Receive facility reports, aggregate and analyze for decision making, planning and management purposes
- Submit monthly reports to the region
- Advocate, sensitize and promote HIV and AIDS QI activities at all levels within the district
- Monitor performance of health facilities on priority QI targets and indicators for HIV and AIDS services
- Conduct regular assessments of health facilities in the district to identify priority areas for improvement
- Ensure integration of QI activities for HIV and AIDS into all Council Comprehensive Health Plans (CCHP)
- Distribute and enforce the use of HIV and AIDS intervention guidelines in health facilities within the district

6.3.1 District Hospital

The following are responsibilities of District Hospitals in relation to QI activities:

Box 6: Roles of district hospital

The district hospital being the referral level within the district, should perform the following functions:

- Provision of clinical services to inpatients and outpatients referred from primary health facilities and other hospitals within the district
- Provision of curative services at the district hospital
- Providing expert and technical support to primary health facilities; public, faith-based and private on HIV and AIDS services

6.4 Health Facility Level (Other Hospitals and Primary Health Facilities)

The roles and responsibilities of health facilities have been broadly described in intervention specific guidelines. Below are QI-specific roles and responsibilities of health facilities:

Box 7: Roles of Health Facilities

- Establish QI team and describe roles and responsibilities of team members
- Ensure implementation and management of QI activities
- Ensure clean and safe working environment for clients and health care workers
- Identify quality gaps through analyzing processes of care within the facility and propose changes for improvement
- Develop work plans and set targets based on defined national indicators
- Test the proposed changes and innovations using the QI model
- Collect, compile, validate, analyze, utilize and timely submission of data to the Council
- Share QI experience through existing internal and external forums including community health committee on HIV and AIDS

SECTION 7

7. 0 OPERATIONALIZATION OF QI ACTIVITIES ACROSS LEVELS OF CARE

Since the HIV epidemic evolved in Tanzania, the Government and stakeholders response to the epidemic has led to a number of policy and institutional arrangements aiming at improving the quality of services for PLHIV. The following have evolved to be core activities for implementation of various HIV and AIDS interventions:

- Assessment of health facilities
- Service provision as guided by intervention- specific guidelines and application of QI model and principles
- Supportive Supervision
- Clinical Mentorship
- Monitoring and Evaluation

For implementation of QI activities for various HIV and AIDS interventions across all levels of the health care system all of the above activities need to be adhered to.

7.1 Assessment of health facilities

Assessments of facilities are conducted to assess whether a facility is able to provide HIV and AIDS Prevention, Care, Treatment and Support Services according to the minimum criteria set. The following specific objectives have been defined for the assessment procedure:

- Determine the availability and quality of the essential elements to start and/or expand HIV and AIDS services
- Identify areas for strengthening and improvement to upgrade health facilities to be able to provide comprehensive HIV and AIDS care, treatment and support services to PLHIV

Assessment is an ongoing process through which areas for improvement are identified and strengthening plans developed. Implementation of this process is regionalized (with coordination by NACP), giving mandate to the RHMT/CHMT and Implementing Partners Organization working in the region to carry out the Health Facility (HF) assessment and preparing the Strengthening Plan in collaboration with facility staff.

Areas of assessment in a health facility include:

- Organization of HIV and AIDS services
- Human Resource capacity
- Training and guidelines
- Clinical HIV and AIDS services
- Patient records and reporting systems
- Continuum of care
- Counseling and testing services
- Laboratory services
- Pharmacy services
- Finances

7.2 Service provision and Application of QI Model and Principles

All HIV and AIDS interventions are guided by specific guidelines (see annex I). For harmonization and standardization of practice, all stakeholders involved in service provision should comply with these guidelines. In addition, principles of Quality Improvement described in section 4 and the Improvement Model using PDSA cycles described in section 5 should be applied in improving quality of services provided to PLHIV.

7.3 Supportive Supervision

Supportive Supervision is a process which promotes quality outcomes by strengthening communication, identifying and solving problems, facilitating team work, and providing leadership and support to empower health providers to monitor and improve their own performance. It expands the scope of supervision method by incorporating self assessment, peer assessment as well as community input. Supportive supervision aims at improving the quality of HIV and AIDS services through joint observation, discussion, and direct problem-solving, mentoring and learning from each other.

Supportive Supervision is guided by national guidelines and tools and its implementation is organized according to levels. Central level supervises consultant hospitals and RHMTs. The regional level supervises regional hospital and CHMTs who in turn supervise all health facilities including hospitals in the district.

7.4 Clinical Mentorship

Mentorship is a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality health care outcomes. It is an integral part of the continuing education process taking place at the facilities where health care workers manage patients.

Effective mentorship for HIV and AIDS care providers involves regular visits by regional and district mentors spending time with health care providers at lower levels of care providing regular on-job-training on various aspects of HIV and AIDS interventions.

7.4.1 Mentorship versus supportive supervision

Mentorship and supportive supervision are used interchangeably with similarities, however, differences may be observed as shown in the table below:

Figure 4: Differences and similarities between supportive supervision and mentoring[12]

Supportive supervision

- Space, equipment and forms
- Supply chain management
- Training, staffing and other human resource issues
- Entry points
- Patient satisfaction

Both (overlap)

- Patient flow and triage
- Clinic organization
- Patient monitoring and record-keeping
- Case management observation
- Team meetings
- Review of referral decisions

Clinical mentoring

- Clinical case review
- Bedside teaching
- Journal club
- Morbidity and mortality rounds
- Assist with care and referral of complicated cases
- Available via distance communication

7.5 Monitoring & Evaluation

A monitoring and evaluation system for HIV and AIDS interventions is made up of forms, cards, registers, records and procedures to collect and report information on indicators used to track programme activities and examine whether the programme is meeting its goals.

Objectives of the monitoring and evaluation framework are:

- Monitoring of implementation progress of National HIV and AIDS interventions
- Timely identification of constraints hindering the implementation process and measures taken to address gaps
- Demonstration of programme effectiveness and impact.
- Evaluation of programme performance

For the M & E system to function properly, managers at all levels need to ensure that monitoring tools are available and health care workers are oriented in the use of tools. Managers should also ensure that data is compiled, analyzed and respective progress reports written and timely submitted to next levels. Furthermore, health care workers need to collect, analyze and use collected information for improvement locally as well as timely submission to relevant higher levels.

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[12] WHO recommendations for clinical mentoring to support scale-up of HIV care, antiretroviral therapy and prevention in resource-constrained settings. 2006.

7.6 Level-specific roles and responsibilities

7.6.1 National level

This level is responsible for providing vision, policy formulation, setting standards and coordination. To achieve this, the following should be accomplished:

- Establish a National QI Team (NQIT) composed of representatives from MOHSW, NACP units and QI stakeholders to coordinate countrywide implementation of QI including regular monitoring and review of implementation progress and providing feedback to NACP. The NQIT would also provide technical support to R/CHMT as need arises.
- Establish national standards and monitoring indicators for evaluation of the various HIV and AIDS interventions
- Coordinate development and regular review of monitoring and supervision tools that are linked with the QI guidelines: measurements/assessment, supportive supervision, mentoring and M&E
- Develop QI training package and provide regular review of the QI training
- Liaise with ZTCs, regions and stakeholders in rolling out QI trainings
- Participate in supervision of QI activities

7.6.2 Regional level

Implementation of QI will depend largely on the core functions allocated to the region (RHMT) and the Zonal Training Centre (ZTC). Both play a role within the health service delivery as recommended by the national health sector reform policy. In order for the QI tasks to be implemented at this level the following performance measures should be considered:

- Establish Regional QI team and appoint a focal person
- Carry out regional QI activities and provide technical support to the districts
- Enforce the use of QI guidelines by all stakeholders
- Coordinate and monitor implementation of QI activities in the region
- Ensure QI activities for HIV and AIDS are incorporated into Comprehensive Regional Health Plan (CRHP)

7.6.3 District level

As it was described in section 6.3 execution of health care policy is done at the district level. In order for the QI tasks to be implemented at this level the following performance measures should be considered:

- Establish a Council QI team and appoint a focal person
- Carry out Council QI activities and provide technical support to the health facilities
- Enforce the use of QI guidelines by all stakeholders
- Coordinate and monitor implementation of QI activities in the district
- Ensure that QI activities for HIV and AIDS are incorporated into Comprehensive Council Health Plans

7.6.4 Facility level

The health facility is the first entry point of HIV and AIDS services for a majority of clients/patients, especially for care. These facilities include dispensaries, health centers, special clinics and hospitals. It is at facility level where most of the QI implementation takes place.

In order for the QI tasks to be implemented at this level the following performance measures should be considered:

- Establish a facility QI team and appoint a focal person
- Use existing data to set improvement priorities and objectives
- Develop work plans based on agreed services standards, best practices and monitor indicators and identify resources
- Implement the work plans and collect data to monitor improvement
- Share experiences within facility, between facilities, with CHMTs and with stakeholders.
- Institutionalize best practices and lessons learnt
- Integrate QI activities into facility work plan and budgets
- Ensure the use of specific existing guidelines for HIV and AIDS interventions

7.7 Implementation Log frame for QI Activities across Levels of Care

National Level				
Main Activity	***Sub-activity***	***Responsible***	***Verifiable indicator***	***Output***
To strengthen leadership structure and mechanisms that will develop, implement, monitor and sustain QI				
Establish a National QI Team (NQIT) composed of representatives from MoHSW, NACP and QI stakeholders	Identify NQIT members	NACP	List of names of appointed and approved NQIT members	NQIT with clear Terms of Reference (ToR)
	ToR	NACP	ToR	
Establish national standards and monitoring indicators for evaluation of the various HIV and AIDS interventions.	Identify a team to work on national standards and monitoring indicators	NACP	A comprehensive team of stakeholders to work on standards and indicators	National standards and monitoring indicators established
	Conduct a workshop to review and agree on national standards and monitoring indicators	NACP	Workshop report on national indicators	
	Convene stakeholder's meeting to disseminate national standards and monitoring indicator	NACP	Dissemination meeting report	
Develop QI guidelines for HIV and AIDS prevention, care, treatment and support services	Identify team and ToR to develop the QI guidelines	NACP	List of team members and ToR	National Quality Improvement guidelines for HIV and AIDS services developed
	Conduct review workshop to review draft QI guidelines	NACP	Workshop report	
	Finalize QI guidelines	NACP	Final Draft of QI Guidelines	
	Disseminate QI guidelines	NACP	Dissemination meeting report	
	Print and distribute QI guidelines	NACP	Printed copies of the guidelines and numbers of copies distributed	

Develop QI training package	Identify team to develop the QI training package	NACP	List of team members	QI training package developed
	Assign roles and responsibilities to team members	NACP	Assigned roles and responsibilities	
	Conduct workshop to review the QI training package	NACP	Workshop report on reviewing QI training package	
	Stakeholder meeting to disseminate the QI training package	NACP	Dissemination meeting report	
	Finalize QI training package	NACP	Final draft of QI training package	
	Printing of the QI training package	NACP	Printed copies of QI training package	
Roll out QI trainings all over the country using ZTCs, regions and stakeholders	Build capacity of ZTCs and Region as ToTs to conduct QI trainings	NACP	ZTCs / Region QI training report	QI trainings rolled out
	Training of healthcare workers and other stakeholders on QI	NACP, ZTCs and RHMTs	Training report	

Regional Level				
Main Activity	***Sub Activity***	***Responsible***	***Verifiable Indicator***	***Output***
Establish Regional QI team and appoint a focal person	Form RQIT with members from RHMT and other HIV and AIDS stakeholders	RHMT	List of RQIT team members	RQIT established with relevant members and clear responsibilities
	Identify Focal Person	RHMT	Name of Regional QI focal person	
	Assign responsibilities to RQIT members	RHMT	List RQIT members each with assigned roles and responsibilities	
Carry out regional QI activities and provide technical support to the districts	Conduct training on QI to CHMTs and health care providers	RHMT	Trainings reports	Regional QI activities implemented and monitored
	Carry out health facility assessments twice a year	RHMT	health facility assessment reports	
	Conduct quarterly supportive supervision to CHMTs and health facilities	RHMT	Supportive supervision reports	
	Conduct quarterly coaching and clinical mentorship	RHMT	Coaching and clinical mentorship reports	
	Support CHMT to conduct M&E of HIV and AIDS services quarterly	RHMT	M&E reports	
Distribute QI guidelines within the region	Distribute QI guidelines in districts within the region	RHMT	Number of copies of QI guidelines distributed	Number of facilities using the Guidelines
Coordinate and monitor implementation of QI activities in the region	Set annual regional QI targets	RHMT	List of annual regional QI targets	Regional QI activities implemented and monitored
	Review quarterly council QI work plans and advise on measure to be taken	RHMT	Quarterly Council work plan review reports	
	Conduct bi-annual QI review meetings with all stakeholders to share experiences	RHMT	Bi-annual QI meetings reports	
	Monitor progress of QI activities in each district per work plan	RHMT	Monthly and quarterly district QI progress reports	

Main Activity	Sub Activity	Responsible	Verifiable Indicator	Output
Ensure QI activities for HIV and AIDS are incorporated into Comprehensive Regional Health Plans	Review, approve and harmonize district QI activities	RHMT	Reports on harmonized regional QI activities	QI activities for HIV and AIDS incorporated into CRHP
	Integrate QI plans into CRHP	RHMT	CRHP with QI activities	

District Level				
Main Activity	***Sub activity***	***Responsible***	***Verifiable Indicator***	***Output***
Establish Council Quality Improvement Team (CQIT) and appoint a focal person	Form CQIT with members from CHMT and other HIV and AIDS stakeholders	CHMT and stakeholders	List of CQIT team members	CQIT established with clear ToR and district QI focal person identified
	Identify QI focal person	CHMT	Name of district QI focal person	
	Assign responsibilities to CQIT members	CHMT	List CQIT members each with assigned roles and responsibilities	
Carry out Council QI activities and provide technical support to the health facilities	Conduct training on QI	CHMT	Training reports	Report on trainings, assessments, support supervision and clinical mentorship available
	Participate in assessment of HF	CHMT	Health facility assessment reports	
	Conduct supportive supervision	CHMT	Supportive supervision reports	
	Conduct clinical mentorship	CHMT	Mentorship reports	
Ensure availability of Q guidelines in all HF within the district	Distribute QI guidelines to all health facilities within the district	CHMT	Number of HF with QI guidelines	All health facilities use QI guidelines

Main Activity	Sub Activity	Responsible	Verifiable Indicator	Output
Coordinate and monitor implementation of QI activities in the district	Set annual district QI target	CHMT	Number of facilities with annual QI targets	Council QI activities implemented and monitored
	Review quarterly health facilities QI work plans and advise on measure to be taken	CHMT	Quarterly health facility work plan review reports	
	Conduct quarterly QI review meetings with all district stakeholders to share experiences	CHMT	Quarterly QI review meetings reports	
	Monitor progress of QI activities in each health facility as per work plan	CHMT	Monthly Council QI progress reports	
Ensure health facility QI activities for HIV and AIDS are incorporated into Comprehensive Council Health Plan (CCHP)	Review, approve and harmonize health facilities QI activities	CHMT	CCHP document with harmonized health facilities' QI activities	Facility QI activities reviewed and integrated into CCHP
	Integrate harmonized QI plans into CCHP	CHMT	CCHP with health facilities' QI activities	

Facility Level				
Main Activity	***Sub-activity***	***Responsible***	***Verifiable indicator***	***Output***
Establish facility QI team and appoint a focal person	Identify QI team members	Facility In-charge	List of facility QI team members and name of focal person	A facility QI team established with clear TOR for members
	Assign tasks to QI team members	Facility In-charge	Clear task list for each of the QI team members	
	Conduct monthly facility QI meeting	Facility QI Team	Monthly QI meeting reports	
Identify improvement priorities based on collected facility data	Collect baseline data on priority areas for improvement	Facility QI Team	Baseline data on priority areas for improvement	Identified priority improvement objectives and collected baseline data
	Set feasible improvement objectives from collected data	Facility QI Team	List of improvement objectives	
Develop work plans based on agreed services standards, best practices and monitoring indicators and identify resources	Identify deficiencies in care delivery process through analyzing processes of care within the facility	Facility QI Team	Gaps in the process of care	HFs working according to set standards based on best practices
	Develop and test changes and innovations formulated after analyzing processes of care using the PDSA model	Facility QI Team	Evaluation report on the tested changes and innovations	
	Write monthly report based on compiled data	Facility In-charge	Monthly QI report	
	Send monthly reports to the district and share with relevant stakeholders	Facility In-charge	Monthly report sent to the district	
	Assess health facility working environment	Facility QI Team	Environmental cleanness and safety assessment report	HFs with clean and safe working environment
	Make facility environment clean and safe for patients and health care workers	Facility QI Team	Environmental cleanness and safety work plan	

ANNEX

ANNEX 1: LIST OF HIV AND AIDS INTERVENTION SPECIFIC GUIDELINES CURRENTLY IN USE

S/N	Name of Guidelines	Year Printed
1.	National Guidelines for the Management of HIV and AIDS	2008
2.	Guidelines for HIV Testing and Counseling in Clinical Settings	2008
3.	TB/HIV Policy Guidelines	2008
4.	National PMTCT Guidelines	2007
5.	National Guidelines for Management of Sexually Transmitted and Reproductive Tract Infections	2007
6.	National Guidelines for Voluntary Counseling and Testing	2005
7.	Guidelines for Home Based Care Services	2005