

Site Level Performance Monitoring SOP

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Introduction

The purpose of this SOP is to define the expectations for ZimPAAC district, provincial and head office staff to provide site level performance monitoring feedback.

Site-level performance monitoring (SLPM), combined with site level support, aim to maintain or improve the performance of ZimPAAC sites and consortium partners in HIV related care and treatment services. It is based on a continuous cycle of regular review of site-level program data with regular feedback to site-level staff and episodic site visits. SLMPM and support are:

- Carried out in a respectful and non-authoritarian way
- Focuses on using feedback that is tailored to the improvement needed.
- Encourages open, two-way communication, and building team approaches that facilitate problem-solving.
- Part of a process that reviews site-level program data, for example, key performance indicators (KPI), analyzes the data, and uses the data to inform how improvements can be made.
- A collaborative and ongoing practice.

Head office, provincial, and district staff may work with direct service delivery (DSD) staff, as well as facility administrators to address systems and resource issues that affect quality of care. The aims are:

- To work with health care workers (HCW) to identify gaps in service delivery for service areas, identify solutions, make plans to implement the solutions and to follow-up on plans.
- To motivate and provide support to often overworked HCWs.

The foundational element of site level performance monitoring is the tracking of key performance indicators (KPIs). There is a “traffic light” dashboard that will inform the focus of the supportive oversight, both through virtual visits and in person. Staff need to access Power BI to review the dashboard. The table in Appendix A provides thresholds and suggested interventions for improvement and Appendix B provides data use expectations. Appendix C is a guide for how to use the Power BI KPI dashboard.

The SOP is focused on using the KPI dashboard and Power BI reports that are generated through the ZimPAAC Data Improvement Project (ZDIP).

Types of Site Support

- **Ongoing and regular virtual visits** (phone, emails, SMS, WhatsApp, Skype, etc)
 - Review of data (successes, challenges, issues, problem solving, planning).
- **Onsite episodic team visits** (face to face):
 - Targeted assessment and documentation review to address issues previously documented but not yet resolved.
 - Team includes clinical and strategic information staff, as well as ministry management.

ALL support provided, whether virtual or in person need to be documented.



Minimum Site Support Performance Monitoring Expectations

- Responsible staff
 - Facility Staff- (OI Nurses, FDFP, VIAC Nurses, VIAC mentors)
 - District – District Site Improvement and Community Linkage Focal Persons (DSICLFP) and District Strategic Information Focal Persons (DSIFP)
 - Provincial – Provincial Focal Persons (PFP)
 - Head Office staff – Senior Program Managers (SPM), Program Coordinators (PC) and Strategic Information Coordinators (SICs)
- Expectations
 - Regular review of KPIs, ensuring that plans are put in place where performance is below expectations and acknowledge where programs are running well
 - KPI review should be done weekly at facility level, twice a month at district level and monthly at provincial and national level (see figure 1 below)
 - Feedback should be provided in a timely manner with clear, documented improvement plans where performance is below expectations
 - Follow-up should be conducted to address improvements, barriers, and strategies to attain targets
- Purpose
 - To provide targeted site support addressing areas that need improvement
 - To assess program implementation reinforcing positives and pointing out areas of possible weakness and discussing how best to overcome gaps in service delivery and record keeping
 - To address staffing for optimal program performance and be able to redistribute staff as needed
 - To learn and encourage best practices and how they can be implemented elsewhere

Frequency of Data Monitoring

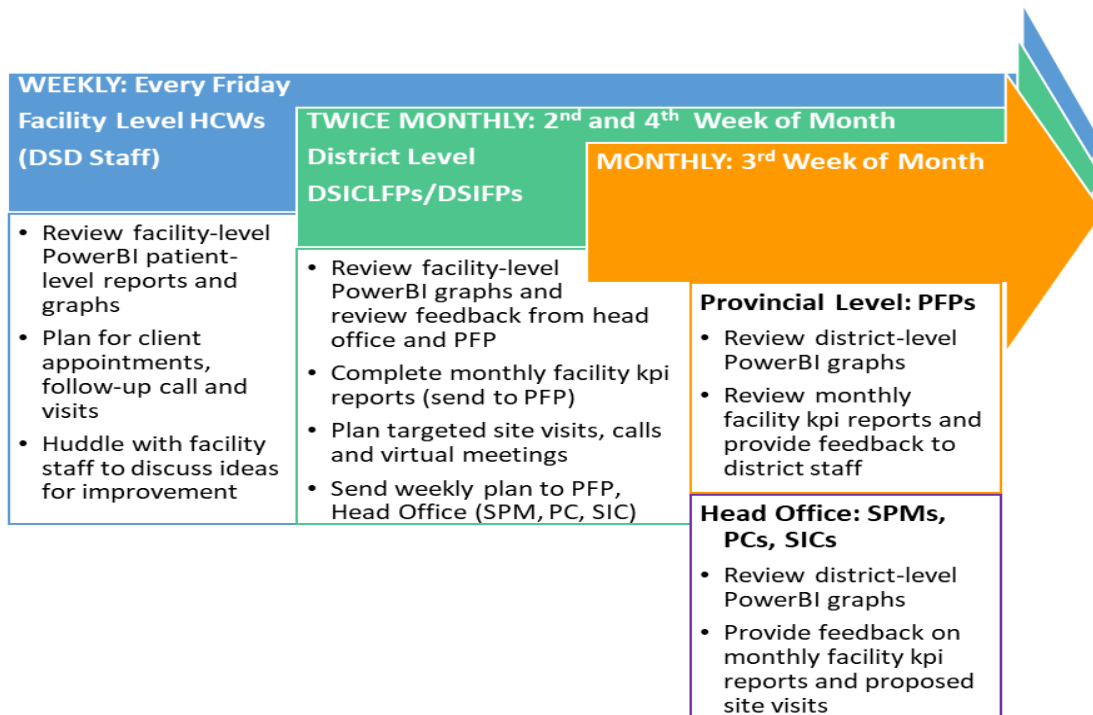


Figure 1: Frequency of data monitoring



Process for Providing Feedback on Facility Performance

Facility Level staff are expected to review the weekly data in Power BI (see **Appendix C: Guide for Accessing Power BI KPI Dashboard**) using the patient-level reports and graphs. Teams should be looking at the dashboards and working together to come up with ways to address issues and maintain momentum in areas they are performing well.

District level staff are expected to work with facility teams to ensure that they are reviewing the weekly data in Power BI and that they are entering data into ZDIP as required. District teams should always begin with virtual visits using an agreed upon format (WhatsApp, phone, zoom, skype, etc.). **Virtual feedback should be the initial methodology for KPI discussions**, making face to face visits less frequent and more targeted. Typically, once virtual feedback has been provided and documented, a targeted site visit is scheduled if there are ongoing performance issues, or a facility is doing exceptionally well and can share their best practices. There are also special circumstances where a visit may occur that is not related to performance, such as onboarding new team members or ministry issues. See Appendix D for more information on circumstances for in-person visits and process of approval for these visits.

Have questions?
Feeling stuck?



Contact your supervisor and let them help you figure out your next steps

Overview

- **Purpose:** Regular review of facility performance
- **Cadre:** DSICLFPs/DSIFPs, and as needed, PFPs, PCs, SICs, SPMs
- **Frequency:** Every 2 weeks at district level and monthly at provincial and national level
- **Documentation (see Appendix E):**
 - DSCILFPs/DSIFPs to use the SLPM District report, name the file with facility name and date (yyyy.dd.mm) e.g. SLPM_Makumbe_2021.21.04 and file on One Drive > Team Drive > Documents > COP20 Site Support Reports > Province > District
 - PFPs to use Monthly District Reporting Template, name the file with district name and date (yyyy.dd.mm) e.g. SLPM_Guruve_2021.21.04 and file on One Drive > Team Drive > Documents > COP20 Site Support Reports > Province > PFP Reports
 - Head Office to use Monthly District Reporting Template, name the file with province name and date (yyyy.dd.mm) e.g. SLPM_MashEast_2021.21.04 and file on One Drive > Team Drive > Documents > COP20 Site Support Reports > Head Office Reports



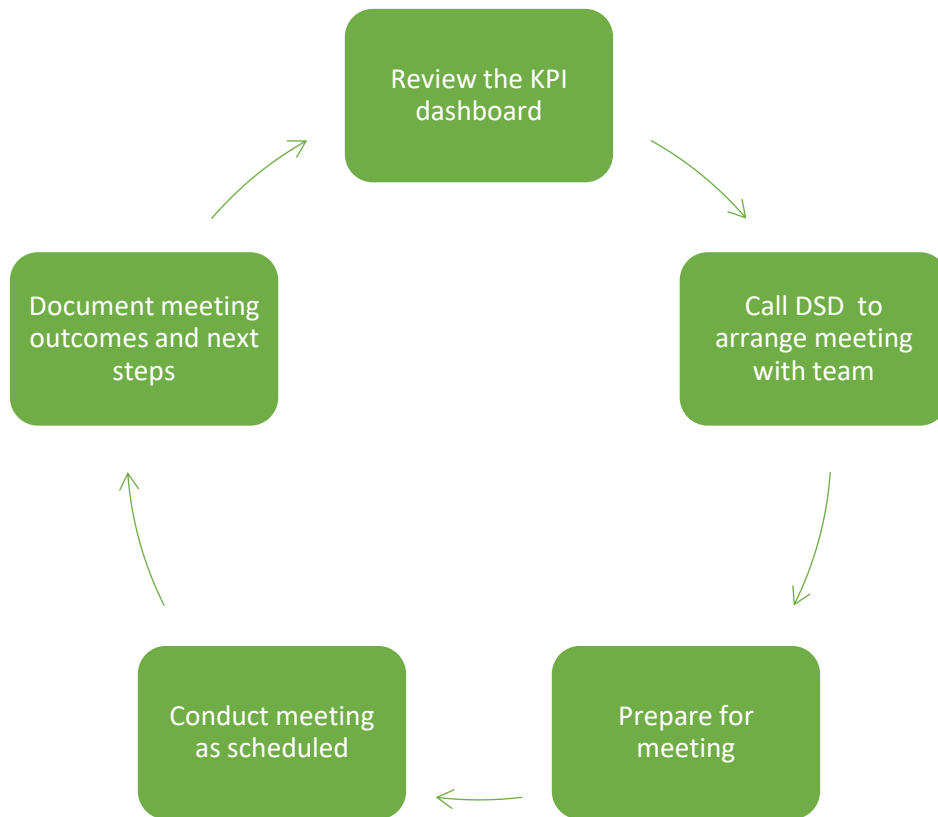


Figure 2: Performance feedback process illustrated as circular because it is regular and repeated

1. **District** team should **review** the KPI dashboard AND any previous reports (each district team should have representation from both the clinical and SI teams)
 - a. Note where facilities are exceeding, approaching, or not meeting expectations (green, yellow and red)
 - b. Check progress in dashboard of any action items that were listed in previous reports
2. Call DSD to arrange meeting with team (Remember that most of these meetings are virtual unless there has been documentation of ongoing performance issues which have not been resolved or other special circumstances that call for a targeted visit, see Appendix D for more details.) **No visits should be made without supervisory approval.**
 - a. District team should also include local ministry leadership in the meeting
 - b. Inform facility team of main focus for discussion and tell them what they will need to have available at the meeting (e.g., specific registers or tools)
 - c. Ask that the team review the KPIs and be ready to discuss performance during the meeting
3. Prepare for meeting
 - a. Write down questions, comments for team
 - i. Start with noting successes and program areas that are performing at or beyond expectations
 - ii. After acknowledging areas of strength, the focus should be on areas needing improvement (in red and yellow on the dashboard)



- iii. Over time, pay attention to trends and make sure that questions are asked to better understand why changes have occurred (note that it is important to find out what challenges are being faced to problem solve, as well as recognizing what successes have been accomplished and sharing best practices)
 - b. Make sure there is sufficient airtime or data for meeting
- 4. Conduct meeting as scheduled
 - a. Share feedback from dashboard using good communication skills (see Appendix F)
 - i. Encourage facility team to share how they are looking at their data before sharing findings,
 - ii. Ask questions about who is reviewing the data, and if they are discussing as a team
 - iii. Share insights on what was seen in the dashboard and if it is in alignment with what the facility has presented
 - iv. Discuss any areas where the data does not align and determine why it doesn't match
 - b. Identify plans for improvement with clear targets and timelines (see Appendix G for Quality Improvement tips and assessing root cause)
 - c. Clarify and agree on next steps and follow-up expectations with timelines and persons responsible
- 5. District team to document meeting outcomes and next steps on SLPM district report (see Appendix E), both the clinical and the SI focal persons need to sign, then file on OneDrive (Team Drive > Documents > COP20 Site Support Reports > Province > District) and share with **PFP**
- 6. **PFP** to provide documented feedback including next steps to district team and district ministry personnel, file on OneDrive (Team Drive > Documents > COP20 Site Support Reports > Province) AND share with head office
- 7. **Head office** to provide documented feedback to **PFP** with next steps file on OneDrive (Team Drive > Documents > COP20 Site Support Reports > Head Office)

Process for Conducting a Targeted Site Support Visit

There are certain situations that require a targeted site support visit. Often these occur when there is a need for on-the-job training, when introducing new or updated tools, when new team members have joined, or when there is a need for coordination or engagement with the district or provincial health executives for updates. There is also a need for targeted site support when after 2 meetings there has been no improvement in performance despite specific agreed-upon improvement activities. There are some special circumstances that require a visit when virtual meetings are unable to be conducted. See Appendix C for more information on the justifications necessary and the approval process. **All performance-related visits need to have documented reports that support the need for a visit and these visits must be approved by provincial and head office management teams, and Head of Programs must be informed.**



Overview

- **Purpose:** A visit to follow-up on a deficiency or issues identified through facility dashboards, MER performance or program reports.
- **Cadre:** DSICLFPs/DSIFPs, and as needed, PFPs, PCs, SICs, SPMs
- **Frequency:** As needed with approval from management
- **Documentation:** Targeted Site Visit Report (appropriate section from the ZIMS Reporting Tool in Appendix H) and Facility Management Book that is kept in the facility office. File on One Drive in (Team Drive > Documents > COP20 Site Support Reports) in the correct folder



Figure 3: Targeted site support process once it has been approved

1. Preparation

- a. Make sure approval has been given for a targeted visit
- b. Schedule visit with appropriate ministry staff at provincial and/or district level, facility SIC and facility team
 - i. Ministry staff need to be included in site support visits in order to ensure full collaboration and cooperation for performance improvement activities
 - ii. Depending on the province, it will be necessary to include the provincial health executives on visits, as well as the district health executives
 - iii. Ensure all approvals needed for the visit are given in advance
- c. Review facility dashboards, previous site assessments and visit reports
- d. Make copies of targeted site visit report using the relevant sections of the ZIMS Reporting Tool (Appendix H)
- e. Collect relevant guidelines, posters, and SOPs for distribution to facility.

2. Visit

- a. Record names of all staff participating on the checklist
- b. Review documentation to determine if gap identified may be an issue with data quality (are records showing the same numbers as dashboard?).
 - i. Before sharing findings, encourage facility team to explain how they are looking at their data
 - ii. Ask questions about who is reviewing the data, and if they are discussing as a team
 - iii. Share insights on what was seen in the dashboard and if it is in alignment with what the facility has presented
 - iv. Discuss any areas where the data does not align and determine why it doesn't match
- c. Observe/discuss patient flow- determine if adjustments to patient flow may address gap identified.
- d. Review performance gaps that have been identified and discuss the challenges that the facility is experiencing which are causing barriers to improvement (see Appendix G)
- e. Share feedback from dashboard using good communication skills (see Appendix F)

- f. Identify plans for improvement with clear targets, timelines and responsible persons

3. Documentation

- a. Complete the report in the Facility Management book at the site
- b. Visiting team to document meeting outcomes and next steps on relevant ZIMS Reporting Tool (see Appendix H), both the clinical and the SI focal persons need to sign, then file on OneDrive with the name of the facility and the date of the visit (One Drive > Team Drive > Documents > COP20 Site Support Reports > Province > District) and share with **PFP** and **head office**

4. Follow-up

- a. One month after targeted visit, data should be analyzed, and feedback provided
- b. Use phone calls for intermediate follow-up
- c. Document follow-up feedback as part of the next SLPM district report, file on OneDrive with the name of the facility and date of the follow-up contact (One Drive > Team Drive > Documents > COP20 Site Support Reports > Province > District): share with **PFP**



Appendix A: Key Performance Indicator Data Review Guide

Use the following to guide review of the Power BI key performance indicator “traffic light” dashboard. Detailed below are the criteria for performance interpretation thresholds and suggested interventions for improvement.

Program Area	Key Performance Indicator (KPI)	KPI Numerator (N)/Denominator(D)	Performance Interpretation Thresholds			Suggested Interventions for Improvement
			Meets Expectations	Approaches Expectations	Needs Improvement	
HTS	HIV testing yield	N: Number of newly diagnosed clients D: Number of clients tested	≥ 10%	9.9%-7%	≤ 7%	<ul style="list-style-type: none"> Dedicate staff for index testing for sexual partners (have flexible working hours) Ensure staff have necessary tools to implement index testing Identify PLHIV eligible for index testing in various facility registers Offer referral to index testing at multiple facility departments Escort newly diagnosed clients from entry point to index testing room Provide supervisory observation and create a targeted action plan for index testing focal person
TX_NEW	Percentage of newly diagnosed clients initiated on ART	N: Number of clients initiated on ART D: Number of newly diagnosed clients	≥ 95%	94%-91%	≤ 90%	<ul style="list-style-type: none"> Escort newly diagnosed clients to the OI/ART department for initiation
HTS_INDEX	Partner Index	N: Number of adult contacts (sexual partners) elicited D: Number of index clients	≥ 1.5	1.4-1.1	≤ 1	<ul style="list-style-type: none"> Use EICT scripts to elicit partners Ensure privacy of counselling space and improve if necessary Elicit partners from index clients after their clinical appointments Continue partner elicitation at follow up appointments especially when index shares 1 contact or none



HTS_INDEX	Percentage of sexual partners tested	N: Number of adult contacts (sexual partners) tested and received their results D: Number of eligible adult contacts (sexual partners) elicited	≥ 40%	39%-11%	≤ 10%	<ul style="list-style-type: none"> • Assist index clients with disclosing their status to their sexual partners- offer multiple options for disclosure • Offer multiple testing options for sexual partners elicited, work with index case to revise plan and encourage partners to be tested • Encourage use of HIVST and follow up to confirm results • Conduct after hours testing if more convenient for contacts • Escort partners presenting for facility testing to index testing room • Ensure tracking of index clients and partners (document appointments, send reminders and follow up missed appointments)
HTS_SELF	Target achievement HIV self-testing kits distributed	N: Number of HIV self-test kits distributed D: Monthly target for HIVST distribution	≥ 80%	79%-61%	≤ 60%	<p>Prioritize distribution of HIVST kits to the following priority and key populations:</p> <ul style="list-style-type: none"> • Sexual partners of index clients, especially those unable or willing to present to the facility • Sexual partners with unknown status of all pregnant and lactating women • Social sexual networks of MSM through distribution by peers and programme champion • Men
Viral Load	Percentage of PLHIV on ART with valid VL test	N: Number of PLHIV with a valid VL result D: Number of PLHIV on ART (TX_CURR)	≥90%	90%-60%	≤ 60%	<ul style="list-style-type: none"> • Conduct VL “surge” in low performing sites (patient education and mobilization, POC VL tests for vulnerable populations e.g. pregnant & lactating women, follow up results physically at the lab) • Use the viral load algorithm to identify all clients eligible for viral load testing • Implement a flagging system to notify health care workers of clients due for VL
Viral Suppression	Percentage of virally suppressed clients at facility	N: Number of PLHIV with a valid VL result <1000 D: Number of PLHIV with a valid VL result	≥95	94-80%	≤80	<ul style="list-style-type: none"> • On-job training on counseling skills • Identify focal person at each site • Train on switching to second line
CAYPLHIV Viral Load	Percentage of CAYPLHIV (0-24 year) on ART with valid VL result	N: Number of CAYPLHIV with a valid VL result D: Number of CAYPLHIV on ART (TX_CURR)	≥ 95%	95%-60%	≤ 60%	<ul style="list-style-type: none"> • Identify CAYPLHIV focal person in each site • Collaborate with AFRICAID CATS to improve CAYPLHIV for VL testing, for example include CATS in planning and conduct community site visits with CLF/VHWs



Retention	Percentage of defaulters returned to care	N: Number of defaulting clients returned to care D: Number of clients defaulting from care to care	≥ 80%	80-51%	≤ 50%	<ul style="list-style-type: none"> Evaluate and enhance counselling messages; identification of what are the drivers of poor retention and address them Offer alternate ART delivery models to the client returning to care which might better fit their needs.
Tx-Curr	Total Number of Clients receiving ART at facility	Total number of active clients receiving ART at facility (Calculate change from previous month)	≥95%	95-80	≤80	<ul style="list-style-type: none"> Defaulter tracking Use of appointment registers Updating of ART booklets
PrEP	Target achievement for PrEP initiations	N: Number of AGYW clients newly initiated on PrEP D: Monthly target for PrEP (PEPFAR target or MoHCC)	≥ 80%	79%-61%	≤ 60%	<ul style="list-style-type: none"> Treatment literacy sessions Use of PrEP champions to generate demand
CA_ Cervix	Screening coverage at facility	N: Number of HIV positive women aged 25-49 screened for cervical cancer in a within past year D: Number of women HIV positive aged 25-49 at facility	≥ 90%	90%-61%	≤ 60%	<ul style="list-style-type: none"> Document Ca Cervix screenings in ART booklet Offer Ca Cervix screening to all eligible women
CA_ Cervix	Percentage of eligible clients treated with LEEP, cryotherapy or thermocoagulation	N: Number treated on with LEEP, cryotherapy or thermocoagulation on same visit D: Number of women VIAC positive after screening (Exclude those with suspicious lesions)	≥ 90%	89%-66%	≤ 65%	<ul style="list-style-type: none"> Efficient referral system See and Treat approach Appointment and tracking system for those who can't get treatment on same visit
TB	Target achievement for TPT initiation	N: Number of clients newly initiated on TPT D: Number of clients eligible for TPT	≥ 95%	94%-66%	≤ 65%	<ul style="list-style-type: none"> Initiate all newly diagnosed HIV positive clients on TPT and ART at the same time Synchronize ART and TPT review and refill dates
PMTCT_EID	Percentage of HIV-exposed infants (HEI) receiving an EID test in the first 2 months	N: Infants who had a first virologic test (sample collected) between birth and 2 months of age (0-≤2mo): D: Number of HEI born 2 months prior	≥ 95%	94%-91%	≤ 90%	<ul style="list-style-type: none"> Ensure cohorting of HEIs Use the tracking register to track mother or infant who have missed a scheduled visit Ensure POC machines are used as far as is possible for immediate availability of results



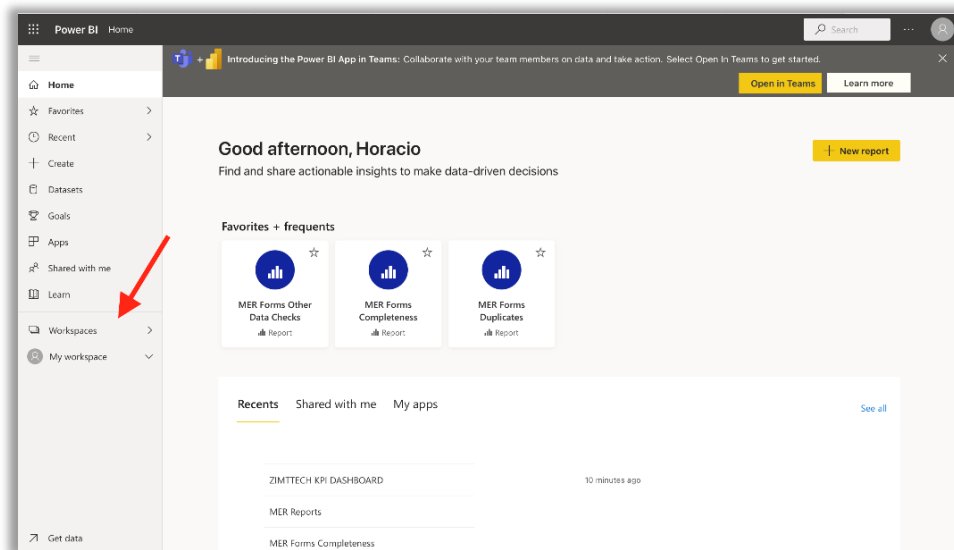
Appendix B: Data Use Expectations

User			
Facility Staff	DSICLFPs/DSIFPs	Provincial Focal Person (PFP)	Head Office
<p>Every Friday:</p> <ul style="list-style-type: none"> • Review patient-level reports <ul style="list-style-type: none"> ○ Plan for client appointments ○ List clients requiring follow-up calls that week ○ List clients for tracking through home visits • Review PowerBI graphs <ul style="list-style-type: none"> ○ Identify gaps in performance ○ Identify possible causes of dips in performance ○ Brainstorm and select interventions to improve ○ Implement plan for improvement 	<p>During 2nd and 4th week of the month:</p> <ul style="list-style-type: none"> • Review Key Performance Indicator “traffic light” dashboard for every supported facility in the district and record finding in the Monthly Key Performance Indicator Report • Provide feedback, determine causes and plans for improvement with facility staff via phone call, WhatsApp or email • Submit Monthly Key Performance Indicator Report to PFP • Schedule targeted site support visits for facilities needing improvement on KPIs <p>Weekly:</p> <ul style="list-style-type: none"> • Make weekly feedback plan and send to PFP and SPM • Conduct performance monitoring feedback sessions • Monitor performance on KPIs requiring improvement- conduct follow-up with sites via phone calls and WhatsApp, in addition to site visits 	<p>During the first week of every month:</p> <ul style="list-style-type: none"> • Review facility key performance indicator reports for all districts in the province • Provide feedback to district staff, inquiring further about performance as needed <p>Weekly:</p> <ul style="list-style-type: none"> • Review district staff plans for weekly feedback targeted site visits-provide feedback • Participate in targeted site visits 	<p>During the first week of every month:</p> <ul style="list-style-type: none"> • SPMs/SICs/PCs: Review facility key performance indicator reports by district • Provide feedback to district staff, inquiring further about performance as needed • Review district plans- giving feedback on that to ensure targeted support • Compare weekly and monthly averages with previous year performances <p>Weekly</p> <ul style="list-style-type: none"> • Monitor performance via Power BI dashboards • Review district site visit plans- provide feedback given facility performance • Participate in targeted site visits



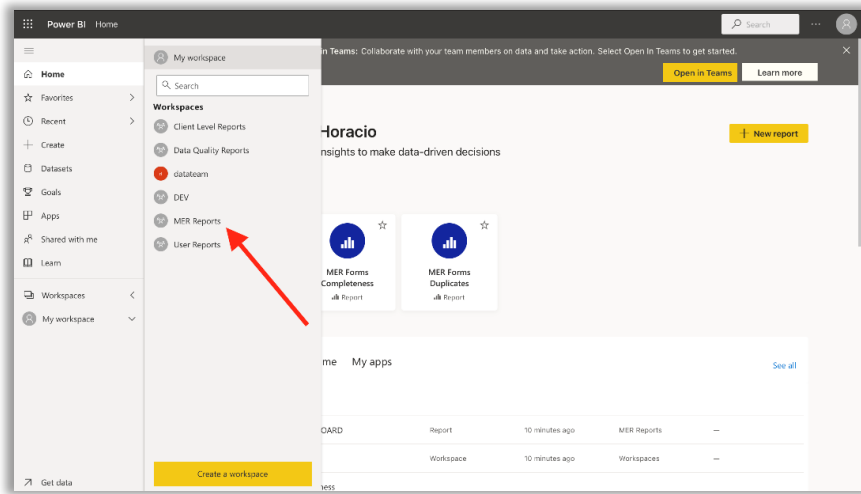
Appendix C: Guide for Accessing Power BI KPI Dashboard

Introduction: The Power BI KPI dashboard is where you will find report visualizations that come from the Zim-TTECH data that is being entered into CommCare (tablet-based forms). These reports are will allow you to see progress towards targets for key indicators. It is important to note that the KPI dashboard is dynamic, and gets updated and refined on a regular basis, therefore it may look a little different than what is in this guide. There are also many options for how to view the data, as you start navigating through the system you will find the views that you like best. If you have any problems with accessing or using Power BI, please contact Trymore Murakwani (tmurakwani@zimttech.org).



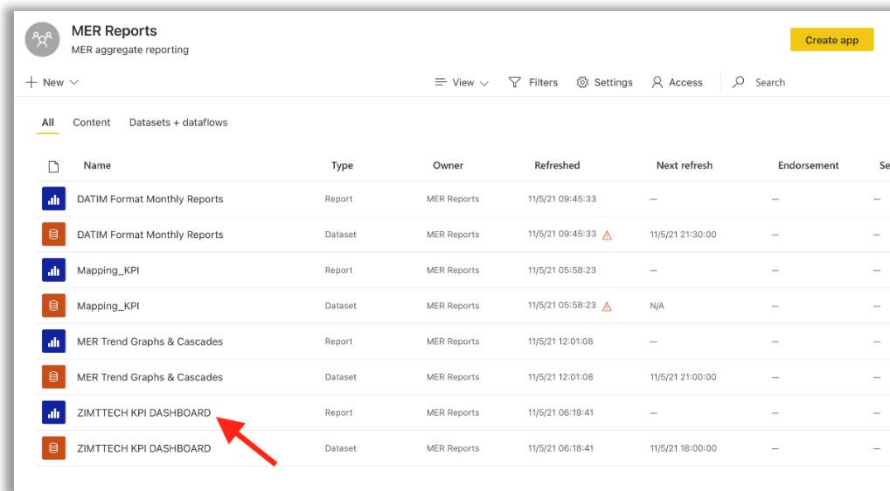
Power BI Access

1. Go to www.powerbi.com and enter your Power BI credentials
2. Once logged in, a screen similar to the one shown on the left will appear.
3. Click on the “Workspaces” button to access the “Workspaces” selection pane.




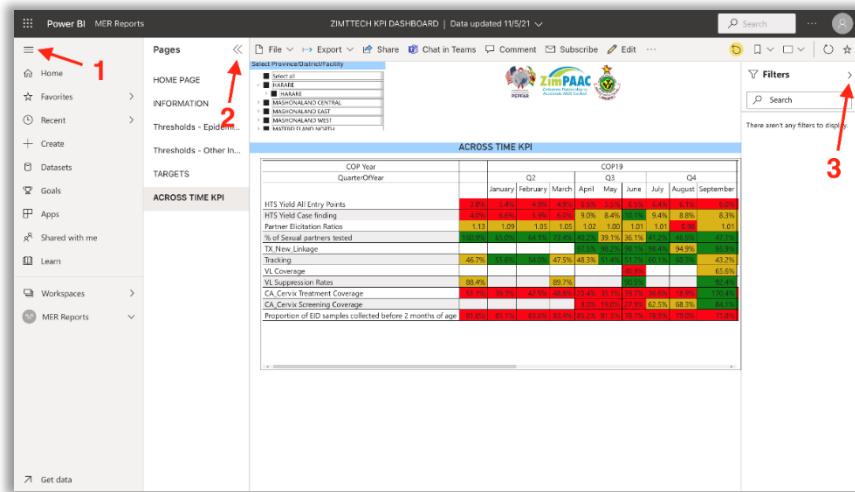
Workspace Selection

1. Once opened the workspaces pane, click on “MER Reports”.
2. If you are not able to access to the “MER Reports” workspace, please report to Trymore Murakwani (tmurakwani@zimttech.org).



Dashboard Selection

1. Once in the “MER Reports” workspace, it’s time to open the KPI dashboard.
2. Click on “ZIMTTECH KPI DASHBOARD”, as shown in the image to the left.
3. IMPORTANT: Click in the row where the  icon appears.



The KPI Dashboard


1. By default, a screen similar to the image on the left will appear.
2. The content of the dashboard is contained at the center of the screen.
3. If more space is needed to navigate or review KPIs, the user can collapse several panes by clicking on [1], [2] or [3].
4. Selecting from the “Pages” pane, we can access the different sections of the dashboard.



Home Page

1. Here the user can be redirected to any section of the dashboard.
2. It basically functions the same as the left “Pages” pane.

Power BI - MER Reports | ZIMTECH KPI DASHBOARD | Data updated 11/5/21




PROGRAM AREA	KEY PERFORMANCE INDICATOR (KPI)	PERFORMANCE INTERPRETATION THRESHOLDS		
		APPROACHES ENCOURAGED	APPROACHES ENCOURAGED	SELECT UNAPPROVED
HIV	% TESTING HIV POSITIVE (ALL ENTRY POINTS)	>=10%	8.5%-7%	<=7%
HIV	% TESTING HIV POSITIVE (CASE FINDING TESTS)	>=10%	8.5%-7%	<=7%
TX_NEW	% OF NEWLY DIAGNOSED CLIENTS INITIATED ON ART	>=95%	94%-91%	<=90%
HIV_INDEX	NUMBER OF SEXUAL CONTACTS ELICITED PER INDEX	>=1.5	1.4-1.1	<=1
HIV_INDEX	% OF SEXUAL PARTNERS TESTED	>=40%	39%-17%	<=10%
HIV_SELF	TARGET ACHIEVEMENT HIV SELF TESTING KITS (DEFINITION)	>=80%	79%-67%	<=60%
VIRAL_LOAD	% OF PLINY ON ART WITH VALID VL TEST	>=90%	90%-60%	<=60%
VIRAL_SUPPRESSION	% OF VIRALLY SUPPRESSED CLIENTS AT FACILITY	>=90%	90%-60%	<=60%
CARVIRVIRAL_LOAD	% OF CARVIRVIR (0-24 YEARS) ON ART WITH VALID VL RESULT	>=95%	94%-60%	<=60%
RETENTION	% OF DEFAULTERS RETURNED TO CARE	>=90%	90%-37%	<=30%
TX_CURR	TOTAL NUMBER OF CLIENTS RECEIVING ART AT FACILITY	>=100%	100%	<=100%
PAIP	TARGET ACHIEVEMENT FOR PAIP INITIATIONS	>=80%	79%-67%	<=60%
CA_CERVIX	SCREENING COVERAGE AT FACILITY	>=80%	79%-67%	<=60%
CA_CERVIX	% OF ELIGIBLE CLIENTS TREATED WITH LEEP (DEFINITION: THRESHOLD CATEGORICAL)	>=80%	89%-67%	<=60%
TB	TARGET ACHIEVEMENT FOR TPE INITIATION	>=95%	94%-65%	<=60%
PREVENT BID	% FOR M4 RECEIVING AN HIV TEST IN FIRST TWO MONTHS	>=95%	94%-97%	<=90%

KPI Information Page

1. In this section, all KPIs are listed for reference, accompanied by their respective thresholds.
2. The green column refers to a KPI value that meets the expectation.
3. Please refer to this table when evaluating the KPI values in the following Dashboard sections.

Power BI - MER Reports | ZIMTECH KPI DASHBOARD | Data updated 16/5/21




Select Province/District/Facility: Select all, HARARE, MASHONALAND CENTRAL, MASHONALAND EAST, MASHONALAND WEST, MATEBELELAND NORTH

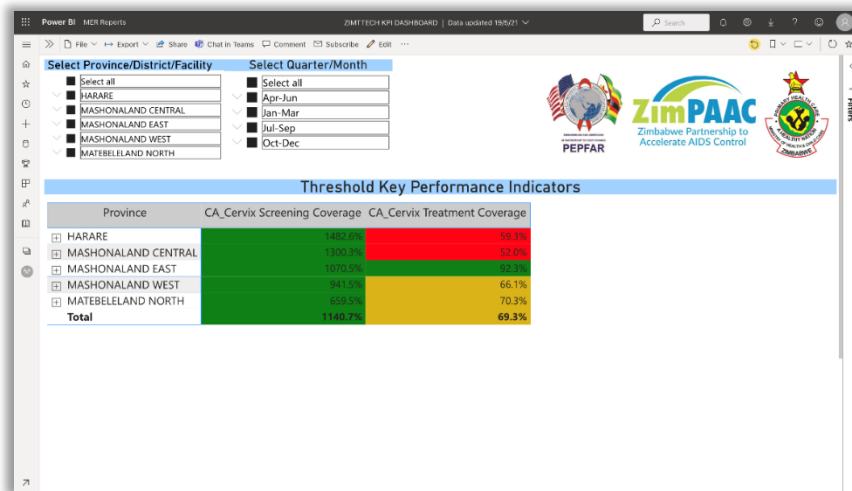
Select Quarter/Month: Select all, Apr-Jun, Jan-Mar, Jul-Sep, Oct-Dec

Threshold Key Performance Indicators

Province	HIV Testing Yield	TX_New_Linkage	Partner Elicitation Ratios	% of Sexual partners tested	VL Suppression Rates	Tracking
HARARE	8.5%	94.2%	1.10	30.2%	75.5%	75.5%
MASHONALAND CENTRAL	4.2%	94.2%	1.17	49%	69.1%	69.1%
MASHONALAND EAST	7.1%	94.2%	1.06	45.9%	87.5%	87.5%
MASHONALAND WEST	4.3%	94.2%	0.98	71.3%	75.8%	75.8%
MATEBELELAND NORTH	4.3%	94.2%	1.06	76.1%	76.1%	76.1%
Total	6.1%	94.2%	1.05	49.7%	78.3%	78.3%

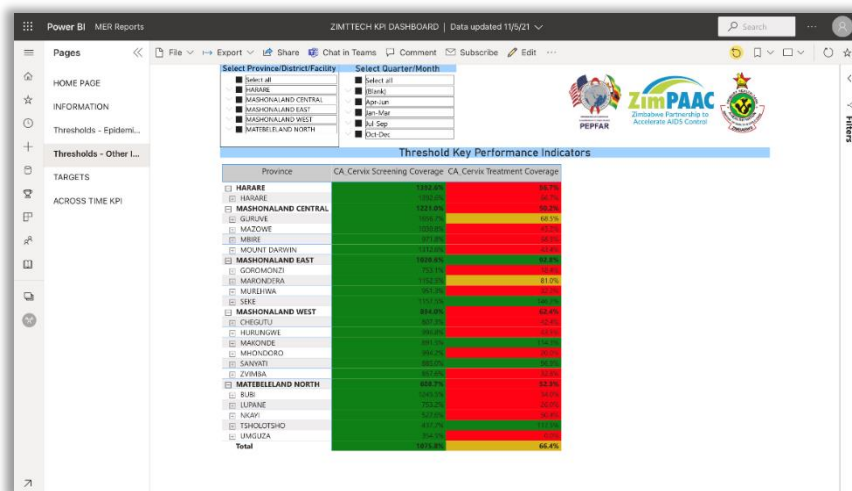
Thresholds - Epidemic Control

1. In this section, we can find HIV Testing Yield, TX_New_Linkage, Sexual Partners tested, Viral Load suppression and tracking percentages, as well as partner elicitation ratios. In the table, the KPIs are defined by columns: the rows show provinces, districts, and facilities.
2. We find two filter boxes in the top area, where Province/district/Facility and Quarter/Month can be selected. The selected filter is applied when the selection is marked and unselected with [1]. Selecting and unselecting is done by clicking on the boxes.
3. Additional drill-down filtering can be made with the  button on the left side of the filtering element [2].



Thresholds – Other Indicators

1. In this section, we can find Cervical Cancer Screening and Treatment Coverage percentages.
2. Similar filter boxes are presented as in the previous section.



Drill-down Province/District/Facility

1. Suppose we need to drill down Province/District/Facility inside the table. In that case, the button on the left side of the row can be pressed to show district and facility specific KPIs.
2. IMPORTANT: Do not forget to filter the desired Quarter/month period to be evaluated before assessing the KPI values.

ACROSS TIME KPI

COP Year QuarterOfYear	COP19			COP20			Q3		
	August	September	October	November	December	January	February	March	April
HTS Yield All Entry Points	6.4%	8.5%	6.2%	5.8%	5.2%	6.3%	7.0%	7.4%	7.0%
HTS Yield Case finding	7.8%	11.1%	7.6%	6.9%	5.9%	7.4%	9.7%	9.9%	8.5%
Partner Elicitation Ratios	0.5%	1.01	1.01	0.99	0.82	0.82	0.82	0.92	0.92
% of Sexual partners tested	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%
TX_New_Linkage	93.0%	93.0%	92.7%	92.7%	81.7%	81.7%	81.7%	81.7%	94.5%
Tracking	76.9%	76.9%	76.9%	76.9%	76.9%	76.9%	76.9%	76.9%	76.9%
VL Coverage	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%
VL Suppression Rates	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%
CA_Cervix Treatment Coverage	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%	76.0%	76.0%	76.0%
CA_Cervix Screening Coverage	3.2%	73.0%	62.0%	105.9%	56.9%	33.7%	50.0%	70.0%	57.4%
Proportion of EID samples collected before 2 months of age									

Across Time KPI

1. Here we can observe KPI indicators in rows and in columns COP year, quarter, and months.
2. Make sure to select the province, district, or facility in the upper filter boxes.
3. In the example to the left, we have filtered the Across time KPI values for Mashonaland East province and all the Goromonzi district facilities.

ACROSS TIME KPI

COP Year QuarterOfYear	COP19			COP20			Q3		
	October	November	December	January	February	March	April	May	June
HTS Yield All Entry Points	6.2%	6.2%	6.2%	6.2%	6.2%	6.2%	6.2%	6.2%	6.2%
HTS Yield Case finding	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%
Partner Elicitation Ratios	1.19	1.26	1.17	1.19	1.19	1.19	1.24	1.24	1.21
% of Sexual partners tested	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%
TX_New_Linkage	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%
Tracking	76.9%	76.9%	76.9%	76.9%	76.9%	76.9%	76.9%	76.9%	76.9%
VL Coverage	66.2%	66.2%	66.2%	66.2%	66.2%	66.2%	66.2%	66.2%	66.2%
VL Suppression Rates	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%
CA_Cervix Treatment Coverage	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%	76.0%	76.0%	76.0%
CA_Cervix Screening Coverage	73.5%	72.9%	40.1%	52.6%	79.7%	79.7%	79.7%	79.7%	79.7%
Proportion of EID samples collected before 2 months of age	60.1%	79.6%	81.2%	81.5%	85.9%	85.9%	85.9%	85.9%	85.9%

Print Dashboard

1. If printing is required for field activities, first select required filters to have the desired view for printing.
2. Click on the “File” button on the top left and then “Print this page”, this will only print the selected page.
3. Making sure the device is connected to a printer, use the device-specific prompt to print the dashboard view.
4. Note that depending on the device you are using to access the KPIs, your options may appear differently. If you need assistance, please contact the IT department.

Appendix D: Process for Special Circumstance Visits

There are times when virtual meetings are not feasible. If documented attempts have been made to conduct virtual meetings, and it has been deemed necessary for a face to face visit, **supervisory approval must be given before planning a site visit.**

Using the correct form (either for head office or seconded staff), the travel request form includes details about the proposed travel. All travel must have a clearly stated purpose before it will be approved.

Process for Approval for Site Support Visit

1. State the reason that it is necessary to conduct an in-person visit
2. Provide documentation of attempts made at virtual meetings and the outcomes on the travel request form
3. Submit form for approval



Travel Request HO
staff.docx



Travel request form
seconded staff.docx

Preparing for Special Circumstance Site Support Visit

Depending on the reason for the visit it may be necessary to prepare documents or presentations in advance. For a targeted visit, see process on pages 8-9. Be sure that the following are ready before your visit:

- Extract from Power BI showing poorly performing KPI (for visits due to poor connectivity make sure to take screen shots or print out the data dashboards as well as more details about areas that are underperforming)
- Site Profile
- Relevant latest circulars if any
- Evidence of any prior communication made
- Copy of this SOP
- Communication with MOHCC district and Provincial staff

For a Ministry or funder visit:

- Presentation with background on district and facility
- Data dashboard
- Any approvals needed at provincial and district level for visitors

For an onboarding visit:

- All SOPs, relevant program documents

Appendix E: District Reporting Template

File names and locations on One Drive

- DSCILFPs/DSIFPs to use the SLPM District report, name the file with facility name and date (yyyy.dd.mm) e.g. SLPM_Makumbe_2021.21.04 and file on One Drive > Team Drive > Documents > COP20 Site Support Reports > Province > District
- PFPs to use Monthly District Reporting Template, name the file with district name and date (yyyy.dd.mm) e.g. SLPM_Guruve_2021.21.04 and file on One Drive > Team Drive > Documents > COP20 Site Support Reports > Province > PFP Reports
- Head Office to use Monthly District Reporting Template, name the file with province name and date (yyyy.dd.mm) e.g. SLPM_MashEast_2021.21.04 and file on One Drive > Team Drive > Documents > COP20 Site Support Reports > Head Office Reports

Click on the icon to open tool.



Monthly Report_PFP
and DSCLFP.vb4Dec.d

Appendix F: Tips for Providing Feedback on Performance

REVIEW	COMMUNICATE*
<p><i>Before scheduling feedback on performance monitoring, review facility performance to inform the focus of the feedback.</i></p> <ul style="list-style-type: none"> • Review facility dashboards: <ul style="list-style-type: none"> • Compare performance to targets • Evaluate trends in performance: look for any big changes over time. • During your feedback, try to determine possible causes for big increases or decreases in performance. • Review previous site assessment findings and support visit reports, if available. Review action plans for follow-up during the visit. 	<p><i>Before beginning feedback, communicate the purpose of the visit with all staff involved.</i></p> <ul style="list-style-type: none"> • Explain purpose of visit and share tools being used • Establish rapport with facility team • Plan for debrief /feedback session • Answer any questions which arise • When conducting site visit, seek out and meet the most senior MoHCC official on duty <p>*See communication tips below</p>
MENTOR/SUPPORT	DEBRIEF
<p><i>During a performance monitoring feedback, ZimPAAC staff should provide supportive mentorship to facilities.</i></p> <ul style="list-style-type: none"> • Seek understanding on gaps, not judgement • Provide positive affirming feedback, highlight best practices being implemented by HCWs • Mentor ways to improve care delivery or documentation • Connect HCWs with relevant training resources and job aids as needed • When conducting site visits, include facility staff in feedback 	<p><i>After completing your feedback, engage in a debrief discussion.</i></p> <ul style="list-style-type: none"> • Discuss possible causes of gaps identified • Brainstorm interventions for improvement • Suggest interventions effective at other sites • Develop an action plan to address gaps with timeline and specific person(s) responsible • Ask facility staff for their feedback • Answer questions which arise • Record your observations in the facility management book.



Tips for Effective Communication During Performance Monitoring Feedback

Communication is a two-way activity, an interchange of ideas, facts, opinions and even feelings. It begins with self-awareness that include one's attitudes, values and beliefs.

- Begin with checking in on how staff is doing emotionally/psychologically
"How are you handling the current situation?"
"How are you feeling?"
- Actively listen, do not jump to judgement or conclusions: reflect on what was said and repeat back in your own word to make sure you understand
- Correct any misinformation that speaker shares in a mindful way
"The latest guidelines actually provide the following protocol: _____, do you have this version?"
- Begin discussion around performance by asking about where they feel they are performing best
"Can you tell me how your facility is performing against targets?"
"Are there program areas that you are feeling proud of?"
"Can you tell me more about what you are doing that is resulting in strong performance?"
"What have you done to achieve such good results?"
- Ask if they are aware of the site performance and see if they can tell you where they are not meeting expectations before you tell them—give them an opportunity to self-assess
"Are there program areas that you are concerned about?"
"Have you attempted to address issues that you have noticed? ... How?"
- Express yourself clearly with facts
"I have reviewed the dashboard for this site and here is what I have seen..."
- Focus on the issues, not the people
"I am concerned about the performance in this area: _____"
- Problem solve together, remember that everyone is looking to reach the same goals for facility performance
"Let's talk about how we can come up with ideas to improve performance."
- Be aware of and handle your emotions (do not yell or express anger)
- Don't make assumptions that everyone understands everything you have said, check back with the listener to confirm/ask them to paraphrase back to you what they heard and correct them mindfully if they did not capture it correctly
- Be specific when giving examples and when discussing timeframes
- Answer questions, if you do not have an answer let them know that you will get an answer and come back to them
- Remind staff that they are important members of the team, give positive reinforcement
"You are a valued team member and your hard work is appreciated."
"Thank you for being a loyal and committed member of the team."



Appendix G: Problem Analysis Tip Sheet


Analyzing the root cause(s) of a problem can be very useful in targeting improvement actions. There are a number of tools that can help your team analyze the possible causes of low performance in a facility. This tip sheet will give a brief summary of, and links to, several of the most commonly used tools and processes for problem analysis, as well as some links to additional resources.

Some factors to consider when deciding whether to do problem analysis activities:

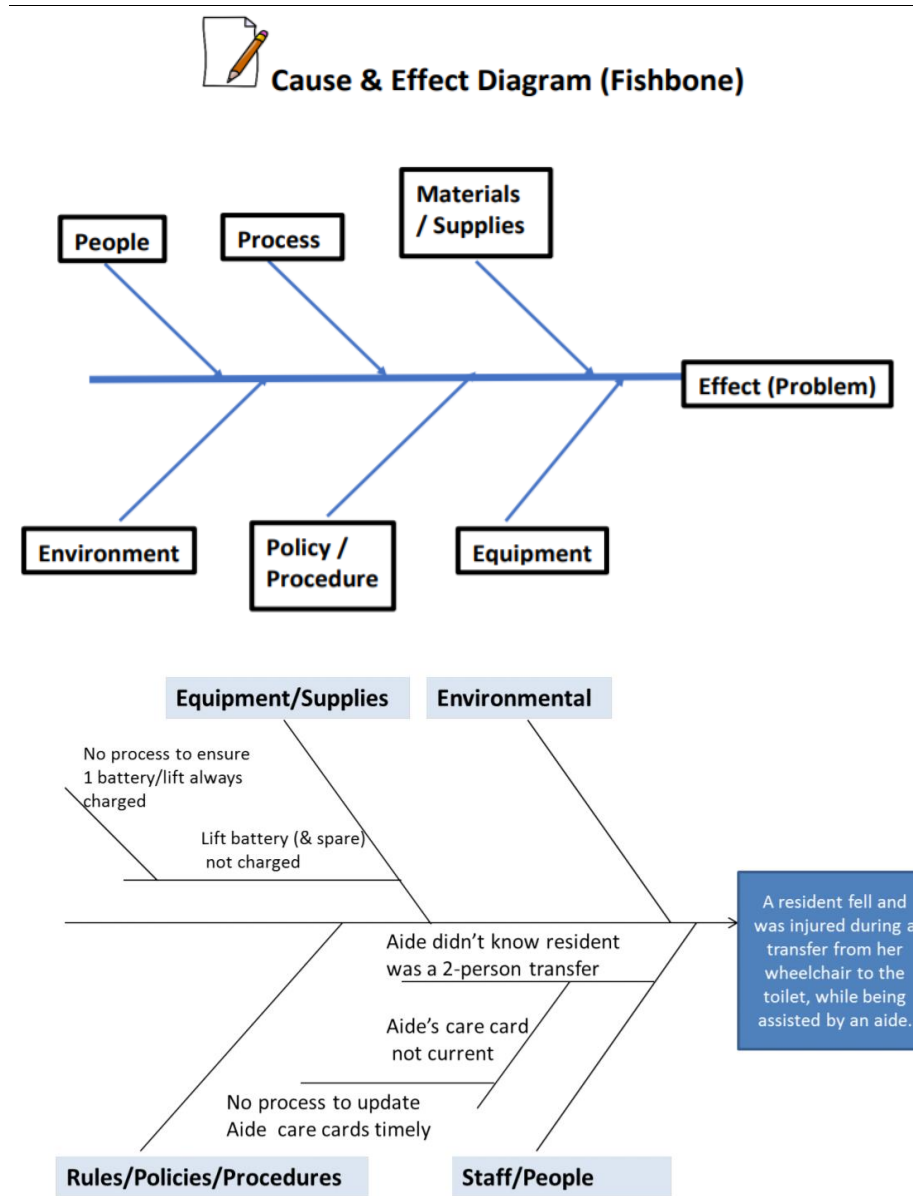
- Do team members disagree or lack a clear idea about the cause of the problem?
- Does under-staffing appears to be the main cause, but there may be additional ways the team could “work smarter rather than harder”?
- Have informal or individual improvement interventions not improved performance?

Which problem analysis tools to use (may use any or all of these depending on time and resources):

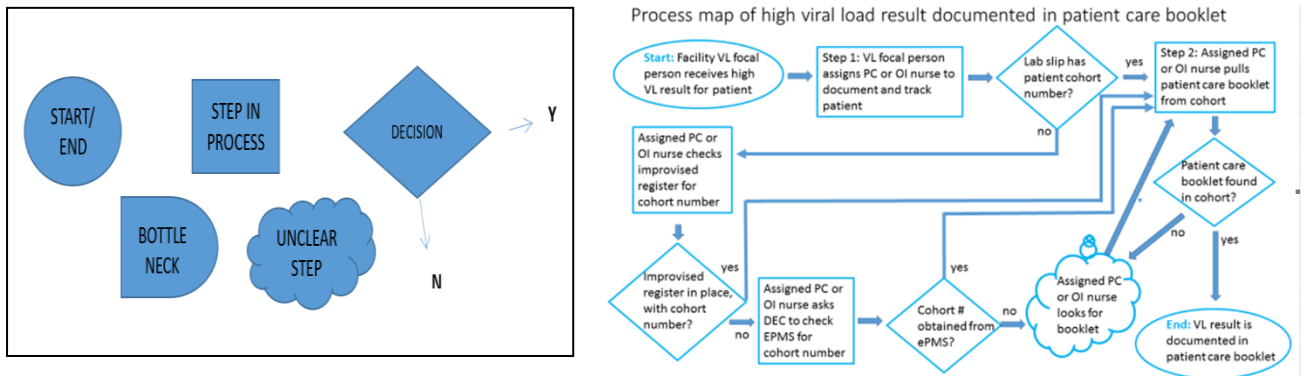
- Simple, quick, limited focus: **5 whys**
 - This activity asks the team to describe a specific problem, then reflect on why this problem is occurring; then ask why is that cause occurring; then ask again for a total of 5 times to get below a simple explanation to the deeper cause of a problem. The example at right is from IHI.org.

 <p>The diagram shows a vertical stack of six downward-pointing chevrons. The top chevron is labeled 'PROBLEM STATEMENT' and is followed by a horizontal input box. The subsequent five chevrons are each labeled 'WHY' and are followed by a horizontal input box. At the top center of the diagram is an icon of a notepad and pencil, with the text '5 WHYS' next to it.</p>	<h3>Example: 5 Whys</h3> <p>A patient received the wrong medication.</p> <ol style="list-style-type: none">1) Why did the patient receive the wrong medication? <i>The nurse did not complete patient identification.</i>2) Why did the nurse not complete patient identification? <i>The patient did not have a wristband.</i>3) Why did the patient not have a wristband? <i>The wristband had been removed for a procedure and not replaced.</i>4) Why was the wristband not replaced? <i>The printer for the wristbands was not working.</i>5) Why was the printer not working? <i>The staff needed to support IT had been reduced and was overworked.</i>
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- More broad focus: **Fishbone / Ishikawa diagram**
 - For this activity, teams write the problem statement (effect) at the mouth of the “fish”. The team then lists categories that are appropriate for the particular problem. The 6 standard categories are shown in the sample, but they could be modified. The team then brainstorms all the possible causes, listing the possible causes as branches from the main categories. Example at right was from the LARC Workbook (see resource list below).



- More complex, time consuming, process-focused: **Process mapping**
 - This activity involves describing the flow of a process using symbols and arrows to connect them in a stepwise process. It is very useful for identifying unclear processes and processes which can be improved. The map at the right was the result of a process-mapping exercise at ZimTTECH looking at VL documentation.



After your analysis:

- Through problem analysis, you will have generated ideas / hypotheses about possible causes of the problem. Remember that you are not sure which, if any, of these are the true cause. The next step is to test your hypotheses and/or do further investigation.
- Use the results of your problem analysis to generate ideas for interventions your team can test out to see if they result in improvement. Decide which interventions to try first based on relative ease of conducting a test, the perceptions of team members around most likely causes and interventions likely to yield improvement

Resources on problem analysis:

LARC (Laboratory African Regional Collaborative) Workbook
<file:///C:/Users/petracca/Downloads/LARC-3.0-WORKBOOK.pdf>

Institute for Healthcare Improvement Tools (only available with sign-in)
<http://www.ihl.org/resources/Pages/Tools/default.aspx>

A Modern Paradigm for Improving Healthcare Quality <https://www.urc-chs.com/sites/default/files/AModernParadigm.pdf>

Appendix H: ZIMS Reporting Tool

Click on the icon to open tool.



ZIMS Tool with
SIMS_v.1.2_1113202C