MINISTRY OF HEALTH AND CHILD CARE
AIDS & TB PROGRAMME

Quality Management Program (QMP) Guide

For the Improvement of HIV Prevention, Care, Treatment and Support Services in Zimbabwe

August, 2015

"The Right Care, for the Right Client at the Right time all the time"

Foreword

Acknowledgement

The Ministry of Health and Child Care would like to acknowledge all stakeholders who participated in the development of the HIV Quality Improvement Guide. This QI Guide would not have been complete without support and assistance from various technical, funding and implementing partners.

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Acronyms

AIDS	Acquired Immuno Deficiency Virus
ART	Anti-Retroviral Treatment
ATP	AIDS and Tuberculosis Control Program
EWI	Early Warning Indicators
FCH	Family and Child Health centre/clinic
HEALTHQUAL	HealthQual International
HIO	Health Information Office
HIV	Human Immunodeficiency Virus
LTFU	Lost To Follow Up
MOHCC	Ministry of Health and Child Care
NCDs	Non Communicable Diseases
OA	HealthQual Organisational Assessment Tool (See Appendix section)
OIC	Opportunistic Infections Clinic
PLWHA	People Living With HIV/AIDS
PM	Performance Measurement
PMTCT	Prevention of Mother To Child Transmission
QI	Quality Improvement
QM	Quality Management
SIC	Sister In Charge
TB	Tuberculosis

Quality Improvement in 10 steps

I. Agree on what needs to be done by answering the question "What are we trying to accomplish?"

- The goals and targets set should be according to the needs of the consumers as well as the national standards/guidelines

II. Sensitize all the stakeholders, including the consumers, on the goals and objectives to be achieved

III. Set up a project team

IV. Measure current performance and determine the performance gap

- Develop indicators and agree on measurement cycles
- Abstract, validate, analyze, report and disseminate the results
- Assess the capacity of the organization to improve care

V. Identify problems and causes of the performance gap

- Process mapping
- Root cause analysis (brainstorming, 5 WHYs, Fishbone diagram)
- Decision matrix for prioritizing the problems and the possible interventions

VI. Develop an improvement plan

- Outline how (activities/ processes), by who (responsible person), when (specific timelines), using what (resources required) and where (location/ department)

VII. Implement the improvement interventions according to the plan

- Support through coaching and mentoring as well as peer learning

VIII. Review progress

- Measure performance at the end of the cycle
- Get feedback from the consumers and other stakeholders

IX. Disseminate the results to all the stakeholders

X. Sustain the improvements

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IMPLEMENTING Quality Improvement

1. INTRODUCTION

1.1 Background

Zimbabwe is a landlocked country with a population of 12,973,808 people (Census 2012). The population is relatively young, with 40% under the age of 15 years. The majority of people (65%) live in rural areas.

The **Vision** of the Ministry of Health and Child Care is to have the highest possible level of health and quality of life for all citizens of Zimbabwe.

The **Mission** is to "provide, administer, coordinate, promote and advocate for the provision of equitable, appropriate, accessible, affordable and acceptable quality health services and care to Zimbabweans while maximizing the use of available resources, in line with the primary health care approach".

One of the goals of the Zimbabwe National Health Strategy 2009-2013, themed Equity and Quality in Health, is to increase coverage, access and utilization of affordable, comprehensive and quality preventive and curative health services. Different strategies will be implemented to improve the quality of care provided in health facilities.

It is against the background of improving the quality of services in both public and private health sectors, that this quality improvement guide was developed.

The guide outlines the MOHCC's planned quality improvement program including the goals and objectives of the quality improvement program, the strategies that will be implemented, staff roles and responsibilities, what will be measured and the indicators to be used, and elaborates a process for ongoing evaluation and assessment of quality improvement activities for HIV and TB.

1.2 Definition of terms

Quality in healthcare is defined as proper performance (according to standards) of interventions that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition (*M.I. Roemer and C. Montoya Aguilar, WHO, 1983*). It is the degree to which a health or social service meets or exceeds established professional standards and user expectations. The following table summarizes the dimensions of quality in healthcare:

Dimension	Definition
Effective	Care that adheres to an evidence base and results in improved health outcomes for individuals and communities, based on need
Efficient	Delivering health care in a manner that maximizes resource use and avoids waste
Accessible	Delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need. It is the degree to which healthcare services are unrestricted by geographic, economic, social, organization or linguistic barriers
Acceptable/patient centered	Delivering health care that takes into account the preferences and aspirations of individual service users and the cultures of their communities
Equitable	Delivering health care that does not vary in quality by personal characteristics, such as gender, race, ethnicity, geographical location, or socioeconomic status
Safe	Delivering health care that minimizes risks and harm to service users
Continuity of services	Consistent care, appropriate delivery of care at site level, appropriate and timely referral and, communication between providers
Interpersonal relations	Trust, respect, confidentiality, courtesy, responsiveness, empathy, effective listening, and communication between providers and clients
Choice	As appropriate and feasible, client choice of provider, insurance plan, or treatment

Quality improvement is the combined and unceasing efforts of everyone—healthcare professionals, patients and their families, researchers, payers, planners and educators—to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning).

It can also be considered to be a discipline or methodology that includes focusing on systems, measuring performance, improving processes of care that lead to improved outcomes, working in teams, involving stakeholders and testing changes with peer learning whenever possible.

Quality Improvement helps to address three fundamental aspects:

1) *The care provided should be based on the needs of the clients. As such, every health worker should ask the clients the key question: What matters to you today? Instead of "what is the matter with you?"*

2) *The care provided should be consistent with the current national guidelines and standards.*

3) *The care provided should be appropriate and have the desired effect/ outcome on the client's health.*

1.3 The National Quality Improvement Programme (QIP)

The main goal of the National Quality Improvement programme is to provide care that meets or exceeds the expectations of the clients. As such, the emphasis is on patient centred care.

Patient centred care is care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. The core themes of patient centred cared includes:

- users identifying the areas that need change
- Involvement in decision making
- Empathy, dignity and compassion
- Clear, timely and comprehensive communication
- Smooth access to care
- Education and empowerment

Patient centred care in Zimbabwe should be enhanced through sharing of health and care experiences. All experiences, across the different levels of the health delivery system, are valuable and can provide a great insight into the care provided.

The QIP in Zimbabwe has the following core components: **performance measurement, quality improvement, quality management, consumer involvement, coaching and mentoring and peer learning.** This document will provide a guide on how to implement each of these components at the different levels of the health delivery system in Zimbabwe as well as the different departments in a health facility.

1.4 Purpose of the Quality Improvement Guide

Quality Improvement, that MOHCC has brought on board recently, is a bid to shift focus from merely collecting information on the reach of the program to closely monitoring the quality with which such services are offered. To date, a structure with Quality Improvement functions has been set up in the MOHCC head office and has been coordinating all the QI activities that have been done so far.

The Guide is primarily intended for use by people who are responsible for a part or whole of a health service unit or organization. The guide also aims to provide practical advice to program managers and health personnel on how to use health care data to improve the quality of HIV services in Zimbabwe.

It was developed primarily for improving the quality of care around HIV services, but can be adapted for use in a broader sense.

Some of the challenges that have influenced the development of this guide include:

- Perceptions of donors and implementing partners. As a new program, funding, technical and implementing partners will have different perceptions as to why this program was introduced. This guide intends to dissipate these perceptions and clarify the intentions and benefits of adopting this methodology.

- Health care quality is a broad field that has many approaches and models and this guide will clarify the model and approach that MOHCC will take in the QI program.

- There are health service provider- and consumer-associated challenges that such as availability of adequate staff, training adequacy, equipment and infrastructure that hinder provision of quality services. Quality improvement may not solve these problems in the strictest sense, but rather, it will assist in maximising efficiency of the available resources. This guide will help in identifying appropriate QI methodologies to achieve this.

- The guide present suggestions for meeting the set standards for QI, which should not be interpreted as being mandatory.

2. DEVELOPING AND IMPLEMENTING A QUALITY MANAGEMENT PROGRAM (QMP)

A quality management programme is a structural umbrella over all processes and activities related to quality.

It is responsible for the coordination and facilitation of these activities in an organization. Specifically, QM is involved in the selection of health care quality personnel, the allocation of other resources, the monitoring and evaluation of plans and the launching of improvement teams.

It encompasses the structures, functions and processes that support systematic implementation of performance measurement and quality improvement activities.

It includes the following components:

- **Structure**
  - *Leadership*
  - *Organizational Structure: adapted to clinic size and staffing*
  - *Resource commitment: people, time*
  - *Quality Management Plan*
- **Planning**
  - *Goals*
  - *Roles and responsibilities*
  - *Work-plan*
- **Measurement**
  - *Indicators*
  - *Routine measurement*
- **Improvement**
  - *Team-based approach to improvement projects*
- **Staff Involvement**
- **Patient Involvement**
- **Evaluation of the Quality Management Program**
- **Achieving Results**

Framework

2.1 Leadership

Leadership is an essential component of the QMP. Leaders are those individuals who have the ability to formally and informally influence and inspire others providing a vision and direction for the quality program. Leaders create the culture in which quality is both prized and promoted, as such, PHE, DHE, hospital management teams and health centre committees should be engaged at the onset of the quality management programme.

Leadership plays a role in allocating resources. It also plays a key role, with the committee, in prioritising goals and projects.

Important tips

- Interview the leaders and stakeholders about their ideas for building a successful quality management program.
- Engage patients to identify their needs and expectations.

Resource allocation by leadership includes;

- Making staff time available for meetings
- Providing space and supplies for meetings
- Providing information and data necessary for QI
- Supporting data collection through systems and staffing
- Determining staffing needed to support QI program
- Adjusting budget or developing budget to support QI program
- Arranging for external support/ coaching if needed.

2.2 Organisational Infrastructure

The Quality Management Committee is a group of individuals who build the facility's capacity and capability for quality improvement. The major task of a quality management committee is to help ensure everything is in place at a facility for the improvement efforts to succeed and be sustained over time. The quality committee plans and oversees all quality program activities at the facility, particularly the quality improvement projects completed by individual project teams.

The committee has the following responsibilities;

- Coordinates and facilitate implementation of the program
- Strategic planning
- Facilitating innovation and change
- Providing guidance and reassurance
- Establishing a common culture
- Allocating resources
- Review of data, and recommending priority areas for action.

It is necessary to include representatives of the consumers in the quality management committee, to facilitate input from this important stakeholder.

To be effective, the committee should be guided by specific terms of reference that include: the goals and objectives of the committee, roles and responsibilities, composition of the committee, leadership of the committee (chairperson and secretariat), frequency

of meetings(monthly), documentation and communication).

All committee members should be educated on quality improvement methodologies and tools.

TIP - Instead of standalone Quality Improvement Committee meetings, use of existing platforms to discuss QI as an agenda item is encouraged. A good example is a Health Centre Committee. Quality can be a standing agenda item for each Health Centre Committee meeting. The size of the committee will depend largely, on the size of the facility. The idea being to have adequate representation of staff and stakeholders, be it the facility is a small rural health centre, or a big central hospital with several departments.

2.3 Develop a quality management plan

The quality management plan describes the overarching purpose of a facility's quality program, the infrastructure that supports improvement activities, and its goals for the upcoming year. The plan sets an accountability framework and forms the basis for self-evaluation. It also serves as a reference tool for both current and future staff. The following two steps are needed;

i. Deciding on a planning approach

The planning process to develop a quality management plan provides an opportunity to create a sense of ownership among staff members and consumers for the facility's improvement initiatives. Before diving into the details of your quality management plan, decide on a general approach for developing and finalizing the plan that includes a wide representation of staff and stakeholders. Select from one, or a combination, of the following planning options.

- *Planning meeting - Facilitate a yearly meeting in which decisions are made regarding the key components of the quality management plan. Prior to the annual meeting, gather and distribute background information to participants pertaining to the meeting and prepare a draft of recommendations to give focus to the decision-making process.*
- *Series of planning meetings - Break the annual meeting down into smaller steps and plan a series of short meetings.*
- *Planning group - Rather than a large-group meeting, form a group comprised of two to three individuals who are responsible for delineating a process to gather staff and stakeholder input to subsequently finalize the quality management plan.*

ii. Creating the quality management plan

A quality management plan defines a quality program's strategic direction and provides a blueprint for upcoming improvement activities for the HIV program. While there is no universal "how-to" template for creating a quality management plan, this section outlines the basic elements that should be covered:

TIPS FOR A QUALITY STATEMENT

- Be brief
- Be visionary
- Include internal and external expectations
- Make references to external (MOH, Donors) requirements on quality management
- Use/Revise existing statement

EXAMPLE: QUALITY STATEMENT

'…The Mission of Warren Park clinic Quality Management Program is to ensure that all patients receive the highest quality medical and support services….'

'…The mission of Belvedere Clinic is to ensure that all people living with HIV/AIDS receive the highest quality of primary medical care and support services….We aim to provide the best care for people living with HIV in the Matabeleland South'

TIPS FOR PERFORMANCE MEASUREMENT

- Develop quality indicators, keeping in mind three main criteria: Relevance, Measurability and Improvability
- Include the process for reviewing and updating the indicators (who/when/how)
- Include a portfolio of process, outcome, structure and satisfaction measures
- Include strategies how to report and disseminate results and findings

2.3.1 Quality statement

A quality statement describes the purpose of the HIV quality program. It is the end to which all other program activities are directed. Some programs may refer to this as their quality mission statement, others as their guiding purpose for quality activities. To write a quality statement for the quality management plan, assume an ideal world and ask yourselves, "What do we want to be for our patients and our community?"

2.3.2 Quality improvement infrastructure

The quality management infrastructure describes how the program is structured and staffed in order to get work done:

- Leadership: Who is ultimately responsible for the program's quality initiatives?
- Quality committee structure: Who chairs the quality committee? Which staff serves on the quality committee?
- Quality committee meeting frequency: When will the quality committee meet to assess progress and plan future activities?
- Quality committee reporting: What is the relationship of the quality committee to the facility at large? How will the quality committee communicate its progress to staff and consumers?

NOTE: This may be in the setting of a standing committee like a Health Centre Committee

2.3.3 Performance measurement

Performance measurement is a method for identifying and quantifying the critical aspects of care within your facility. This is essential to assembling baseline performance data and measuring the effectiveness of improvement efforts over time.

Performance measurement is discussed in detail in Section 3.

2.3.4 Annual quality goals

Quality goals are endpoints or conditions toward which the facility will direct its efforts and resources during project work. Quality goals help staff focus on improving aspects of care. The quality committee needs to work with staff and stakeholders to develop annual goals so that they are understood and embraced by everyone at the facility. Prioritization helps the facility to direct resources toward the issues that need it the most. The following three criteria can be helpful to a quality committee in prioritizing annual improvement goals:

- Frequency: How many patients received and how many did not receive the standard of care?
- Impact: What is the effect on patient health if they do not receive this care?
- Feasibility: Can something be done about

EXAMPLES: QUALITY GOALS

Improve the rate of TB Screening of HIV infected clients on ART seen at the clinic from 50% to 80% by end of year.

Improve the rate of HIV infected pregnant women initiated on lifelong ART from 70% to 90% by December 2014.

Improve the 6month retention-in-care of HIV infected clients on lifelong ART from 71% to 90% by end of year.

EXAMPLES: QUALITY GOALS

To improve the proportion of HIV infected clients on lifelong ART with virological suppression from 70% to 95% by end of year.

To improve the rate of EID testing of HIV exposed infants from 80% to 90% by end of year.

TIPS

- Detail when and who is performing the evaluation
- Compare annual QM goals with year-end results
- Use findings to plan next year's activities; learn and respond from past performance
- Routinely use organizational assessment tools

2.3.5 Participation of stakeholders

Provisions need to be outlined in the quality management plan for actively engaging staff and consumers, communicating information about quality improvement activities and providing opportunities for learning about quality.

Engage staff and consumers. The needs and expectations should be understood and their feedback is reflected in the quality improvement management plan.
The next section outlines how to actively engage staff in QI. For consumer engagement, see Section 7.

2.3.5.1 Staff engagement

This can be achieved through,

- Development and promotion of staff knowledge and practice of QI Methodology
- Clearly defined roles and responsibilities
- Routine engagement in QI activities
  - *QI committee*
  - *QI teams*
  - *Department Meetings*
- Training and Retraining
- Regular communication to all staff on data and improvement progress
- Staff identification of Improvement opportunities
- **Staff Involvement**
  - ***Communication****—how is information about quality activities and project results shared?*
  - ***Education****—how are staff training and learning opportunities provided?*
- Quality manuals, formal training sessions, in-service sessions
- Convey the importance of quality
- Display quality activities to staff and consumers – storyboards, bulletin boards
- Provide educational activities to promote quality
- Build quality into all staff's work
- Demonstrate successes and recognize staff for efforts

2.3.6 Evaluation

Performance measurement provides the hard data about improvements to care delivery over time, but it is also important to assess how efficiently the overall QM program is operating as a whole.

How can we evaluate the overall performance as a program?

- ***Evaluate structure effectiveness***
  - *Was the quality committee effective in its efforts to improve the quality of HIV care/services? Does the quality infrastructure require any changes to improve how quality improvement work gets done?*
- ***Evaluate QI activities***
  - *Were annual quality goals for quality improvement activities met? How effectively did you meet your goals?*
  - *Did the implementation of the annual work plan go as planned? Did you meet established milestones?*
  - *Were stakeholders informed about ongoing quality activities? Were staff and providers trained on QI methodologies and tools?*
- ***Performance measures***
  - *Were the measures appropriate to assess the clinical and non-clinical HIV care? Are the results in the expected range of performance?*

2.4 Strategize to implement the plan: Develop an Annual work-plan

While a Quality Management plan outlines the "WHAT" needs to be achieved by end of year, the work-plan outlines the "WHO, WHEN, WHERE and HOW" of its implementation.

It benefits the quality implementation efforts by:

- Clearly documenting the necessary steps to implement the quality management plan.
- Assisting the quality committee to allocate the appropriate resources essential for quality activities, including project teams, staff training, data collection, and evaluation efforts.
- Effectively communicating quality activities to staff and stakeholders.
- Creating a template to monitor the implementation process of the quality management plan.

Possible Activities to be included in a work-plan include:

- QM Committee meetings
- Drafting/updating QM Plan
- Data collection and analysis
- Presentation of data and results
- QI Projects
- Evaluation of QM Program

Fig 1: An example of an annual work-plan

Goal: Conduct Monthly Quality Management Committee Meetings			
Action Steps	*Staff Responsible	Time Line	Measurable Outcomes
Determine QM Committee Membership	Hospital Director	April 30, 2013	Membership determined, members invited
Determine QI Focal Person to support QM Committee Meetings and other QI activities	Hospital Director	April 30, 2013	QI Focal person identified Terms of reference adopted
Develop and communicate QI committee terms of reference and meeting schedule	Hospital Director QI Focal person	June 1, 2013	Schedule distributed to membership First meeting conducted
Goal: Develop system to routinely review performance measures related to QM plan goals			
Action Steps	*Staff Responsible	Time Line	Measurable Outcomes
Identify indicators based on QM plan goals (existing or new)	Hospital Director Dept. Heads	July 1, 2013	Completed list of indicators with definitions Indicators communicated to QI committee, staff, leadership.
Develop system to collect, analyze and report results	Dept Heads Data managers	July 1, 2013	Data management plan completed Routine reports provided to key stakeholders

3. PERFORMANCE MEASUREMENT

Performance measurement is a component of the Quality Improvement approach that aims to evaluate how well services are delivered to the community.

It is the process of collecting, analysing and reporting information regarding the performance of the health system. Performance measurement distinguishes what is perceived to be happening from what is really happening, and helps to avoid putting ineffective solutions in place. Performance measurement is conducted to:

- determine the appropriateness of care;
- determine if a patient visiting the clinic/post/hospital received the care that they were supposed to receive
- assess the likelihood that any patient coming will receive the right care.

3.1 Benefits of measuring performance

- Separates what you think is happening from what is really happening
- Establishes a baseline: It's ok to start out with low scores!
- Helps to avoid putting ineffective solutions in place
- Monitors improvements and prevents slippage
- Indicates whether changes lead to improvements
- Standardizes measures allowing for comparison of performance across sites
- Helps to make decisions based on performance results.

Performance measurement involves the following elements:

i. Selection of a quality of care indicator.
ii. Setting targets and goals
iii. Defining the measurement population.
iv. Defining the measure.
v. Creating a data collection plan.
vi. Developing data collection tools and instructions.
vii. Training the medical record abstractors.
viii. Pre-testing and evaluation of the pilot of the tools.
ix. Collection of data.
x. Validation and analysis of data and report writing.
xi. Dissemination of results and planning QI activities.
xii. Evaluating the measurement process and formulating recommendations that will improve the process.

"YOU CANNOT IMPROVE ON SOMETHING THAT YOU ARE NOT MEASURING"

3.2 Performance Measurement Guide

The following steps should be taken towards measuring performance in any area/department of the health delivery system.

Step 1: Selection of a quality of care indicator

When selecting an indicator, remember to refer to national care guidelines e.g. National OI/ ART Guidelines in Zimbabwe. The following four characteristics need to be considered when selecting the indicators:

- **Relevance** - Does the indicator relate to a condition that occurs frequently or have a great impact on the patients at your facility?
- **Measurability** - Can the indicator realistically and efficiently be measured given the facility's finite resources?
- **Accuracy** - Is the indicator based on accepted guidelines or developed through formal group-decision making methods?
- **Improvability** - Can the performance rate associated with the indicator realistically be improved given the limitation of your services and patient population?

A consultative process, with all stakeholders' involvement, should be carried out to select the indicators. Indicators for PM can be at three different levels, i.e. process, outcome and impact level. It is important to note that that benchmarking is a critical component of quality improvement; hence most of the indicators will need to be standardized across sites, districts, provinces and at national level. Refer to Annex 1 for examples of QI indicators and indicator definitions.

Step 2: Defining the measurement population

Define target population. Be sure to specify:

- **Location:** What facilities within the system will be included?
- **Sex:** Does the indicator apply exclusively to men or women, or to both?
- **Age:** Are there particular age limits?
- **Client condition:** Is a confirmed diagnosis required, or simply symptoms or signs? Do certain conditions make the client ineligible? Does the client have any special needs e.g. difficulty in hearing.
- **Active treatment status:** How many visits are required for eligibility? Is the client currently on treatment? Was the treatment initiated within the recommended timeframe?

Step 3: Defining the measure

- Phrase indicator in the form of a question e.g. was the CD4 count measured and the result documented in the past four months?
- Determine whether any "not applicable" (N/A) conditions exist and define them.

The "N/A" population consists of those clients who are eligible based on criteria such as location, sex, age, and treatment status, but must be excluded, for example, based on treatment time frame. In some cases, your eligibility criteria will preclude the identification of any "N/A" conditions.

Step 4: Creating a data collection plan

- Involve other staff of the measurement process.
- Sharing information helps build support for the facility's quality improvement efforts.
- Identify and validate existing data
- Select a data collection plan
  - *Data abstraction can be achieved through record review and/or administrative review.*
- Identify eligible records
- Select the data abstractors

Step 5: Developing data collection tools and instructions

- Don't forget to consider document review criteria
- Create a paper or electronic document listing your review criteria. Be sure to include eligibility criteria, and question/ response parameters that define the "yes" and "no" responses, and N/A conditions.
- Create a data entry form
- Develop a paper or electronic data entry form on which abstractors will record information during the collection process.
  - *The form should be straightforward and concise to facilitate accurate data collection as well as any future data compilation efforts.*

Step 6: Training the medical record abstractors

When training data abstractors remember, it is better done practically;

- To review the measurement process.
- To provide useful context on how data collection will contribute to the facility's overall quality improvement.

If possible, allow abstractors to do a "dry run" using a sample medical record at the end of the training session.

Step 7: Pre-testing and evaluation of the pilot of the tools

Pilot test the developed tools using 2 or 3 records. Select 2 or 3 records from the total sample and ask the abstractors to collect the required information as explained during the training session. Discuss pilot test results with abstractors and adapt the measurement process as needed.

Step 8: Collection of data

Describe the performance measurement process. Distribute the collection tools to the rest of the staff. Abstract client level data from primary data sources to data collecting forms. If come across a record with inadequate information replace the record. Enter into the electronic form.

Step 9: Validation and analysis of data and report writing

- Validate the data.
  - *randomly select 10% of the abstracted records.*
  - *independently re-abstract the records (preferably using an abstractor who was not involved in the initial abstraction).*
  - *head-to-head comparison of these records is done noting the differences.*
  - *If the difference constitute ≥10%, there is need for re-abstraction of all the records.*
  - *But if <10% differences, correct the differences and then go on with data entry.*
- Compile and analyze longitudinal data, if possible.
- If historical data are available, longitudinal studies are useful in tracking upward and downward trends in clinical performance.

Step 10: Dissemination of results and planning QI activities

- Present your results in the appropriate format e.g. graphs, tables. (Graphs help to convey outcomes at-a-glance.)

Step 11: Evaluating the measurement process and formulating recommendations that will improve the process

- Data abstractors to evaluate what aspects of the measurement process worked well and what posed challenges.
- Test reliability; examine both the degree to which values recorded by different reviewers are the same and the extent to which there is agreement on the final scores.
- Use the recommendations from this evaluation to improve the measurement process.

Annexe 2 highlights the steps and instructions for measuring performance at facility level.

4. QUALITY IMPROVEMENT

"THE RIGHT CARE , FOR THE RIGHT CLIENT AT THE RIGHT PLACE ALL THE TIME"

4.1 Definition

Quality improvement is a formal approach to the analysis of performance and systematic efforts to improve it.

It is the combined and unceasing efforts of everyone—healthcare professionals, patients and their families, researchers, health insurance, planners and educators—to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning) (Batalden *et al*, 2007).

4.2 Principles of Improvement

- Understanding work in terms of processes and systems
- Developing solutions by teams of health care providers and patients
- Focusing on patient and population's needs
- Providing care according to professional standards
- Testing/piloting and measuring effects of interventions routinely
- Shared learning

4.3 Benefits of Quality Improvement

- Enhances patient and client satisfaction – provides care that is responsive to patients, clients and communities needs and expectations
- Improves safety of staff, patients, clients and communities
- Reduces morbidity and mortality of patients
- Reduces health care costs and waste of resources, (prevents complications), hospital stay
- Cultivates teamwork and effective communication
- Provides good reputation of health institutions and health workers
- Improves staff motivation

4.4 Rationale for Quality Improvement

- Focus towards quality
- The availability of real-time clinic performance data to guide changes
- Changes in the diagnostic methods
- The need to efficiently utilize available resources

4.5 The Differences Between Quality Assurance and Quality Improvement

Fig 2: The Differences Between Quality Assurance and Quality Improvement

	Quality Assurance	Quality Improvement
Motivation	Measuring compliance with standards –is the CD4 machine is built to a standard?	Continuously improving processes to meet or exceed standards – always having a CD4 machine giving accurate results.
Means	Inspection – identifying CD4 machine that is giving faulty results and removing it from use.	Prevention – redesign/change the process of servicing the CD4 machine so that it never has to be de-commissioned.
Attitude	Required, 'have to do this'	Chosen, proactive
Focus	Outliers: "bad apples" Individuals Focus on faulty machine	Processes Systems Focus on the process/system of servicing CD4 Machine
Scope	Medical provider- who failed/forgot to get machine serviced	Patient care- how can we change about how machine gets serviced to avoid service disruption
Responsibility	Few	All

The above table summarizes the main differences between QA and QI, but in reality, these two play a complement role, and have a part to play in delivering quality services.

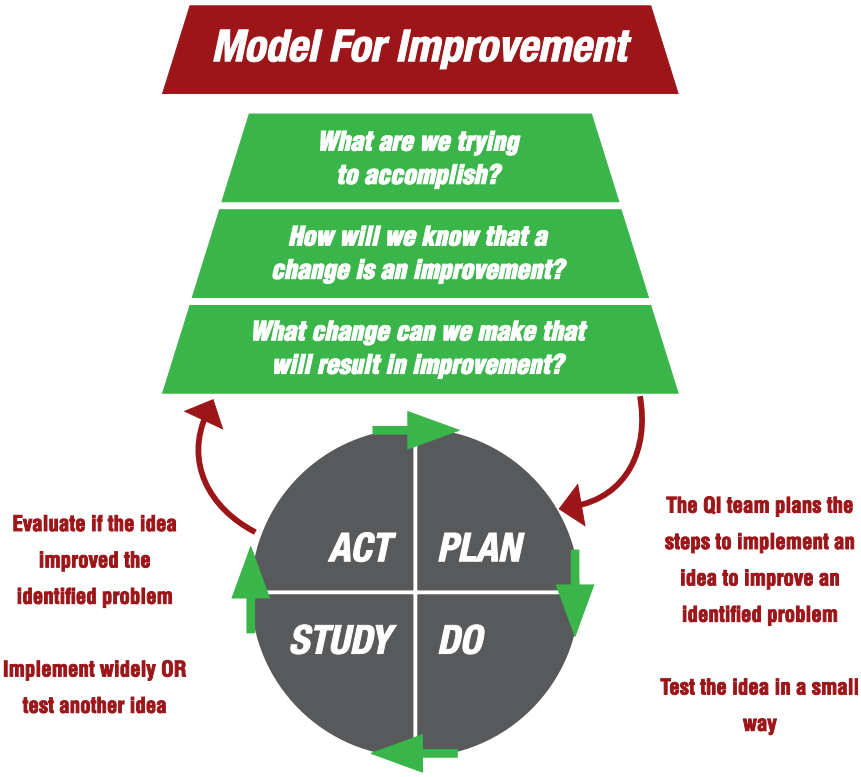
4.6 The Recommended Model For Quality Improvement

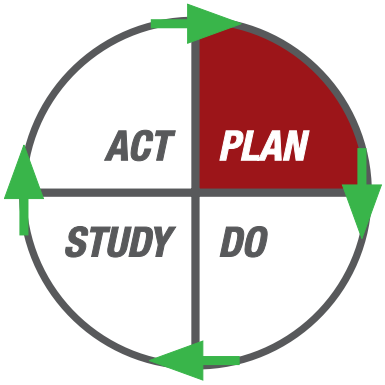
4.6.1 Plan-Do-Study-Act Cycle

The Model for Improvement is a simple yet powerful tool for accelerating improvement. The model has two parts:

a) Three fundamental questions, which can be addressed in any order and

b) The Plan-Do-Study-Act (PDSA) cycle. The three questions are fundamental to developing the Aim of the improvement initiative. The PDSA cycle guides the tests of a change to see if the change is an improvement.





4.6.1.1 Step 1 PLAN

- State the purpose of the PDSA — are you developing a change idea, testing a change or implementing a change?
- What is your intervention/change?
- What indicator(s) of success will you measure?
- How will data on these indicators be collected?
- Who or what are the subjects of the test?
- How many subjects will be included in the test and over what time period?
- What do you hypothesize will happen?

Steps towards understanding the system and processes

4.6.1.1.a Establish an improvement team

Improving a system of care and its processes is best done by a team that involves all staff whose work is part of the process being improved. Each team members provides a unique perspective on the common improvement goal. The team may include patients, staff and community leaders. (WHO QI). The focal person or quality manager working with the quality management committee to facilitate the establishment of the quality team

The following steps can be taken to set up the improvement team:

- Identify staff, including non-clinical staff, that have the most knowledge of the selected area for improvement. If the area to be improved involves laboratory testing and pharmacy, it would be prudent to have representation from these departments. Another commonly overlooked staff members are health information, reception and administration.
- Form an improvement team to work on the improvement area

IT IS IMPORTANT TO NOTE THAT THIS TEAM IS DIFFERENT FROM AND REPORTS TO THE BROADER QUALITY MANAGEMENT COMMITTEE AND HEALTH FACILITY CAN HAVE MORE THAN ONE QUALITY TEAM.

- Assign a team leader who will take responsibility for the team

Roles of the quality team

The team can use the following tools to understand the processes underlying care

4.6.1.1.b Brainstorming

This is a technique to freely generate ideas using a group approach. It is a useful tool when a team needs to generate a large volume of ideas. The basic steps for brainstorming are:

i. Write the topic statement or question in a central location. It should be clearly defined and written where everyone can see it.
ii. Review general rules for brainstorming. Basic ground rules include:
    - *Go for quantity of ideas; do not censor your ideas or anyone else's. (no wrong answers).*
    - *Utilize free-association and building on previous ideas.*
    - *Record ideas as stated; do not edit—only clarify, if necessary.*
    - *Do not discuss or debate the merit of individual ideas.*
iii. Establish a time limit. 7 to 10 minutes is recommended.
iv. Generate ideas with the group until time is up. Begin idea generation by going around the group, allowing one idea per person. Participants may pass if they do not have an idea. Ideas should be written down where everyone can see them. The process of generating ideas usually goes through several cycles. Later cycles tend to have a slower pace, but may result in the most innovative ideas. It is important not to rush the process.
v. Review and refine ideas. Discard any ideas that are virtually identical.

4.6.1.1.c Process Map (Flow chart)

A flowchart shows the steps of any process in sequential order. Flowcharts can be used to illustrate a sequence of events, activities or tasks for processes ranging from simple to complex. They help staff members to identify and understand problems and find possible solutions by visualising the current processes.

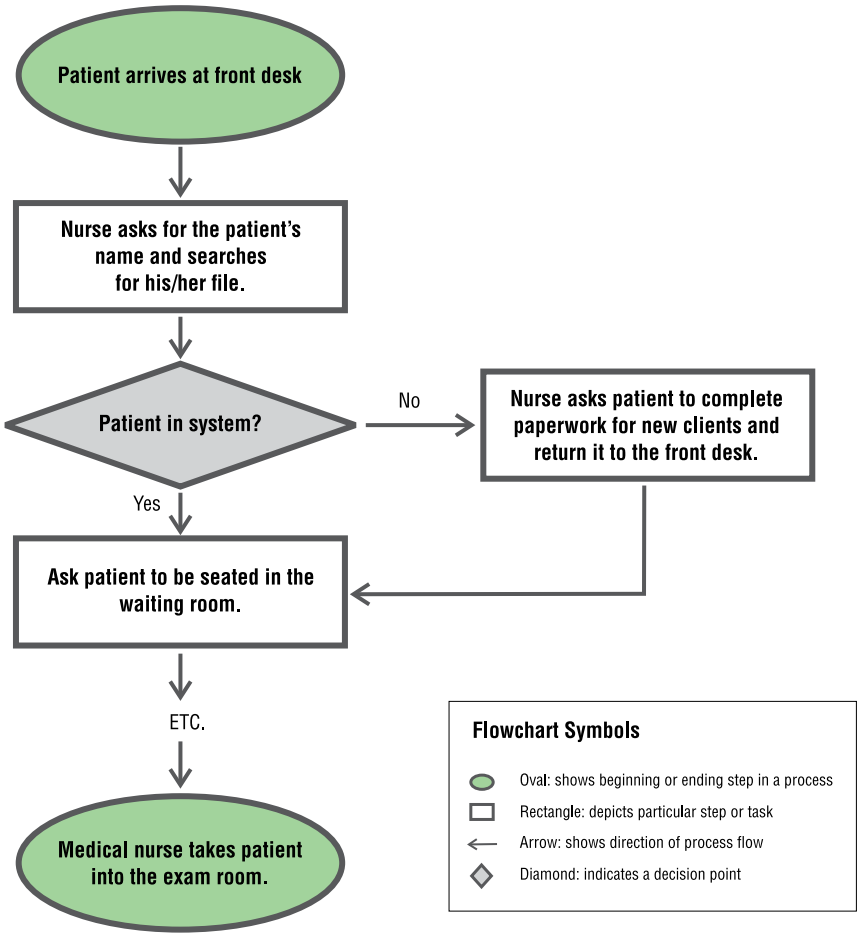
In this context, a process is a series of steps or actions needed to provide care.

A flowchart:

- Provides a fast and efficient way to understand the process.
- Identifies potential sources of problems and provides a clear frame of reference for pinpointing the part of the process that requires change.
- Enables the team to communicate to others what they are doing and why.

"IT ISN'T THAT THEY CAN'T SEE THE SOLUTION. IT IS THAT THEY CAN'T SEE THE PROBLEM"

Fig 3: Flowchart of a patient registering before consultation



How to create a flow chart

Map the actual process not the ideal

i. Agree what the flowchart should accomplish and the level of detail you will need to accomplish that goal.
ii. Define starting and ending points
iii. Carry out the mapping process using the practical method (e.g. following a patient from one point to another or getting the patient to document each step).
iv. Document each step.
v. Follow each branch to the end / they often intersect with other processes or systems.
vi. Review the chart as a team.
vii. Verify accuracy by observing the. actual process and assign actions to address any remaining questions.

4.6.1.1.d Cause and Effect Diagram *(Also known as fishbone OR Ishikawa diagram)*

Used to identify issues that may cause or influence a problem, outcome, or effect Helpful in identifying problems' potential causes or solutions.

i. Draw the diagram's skeleton. Explain that the skeleton consists of a horizontal arrow pointing to the effect and additional arrows—representing causes—pointing to the horizontal arrow. Major causes can be separated

into basic categories such as: Equipment, Environment, Procedures, People. These are only suggestions. A team should use categories that best fit their improvement needs. Others could be: Methods, Materials, Resources, and Measurement. Make them fit your problem.

ii. Write the problem (or desired outcome) in the box at the end of the arrow.

iii. Brainstorm potential causes and subcategories to fill in the "bones" of the skeleton if not done prior to this. Review the potential causes. Note how major causes typically have subcategories, identified by asking: Why does this happen? (ask 5 WHYs).

iv. Review and refine causes. This sets the stage to examine a few of the causes further and prioritize them.

Fig 4: An example of a fishbone diagram

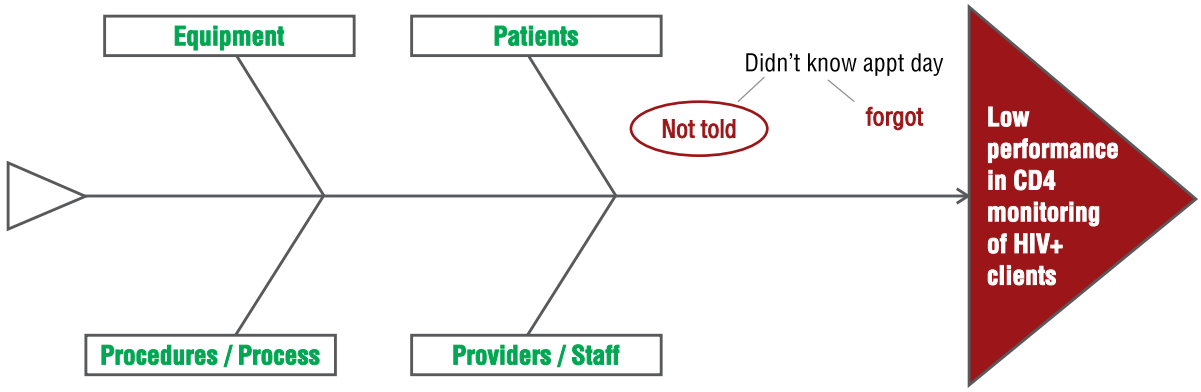
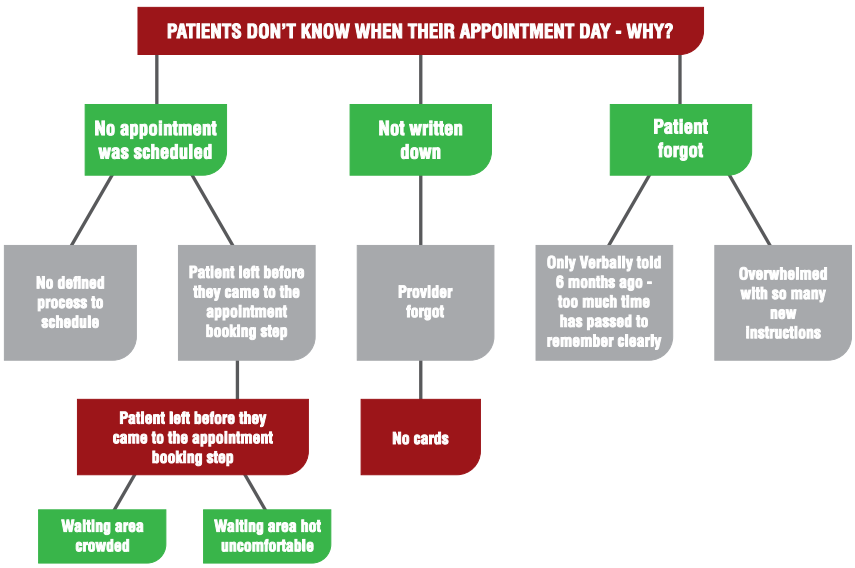
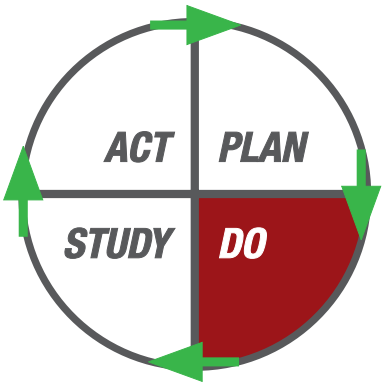


Fig 5: An example of Five Whys



After applying the above tools, list the identified root causes of the problems.

DIFFERENT PROBLEMS REQUIRE DIFFERENT SOLUTIONS



4.6.1.1.e Prioritizing Underlying Causes and Possible Solutions

Not all underlying causes are equal. Prioritization helps teams determine which one of the underlying causes has the greatest impact on the system and potential for improving the aspect of care under review. Teams answer the following question: "Which underlying causes of the problem should we focus on first?" Prioritization of underlying causes is a decision reached through team consensus.

Possible criteria for prioritization are:

- Underlying cause within control of the team
- Impact to consumers (client inconvenience versus 'pain' caused by the problem)
- Difficulty in solving the underlying cause
- Resources required for addressing the underlying cause (e.g., staff time, money or space)
- Impact on delivery system (target those causes that occur most frequently

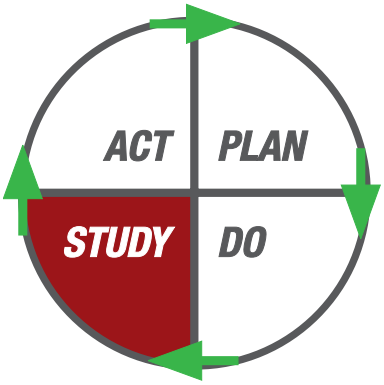
4.6.1.2. Step 2 DO

Implement/pilot the planned intervention over a short period of time. The period of time depends on the intervention and the cycle e.g. using SMS system to improve turnaround time on EID results can be done over 3 months whilst the distribution system to improve the availability of medicines will take 12 months as each cycle could be 6 months.

Document any problems and unintended consequences.

Fig 6: Sample Project Intervention Workplan

Intervention /Change	Key Action Steps	Measure	Timeline	Persons Responsible
1.	1. 2. 3. 4.			
2.	1. 2. 3. 4.			

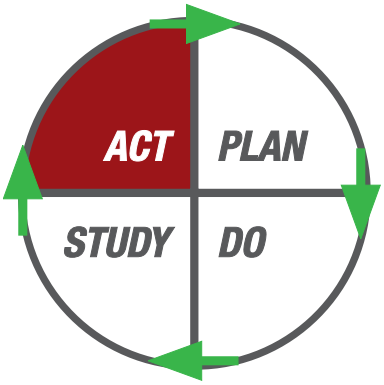


4.6.1.3 Step 3 STUDY

Analyze the data and study the results.
Compare the results before (baseline-performance measurement) and after implementing changes
Compare the data to your predictions.
Summarize and reflect on what was learned.

4.6.1.4 Step 4 ACT

Refine the intervention, based on lessons learned from the pilot.
Prepare a plan for the next test.
Scale up and sustain the intervention.



5. COACHING AND MENTORING

Coaching is a process that enables learning and development of skills to occur and improve performance.

The main objective is to help sites understand their systems and processes, identify problems and find solutions to reach the goal of implementing and performing well the quality of care in the service delivery areas.

Fig 7: Differences between Coaching; Mentoring; and Support and Supervision

COMPONENT	SUPERVISION	CLINICAL MENTORING	QI COACHING
Target Audience	Individual or Organization	Individual	Organization
Methodology	Inspection; Checklist Supportive Supervision may involve provision of TA	Observation; teaching	
Qualifications			
Technical Content		Evidence-based medicine; Guidelines	Standards for Quality Management
Documentation/ Plan			

It is important to note that coaching and supervisory roles are different and ideally should not be played by the same persons!!!

5.1 Roles of a coach

TIP
Do the activities on behalf of the team.

To be a successful coach requires knowledge and understanding of processes. It also requires the variety of styles, skills and techniques that are appropriate to the context in which the coaching takes place. Eric Parsloe, *The Manager as Coach and Mentor (1999).*

The roles of a quality improvement coach include;

- Assist the QI teams to identify their strengths and weaknesses in QI implementation
- Assessing strengths and weaknesses of the system and processes and giving feedback honestly.

THE PREFERRED GOAL IS TO HAVE THE SERVICE PROVIDERS KNOW WHAT TO DO, DO IT AND DOCUMENT ADEQUATELY AND TIMELY!!

- To help the team keep focused on the goal and moving forward.
- To provide technical information and assistance about how to achieve the goal.
- To encourage and push the teams to do the activities themselves.

The coaches should support the quality improvement teams during the following steps:

- Performance measurement.
  - *Data abstraction, entry, validation, analysis and reporting.*
- Problem analysis and prioritization.
  - *Process mapping, root cause analysis.*
- Development and implementation of the quality improvement plans.
  - *Prioritization of the interventions.*

5.2 Who can be a QI coach?

A coach for quality improvement should have the following characteristics:

- Effective interpersonal skills(especially listening skills), communication, documentation and analytical skills.
- Commitment to quality management and improvement.
- In depth knowledge of the systems and processes including the national standards and guidelines and performance indicators.

How often should the coaching visits be conducted?

The frequency of coaching visits depends on the competencies of the facility QI team, and how well QI implementation is progressing. Sites struggling with grasping with QI tools, or with slow implementation will require more intense coaching, while those doing well will require less. Ideally though, quarterly coaching visits are recommended.

5.3 Documenting progress

Following a visit, the coach should document the following:

- Purpose of the visit
- Site goals
- Baseline performance
- Review of the current processes
- Challenges
- Recommendations
  - *Goals*
  - *QI activities*
  - *Communication processes with coach for follow-up: channels, focal person,*
  - *QI activities*

Fig 8: An example of how to document a coaching visit

Date of encounter	**February 11, 2014**
Site Name	**XXXXX Hospital**
Encounter type	**On-site __X_____Telephone_____ Email _____ Other_____**
Attendees/Individual	**Sr Mpalume-FCH, Sr Mwarehwa-OI, Mr Makaya-Lab, Doreen Saganya-HIO**
Coach (Name) (HEALTHQUAL Consultant, MOH, Partner)	**Dr. Khabo, Mrs Dzangare**
Activity	**Outcome/Comments**
Discussion with senior leadership re status of quality management activities and infrastructure components - Is senior leadership aware of QI activities and can they describe the current activities - Do they understand infrastructure components	- Nobody from Admin/Executive was trained on either PM or QI - SNO2 is supportive and understands system concepts from feedback from trained staff(in the form of a report written) - QI committee has been established but yet to meet. No plan or set infrastructure of regular meetings was in place- so advised to use peri-natal/mortality meetings as platform to introduce QI. - Team: SIC(OI), SIC(FCH), matron, Admin, Accounting, and Pharmacy **– Suggested to add Lab and a consumer as per training recommendations.**
Identify major changes in the organization or program that may impact the quality improvement activities, i.e. staffing changes	**- Low performance on TB Screening of ART patients** **- Low performance of OI/ART dept on routine CD4 monitoring.** **- Data quality issues**
Meet with quality team to discuss status of quality project (s) - Project - Interventions - Measurement - Barriers/Challenges	**Improving CD4 monitoring, TB Screening and general data quality** identified by team during QI training. • **Low CD4 Monitoring** (*Gap*-lab limitations, and no clearly defined process to remind HWs that a particular client is due for CD4 ;*Interventions* - Lab now processing CD4s throughout the week without threshold of number of samples sent there, but no clearly defined processes in place to remind HWs that a particular client is due) • **TB Screening** - (*Gap* - old registers without columns to capture TB screening; *Intervention* - using updated registers • **Data quality issues** (*Gaps* - Poor documentation for all areas (incomplete registers; challenges with cohorting clients), high workload for all areas; *Interventions* - decentralization of ART clients to smaller facilities, use of updated registers)
Observations	• Caseload - @1600 yr(Some clients now decentralized to smaller facilities- reducing workload) • Lack of an executive/administrative member of the QI team during trainings has slowed the QI process at site(eg meetings would be easier and quicker to coordinate if invitations were coming from an SNO2/3 rather than a SIC, so this activity is still pending) • Use of new/latest registers, coupled with decentralization will most likely improve indicator performance in next cycle. • Plans underway to facilitate the site to process DBS at their lab • Because the site is a referral site, with a number of clients being initiated on ART and then later de-centralized to a smaller facilities, M&E needs to be strengthened in order to reflect real retention figures
Coaching provided	Problem solving by team: • Committee to **regular schedule for QI** committee meeting. Add **lab** person, and a consumer, to **QI team**. Instead of setting up a different meeting, can utilize a meeting that is held regularly eg peri-natal meetings/OI/ART or PMTCT meetings as platform to discuss QI. • Main issue to be addressed overally is M&E, work being done, but capturing the work being is great challenge • Nurse rotation now being done in phases, so HWs new to the dept can be oriented by those not yet rotated • On-site orientation given to SNO2 on PM/QI • consider **appointment system** for patients due for CD4 for monitoring(Lab aspect has essentially been solved, so HW-reminder systems now weakest link in improving this indicator)

6. PEER LEARNING

Peer learning, here, refers to health workers learning with and from each other as fellow learners without any implied authority to any individual. It is easy to explain ideas to peers and participating in activities in which you learn from peers.

Several fora/platforms can be used to foster peer learning, including, but not limited to the examples below. This is not an exhaustive list, and sites are encouraged to further innovate to explore new ways of fostering learning,

1. Meetings- like PHTs, DHTs, Review meetings and support group meetings.
2. Exchange visits- where site-to-site peer learning occurs through one site visiting another.
3. Distance learning- through using technological advances like video conferencing, chat groups, and email lists.

7. COMMUNITY INVOLVEMENT

Community refers to group of people living in the same place, sharing the same characteristics and common values. It is important to involve the community in QI activities since, as consumers, they are a key stakeholder in service delivery.

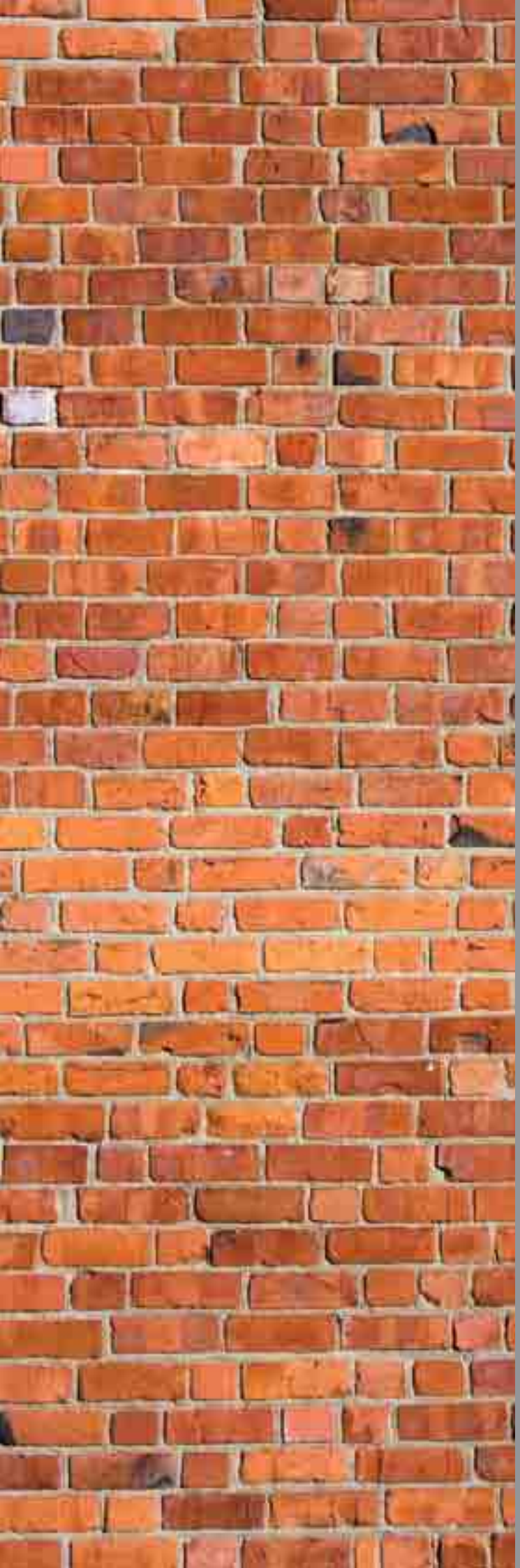
The community perspectives should be incorporated in all the stages of QI.

It is critical to have meaningful engagement of the community that consumes the services(through active participation).

Identify strategies to solicit consumer perspectives

- Focus groups
- Key informant interviews
- Exit interviews
- Satisfaction surveys
- Formal consumer advisory boards
- Needs assessment
- Membership on hospital quality committees
- Suggestion boxes
- Hotline
- Have a strategy to make patient's aware of the Patient's Charter- eg health education talks, IEC materials.

It is important to provide feedback to the community pertaining to actions implemented and general improvements based on their input.



SECTION two

2

BUILDING A CULTURE FOR IMPROVING QUALITY OF CARE

8. ROLES AND RESPONSIBILITIES

In order to achieve the stated goals and objectives of the QI there is need to clearly define the roles and responsibilities at various levels of the health system.

8.1 The National Technical Working Group

Representatives from the Ministry of Health and Child Care department at national and subnational level, technical and funding partners, training institutions and consumers such as PLHIV will form the National Technical Working group. The team will work in close collaboration with the provincial, district and site level to support QI activities:

8.1.1 The National Technical Working Group's responsibilities

- Provide input into the national QM/QI Program, including, but not limited to, performance measurement, quality improvement, quality infrastructure requirements, and targeted consumer and provider initiatives.
- Provide strategic guidance and commitment to the direction and outcomes of the program within the objectives of the MOHCC.
- Support and mentor, in collaboration with provincial, district and site level coordination teams, the appropriate implementation of improvement strategies to improve health services delivery, starting with HIV/AIDS including compliance to the national guidelines and capacity development at all levels.

8.2 Provincial Level QI Committee

The provincial QI committee will be chaired by the PMD or an appointed representative and will work in consultation with the National technical working group to ensure the implementation of QI activities in the province as well as building the provincial capacity in QI. The committee will incorporate the members of the PHE and other stakeholders such as consumers, implementing and technical partners.

8.2.1 Roles and Responsibilities of the Provincial QI committee

- Facilitate and ensure training of district and site staff on QI.
- Assist the districts in the development of QI plans.
- Support the implementation of QI plans and activities in the districts.
- Ensure that district incorporate the consumer within their committees.
- Provide a platform for the district QI committees to meet and share their experiences on QI.
- Monitoring and Evaluation of the district QI activities.

8.3 District Level QI Committee

This team will be constituted by the District Medical Officer (DMO), District Nursing Officer (DNO) and Community Health Nurse, District Laboratory Scientist, District Pharmacist as well as the District Environmental Health Officer among others will function as the district QI steering committee. The team will be supported by the Provincial teams.

8.3.1 Roles and responsibilities of district QI committee:

- Develop and implement district QI plans;
- Identify sites to implement QI for improvement in the targeted service delivery areas;
- Oversee development and implementation of site-level QI plans;
- Ensure effective and efficient collaboration of all departments responsible for QI in the identified service delivery areas;
- Monitor and measure performance at the district and site level in the QI implementing sites; and
- Facilitate experience sharing in QI through presentations at district planning and review meetings.

8.4 Facility Level QI Committee

Site organizational cultures set the stage for quality improvement and sites with supportive leadership, a philosophy of quality as everyone's responsibility, individual accountability, and effective feedback will definitely offer greater opportunities for quality improvement.

The facility level QI committee will work in collaboration with the district committee in ensuring QI activities at their site. Large sites should incorporate representatives from various departments namely Administration, Pharmacy, Laboratory, Health Information, Clinical Care, while smaller sites should include all key staff members in ensuring the implementation of QI activities. A representation from the consumer groups should not be omitted as they serve to give a critical view in terms of how services are being offered by the site.

8.4.1 Health Facility Committee's roles and responsibilities

- Plan and implement the QI activities.
- Ensure the input of consumers in coming up with the QI plans.
- Ensure routinely-collection of data, its entry and analysis as well as gap identification.
- Document, file and share site QI plans and reports with district management team; and
- Share QI experiences at district planning and review.

9. MANAGEMENT OF RESISTANCE TO CHANGE

9.1 Definition

Resistance is the refusal to accept or comply with change or improvement of a process or system by healthcare providers and consumers.

It is a very real and common issue during the process of instituting change.

It is important to identify the causes of the resistance to change, in order to be able to use the appropriate method of managing it.

Resistance to change has three components which can be summarised as :

– **Affective:** how a person feels about change.
– **Cognitive:** what they think about it.
– **Behavioural:** how they act or what they do in the face of change.

Resistance to change can manifest in the following ways,

- **active/aggressive forms -** for example sabotage, manipulation, intimidation) or
- **passive forms -** for example procrastination, feigning ignorance, agreeing to do something verbally but failing to implement.

9.2 Causes

Resistance to change can be caused by the following

- Fear of
  – *The unknown*
  – *Change*
  – *Being overwhelmed*
- Distrust of
  – *Administration*
  – *Opinion Leader/Change Agent*
- Complacency
- Lack of incentive

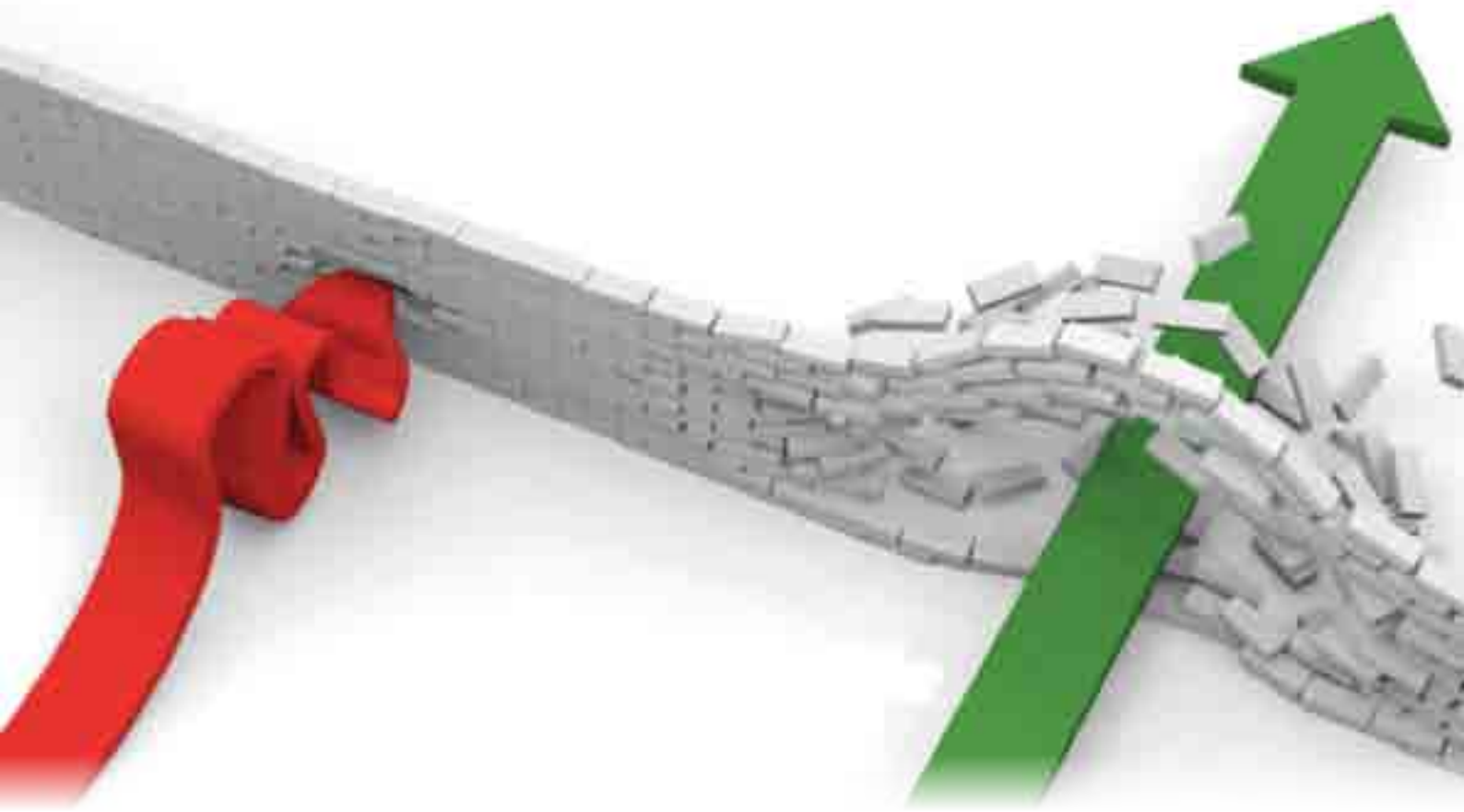
9.3 How to manage resistance to change

As the commonest reason for the resistance is fear of the unknown, it is critical to dispel any fears by sharing information to help people to understand the reason for why change is necessary. This engagement process will go a long way towards managing the resistance through encouraging people to articulate their fears and addressing them.

Other techniques include;

- Using the pushback as an opening again to share information about the change which can also generate ideas that might not have been previously considered equal or adaptations that don't change the intent of the change but shift it in a way that engages stakeholders and empowers them.

- Letting people know you are aware of the resistance and understand it, help them move from denial and depression into a stage where they are at least willing to try.
- Understanding that resistance is a valid and understandable reaction. Work on managing it positively rather than treating a resistor as a "negative outlier."
- Listening to those who are resisting. Listen so you can help them through their transition, but also listen for their ideas about the change itself. They may bring additional information to the process improvement effort, information that can be used in the improvement work.
- Use tests, data.
- Allow reinvention.
- Create tension for change.
- Show benefit.



10. ORGANIZATIONAL ASSESSMENT (OA)

This is a process of assessing the organizational level quality program and helps the site leadership with information to identify priorities, develop annual goals and objectives. It can also be used for organizational self-evaluation as well as a tool to evaluate progress by the coaches and the national team.

How to conduct an organizational assessment (see annex 5 for the tool).

The OA is implemented in two ways: 1) by an expert QI coach or 2) as a self-evaluation. The results are ideally used to develop a workplan for each element with specific action steps and timelines guiding the planning process to focus on priorities, setting direction and assuring that resources are allocated for the QMP.

- Ask open ended questions (and score) vs question by question scoring.
- Always go back to the scoring tool.
- Share scoring and major findings at the end of the assessment.
- identify areas of and priorities for improvement.
- Assess annually.
- Share the tool in advance with those you conduct the assessment (when possible).
- Clarify the expectation for the assessment as an opportunity for improvement (and diffuse any anxiety). It is normal to have lower scores when first starting a QM program.
- Ask providers to self-assess in advance of meeting.

The following domains are reviewed during the organizational assessment:

A. Quality management
   - *i) Leadership*
   - *ii) Quality committee*
   - *iii) Quality plan*

B. Workforce engagement in the quality program
C. Measurement, analysis and use of data to improve program performance
D. Quality improvement initiatives
E. Patient involvement
F. Quality program evaluation
G. Achievement of outcomes

11. DOCUMENTATION FOR QI

It is critical to be able to document all the activities that are carried out during implementation of Quality Improvement. This is important as,"what is not documented has not been done!"

The most important issues to be documented are listed below. Please refer to the relevant section above, where the actual activities to be documented are discussed in greater detail.

a. Quality Management Plan (See **Section 2.3**).
b. Quality Management Work-plan (See **Section 2.4**).
c. Quality Improvement Priority Areas
d. Quality Improvement Work-plans (See **Section 4.6.1.2**).
e. Quality Improvement Committee Meeting Minutes (See **Section 2.3.2**).
f. Quality Improvement Team Meeting Minutes (See **Section 4.6.1.1a**).
g. Performance Measurement Reports (See **Section 3**).
h. Quality Improvement Coaching Visit Report/Checklist (See **Section 5**).

BUILDING A CULTURE FOR IMPROVING QUALITY OF CARE

ANNEXES

ANNEXE 1:
HIV QUALITY IMPROVEMENT INDICATORS

a. HIV TREATMENT AND CARE

Se#	Indicator Type	Indicator	Eligible Population [Program standard of care]	Denominator (sample size)	Numerator	Data Source
ART Indicators						
1	Retention of patients on ART	Proportion of patients retained on ART at this site.	ART patients who visited the clinic in the six months prior to the review period **[Standard: 100% of ART patient seen for follow-up at least once per 6m time period]**	Number of patients who visited clinic in the six months prior to the review period	Number of patients who visited the clinic at least once during six months review period	ART Register Patient file
2	Adherence Assessment	Proportion of patients who had an ART adherence assessment at the most recent visit.	ART patients seen during the review period **[Standard: 100% of ART patients have adherence assessment performed at each clinic visit]**	Number of patients on ART with at least one visit during the review period	Number of patients with ART adherence assessment at the most recent visit	ART Register Patient file
3	CD4 Monitoring	Proportion of patients who had a CD4 test performed.	Patients on ART seen during the review period **[Standard: 100% ART patients have CD4 test performed every 6 months]**	Number of patients on ART due for 6 month CD4 test during the review period	Number of patients with a CD4 test performed during the review period	ART Register Patient file

Se#	Indicator Type	Indicator	Eligible Population [Program standard of care]	Denominator (sample size)	Numerator	Data Source
ART Indicators						
4	TB Screening	Proportion of ART patients screened for TB at the most recent visit	Patients on ART seen during the review period **[Standard: 100% of ART patients screened for TB at each clinic visit]**	Number of patients on ART with one visit during the review period	Number of patients on ART who were screened for TB at the most recent visit (5 question assessment)	ART Register Patient file
5	Paediatric ART	Proportion of HIV positive and eligible children (<15yrs) who were initiated on ART during the reporting period	HIV+ (confirmed) and eligible children 0-15 **[Standard: 100% of HIV+ eligible clients initiated on ART eg all HIV+ <5yr olds]**	Number of children with HIV infection and eligible for ART with one visit during the review period	Number of eligible children initiated on ART	Pre-ART register OR Paediatric register Patient file

b. PMTCT

Se#	Indicator Type	Indicator	Eligible Population	Denominator (sample size)	Numerator	Data Source
ART Indicators						
1	ART initiation in ANC	Proportion of pregnant women that are HIV+ that are initiated on ART on the same day of identification	Pregnant women who are known to be HIV+ but not on ART **[Standard: 100% of HIV+ pregnant women not on ART initiated on ART]**	Number of known HIV+ pregnant women not on ART @ booking.	Number of HIV+ pregnant women that are initiated on ART on the same day as booking date.	ANC register (Column 12, 13, 14, 15, 31 and 32)
2a	Early Infant HIV Diagnosis	Proportion of infants born to HIV+ women who had a DNA PCR sample within 2months of birth	All HIV exposed infants less than 2 months. **[Standard: 100% of HIV exposed infants have DNA PCR sample collected before 2months age]**	Number of HIV exposed infants less than 2 months who are enrolled in HIV Exposed Infant follow-up during review period.	Number of HIV exposed infants ≤2 months who had DNA PCR sample collected.	Delivery register DNA PCR register
2b		Proportion of HIV exposed infants who had a DNA PCR sample collected within 2months of birth and received result within a month of collection.	All HIV exposed infants who had a DNA PCR sample collected. **[Standard: 100% of HIV exposed infants receive DNA PCR test result within a month of collection]**	Number of HIV exposed infants who had a DNA PCR sample collected	Number of HIV exposed infants who had a DNA PCR sample collected within 2 months of birth and received results within a month of collection.	Exposed infant DNA PCR Clinic register
3	ART Initiation for HIV+ children	Proportion of HIV+ children <2 years initiated on ART.	All HIV+ children < 2 years old. **[Standard: 100% of confirmed HIV infected children <2 years put on ART]**	Number of HIV+ children < 2 years old (confirmed HIV+)	Number of HIV+ children < 2 years old that have been initiated on ART within 21days of caregiver receiving results.	DNA PCR register ART register Patient file Pre-ART(To link DNA PCR to ART register)

Se#	Indicator Type	Indicator	Eligible Population	Denominator (sample size)	Numerator	Data Source
ART Indicators						
4a	Retention in Care	Proportion of HIV+ women retained on ART 6 months after initiation in ANC	All HIV+ women who initiated ART in ANC in the six months prior to the review period. **[Standard: 100% of HIV+ women initiated on ART in ANC retained in care 6-months after initiation]**	Number of HIV+ women who initiated ART in the six months prior to the review period	Number of HIV+ women who initiated ART in ANC in the six months prior to review period and had a visit during the last 3 months of the review period at the clinic	ART register Patient file
4b		Proportion of HIV+ children retained on ART 6 months after initiation	All HIV+ children who initiated ART in the six months prior to the review period. **[Standard: 100% of HIV+ children initiated on ART retained in care 6-months after initiation]**	Number of HIV+ children who initiated ART in the six months prior to the review period	Number of HIV+ infants who initiated ART six months prior to review period and visited the clinic at least once during the last month of the review period	ART register Patient file
5a	HIV re-Testing to detect incident infection	Proportion of pregnant women that tested HIV negative during the 1st and 2nd trimester that were re-tested for HIV during the period 32 weeks to onset of labour.	All HIV- pregnant women at 32 week gestation to onset of labour. **[Standard: 100% of initially HIV negative women re-tested for HIV in the third trimester]**	Number of pregnant women testing HIV negative during the 1st and 2nd trimester and are currently between 32 week gestation and onset of labour.	Number of pregnant women that tested negative for HIV in the 1st and 2nd trimester that were re-tested for HIV from 32 weeks gestation to onset of labour.	ANC register HTC register
5b		Proportion of HIV negative postpartum women tested for HIV and received result.	All HIV- postpartum women . **[Standard: 100% of initially HIV negative women re-tested for HIV in the post-partum period]**	Number of HIV- postpartum women enrolled in post-partum care	Number of HIV- postpartum women re-tested for HIV	PNC register HTC register

Se#	Indicator Type	Indicator	Eligible Population	Denominator (sample size)	Numerator	Data Source
ART Indicators						
6	Cotrimoxazole initiation in HIV exposed infants	Proportion of HIV exposed infants less than two months initiated on Cotrimoxazole.	All HIV exposed infants < 2 months old. **[Standard: 100% of HIV exposed infants <2months old initiated on Cotrimoxazole]**	Number of HIV exposed infants < 2 months old enrolled in HEI follow-up care during the past 6 months.	Number of HIV exposed infants < 2 months old enrolled in HEI follow-up who have been initiated on Cotrimoxazole	Delivery register Infant Dispensing Register

ANNEXE 2:
MANUAL FOR DATA ABSTRACTION

PART 1: Case Listing

Step 1:

Identify the clinic population whose care you want to measure.

Population: Depends on the indicator under review

Step 2:

Define the active case list eligibility criteria for that clinic population.

Eligibility Criteria: Depends on the indicator under review

Step 3:

Identify the data sources where those patients can be found.

Data Sources: Depends on the indicator under review

Patient Information to Collect:

Step 4:

Decide on the data fields necessary to include in the case list.

Enough unique patient identifiers need to be included so that duplicate entries can be consolidated even if some information is missing.

Step 5:

Transfer patient information from the data sources to the case list.

Step 6:

Verify that each entry in case list is a unique and eligible patient.

Note: Separate case lists need to be created for each indicator

1. Clinical visit is an encounter between a nurse or doctor and a patient.
2. Clinical visits should be arranged in chronological order. Additional columns should be added to accommodate all clinical visits during the review period.

PART 2: Sampling

Step 1:

Determine and record the case load of the active case list that you will be sampling from.

Step 2:

Using the case load, determine and record the intended sample size from the sampling chart below.(Calculated to achieve 95% CI (+8%) based on a performance score of 50% (ie maximum probability)

Caseload	Sample Size
1-40	All
41-50	38
51-60	43
61-70	48
71-80	53
81-90	57
91-100	61
101-119	67
120-139	73
140-159	78
160-179	82
180-199	86
200-249	94
250-299	101
300-349	106
350-399	110
400-449	113
450-499	116
500-749	127
750-999	131
1000-4999	146
5000 or more	150

Step 3:

Generate a list of random numbers equal to the intended sample size in length with each number ranging between 1 and the case load and corresponding to a client on the case list. No number should be repeated.

In the HIVQUAL randomizer,

Enter the case load into # of eligible cases.

Enter intended sample size into # of randomized charts needed.

Click generate.

Step 4:

Sample the medical charts corresponding to the random numbers generated.

Replacement Strategy: If a sampled chart is not eligible for review, set it aside and record in a log book why the chart was not eligible for review. Afterwards, count how many charts need to be replaced. Generate a new random list of numbers equal in length to the number of charts that need to be replaced. Each number should range between 1 and the number of eligible charts that have not yet been sampled.

PART 3: Data Collection

Step 1:

Use the data collecting tools to collect patient level data for the sampled charts for each indicator.

Step 2:

Patient level data is then entered into the HIVQUAL software.

PART 4: Data Validation

Step 1:

Randomly select 10% of the sampled charts.

Step 2:

Independently re-abstract data for these charts.

Step 3:

Compare the two sets of data

Step 4:

If there are ≥ 10% differences, then start all over again.

If there are < 10% differences then correct the errors and then go on with the analysis using the HIVQUAL software.

Step 5:

Create validation reports from the HIVQUAL software and ensure that there is correct data for each patient.

PART 5: Data Analysis

Step 1:

Create histogram using the HIVQUAL software

ANNEXE 3:

SAMPLE DATA ABSTRACTION TOOL

a) Data Abstraction tool

OI ART # (For HIV infected pregnant women use PMTCT #; for exposed infants use mother's PMTCT #; for HIV negative women retesting in 3rd trimester use ANC #)	Initials	DOB	Gender	PREG?	HIV Status	Visit date from 6/12 prior, WHO status (Retention indicator)	Date DNA PCR collected	Date DNA PCR result received	Visit from current review period, and WHO status	

	CD4 & Date	Regimen and start date	Adherence Done Y/N	On TB Rx?	TB Screened? (Y/N)	TB Screening Outcome (S-Suspect/ Not suspect)	Preg woman 3rd trimester HIV retesting done? (Y/N)	Pregnant woman ART Initiated during R/V? (Y/N)	ART Initiated on ART within 21 days of receipt of DNA PCR result (Y/N)

b) Data Abstraction tool with dummy data

OI ART #(For HIV infected pregnant women use PMTCT #; for exposed infants use mother's PMTCT #; for HIV negative women retesting in 3rd trimester use ANC #)	Initials	DOB	Gender	PREG?	HIV Status	Visit 6/12 prior, WHO status	Date DNA PCR collected	Date DNA PCR result received	
0906062012A00567	NMD	12-Jul-03	M	N/A	Pos	12/04/2014, 2	N/A	N/A	
0906062014P00441	PM	01/03/1988	F	YES	Pos	Nil, 1	N/A	N/A	
0906062014P00796	HEI	13/09/2014	M	N/A	HEI		27/10/2014	19/12/2014	
0906062006A00458	ADD	02/01/1956	F	NO	POS	12/04/14, 2	N/A	N/A	
0906062005A00112	LTT	03/03/1964	M	N/A	POS	09/03/2014, 2	N/A	N/A	
0906062014A00645	DNR	03/07/2014	F	N/A	HEI	N/A	17-Aug	Not received	
0906062014A00751	HIV	02/10/1990	F	YES	NEG	N/A	N/A	N/A	
0906062014A00331	MBP	11/12/1988	F	Yes	POS	02/02/2014, 02/04/14, 02/06/14			
0906062014A09745	PAE	04/08/2011	F	N/A	POS	28/04/2014, 2	N/A	N/A	
0906062014A08541	INF	21/02/2014	M	N/A	POS	06/04/2014, 1	N/A	N/A	

	Visit during, and WHO	CD4 &Date	Regimen and start date	Adherence Done Y/N	On TB Rx?	TB Screened	Outcome	3rd trimester HIV retesting?	ART Initiated during R/V?	ART Initiated on ART within 21days of receipt of DNA PCR result	Comments
	03/07/2014, 3	400, 3 July	zidolam E, 03 Jul	Y	No	Yes	Not susp	N/A	Yes	N/A	Adolescent
	22-Nov-14	800, 22 Nov	Tenolam E, 22/10/14	Y	No	No	N/A	N/A	Yes	N/A	Option B+
	27/10/14, 1	N/A	N/A	N/A				N/A		N/A	Exposed infant
	15/10/14, 2	750, 15/10/14	Tenolam E, 15/04/2013	Y	Yes	No	N/A	N/A		N/A	Adult retained in care
	Nil	N/A	AZT/3TC/EFV, 10/10/13	N/A	N/A	N/A	N/A	N/A	NO	N/A	Adult LTFU
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Exposed infant- not received results
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	HIV neg preg woman retested in 3rd trimester
	02/08/2014,2	700, 02/08/2014	Tenolam E	y	No	Yes	Not suspect	N/A	N/A	N/A	Retention of Mother-baby pairs
	26/08/2014, 3	60%, 26/08/14	NIL	N/A	Yes	N/A	N/A	N/A	NO	N/A	PAEDS ART INITIATED
	07/07/14, 1	80%, 07/07/14	ZIDOLAM N, 07/07/14	YES	NO	YES	SUSPECT	N/A	YES	YES	PAEDS ART INITIATED

ANNEXE 4:
PEPFAR SIMS FACILITY TOOL

Domain: 23 Site Management—QM/QI (Quality Management/ Quality Improvement)

23.1 HIV QM/QI System

Each site should have a QM/QI system, with routine monitoring of processes and quality of services.

	QUESTION	RESPONSE	SCORING
Q1	Are any QM/QI activities or plans in place?	Y N	If N=Red
If Y, then Q2			
Q2	Is there a staff person responsible for QM/QI?	Y N	If N=Red
If Y, then Q3			
Q3	Does a functional QM/QI committee/team exist that does all of the following? 1) Convene regular (e.g. monthly, weekly) QI team meetings at the facility 2) Follows a site QM/QI plan and 3) Routinely reviews performance and service delivery standards	Y N	If N=Yellow
If Y, then Q4			
Q4	Is there a *written* site QM/QI plan being implemented with defined staff roles and responsibilities?	Y N	If N=Light Green If Y=Dark Green
SCORE			

ANNEXE 5:
ORGANIZATIONAL ASSESSMENT TOOL

National Quality Improvement Programme
Organizational Quality Assessment Tool

Purpose of the Organizational Assessment:

Sustained improvement activities require attention to the organizational Quality Management Program (QMP), in which structures, processes and functions support measurement and improvement activities. Development, implementation and spread of sustainable QI requires an organizational commitment to quality management. Organizational structure is fundamental to QI success, and involves a receptive health care organization, sustained leadership, staff training and support, time for teams to meet, and data systems for tracking outcomes. This structure supports quality initiatives that apply process improvement including: reliable measurement, root cause analysis and finding solutions for the most important causes identified.

This assessment identifies all of the important elements associated with a sustainable QMP. Scores from 0 to 5 are defined to identify gaps in the QMP and to set organizational priorities for improvement. The scoring structure measures program performance in specific domains along the spectrum of improvement implementation. When assigning a score of 0 to 5 for individual components, select the number that most accurately reflects organizational achievement in that area. **You must meet all of the elements associated with a particular number in order to receive that score**. If all of the boxes are not checked within one particular score section, then the score should be the number preceding that one. To score "2" for example, each box for the elements corresponding to that score section must be checked. If there is any uncertainty in assessing whether performance is closer to the statement in the next higher or next lower range, **choose the lower score**. Applied annually, this assessment will help a program evaluate its progress and guide the development of goals and objectives. Note that you may decide to check boxes for criteria in some of the higher scores and use that information to address gaps in the program that will help you meet the higher score.

The OA is implemented in two ways: 1) by an expert QI coach or 2) as a self evaluation. The results are ideally used to develop a workplan for each element with specific action steps and timelines guiding the planning process to focus on priorities, setting direction and assuring that resources are allocated for the QMP. Whether performed by a QI coach or applied as a self evaluation, key leadership and staff should be involved in the assessment process to ensure that all key stakeholders have an opportunity to provide important information related to the scoring.

Results of the OA should be communicated to internal key stakeholders, leadership and staff. Engagement of organizational leadership and staff is critical to ensure buy-in across departments, and essential for translating results into improvement practice.

Improvement activities should be aligned with National Quality Improvement strategies, where applicable.

Note: for small centers with few staff, a formal committee or project team may not be necessary to complete the functions described in this assessment. In these organizations, the entire staff should be considered the "committee" or the "team" that is involved in improvement activities.

A. Quality Management

GOAL: To assess how the organizational Quality Management Plan support a systematic process with identified leadership, accountability and dedicated resources.
Three components form the backbone of a strong sustainable QMP: Leadership, Quality Planning and a Quality Committee.

Leadership

Senior leadership staff are defined by each organization since titles and roles vary among organizations. Clinical programs should include a clinical leader and an administrative leader. Larger programs may include additional leadership positions. There may be other informal leaders in the organization that support quality activities, but these are not included in this section. When reviewing the criteria for each score, consider the clinical or administrative leader who is responsible for the quality management program or is most closely associated it with it if there is no one officially designated for this function. Ideally, this person should be a hospital or health center senior leader who has the authority to convene committees and approve actions that are important to implement the quality management program.

Leaders establish a unity of purpose and direction for the organization and work to engage all staff, patients and external stakeholders in meeting organizational goals and objectives, this includes motivation that promotes shared responsibility and accountability with a focus on teamwork and individual performance. Organizational leaders should prioritize quality goals and improvement initiatives for the year, and establish accountability for performance at all organizational levels. The benefits of strong leadership include clear communication of goals and objectives, where evaluation, alignment and implementation of activities are fully integrated.

Evidence of leadership support and engagement includes establishment of clear goals and objectives, communication of program/organizational vision, creating and sustaining shared values, and providing resources for implementation.

Quality Committee

A quality committee drives implementation of the quality plan and provides high-level comprehensive oversight of the quality program. This involves reviewing performance measures, developing workplans, chartering project teams and overseeing progress. Teams should be multidisciplinary and include a client when feasible. The committee should meet monthly, document their activities and share meeting notes with committee members and other organizational staff and key stakeholders. For smaller organizations the entire staff may be the QI committee and should be considered in that way since they perform all of the functions of the Quality Management Program.

Quality Plan

A quality management plan documents programmatic structure and annual quality program goals. The quality plan should serve as a roadmap to guide improvement efforts, and include a corresponding workplan to track activities, monitor progress and signify achievement of milestones.

A.1. To what extent does senior leadership create an environment that supports a focus on improving the quality of care in the organization?		
Getting Started	0	☐ Senior leaders are not visibly engaged in the quality of care program
Planning and initiation	1	Leaders are: ☐ Primarily focused on reporting requirements ☐ Inconsistent in use of data to identify opportunities for improvement ☐ Not fully involved in improvement efforts ☐ Not fully involved in quality meetings ☐ Not supporting provision of resources for QI activities, including dedicated time for improvement
Beginning Implementation	2	Leaders are: ☐ Engaged in quality of care with focus on use of data to identify opportunities for improvement ☐ Somewhat involved in improvement efforts ☐ Somewhat involved in quality meetings ☐ Supporting resources for QI activities but not yet at optimal levels to support improvement
Implementation	3	Leaders are: ☐ Providing routine leadership to support the quality management program ☐ Providing routine and consistent allocation of staff or staff time for QI (depending on organization size) ☐ Actively engaged in QI planning and evaluation ☐ Actively managing/leading quality committee meetings ☐ Clearly communicating quality goals and objectives to all staff ☐ Recognizing and supporting staff involved in QI ☐ Routinely reviewing performance measures and patient outcomes to inform program priorities and data use for improvement. ☐ Attentive to national health care trends/priorities that pertain to the program
Progress toward systematic approach to quality	4	Leaders are: ☐ Supporting development of a culture of QI across the program, including provision of resources for staff participation in QI learning opportunities, seminars, professional conferences, QI story boards for distribution ☐ Supporting prioritization of quality goals based on data, and critical areas of care ☐ Promoting patient-centered care and patient involvement through the QMP ☐ Routinely engaged in QI planning and evaluation ☐ Routinely providing input and feedback to QI teams

Full systematic approach to quality management in place	5	Leaders are: ☐ Actively engaged in the implementation and shaping of a culture of QI across the program, including provision of resources for staff participation in QI learning opportunities, seminars, professional conferences, QI story boards ☐ Encouraging open communication through routine team meetings and dedicated time for staff feedback ☐ Routinely and consistently engaged in QI planning and evaluation ☐ Routinely and consistently providing input and feedback to QI teams ☐ Encouraging staff innovation through QI awards and incentives ☐ Directly linking QI activities back to institutional strategic plans and initiatives

A.2. To what extent does the organizational program have an effective quality committee to oversee, guide, assess, and improve the quality of services?		
Getting Started	0	☐ A quality committee has not yet been developed or formalized or is not currently meeting regularly to provide effective oversight for the quality program
Planning and initiation	1	The quality committee: ☐ May review data triggered by an event or problem, or generated by donor or Ministry of Health urging ☐ Has not yet developed a systematic process for data use to identify and prioritize annual goals ☐ Has not yet defined roles and responsibilities for participating individuals
Beginning Implementation	2	The quality committee: ☐ Has plans to hold regular meetings, but meetings may not occur regularly and/or do not focus on performance data ☐ Has been formalized, representing most institutional departments ☐ Has identified roles and responsibilities for participating individuals including the QI focal person ☐ Has not yet implemented a structured process to review data for improvement
Implementation	3	The quality committee: ☐ Is formally established and led by the organization's director or manager as chair ☐ Represents most departments and disciplines ☐ The quality committee has established annual calendar of meeting dates ☐ Has defined roles and responsibilities as codified in the quality plan including the QI focal person ☐ Reviews performance data at each meeting ☐ Discusses QI progress and redirects teams as appropriate ☐ Introduces early stages of ground rule management and efficiency tools during meetings

Progress toward systematic approach to quality	4	The quality committee: ☐ Is formally established and led by an organizational director or manager as chair who actively oversees the work of the quality program with established annual meeting dates ☐ Represents all departments and disciplines ☐ Has established a performance review process to regularly evaluate clinical measures and respond to results as appropriate, including staff and patient satisfaction ☐ Communicates with non-members through distribution of minutes and discussion in regular staff meetings ☐ Actively utilizes a workplan to closely monitor progress of quality activities and team projects
Full systematic approach to quality management in place	5	The quality committee: ☐ Is a formal entity led by the organizational director or manager or by an individual as designated by the organization ☐ Represents all departments and disciplines ☐ Has defined roles and responsibilities as codified in the quality plan including a QI focal person ☐ Has established a systematic performance and review process, including structure, and process and outcomes measures. ☐ Is responsive to changes in treatment guidelines and external/national priorities, which are considered in development of indicators and choosing improvement initiatives ☐ Has fully engaged senior leadership who lead discussions during committee meetings ☐ Effectively communicates activities, annual goals, performance results and progress on improvement initiatives to all stakeholders, including staff and patients

A.3. To what degree does the organization have a comprehensive quality plan that is actively utilized to oversee quality improvement activities?		
Getting Started	0	☐ A quality plan, including elements necessary to guide the administration of a quality program has not been developed
Planning and initiation	1	The quality plan: ☐ Is written but does not include the essential components necessary to direct an effective quality program (see level 3)
Beginning Implementation	2	The quality plan: ☐ Is written for the HIV program only, and contains some of the essential components (see level 3) ☐ Is under review for approval by senior leadership, and includes steps for implementation ☐ Includes a designated point of contact to manage QM program communication within the organization and with the national program

Implementation	3	The quality plan: ☐ Is complete, defining all essential QI components. This includes goals and objectives, quality committee roles, responsibilities and logistics, performance measurement and review processes, annual goal identification and prioritization processes, QI methodology, communication strategy, patient involvement, and a program evaluation procedure. ☐ Includes a workplan/timeline outlining key activities of the quality program and improvement initiatives, including individuals accountable for each. The timeline is reviewed regularly by the quality committee and modified as necessary to achieve the identified goals. ☐ An organogram visually depicting the organizational quality management structure
Progress toward systematic approach to quality	4	The quality plan: ☐ Has been implemented and regularly used by the quality committee to direct the quality program ☐ Includes annual goals identified based on data generated through internal and external reviews, and engagement of the quality committee and staff to elicit priorities ☐ Includes a workplan/timeline outlining key activities in place and routinely used to track progress of performance measures and improvement initiatives, and is modified as needed to achieve annual goals ☐ Is routinely communicated to most stakeholders, including staff, patients, board members and the parent organizations, if appropriate ☐ Is evaluated annually by the quality committee to ensure that the needs of all stakeholders are met
Full systematic approach to quality management in place	5	The quality plan: ☐ Is written, implemented and regularly utilized by the quality committee to direct the quality program and includes all necessary components (see level 3) ☐ Includes regularly updated annual goals that were identified by the quality committee using data based on internal performance measures and externally required indicators through engagement of the quality committee and staff to identify priorities for improvement ☐ Includes the workplan/timeline outlining key activities in place ☐ Is routinely used to track progress on performance measures and improvement initiatives, and modified as needed to achieve annual goals ☐ Is communicated broadly to all stakeholders, including separate staff, patients, board members and the parent organizations, as appropriate ☐ Is evaluated annually by the quality committee and revised as needed to ensure that the needs of all stakeholders are met. ☐ Is adapted to changes in national policies and to ensure that the program continues to meet the changing needs of the patient as the evidence base and guidelines evolve
Opportunity/Gaps		

B. Workforce Engagement in the quality program

GOAL: To assess awareness, interest and engagement of staff in quality improvement activities.

Staff engagement in the quality management program at all organizational levels is central to the success of improvement activities. Engagement includes development and promotion of staff knowledge around organizational systems and processes to build sustainable quality management programs, such as internal management processes, operational barriers, patient interaction, and successful strategies and barriers to QI implementation.

Ongoing training and retraining in QI methodology and practical skills reinforces knowledge and the building of workforce expertise around improvement. As staff progress along the continuum of QI sophistication, improvement is slowly integrated into routine work and practice, enhancing staff engagement in the process. Immediate access to improvement data for example, empowers staff to focus on key areas of care and build consensus around QI activities to improve patient outcomes.

As QI becomes part of the institutional culture and team work progresses, staff embrace their respective roles and responsibilities, acquiring a sense of ownership and deeper involvement in improvement work.

B.1. To what extent are clinicians and staff routinely engaged in quality improvement activities and provided training to enhance knowledge, skills and methodology needed to fully implement QI work on an ongoing basis?		
Getting Started	0	☐ All of the staff (clinical and non-clinical) are not routinely engaged in QI activities and are not provided training to enhance skills, knowledge, theory or methodology or encouragement to identify opportunities for improvement and develop effective solutions
Planning and initiation	1	Engagement of core staff in QI (clinical and non-clinical): ☐ Is under development and includes training in QI methods and opportunities to attend meetings where QI projects are discussed
Beginning Implementation	2	Engagement of core staff in QI (clinical and non-clinical): ☐ Is underway and some staff have been trained in QI methodology ☐ Includes QI meetings attended by some designated staff

Implementation	3	Engagement of core staff in QI (clinical and non-clinical): ☐ Includes attendance in at least one training in QI methodology. Staff members are generally aware of Program QI activities (quality plan/priorities) ☐ Includes involvement in QI projects, project selection and participation in a QI committee ☐ Includes QI project development, where projects are discussed and reviewed during staff meetings ☐ Includes defined roles and responsibilities related to QI. Clinicians and staff are aware of the organizational quality management plan and priorities for improvement. ☐ Includes a formal process for regularly recognizing staff performance in QI via performance appraisals, public recognition during staff meetings, etc.
Progress toward systematic approach to quality	4	Engagement of core staff in QI (clinical and non-clinical): ☐ Is demonstrated by evidence that staff members are engaged and encouraged to use those skills to identify QI opportunities and develop solutions ☐ Involves a shared language regarding quality, which is evidenced in routine discussion ☐ Is described in the annual quality plan, and includes staff training and roles and responsibilities regarding staff involvement in QI activities ☐ Includes a formal process for recognizing staff performance internally. QI teams are provided opportunities to present successful projects to all staff and leadership.
Full systematic approach to quality management in place	5	Engagement of core staff in QI (clinical and non-clinical): ☐ Is defined by staff awareness of the importance of quality and continuous improvement, and their participation in identifying QI issues, developing strategies for improvement and implementing strategies ☐ Is evidenced by regular and continuous QI education and training in QI methodology ☐ Is reinforced by leadership who encourages all staff to make needed changes and improve systems for sustainable improvement including the necessary data to support decisions ☐ Involves formal and informal discussions where teamwork is openly encouraged and leadership shapes teamwork behavior ☐ Incorporates routine communication about new developments in QI, including promotion of QI projects both internally (e.g., quality conferences) and externally (e.g., national meetings) ☐ Includes a formal process for recognizing staff performance internally. QI teams are provided opportunities to present successful projects to all staff and leadership ☐ Includes opportunities for abstract development and submission to relevant professional conferences and authorship of related publications about development and implementation of institutional QM programs ☐ Involves clearly defined roles and responsibilities which are utilized to assess staff performance

C. Measurement, Analysis and Use of Data to Improve Program Performance

GOAL: To assess how the organization uses data and information to identify opportunities for improvement, develops measures to evaluate the success of change initiatives, to align initiatives with national priorities, and to monitor results; and to ensure that accurate, timely data and information are available to stakeholders throughout the organization to drive effective decision making.

The Measurement, Analysis and Use of Data section assesses how the organizational program selects, gathers, analyzes and uses data to improve performance. This includes how leaders conduct performance reviews to ensure that actions are taken, when appropriate, to achieve the organization's program goals.

C.1. To what extent does the organization routinely measure performance and use data for improvement?		
Getting Started	0	Performance measures: ☐ Have not been identified
Planning and initiation	1	Performance measures: ☐ Have been identified to evaluate some components of the organization's program, but do not cover all significant aspects of service delivery
		Performance data: ☐ Collection is planned but has not been initiated
Beginning Implementation	2	Performance measures: ☐ Are defined and used by staff in all applicable service delivery areas
		Performance data: ☐ Analysis and interpretation of results on measures is in early stages of development and use ☐ Results are occasionally shared with staff and patients, but a structured process is not yet in place

Implementation	3	Performance measures: ☐ Are defined by the Ministry of Health or donor partner ☐ Are consistently used by staff in all applicable service delivery areas
		Performance data: ☐ Are longitudinally tracked, analyzed and reviewed with the frequency required to identify areas in need of improvement. A structured review process is used regularly by the leadership to identify and prioritize improvement needs and initiate action plans to ensure that goals are achieved. ☐ Are collected by staff with working knowledge of indicator definitions and their application ☐ Results and associated measures are routinely shared with staff and their input is elicited to make improvements ☐ Clinic has a process for checking the accuracy of its data occasionally but not systematically
Progress toward systematic approach to quality	4	Performance measures: ☐ Are tied to organizational goals and priorities ☐ Are defined and consistently used by staff in all applicable departments
		Performance data: ☐ Are reviewed for accuracy on all measures in all departments ☐ Are actively used to drive improvement activities ☐ Results and associated measures are frequently shared with staff to elicit their input and engage them in improvement processes aligned with organizational goals
Full systematic approach to quality management in place	5	Performance measures: ☐ Are selected using national/donor partner measures and organizational annual goals, with the intent to meet Ministry of Health requirements and the needs of stakeholders and patients ☐ Reflect organizational priorities and patients, in consideration of organizational & local issues ☐ Are defined for key component ☐ Are evaluated regularly to ensure that the program is able to respond effectively to internal and external changes quickly. ☐ Are linked to performance of key clinical outcomes
		Performance data: ☐ Are reviewed for accuracy on all measures in all applicable departments ☐ Visible or easily accessible to ensure data reporting transparency throughout the organization ☐ Are arrayed in formats that enable accurate interpretation, such as run charts or simple bar graphs ☐ Results and associated measures are systematically shared with all key stakeholders, including staff and patients ☐ Are systematically reviewed through a Formal Data Quality Assurance program
Opportunities/Gaps:		

D. Quality Improvement Initiatives

GOAL: To evaluate how the organization uses QI methodology and teamwork to achieve program goals and maintain high levels of performance over long periods of time.

The Quality Improvement Initiatives section examines how leadership and workforce use these methods and tools to conduct improvement initiatives with emphasis on identification of the exact causes of problems and designing effective solutions; determining program specific best practices and sustaining improvement over long periods of time. In high reliability organizations, robust process improvement methodology is routinely utilized for all identified problems and improvement opportunities to assure consistency in approach by all staff members.

D.1. To what extent does the organization identify and conduct quality improvement initiatives using QI methodology to assure high levels of performance over long periods of time?		
Getting Started	0	☐ Formal quality improvement projects have not yet been initiated in the organizational program
Planning and initiation	1	QI initiatives: ☐ Focus on individual cases without assessment of organizational performance or system level analysis of data. Reviews primarily used for inspection. ☐ Are not team-based ☐ Do not use specific tools or methodology to understand causes and make effective changes
Beginning Implementation	2	QI initiatives: ☐ Are prioritized by the quality committee based on program goals, objectives and analysis of performance measurement data ☐ Involve team leaders and team members who are assigned by the quality committee or other leadership ☐ Begin to use specific tools or methodology to understand causes and make effective changes

Implementation	3	QI initiatives: ☐ Are ongoing based on analysis of performance data and other program information, including external reviews and assessments ☐ Focus on processes of care in which QI methodology is routinely utilized ☐ Are regularly documented and provided to the Quality Improvement Committee ☐ Involve staff on QI teams. Cross departmental/cross functional teams are developed depending on specific project needs. This would include laboratory, administrative and pharmacy staff where relevant.
Progress toward systematic approach to quality	4	QI initiatives: ☐ Are ongoing based on analysis of performance data and other program information, including external agency reviews and assessments ☐ Can be identified by any member of the program team through direct communication with program leadership ☐ Routinely and consistently reinforce and promote a culture of quality improvement throughout the program through shared accountability and responsibility of identified improvement priorities ☐ Are supported with appropriate resources, including people and time, to achieve effective and sustainable results ☐ Involve support of data collection with results routinely reported to QI project teams
Full systematic approach to quality management in place	5	QI initiatives: ☐ Are ongoing in core service categories ☐ Correspond with a structured process for prioritization based on analysis of performance data and other factors, such as patient surveys ☐ Are implemented by project teams. Further, physicians and staff can identify an improvement opportunity at any point in time and suggest a QI team be initiated ☐ Consistently and routinely utilize robust process improvement and multidisciplinary teams to identify actual causes of variation and apply effective, sustainable solutions ☐ Are guided by a team leader, and include all relevant staff depending on specific project needs ☐ Are regularly communicated to the Quality Committee, staff and patients ☐ Routinely involve patients on QI project teams ☐ Are presented in storyboard context or other formats and reported to the larger organization and/or placed in public areas for staff and patients (if relevant) ☐ Involve recognition of successful teamwork by senior leadership ☐ Are supported by development of sustainability plans
Opportunities/Gaps:		

E. Patient Involvement

Goal: This section assesses the extent to which patient involvement is formally integrated into the quality management program.

Patient involvement encompasses the diversity of individuals using the organization's services and can be achieved in multiple ways, including solicitation of patient perspectives through focus groups, key informant interviews and satisfaction surveys; a formal patient advisory board that is actively engaged in improvement work; including patients as members of organizational committees; conducting patient needs assessments and including patients in specific QI initiatives. Ideally patients have a venue to identify improvement concerns and are integrated into the process to find solutions and develop improvement strategies. Overall, patients are considered valued members of the program, where patient perspectives are solicited, information is used for performance improvement and feedback is provided to patients. Patient experience is considered an important dimension of quality that is considered in determining improvement priorities and included as an important component of the quality management plan.

E.1. To what extent are patients effectively engaged and involved in the HIV quality management program?		
Getting Started	0	☐ There is currently no process to involve patients in HIV quality management program activities
Planning and Initiation	1	Patient involvement is demonstrated by: ☐ Occasionally soliciting patient feedback, but no formal process is in place for ongoing and systematic participation in quality management program activities
Beginning Implementation	2	Patient involvement is demonstrated by: ☐ Soliciting patient feedback, with development of a formal process for ongoing and systematic participation in quality management program activities, such as through patient satisfaction surveys
Implementation	3	Patient involvement is demonstrated by: ☐ Engagement with patients to solicit perspectives and experiences related to quality of care ☐ Formal involvement in quality management program activities through a formal patient advisory committee, satisfaction surveys, interviews, focus groups, storytelling and/or patient training/skills building. However, the extent to which patients participate in quality management program activities is not documented or assessed.

Progress toward systematic approach to quality	4	Patient involvement is demonstrated by: ☐ A formal process for patients to participate in quality management program activities, including a formal patient advisory committee, surveys, interviews, focus groups and/or patient training/skills building ☐ Three or more of the following activities: • *Sharing of performance data and discussing quality during formal patient meetings* • *membership on the internal quality management team or committee* • *training in quality management principles and methodologies* • *engagement to make recommendations based on performance data results* • *increasing documentation of how recommendations by patients are used to implement quality improvement projects* ☐ Use of documented information gathered through the above activities to improve the quality of care. However, staff does not review with patients how their involvement contributes to refinements in quality improvement activities.
Full systematic approach to quality management in place	5	Patient involvement is demonstrated by: ☐ A formal, well-documented process for patients to participate in HIV quality management program activities, including a patient advisory committee with regular meetings, patient surveys, interviews, focus groups and patient training/skills building ☐ Quality improvement activities that include at least four of the items bulleted in E1#4 ☐ Information gathered through the above noted activities being documented, assessed and used to drive QI projects and establish priorities for improvement ☐ Review of changes by patients with program staff based on recommendations received with opportunities to offer refinements for improvements. Information is gathered in this process and used to improve the quality of care. ☐ Involvement on at least an annual basis in the review by the quality management team/ committee of successes and challenges of patient involvement in quality management program activities, with the goal of enhanced collaboration between patients and providers engaged in improvement
Opportunities/Gaps:		

F. Quality Program Evaluation

GOAL: To assess how the organization evaluates the extent to which it is meeting the identified program goals related to quality improvement planning, priorities and implementation.

Quality program evaluation can occur at any point during the cycle of quality activities, but should occur annually at a minimum. The process of evaluation should be linked closely to the quality plan goals: to assess what worked and what did not, to determine ongoing improvement needs and to facilitate planning for the upcoming year. The evaluation examines the methodology, infrastructure and processes, and assesses whether or not these led to expected improvements and desired outcomes. At a minimum, the evaluation should assess access to data to drive improvements, success of QI project teams; and effectiveness of quality structure. The evaluation is most effectively performed by program leadership and the program's quality committee, optimally with some degree of patient involvement. Although external evaluations may be useful by peers or formal evaluators, the purpose of this assessment is focused on internal routine evaluation of the quality management program.

F.1. Is a process in place to evaluate the organization's quality management plan and related activities, and processes and systems to ensure attainment of quality goals, objective and outcomes?		
Getting Started	0	☐ No formal process is established to evaluate the quality program
Planning and Initiation	1	Quality program evaluation: ☐ To assess program processes and systems is exclusively external (National/donors/partners)
Beginning Implementation	2	Quality program evaluation: ☐ Is part of a formal process and is integrated into annual quality management plan development, but has not been consistently employed
Implementation	3	Quality program evaluation: ☐ Occurs annually, conducted by the quality committee, and includes QM plan and workplan updates and revisions ☐ Involves annual (at minimum) revision of quality goals and objectives to reflect current improvement needs ☐ Results are used to plan for future quality efforts ☐ Includes a summary of improvements and performance measurement trends to document and assess the success of QI projects ☐ Results, noted above, are shared with patients and other key stakeholders

Progress toward systematic approach to quality	4	Quality program evaluation: ☐ In addition to the elements listed in F1.3, findings are integrated into the annual quality plan and used to develop and revise program priorities ☐ Is reviewed during quality committee meetings to assess progress toward planning goals and objectives ☐ Includes review of performance data, which is used to inform decisions about potential changes to measures ☐ Is used to determine new performance measures based on new priorities if they are identified ☐ Includes analysis of QI interventions to inform changes in program policies and procedures to support sustainability
Full systematic approach to quality management in place	5	Quality program evaluation: ☐ In addition to the elements listed in F.1. 3 and 4, findings are integrated into routine program activities as part of a systematic process for assessing quality activities, outcomes and progress toward goals. Data and information from the evaluation are provided regularly to the quality committee. ☐ Is used by the quality committee to regularly assess the success of QI project work, successful interventions and other markers of improved care ☐ Includes data reflecting improvement initiatives, and is presented to ensure comprehensive analysis of all quality activities ☐ Uses a detailed assessment process. The results of this assessment are utilized to revise and update the annual quality plan; adjust organizational program priorities; and identify gaps in the program. ☐ Includes an analysis of progress towards goals and objectives and QI program successes and accomplishments ☐ Describes performance measurement trends which are used to inform future quality efforts
Opportunities/Gaps		

G. Achievement of outcomes

GOAL: To assess HIV program capability for achieving excellent results and outcomes in areas that are central to providing high quality HIV care.

To determine whether a program is achieving excellence in HIV care, a system for monitoring and assessing clinical outcomes should be in place. This system should include routine analysis of an appropriate set of measures; trending results over time; stratifying data by high-prevalence populations and comparison of results to a larger aggregate data set* used for programmatic target setting. A set of appropriate measures may be externally developed (national government, PEPFAR, WHO/UNAIDS) and/or internally developed based on program goals. Examples of outcome measures include viral load suppression, retention in care, mother-to-child transmission rates, and late diagnosis of HIV as measured by either CD4<200 or AIDS diagnosis at time of testing. At least one of these measures should be incorporated into the program's set of clinical measures.

*Possible data sets for comparison include national, provincial or partner network data sets.

G.1. To what extent does the HIV program monitor patient outcomes and utilize data to improve patient care?		
Getting Started	0	☐ No clinical performance results are routinely reviewed or used to monitor patient outcomes and guide improvement activities
Planning and Initiation	1	Data: ☐ A clinical database is used to routinely measure performance of care (EMR, database, register) ☐ Some measures are routinely reviewed and used to guide improvement activities ☐ Trends for some measures are reported to determine improvement over time
Beginning Implementation	2	Data: ☐ Results for most measures are routinely reviewed and used to guide improvement activities ☐ Trends for most measures are reported and many show improving trends over time
Implementation	3	Data: ☐ A listing of active patients is maintained and refreshed at least annually to remove those who have died, transferred or are lost to follow-up according to national definitions ☐ Results for all measures are routinely reviewed and used to guide improvement activities, including one of the following: viral load suppression (CD4 may be used as a proxy if viral load is not available), retention in care, late diagnosis, MTCT transmission rate ☐ Trends for all measures are reported and many show improving trends over time ☐ Results are compared to a larger aggregate data set for at least one outcome measure (see above) ☐ Comparison to a larger aggregate data set is used to set programmatic targets

Progress toward systematic approach to quality	4	Data: ☐ Results for all measures are routinely reviewed and used to guide improvement activities, including outcome measures ☐ Trends are reported for all measures and most show improving trends over time ☐ Results are compared to a larger aggregate data set for two outcome measures ☐ Comparison to a larger aggregate data set is used to set improvement goals which are met for at least 50% of measures
Full systematic approach to quality management in place	5	Data: ☐ Results for all measures are routinely reviewed and used to guide improvement activities, including outcome measures ☐ Trends are reported for all measures and most show sustained improvement over time in areas of importance aligned with organizational goals ☐ Results are compared to a larger aggregate data set for all core national prioritized outcomes measures (such as retention, viral load suppression, etc) ☐ Comparison to a larger aggregate data set is used to set programmatic goals which are met for at least 75% of measures ☐ Results for outcomes measures are above the 75th percentile of the comparative data set
Opportunities/Gaps		

What are the major findings from the Organizational Assessment?

What are the key recommendations and suggestions?

What specific areas should be improved?

What are specific improvement goals for the upcoming year?

Organizational Quality Assessment Tool

Hospital/Clinic name.....

Rater team:

( ) Administrative/Hospital committee/hospital quality team
( ) HIV coordinator team/clinic team
( ) external survey/assessment

Organization Assessment	Score					
	0	1	2	3	4	5
A. Quality Management						
A.1. To what extent does senior leadership create an environment that supports a focus on improving the quality of care in the hospital?						
A.2. To what extent does the hospital program have an effective quality committee to oversee, guide, assess, and improve the quality of hospital services?						
A.3. To what degree does the hospital have a comprehensive quality plan that is actively utilized to oversee quality improvement activities?						
B. Workforce engagement in the quality program						
B.1. To what extent are clinicians and staff routinely engaged in quality improvement activities and provided training to enhance knowledge, skills and methodology needed to fully implement QI work on an ongoing basis?						
C. Measurement, analysis and use of data to improve program performance						
C.1. To what extent does the Hospital routinely measure performance and use data for improvement?						
D. Quality improvement initiatives						
D.1. To what extent does the hospital identify and conduct quality improvement initiatives using QI methodology to assure high levels of performance over long periods of time?						

Organization Assessment	Score					
	0	1	2	3	4	5
E. Patient involvement						
E.1. To what extent are patients effectively engaged and involved in the HIV quality management program?						
F. Quality program evaluation						
F.1. Is a process in place to evaluate the hospital's QMP and related activities, and processes and systems to ensure attainment of quality goals, objective and outcomes?						
G. Achievement of outcomes						
G.1. To what extent does the HIV program monitor patient outcomes and utilize data to improve patient care?						

ANNEXE 6:

TERMS OF REFERENCE FOR THE NATIONAL TWG

Ministry of Health & Child Welfare, Zimbabwe

AIDS & TB UNIT/Department of Quality Assurance and Quality Improvement

TERMS OF REFERENCE FOR THE NATIONAL COMPREHENSIVE HIV QUALITY MANAGEMENT TECHNICAL WORKING GROUP

Chair: MOHCC, AIDS & TB Programme
Co-Chair: Implementing Partner

Background

Zimbabwe is one of the Sub Saharan countries with a high burden due to the HIV and AIDS epidemic. The country has achieved significant milestones in implementing a comprehensive multi-sectoral and multidisciplinary response that has resulted in the decline in both the incidence and prevalence rates. However, a lot more needs to be done.

The Ministry of Health and Child Welfare aims to provide, administer, coordinate, promote, and advocate for the provision of equitable, appropriate, accessible, affordable and acceptable quality health services and care to Zimbabweans while maximizing the use of available resources in line with the Primary Health Care Approach.

One of the goals in the Zimbabwe National health Strategy 2009-2013 is to increase coverage, access and utilization of affordable, comprehensive and quality preventive and curative health services. Different strategies will be implemented to improve the quality of care provided in health facilities. It is against this background that the AIDS & TB programme has embarked on developing and implementing a quality management and quality improvement programme for HIV prevention, care, treatment and support. Quality is defined as proper performance (according to standards) of interventions that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition *(M.I. Roemer and C. Montoya Aguilar, WHO, 19883)*. It is the degree to which a health or social service meets or exceeds established professional standards and user expectations. **Quality improvement** is an interdisciplinary process designed to raise the standards of the delivery of preventive, diagnostic, therapeutic and rehabilitative measures in order to restore and improve health outcomes of individuals and populations.

The HIV Quality Management and Quality Improvement Technical Working Group

The Technical working group (TWG) will steer the development, implementation and coordination of HIV quality management and quality improvement activities within the context of the national quality assurance and quality improvement strategy through the provision of technical and managerial expertise.

The TWG will serve as the primary technical assistance resource for quality management/quality improvement of HIV prevention, care, treatment and support.

Goals and Objectives

The goals of the TWG are to:

- Provide input into the national HIV QM/QI Program, including, but not limited to, performance measurement, quality improvement, quality infrastructure requirements, and targeted consumer and provider initiatives.
- Provide strategic guidance and commitment to the direction and outcomes of the program within the objectives of the MOHCC.
- Supervise, in collaboration with provincial, district and site level coordination teams, the appropriate implementation of improvement strategies to improve health services delivery, starting with HIV/AIDS including compliance to the national guidelines and capacity development at all levels.

Membership:

Representatives from Ministry of Health and Child Welfare (Quality Assurance Quality Improvement department, ART, PMTCT, NTP, HTC, M & E, Lab, Health Information), CDC, EGPAF, OPHID, MCHIP, WHO, UNICEF, MSF, ZNNP+, CHAI, Nursing Directorate, UZCHS.

TWG members are expected to actively participate and make a commitment to this process and its results. Members are expected to;

- Demonstrate commitment to improving the quality of HIV prevention, care, treatment and support and understanding of HIV quality initiatives
- participate in all TWG meetings
- offer their experience and provide constructive input during the TWG activities
- The members of the TWG are accountable to the Ministry of Health and Child Welfare, communities and organizations they represent.

In addition to knowledge, skills and abilities to satisfy member roles and responsibilities, special considerations will be given to create a membership reflective of the diverse impact of the HIV epidemic in Zimbabwe.

Meetings:

The TWG meetings will be held on a quarterly basis at the AIDS & TB Unit boardroom unless otherwise stated. However, special meetings will be scheduled as needed.

The TWG will keep minutes and records of all proceedings for the proper conduct of business and affairs.

No stipends will be paid to TWG members for attending the meetings.

A quorum is required to conduct TWG business. A quorum is defined as 50 percent of all members on the TWG plus one.

Conflicts of Interest:

A conflict of interest shall be defined as participation in decision-making which has direct fiscal or fiduciary benefits including, without limitations to, ownership, employment, contractual and sub-contractual, creditors, board members, staff, entities, individuals, family members or significant others.

Terms of Reference Amendments:

These Terms of Reference may be amended at regular or special meetings as needed.

Lifespan of the subcommittee:

The TWG shall remain in existence for as long as HIV prevention, care, treatment and support is being implemented in Zimbabwe. The composition of the subcommittee may be reviewed when necessary.