All-Country Learning Network

Windhoek, Namibia
March 14-18, 2011

Safari Court Hotel & Conference Center
EXECUTIVE SUMMARY

May 2011

Dear Colleague,

The second HEALTHQUAL-International All Country Learning Network, March 14-18, 2011 in Windhoek, Namibia was attended by 138 participants from 15 countries in Asia, Africa, South America, the Caribbean and the U.S., and included representatives from Ministries of Health, CDC country offices, CDC Atlanta, and the Health Resources and Services Administration HIV/AIDS Bureau.

Aligned with the goals of PEPFAR II, the ACLN once again demonstrated the inspiring force behind peer learning, focusing on the theme of results and sustainability, to build capacity for government led quality management programs. This document catalogues the innovative and dynamic work taking place in each country represented here. This includes outstanding accomplishments in the process of implementing a national framework for quality management, unique approaches to quality improvement and performance measurement, and the recognition that successes and challenges can be effectively utilized to develop strategies to move work forward.

Plenary presentations offered valuable insight into a range of topics including sustainability, prevention for people living with HIV, TB guidelines and TB/HIV coinfection, a pilot program based on the UNICEF Mother Baby Pack to prevent mother to child transmission of HIV in Kenya, measurement for QI and retention in care, and the use of an electronic health record to reinforce quality improvement in Haiti’s unique quality management model for sustainability.

Open Space sessions, characterized by a participant-driven and self-organizing model for group learning, again produced an impressive array of topics and much creative and informative discussion. Some examples of Open Space session topics include: sustaining QI in resource limited settings, integration of QI and QA, consumer involvement, health care financing, human resources for health, and validating QI, among many others. This high-level of enthusiasm, engaging peer-to-peer interaction and sharing of experiences effectively built on last year’s momentum to produce an unparalleled learning experience.

Morning workshops and a case study exercise reinforced improvement methodology offering further lessons in systems building and processes to bolster national quality management frameworks.

I want to thank all participants and HEALTHQUAL staff for their unique contributions to this event, and acknowledge the truly remarkable work evident in each participating country. A special thanks to our colleagues in Namibia; we could not have achieved this success without your unwavering support and hospitality.

Best wishes,

Bruce Agins, MD, MPH

Director, HEALTHQUAL-International
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Results

Sustainability
Focusing on Sustainability:
What do we know? What can we learn? What can we do?

Bruce D. Agins, MD MPH
Director, HEALTHQUAL International

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

Model for Improvement
- What are we trying to accomplish?
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What are we trying to accomplish?

We want to build sustainable government-led quality management programs that are formally integrated into the health system structure and functions.


- **Institutionalization**: defined as “...when essential and appropriate QA activities are carried out effectively on a routine basis throughout an organization, health system or health sector”.
- **Sustainability** occurs when “expertise, commitment and resource allocation are sufficient to apply, adapt, sustain and further develop the QA approach.”
- A fully developed QA Program includes the following elements: structure; standard-setting; monitoring; CI activities; quality culture.


- Methodology needs to be both standardized and flexible to adapt to the local organization and culture
- Methodological decisions should be made by insiders
- Experts evolve from teachers to coaches to colleagues
- Training is part of the strategy
- Gradual development is important
- Need both top-down and bottom-up approaches
- Anticipate staff turnover
- Storytelling and dissemination are important
- Dedicated funds will detract from sustainability
- New Programs must document results and show impact


- Based on 10 years of experience in many countries by URC through the Quality Assurance Project (QAP)
- Core Quality Activities:
  - Defining quality: develop expectations, standards and design systems for quality
  - Measuring
  - Improving

Silimperi (2)

- Essential ingredients for institutionalization:
  - Internal enabling environment
    - Policy, leadership, core values, resources
    - Must show synergy between these
  - Organizing for quality
    - Structure: responsibilities, accountability, coordination of implementation
  - Support functions
    - Capacity building (coaching and mentoring; training)
    - Communication and Information (record improvements; use data to show results; share stories about how results achieved)
  - Rewarding quality
  - Other key strategies
  - Share information and stories with the community served
  - Use results for policy changes and allocation of resources
What does Silimperi tell us?

- Institutionalization of quality activities requires implementation of several key factors related to the environment and to structure that require supporting elements.
- The implementation of a national quality program that reaches what URC calls the “maturity” phase occurs along a continuum of time with stages of change that may involve forward and backward motion until the activities become fully integrated into the routine operations of the health sector.

Glickman (2007): Promoting quality: the healthcare organization from a management perspective

- Organizational dynamics need to be considered in the understanding of implementation of quality management, including human capital, information management and group dynamics.
- Methods of the social sciences and from management science offer a lens through which to understand sustainability in healthcare organizations, including an understanding of people and organizational arrangements which affect performance and quality.

Umar 2009: The “Little Steps” Approach to Sustainability

- Capacity refers to the ability of an organization to carry out essential processes associated with successful QI.
- Sustainability poses a challenge at national and regional levels and requires attention to local implementation and context.
- Focus on attaining high impact immediate change threatens sustainability when systems, resources and culture are not aligned with the targeted changes.
- Literature review identifies four major categories of external models: accreditation/certification; quality awards/recognition; professional supervision; payment incentives
- Models may be mixed but one tends to predominate and donor agencies often drive their application.

Umar (2)

- Overcoming barriers to sustainability requires:
  - Attention to politics and infrastructure with ongoing adaptation to changes in the political environment
  - Resources and standards
  - Training of workforce and attention to burden
  - Caution when results are not achieved to avoid negative impact.
What does Umar tell us?

- Literature focusing on national level does not include much about actual improvement methods which are embedded in smaller projects.
- All work must be contextual, building upon existing political and management systems.
- Work towards incremental improvements that do not require large increases in resources: focus on what is achievable and sustainable.
- Advocates for a “little steps” model.

What does the JSI HEALTHQUAL-International Evaluation tell us? (Hirschhorn, et. al.)

- Conducted in 3 countries through extensive qualitative review and analysis of existing data
- Key steps to sustainability:
  - National lead based in MOH
  - Technical expertise in QI is critical: the country HQ team
  - National core QI indicators
  - Commitment of resources
  - Data infrastructure: Reports drive improvement
- Limitations:
  - Short-term project addressing initial phase of work
  - Details related to key concepts, such as “resources” and “data infrastructure” require elaboration
  - Variability among countries should be captured to reflect range of implementation strategies adapted to local context.

Looking Forward: QI and Health Systems Strengthening

The agencies and professionals who focus on quality management or quality improvement or quality assurance full time are few.

Some of the experts in the field, including URC and IHI met with representatives from various Ministries of Health in resource-limited settings to discuss the role of quality improvement and how it can specifically strengthen healthcare systems.
Leatherman et al 2010 (2) Review of literature and presentations at summit.

- Interventions are usually multimodal; concurrently addressing providers and patients and system level interventions.
- Establishing guidelines/standards and continuously giving feedback on their implementation is a key ingredient of successful interventions.

Leatherman 2010 (3): Framing Principles

- 1) QI has enormous potential in resource-limited settings where gap between current care and best possible care is large.
- 2) QI activities need to occur at national, regional and local level and incorporated into activities of NGOs. HSS activities should specifically include QI.
- 3) Nation to nation and site to site spread of QI and QI learning needs to occur.
- 4) QI is not a magic bullet. Reaping its benefits will require much work.

Leatherman: Quality and Health Systems Strengthening

- WHO Building Blocks

- Quality as a mediator between the blocks and achieving desired health outcomes
- As specialists in the field of improvement, we are looking at system strengthening then in two ways. One as a strategy to achieve a sustainable system defined as the entire health sector, but also as a system in and of itself that needs to be strengthened.

The Quality Strategy for HSS: Block by Block (Leatherman 2010)

- Service delivery: QI closes the gap between actual and achievable practice.
- Health workforce: QI enhances individual performance, satisfaction and retention.
- Information: QI enhances the development and adoption of information systems.
- Medical products and technology: QI improves the appropriate, evidence-based use of limited resources.
- Financing: QI helps optimize the use of limited resources and reduces the cost of financial transactions.
- Leadership and governance: QI strengthens measurement capacity, stewardship, accountability and transparency.

Leatherman 2010 (4): How might the visibility and technical knowledge of QI in discussions on global health be improved?

- Those of us working in the QI field in RLS need to create a movement.
- Make the case for QI integration into health sector activities:
  - Establish evidence documenting the benefits of QI and communicate the evidence
  - Evidence must be pragmatic and easily translated into practice
  - Knowledge base can be derived from existing evidence, new evidence and by documenting experience of demonstration projects and pilot sites
  - Spread through grass-roots initiatives and permission of leaders at all levels of healthcare
Leatherman 2010 (5): How might the visibility and technical knowledge of QI in discussions on global health be improved?

- Recommendations
- QI needs to be built into existing policies and infrastructure - it must become part of fabric of care and not separated as a “program”
- QI should not involve taking money away from important activities (e.g. poverty reduction) even if cost is modest. Suggest allocating future growth in healthcare spending to assessment and continual improvement of quality of health care.

What can HEALTHQUAL contribute to this movement?

- Can these domains from the six building blocks also be the domains in which we test changes and in which improvements are made at the health sector level to improve care?

Model for Improvement

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

COUNTRY CAPACITY FOR QUALITY MANAGEMENT
- Knowledge
- Team
- Plan

COUNTRY OWNERSHIP OF QUALITY MANAGEMENT
- Identifies as QM Program
- Site selection
- Indicator selection
- Reports
- Using data for policy

LEADERSHIP OF QUALITY MANAGEMENT
- Champion
- Engaging all stakeholders
- Oversight
- Coaching and Mentoring
- Recognition

NATIONAL LEVEL
- Oversight of national QM program
- Develops national quality indicators
- Convenes key national stakeholders
- Harmonizes data systems
- National toolkit and training curricula

PROVINCE – REGION - DISTRICT LEVEL
- Convenes providers for peer learning and sharing of QI experiences
- Define group priorities based on data and identified needs
- Recognizes and rewards top performers
- Sponsors QI training
- Implements quality management plan and workplan
- Lead for QI identified who oversees coaching and TA
- Reviews regional data to establish local priorities for improvement
- Convenes regional stakeholders data review
- Coordinates regional Quality TWG

FACILITY LEVEL
- Routine performance measurement
- Use of data for improvement
- Team-based QI projects
- Quality Plan
- Staff involvement
- Quality committee or team meetings
- Leadership support
- Patient involvement

NATIONAL LEVEL
- Oversight of national QM program
- Develops national quality indicators
- Convenes key national stakeholders
- -Providers-Patients-Government officials
- Harmonizes data systems
- National toolkit and training curricula
- Sets expectations for improvement activities
- Disseminates national benchmarking reports
- Recognizes and rewards top performers
- Oversees execution of national plan & workplan
- Convenes national Quality TWG

Sets expectations for improvement activities
Disseminates national benchmarking reports
Recognizes and rewards top performers
Oversees execution of national plan & workplan
Convenes national Quality TWG

Promotes communication of stories and share successes
Facilitates regional and local improvement activities
What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?
Title: Focusing on Sustainability: What do we know? What can we learn? What can we do?
Speaker: Bruce D. Agins, MD, MPH

Overview of presentation:
• What are we trying to accomplish? Sustainable, integrated government-led QM programs
• How will we know that a change is an improvement?
• A review of the literature provides a number of key concepts and principles to consider in developing an integrated, sustainable quality management program in resource limited settings*, including:
  o Structure
  o Coordination at all levels: national, regional, local
  o Building and preserving expertise and knowledge
  o Workforce development
  o Policy
  o Attaining and maintaining adequate resources to get the work done effectively
  o Communication within the QM program, throughout the country and across countries
  o Incremental steps forward toward larger gains
  o Program management
  o Attention to organizational structure
  o Use of information technology
• QI holds great potential to improve patient outcomes in resource limited settings…and we must harness and document the evidence to facilitate wider spread of improvement methodology
• Importance of spreading QI knowledge within and across countries
• HEALTHQUAL impact on
  o Country capacity
  o Country ownership
  o Program leadership
• Attention to domains covering:
  o National
  o Regional
  o Facility levels
• HIV has provided a challenge and an opportunity to galvanize focus on disease specific interventions and disease specific QM initiatives, but programmatic sustainability remains uncertain
• Dearth of literature demonstrating sustained QM initiatives in resource limited settings
• Can we consider our efforts to build capacity for HIV-specific QM as part of an extended Plan-Do-Study-Act cycle?
  • Is this, in itself, part of the development of a larger health sector QM program?
  • If so, we need to focus on its integration into the broader health sector, and how it can contribute to the implementation of an effective and sustainable health sector-wide QMP.
  • To sustain our achievements, we should focus on the transformation of the culture embedded in our health systems, to embrace steady and incremental improvements of outcomes, and a focus on systems building as a national undertaking.
  • We should simultaneously consider how we move ahead, to spread these innovative programs beyond HIV and into the larger health system.
  • We have to learn from our experiences, continually measure our progress – we must start small, think big and be systematic in our approach to achieving these goals.

* Multiple cycles of work by Quality Assurance Project/Health Care Improvement Project; and Lori DiPrete Brown; Diana Silimperi.
**Please see slides for complete citations.
HEALTH RESOURCES AND SERVICES ADMINISTRATION
HIV/AIDS Bureau
Global HIV/AIDS Program

Dr. Barbara Aranda-Naranjo, RN, PhD, FAAN
Director, Global HIV/AIDS Program

HRSA Global HIV/AIDS Portfolio

<table>
<thead>
<tr>
<th>Grade</th>
<th>Function</th>
<th>No. of Countries</th>
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| Care and Treatment | 5
| No. of Sites | 187
| Cum. No. of Individuals on ART | 164,937 |
| Capacity Building/Training | 2
| No. of Sites | 66
| Cum. No. of Individuals on ART | 136,667 |

PEPFAR Coordination/Collaboration

The U.S. Government’s Global Health Initiative

“We will not be successful in our efforts to end deaths from AIDS, malaria, and tuberculosis unless we do more to improve health systems around the world, focus our efforts on child and maternal health, and ensure that best practices drive the funding for these programs.”—President Obama, May 5, 2009

U.S. Government’s Global Health Initiative

- Through the Global Health Initiative (GHI) the United States will invest $63 billion over six years to help partner countries improve health outcomes and strengthen health systems.
- GHI focuses on improving the health of:
  - women
  - newborns
  - children
- Program areas include:
  - Infectious disease
  - Nutrition
  - Maternal and child health
  - Safe water

Global Health Initiative Principles

- Support country ownership and invest in country-led plans.
- Implement a woman and girl-centered approach— to both improve health outcomes for women and recognize that women are central to the health of families and communities.
- Increase impact through strategic coordination and integration— for patients and for those involved in providing or paying for services.
- Strengthen and leverage key multilateral organizations, GH partnerships and private sector engagement— because improving health outcomes is a shared responsibility.
- Build sustainability through health systems strengthening.
- Improve metrics, monitoring and evaluation (M&E).
- Promote research and innovation to identify what works.
### Global Health Initiative Targets by 2015

The GHI is expected to achieve aggregate goals including:

- **HIV/AIDS**: Support prevention of more than 12 million new infections, provision of care to more than 12 million people, and treatment for more than 4 million people.
- **Child health**: Save approximately 3 million lives by reducing under-five mortality rates by 35 percent in assisted countries.
- **Maternal health**: Save 360,000 women’s lives by reducing maternal mortality by 30 percent in assisted countries.
- **Tuberculosis**: Reduce TB prevalence by 50 percent, saving approximately 1.3 million lives.
- **Malaria**: Reduce the burden of malaria by 50 percent for 450 million people.
- **NTDs**: Reduce the prevalence of 7 NTDs by 50 percent among 70 percent of the population affected by NTDs.
- **Family Planning**: Prevent 54 million unintended pregnancies.
- **Nutrition**: Reduce child undernutrition by 30 percent in food-insecure countries in conjunction with the President’s Global Food Security Initiative.

### GHI - A New Business Model

- **Collaborate for impact** – with country governments, other development partners, and across U.S.
- **Do more of what works** – by scaling up proven interventions that address the health challenges of women, newborns, and children as well as their families and communities.
- **Expand existing platforms to foster stronger systems and sustainable results** – including U.S. platforms in HIV/AIDS, malaria, MCH and family planning.
- **Innovate for results** – through introduction and evaluation of new interventions and promising new approaches.

### Quality Improvement Center

The Quality Improvement Center supports GHI’s vision by:

- **focusing on sustaining self-sufficient local quality management programs** with the goal of strengthening and improving health systems.
- **involving clinic staff, consumers, and program leadership to build programs that remain sustainable** even with staff turnover, organizational leadership changes, or political transitions.
- **applying a public health approach** to quality management to improve processes and outcomes of care, advancing overall population health.

### Resources

- PEPFAR website
  www.pepfar.gov
- HRSA HIV/AIDS Bureau website
  www.hab.hrsa.gov
- Dr. Barbara Aranda-Naranjo
  baranda-naranjo@hrsa.gov
Title: Health Resources and Services Administration HIV/AIDS Bureau Global HIV/AIDS Program
Speaker: Barbara Aranda-Naranjo, RN, PhD, FAAN
Overview of presentation:

• Current Aim of Global Health Initiative:
  o Harmonize quality efforts across programs
  o Help partner countries improve health outcomes and strengthen health systems

• Changes in Coordination and Collaboration Efforts
  o PEPFAR I
    - Legislation was driven by expanding access to ARTs
    - Linear/vertical funding addressing a particular impact
  o PEPFAR II
    - Horizontal approach to healthcare
    - Looking at quality and human resources for health (HRH) to ensure sustainability
  o All collaborators looking at strengthening components of the system
  o Tool used to harmonize:
    - Partnership framework/partnership implementation plan:
      5 year strategic plan for US government agencies with country government to ensure alignment of strategies
  Speaker stressed the importance of documenting quality work to secure funding
Quality Improvement Initiatives in Mozambique’s National Health Care System

Dr. Mussa Calu, MD
Daniel D. Lee, MPH
Margaret Palumbo, MPH
14 March 2011

Quality Improvement Initiatives in Mozambique’s National Health Care System

Summary

• Update of Current Situation;
• Integration of QI Activities into Wider Health Sector;
• Data Use & Data Analysis;
• Challenges to Overcome
• Next Steps & Conclusions

Update of Current Situation

• Currently in 3rd Adult Round
  ➢ 97 / 229 HFIs have submitted data
    ➢ ~110 expected to participate
    ➢ Expansion to all HFIs expected by 4/5th Round
• Currently in 1st Pediatric Round
  ➢ 60 / 229 HFIs have submitted data
    ➢ ~70 expected to participate
• Majority of HFIs have analyzed data, selected QI projects and begun implementation

Integration of QI Activities into Wider Health Sector

• In the context of HIV intervention with Primary Health Care decision to change project name from “HIVQUAL” to “CLINIQUAL”
  ➢ Demonstrates change in approach
    ➢ Plans to expand to PMTCT (indicators already agreed upon)
    ➢ Plans to extend CLINIQUAL to Chronic diseases
• ART Committee re-structured to form (at all levels) “Committee for Quality Management”
  ➢ Tasked with CLINIQUAL expansion to include all HFIs providing HIV care & TTX services
    ➢ Supervise data collection, analysis, and QI activities

Integration of QI Activities into Wider Health Sector

MOH Model for Quality Management

• Created a National Committee for Quality Management and 11 Provincial Committees for Quality Management
• The National Committee for Quality Management is composed of:
  1. Director of NPC STI/HIV/AIDS
  2. M&E specialist
  3. Counseling and Testing Specialist
  4. 2 Members of the National Therapeutic Committee

Integration of QI Activities into Wider Health Sector
Integration of QI Activities into Wider Health Sector

The tasks of the National Committee are the following:
1. To identify and prioritize the needs in quality improvement in the whole country;
2. To create, monitor and build the capacity of the 11 Provincial Committees for Quality Management;
3. To define and disseminate the strategies for quality improvement, and standards of quality programs;
4. To produce and disseminate national reports regarding quality improvement

The Provincial Committee for Quality Management is composed of:
1. Provincial Medical Chief;
2. Chief of Provincial Planning Department
3. Provincial Manager of ITS/HIV/AIDS;
4. Provincial Chief of MCH;
5. M&E Advisor
6. Clinical Advisor

The Provincial Committee for Quality Management tasks are the following:
1. To expand the activities related to quality improvement to all health facilities that are providing ART within the Province;
2. To lead and monitor activities related to quality improvement in the Province;
3. To create a team of trainers who will provide HIVQUAL training to the District Health facilities staff;
4. To establish the composition of the committee that will lead quality management activities at the District health facility level

To build the capacity of District health facilities staff in quality management;
6. To supervise data collection at the District and facility level;
7. To supervise the QI activities at the Health Facility level;
8. To produce a provincial report to be sent to the National Committee for Quality Management;
9. To identify the needs in quality improvement within the Province;
10. To install and manage an HIVQUAL database in the Provincial Directorate of Health;
11. To organize quarterly meetings with the District health staff for sharing best practices.

The District Quality Management Committee is composed of
1. District Medical Chief;
2. Clinical Director;
3. HIV/AIDS Focal point;
4. MCH Nurse.

The District Quality Management Committee tasks are the following:
1. Oversees data collection process at facility level;
2. Integrates QI review into monthly/quarterly supervision visits and report findings to the Provincial QM Committee;
3. Prioritizes facility and district support and training needs based on supervision visits;
4. Communicates with the Provincial QM Committee through specified reporting structure
Integration of QI Activities into Wider Health Sector

- The Health Facility QM Committee is composed of:
  1. Medical Director;
  2. Clinical Director;
  3. HIV/AIDS Focal point;
  4. MCH Nurse.

Integration of QI Activities into Wider Health Sector cont...

- “Model Ward” approach for Health Sector QI
  - Non-program specific QI activities:
    - Activities to assess and reduce patient waiting times (patient flow analysis, etc);
    - Activities to assess and improve patient satisfaction;
    - Activities to improve HF hygiene / cleanliness
    - In 2010 MOH has created “Model maternities”

Data Use & Data Analysis

Dual Approach” to Data Analysis
1. “Bottom Up”
   - on-site data analysis by HF staff for rapid response
2. “Top Down”
   - HF data submitted by Provincial Health Directorate and analyzed at Central level with timely feedback to:
     - Evaluate HF improvement over time
     - Support Provincial QM Committee activities
     - Guarantee data quality

Challenges to Overcome

- Inconsistent involvement of Provincial QM Committees;
- Lack of integration between the HIV-specific CLINIQUAL and general non-program specific QI activities;
- Need to reinforce data analysis for selection of QI activities and assessment of their success (PDSA);
- Weak documentation of QI activities;
- CLINIQUAL HIS must be more flexible to reduce dependence on central level (ie. indicator definitions need to be adjustable to reflect changes in protocols);
- Client involvement very weak
- Lack of outcome indicators such as patient retention

Questions?

Obrigado...
Country Program Highlights: Swaziland  
Presenter: Thembie Dlamini

Swaziland Ministry of Health  
National Quality Program  
Integration of QA and QI Programs  
Thembie Dlamini  
QI Focal Person

Background  
• Quality Assurance program was introduced October, 2006 by COHSASA in collaboration with SAHCD  
• Introduced to stakeholders in 2007 February.  
• Multidisciplinary team was nominated and capacitated  
• 18 pilot sites were identified  
• Baseline survey conducted, subsequent assessments visit done up to April 2010

Mission/Vision  
Swaziland is committed to providing high quality health care to all of our citizens in all health facilities and communities in the country to attain a healthy Swazi nation by the year 2022

Who Are We?  
• The Swaziland National Quality Program for Health Care Services is  
  – Fully integrated into the overall Ministry of Health organizational structure including:  
    • Ministry of Health leadership– A Directorate of Quality  
    • Departments and departmental leaders for quality  
    • Regional quality assurance teams  
    • Health care workers- Quality part of routine work  
    • Patients – those whom we serve  
    • Other key stakeholders

Background cont’d  
• 4 health facilities qualified for a final survey  
• Conducted in three facilities, 1 facility withdrew due to internal challenges  
• 3 facilities were accredited, assessment ongoing  
• HIVQUAL came into inception in August, 2009  
• HCWs capacitated on QI concept  
• National indicators developed

What Are We Trying to Accomplish?  
• Improve the health and well being of all people living in Swaziland  
• Develop and disseminate National standards of care to accelerate measureable and continuous progress toward effective and patient-centered services  
• Develop a culture of quality across all health care services and at all levels of the health care system  
• Quality viewed as part of routine work of every health worker who regularly strives for excellence
What Do We Want to Become?

- A unified quality program that combines the best elements of our experiences with QA and QI programs
- A recognized leader in quality health care across the world
- A model for equitable and excellent health services

Guiding Principle

“Quality” is not a department

- An organization will only make meaningful and sustainable quality improvements when people at every level feel a shared desire to make processes and outcomes better every day, in bold and even imperceptible ways (www.IHI.org)

Quality Department Responsibilities

- Implement the national plan
- Provide support for data collection, preparation of reports and analysis; and disseminate successful interventions
- Support Technical Working Group Activities

Operational structure

- Swaziland National Quality Program Department Structure

Swaziland National Quality Program Components

- Create a National Quality Strategic Plan
- Development and dissemination of standards of care
- Development of national performance measures based on standards
- Prepare and disseminate aggregate performance reports (benchmarking)
- Set priority areas such as Adherence standards, PMTCT, ART, TB, MNCH and Malaria.
- Develop, Support and Sustain Regional Quality Assurance teams
- Use standard assessment tools to identify gaps in quality at the national, regional and facility level
- Target resources to low performing facilities and regions
- Solicitation of input from key stakeholders
- Align and coordinate all donor-driven quality activities and resources
- Create a Department to implement the national plan
Structure

• National Technical Working Group
  • Provides expertise in all related quality areas
  • Provides general oversight, and prioritization of quality activities
  • Organizes trainings
  • Develops standardized materials
  • Membership from Directorates, Departments and major partners

• Regional quality assurance teams
  • Conduct facility assessments
  • Provide coaching to facilities in the region
  • Provide progress reports to facilities and national level

• Facility level
  • Nominate multidisciplinary quality steering committees
  • Prioritize and conduct QI projects
  • Collect and report data based on national indicators
  • Communicate QI project status and outcomes to Regional and national levels
  • Promote leadership and teamwork

• Use Health Awards to recognize best performers

Way Forward

• Finalization of the country’s strategic plan document
• Strengthen and capacitate the QA Regional Teams
• Roll out the QA program
• Sustain the QA program through continuous monitoring and evaluation

Acknowledgements

• MoH leadership for the continued support
• Partners such as UNICEF, WHO, CDC and others
• QA participating facilities
• Our lead consultant – Margaret Palumbo
• QA core team
Integration for sustainability: QA/QI

Quality assurance / improvement; performance monitoring - e-registers for improving retention

BOTSWANA NATIONAL QUALITY MANAGEMENT TEAM
Windhoek, Namibia – 14-18 March 2011

Size and population density of Botswana

- 2009 estimate: 1.8m
- 61% aged 15-64
- 1.9% growth rate
- 0.8% death rate
- 0.5% migration
- 62yrs life expectancy
- 60% urban
- 81% literate
- 581,730 sq km
- Texas/France

Achievements of HCT, PMTCT and ART

- 41% of adult population tested for HIV and know results in the last 12 months (56% ever tested)
- ~90% of women tested at ANC and 98% by delivery
- ~95% of women on PMTCT
- <4% rate of mother-to-child transmission – phased introduction of triple prophylaxis
- ~95% coverage of ART (160,000 patients on HAART

Government health facilities

National strategies to improve quality

- The Botswana Government initiated quality assurance and improvement
  - Health Inspectorate (external)
    - Development of service standards and accreditation
  - Leadership Development Program
    - Equip management with knowledge/skills to coordinate QI
  - National HIV/AIDS Quality Management Program (internal)
    - Build sustainable infrastructure and a culture of quality
    - Train all healthcare workers to participate in QI
    - Monitor performance and support QI initiatives
    - Facilitate peer-learning and sharing of best practices

Content

- Background to Botswana national quality initiatives
- Harmonisation of QA/QI: example of standards and indicators for referral and retention
- E-registers – performance monitoring tools for QI
- ARV Program data analysis
- Summary remarks
Goal of the National HIV QM Program

To improve HIV care and preventative services in Botswana and contribute to the strengthening of the entire healthcare system by 2016.

Approach: use HIV services as a vehicle for overall healthcare service improvement

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Referral and retention

Standards and indicators for quality improvement

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Indicators for referral and retention (I)

- M&E: Number of HIV+ TB patients referred to HIV care and support services during TB treatment, of all HIV+ TB patients
- M&E: Number of males circumcised who return at least once for postoperative follow-up care within 14 days of surgery
- QM: Percentage of clients who tested HIV+ in the past 6 months and who have a documented referral for treatment, care & support services (possibility of monitoring presentation after referral)
- M&E: Percentage of HIV-positive pregnant women newly enrolled into HIV care and support services
- QM: Percentage of HIV-exposed babies with samples taken for HIV testing from 6 to 8 weeks of age

---

Indicators for referral and retention (II)

- QM: Percentage of HIV+ infants initiated on HAART within one week after receiving a positive HIV test result
- QM: Percentage of HIV+ patients who have never been on HAART and with at least one HIV clinic visit in the last six months who had at least one CD4 cell count test in the last six months
- QM: Percentage of HIV+ patients on HAART and with at least one HIV clinic visit in the last six months who had at least one viral load test in the last six months
- M&E: Percentage of adults and children with HIV still alive and known to be on treatment 1/2/5 years after initiation of ARV therapy
  - Breakdown of lost to follow-up, stopped therapy, died, transferred in/out

---

QA standards for referral and retention

- Processes ensure that all clients with TB / STI are referred for HTC
- HTC includes defined referral following diagnosis
- All HIV-positive mothers are referred to HIV services after delivery
- All infants born to HIV-positive mothers are treated and tested for HIV transmission according to guidelines
- ARV agents are administered in the context of a system to monitor patients defaulting appointments and ARV pharmacy refills
**E-registers**

Leveraging performance monitoring tools for quality improvement

---

**Background**

- PIMS – Patient Information Management System
  - Electronic medical record for ARV patients
  - In facilities providing ART since start of program in 2002
    - Currently over 120 facilities nationwide
    - Additionally, some key hospitals have centralised IPMS
    - A few clinics and health posts do not have electricity

- E-registers
  - Capture data from non-ART programs electronically
  - Minimise burden
    - Replicate paper registers to reduce training and data entry
    - Integrate system to reduce repeat entry of demographic data etc

---

**E-systems for quality improvement**

Develop systems to support quality patient care

- Current
  - Lists of defaulters / lost to follow-up
  - Record contact details of clients, next-of-kin, buddies
  - Document follow-up efforts
  - Enable efficient reporting
  - Data integration and analysis at national and district level
  - Link to cellphone systems for reminders / follow-up

- Next step
  - Monitor referral between programs

---

**PIMS**

E-registers

---

**PIMS / E-registers – LTFU / Defaulters**
Patients on HAART with no recent visits

Summary M&E data from ART program
- ~1,800 starting HAART per month
- ~160,000 patients on HAART – end Jan 2011
  - includes ~10,000 children (<15 years)
- ~6,000 LTFU while on HAART
- ~1,800 LTFU while eligible for HAART but not yet started
- ~17,000 died while on HAART
- ~2,000 died while eligible but not yet started on HAART
- ~700 died after diagnosis but not yet eligible for HAART
- ~500 patients stopped HAART
Analysis of national ARV dataset

- Initiation between 2002 and 2009
- 126,232 patients - median follow-up 2.4 yrs (IQR 0.8-4.3 yrs)
- 333,000 patient years at risk
- 61% women
- Median age at initiation: 35 yrs (IQR 30-43 yrs)

Loss to follow-up and deaths: 23,495 patients initiated in 2005

Loss to follow-up and deaths: 13,328 patients initiated in 2009

Summary remarks

Botswana National HIV QM Program:
- Being aligned with the national QA program
  - need to align indicators, and training as well as structures
  - Integrating with and leveraging monitoring systems
    - using data collected for routine care
    - increases amount of data available
    - incentive for data quality?
    - developing data quality improvement structures and initiatives
  - Potential to monitor referral/retention between programs
  - E-registers unlikely to provide all data needed for QM
    - e.g. client satisfaction surveys

Re a leboga

Acknowledgements:
- All healthcare workers who capture data into e-registers
- Patients who provide information and wait patiently
- Partners who support QM and data quality
- BOTUSA
- Partners who support performance monitoring
  - Botswana Harvard Partnership, SCMS, I-TECH
  - HEALTHQUAL for all their support
  - especially Clemens Steinbock
QI Institutionalization in Uganda

Dr. Godfrey Kayita
HEALTHQUAL All Country Learning Network
15th March, 2011

Implementation of QoC

- Started in 1994 with creation of the Quality Assurance Department
- Implemented QoC under the Yellow Star Program – Project mode (1998 - 2002)
- QI approaches focusing on HIV introduced in 2005 (HIVQUAL, QAP)
- Other program specific QI initiatives introduced subsequently

Implementation of QI

- QI activities currently implemented in all districts with support from implementing partners
  - National Referral Hospitals (2)
  - All Regional Referral Hospitals (13)
  - General Hospitals (114)
  - Health Center IVs (148/165)
  - A few Health Center IIs

- These include Public, PNFP and Private facilities

Program Design

Structure
- Fully integrated into MoH Department of Quality Assurance
- Model follows decentralized health system and promotes QI activities at regional, district and facility level

Performance Measurement
- indicators based on national health standards

Quality Improvement Approach
- Capacity building
- Coaching and Mentoring
- Peer Learning

QM Program Organogram
Roles – Steering Committee

**Role**
- Determine QI priorities
- Provide leadership to initiate and maintain partnerships for QI within the health sector
- Review the quarterly work plans
- Provide strategic guidance and direction based on program objectives and priorities
- Assist Core Team in dissemination of strategies and of the programs’ findings and impact on policy levels.

**Membership**
- Director HS Clinical Services – Chair
- QA Dept. - Secretariat
- Clinical Services Dept
- National Disease Control Department
- Nursing Department
- Pharmacy Department
- Resource Centre – HMIS
- STD/ACP
- Major QoC DPs
- Major QoC IPs

Core Team

**Roles**
- Ensure compliance with National guidelines and standards
- Build capacity at regional, district, sub-district and facility level
- Support QI implementation at regional level
- Prepare reports and manages financial accountability
- Network with partners to assure alignment of activities
- Receive and review QI indicators

**Membership**
- HIV QI Team Leader - Chair
- STD/ACP, Clinical services & QA Department Senior Officers
- QI Implementing Partners

Roles – Regional/District

- Facilitate and organize regional learning network meetings
- Provide on-site Coaching and Mentoring
- Over see QI projects implementation at facilities
- Collect successful interventions
- Conduct Organizational Assessments

Institutionalization 1

- QoC priority component of the National Health Sector Strategic and Investment Plan
- Integration of QI into HIV Health sector Strategic plan
- Network with other Dev. Partners (DPs) like WHO, UNICEF, USG, JICA, etc and IPs (AIDS Relief, Baylor, TASO, Numat, MildMay, Stars, JCRC, Sustain etc) to facilitate QI activities
- Using Public-Private-Partnership approach in implementation

Institutionalization 2

- QoC guided & advised by National Steering Committee
- Quality Assurance Department takes lead in Coordination of QoC program
- Capacity building at national level
  - Creation of M&E division in the QAD
  - Increasing in staffing levels
- Capacity at National University in QI training and placements

Institutionalization 3

- Capacity building at regional level (RRHs Community Health Department) to
  - support district teams in mentoring and coaching of health facilities
  - Organize regional Learning Network meetings
- Performance Measurement (PM) indicator report bench marked @ district, regional and national level for prioritization of QI projects and support
- Dissemination of PM reports at national, regional and district level
Institutionalization 4

- Scale up QI activities at all levels (HC III, HC II, Village Health Team) in phases based on the health systems strengthening model
- Launched and disseminated the patients / consumers charter
- Finalization of the National QI Framework (to guide all stakeholders in coordination, planning, training, implementation & M&E of QI activities in the country)
- Linking support supervision with QI

Challenges

- Under staffing and high staff attrition
- Bureaucratic delays in operationalization of plans
- Limited logistical support – supplies, computers for facilities
- Aligning the multiple QI models in the country
- Coping with rapid expansion of administrative units
- Irregular reporting and feedback

Lessons

- MoH Leadership is critical for sustainability
- Harmonization of QI efforts across different DPs & IPs (tools, training materials & mapping) is critical in minimizing duplication and wastage of resources
- Integration of QI into pre-service training curricular important for development of QI culture
- The rule of one

Acknowledgements

- USG
- UNICEF
- WHO
- Implementing Partners
- HEALTHQUAL International Team
- AIDS Institute, New York State Department of Health

Mwebale Nnyo!!
Implementing a comprehensive QI Program in Kenya

John Wanyungu - MCommH
HIVQUAL Program Coordinator

Country profile

General country Facts

- Population – 38.6 million
- HIV prevalence: Adult 6.3%; No data on Pediatric prevalence
- TB/HIV co-infection – 44%
- HIV/TB co-infection – 69%

Other pertinent Demographics (country specific)

- Total fertility rate - 4.6/woman
- Mean size of household - 4.2 persons
- Illiteracy rates are 19% for women and 13% for men age six and above
- Total expenditure on health as % of GDP (2006) 4.6%
- House holds getting water from improved source are 63%

HIVQUAL in Kenya

HIV Prevalence Kenya DHS’08

<table>
<thead>
<tr>
<th>Province</th>
<th>HIV Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nairobi</td>
<td>7.0</td>
</tr>
<tr>
<td>Central</td>
<td>4.6</td>
</tr>
<tr>
<td>Coast</td>
<td>4.2</td>
</tr>
<tr>
<td>Eastern</td>
<td>3.5</td>
</tr>
<tr>
<td>Nyanza</td>
<td>13.9</td>
</tr>
<tr>
<td>R. Valley</td>
<td>4.7</td>
</tr>
<tr>
<td>Western</td>
<td>6.6</td>
</tr>
<tr>
<td>N. Eastern</td>
<td>0.9</td>
</tr>
<tr>
<td>NATIONAL</td>
<td>6.3</td>
</tr>
</tbody>
</table>

HIVQUAL sites in Kenya

Key:
- Wave I Health Facilities
- Wave II Health Facilities

Process

HIV Qual sites in Kenya

<table>
<thead>
<tr>
<th>Province</th>
<th>Wave I Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nairobi</td>
<td>Kenyatta Health Center, KMC 2, Mathare Health Center, Mathare North Health Center, Kieni District Hospital, Kieni District Hospital, Embu District Hospital, Eldoret District Hospital</td>
</tr>
<tr>
<td>Nyanza</td>
<td>Mfangano Health Center, Makueni Health Center, Mathare North Health Center, Nyahururu Health Center, Nyeri Health Center, Mwingi District Hospital</td>
</tr>
<tr>
<td>Coast</td>
<td>Malindi District Hospital, Mombasa District Hospital, Malindi District Hospital, Mombasa District Hospital, Malindi District Hospital</td>
</tr>
<tr>
<td>Coastal</td>
<td>Malindi District Hospital, Mombasa District Hospital, Malindi District Hospital, Mombasa District Hospital, Malindi District Hospital</td>
</tr>
<tr>
<td>Western</td>
<td>Mombasa District Hospital, Mombasa District Hospital, Mombasa District Hospital, Mombasa District Hospital, Mombasa District Hospital</td>
</tr>
</tbody>
</table>

Country profile

HIV Prevalence in Kenya

HIV prevalence as of 2008

- Nairobi: 7.0%
- Central: 4.6%
- Coast: 4.2%
- Eastern: 3.5%
- Nyanza: 13.9%
- R. Valley: 4.7%
- Western: 6.6%
- N. Eastern: 0.9%
- National: 6.3%
**Background**

- Kenya has implemented HIVQUAL program since 2009
- HIVQUAL is being implemented in 15 sites in 3 regions in the country
- Started with three HIV service areas simultaneously i.e. HIV infected adults, pediatrics and pregnant women on care and treatment

**Rationale for a comprehensive HQ program**

- Different stakeholders interested in different areas of HIV care – adults, pediatrics and PMTCT
  - Tried to accommodate QI needs of different key stakeholders together with MoH
- Desired to make QI impact in a wider spectrum of HIV care
- Underestimated the magnitude of QM process

**Technical Working Group**

- Set up a Technical Working Group comprising of MOH, CDC and other key USG Implementing partners
- Main role is to provide technical guidance to the HQ program and steer the operations of HQ program
- A liaison between the Government and QI partner organizations

**QM program organogram**

**Background cont...**

- Each service area has a separate set of indicators; adults – 10, pediatrics – 9 and PMTCT – 6
- All indicators adapted to HQ software

**TWG cont...**

- TWG meets every three months to review work-plans, progress and any ongoing QI projects
- Creates a forum for sharing QI plans and experiences among different implementing partners and facilitates country-wide expansion
- Helps drive HQ national agenda and enhances program continuity and government ownership with stakeholders
Challenges in implementing a comprehensive HQ program

• Changing guidelines such as ART and PMTCT rendered some indicators redundant
• Changing software while data collection went on
• Did not test feasibility of collecting data on some service areas such as exposed infants and pregnant women which did not have data capture tools!

Challenges cont...

• Attrition of some clinic staff trained on HQ through re-deployment, transfer out or resignation
• Delayed follow up to clinics while they collected data
• A long list of indicators for each service area, most of which were repetitive

Challenges cont...

• Difficulties in determining sample size for exposed infants and pregnant women due to low documentation – (no files for infants; no separation of pregnant women files from adults)

What we would do differently

• Determine feasibility of collecting data at the clinic before we ask staff to do it
• Pick on the most important indicators with greatest impact on quality for each service area
• Make a quick follow up to sites while they collect data to fix any emerging issues
• Advocate for retention of CQI teams in HIV clinics especially during data collection and QI project implementation.

Ahsanteni sana.

Thank you.
**Outline of Presentation**

- Background information of Guyana, HealthQUAL and MCH
- Overview of the Well Child Indicators
- Selection Criteria of indicators
- Implementation Strategies
- Achievements
  - Health Qual Reviews
  - Monitoring and Evaluations
  - Future projections

**Introduction to Guyana**

- Continent of South America
- Only English speaking country in South America
- Member of CARICOM
- Ten Regions, 4 remote hinterland areas - Regions 1, 7, 8, and 9
- Estimated Population: 750,000
- 321 Health facilities
- HIV prevalence - 1.2% (2009)
- PMTCT prevalence > 1% (2009)
- MCH Regional Supervisors for each region

**Background**

- HEALTHQUAL-collaboration between MOH (NAPS+ MCH), HIVQUAL Int'l, UNICEF and PEPFAR
- Goals: Improve the quality of care provided to all children and people living with HIV/AIDS in Guyana.
  - Improve the well child Indicators under 5 years
- Balances performance measurement and quality improvement while building a solid foundation of programmatic infrastructure

**Performance measurement Indicators of quality of care**

- Pediatric indicators:
  - Weight Monitoring
  - Height/Length measurements
  - Head Circumference measurements
  - Weight for Age Plotted on the growth chart
  - Developmental Milestones Assessment
  - Vaccinations – Up to Date
Methodology

- Sites selected
- Staff trained in HEALTHQUAL methodology
  - 1st audit period January 1st – June 31st 2008
  - 2nd Audit Period July - December 2009
- Case lists of active patients generated
- Calculation of sample sizes proportionate to clinic size
- Random selection of clinical records
- Data abstraction
- Data entry at clinic level
- Data analysis centrally

Implementation of Well Child Sites

Sites

Region 2
- Windsor Castle
- Region 3:
  - Vreed-en-Winden clinic
  - Parika Health Center
Region 4
- Campbelville Health Centre (CVHC)
- Dorothy Bailey Health Centre (DBHC)
- Beterverwagting Health Centre (BVHC)
Region 5:
- Region 6:
  - New Amsterdam ANC
Region 7:
- Bartica Health Center
Region 8:
- Region 9:
  - Region 10:
    - One Mile Health Center
    - Campbelville Health Center
    - Dorothy Bailey Health Center

Chronology of expansion of MCH sites

<table>
<thead>
<tr>
<th>Year</th>
<th>MCH Health Qual Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>Initiated with 3 sites</td>
</tr>
<tr>
<td></td>
<td>Region 4 Dorothy Bailey Health Center</td>
</tr>
<tr>
<td></td>
<td>Region 4 Campbelville Health Center</td>
</tr>
<tr>
<td></td>
<td>Region 10 One Mile Health Center</td>
</tr>
<tr>
<td>2009</td>
<td>Seven additional sites</td>
</tr>
<tr>
<td></td>
<td>Region 2 Windsor Castle</td>
</tr>
<tr>
<td></td>
<td>Region 3 Vreed-en-Winden, Parika, East Coast Enmore, Beever-wagting, Region 5 Bassetoul</td>
</tr>
<tr>
<td></td>
<td>Region 6 New Amsterdam ANC</td>
</tr>
</tbody>
</table>

Chronology of expansion of MCH sites

<table>
<thead>
<tr>
<th>Year</th>
<th>MCH Qual Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>11 additional sites</td>
</tr>
<tr>
<td></td>
<td>Region 52 High Cliffs Health Center</td>
</tr>
<tr>
<td></td>
<td>Region 53 la Grange and Goed Intent Health Centre</td>
</tr>
<tr>
<td></td>
<td>Region 54 Boissee, Troulay, and Melissa Health Centers</td>
</tr>
<tr>
<td></td>
<td>Region 55 High Dam Health Center</td>
</tr>
<tr>
<td></td>
<td>Region 56 Vreed-en-Winden and Central Health Centers</td>
</tr>
<tr>
<td></td>
<td>Region 57 Bassetoul Health Center</td>
</tr>
<tr>
<td></td>
<td>Region 510 Awerl’s Village</td>
</tr>
</tbody>
</table>
Achievements of the Well Child Indicators 2008 to 2009

Health Qual Projects

- Quality Projects: improvement in the head circumferences at Health Qual sites.
  - Windsor Castle and most of the centers in Region #2
  - Vreed-en-hoop Health Center
  - Campbelville Health Center
  - Rosignol Health Center
  - New Amsterdam and most of the health centers in Region #6
  - Melanie Health Center

Monitoring and Evaluation/Future Projections

- Done on a weekly and monthly basis by MOH Health Qual Field Officer, using also the supervisors of the MOH clinics in the respective regions.
- National feedback meetings are conducted on a bi-annual basis.
- Projected to expand to 20 additional MOH clinics in 2011.
- We have started to use the Health Qual indicators for all other MOH clinics for assessment.

Acknowledgments

- Health Qual team New York
  - Dr Bruce Agins
  - Ms Margaret Plumbo

- Health Qual team Guyana
  - Dr Stuart Singh
  - Ms Betty Comberbach
  - Ms Nicholas Perreau
  - Dr Curtis La Plan
  - Dr Andrea Lambert
  - Mr Allister Collins
  - Mr Gregory Silh
  - Mr Javel Crosse

"Get a bird’s eye view on the quality of care from the top of the beautiful and majestic Kaieteur Falls - World’s Tallest single drop fall!"
NIGERIA
AIDS Prevention Initiative in Nigeria (APIN)
Capacity Building for the Quality Management Programme

Monday, April 04, 2011
AIDS Prevention Initiative Nigeria

Human Development Profile of Nigeria and HIV/AIDS
- Population: 150 million
- Population growth: 2.8% (NS)
- Infant mortality: 72/1000 birth (†)
- HIV prevalence: 4.6% (2008)
- GDP per capita: $260 (†)
- Growth rate: 3.5% (†)
- Debt burden: $28.5 billion

Monday, April 04, 2011
AIDS Prevention Initiative Nigeria

Where we are now (1)
- No. of PLWIH: 2.98 m
- HCT coverage: 14%
- PMTCT coverage: 11%
- Annual HIV+ Births: 70,000
- New infections: 336,379/year
- Number requiring ART: 857,455
- Number on ART: 450,000
- Annual AIDS Deaths: 192,000
- Cumulative AIDS Deaths: 2.99m
- Total orphaned by AIDS: 2.17 m

Monday, April 04, 2011
AIDS Prevention Initiative Nigeria

Where we are now (2)

HIV Prevalence Trend

4 million infected, 1 million with symptoms
Experts project $500-675 million for comprehensive prevention and care
$194 million for limited scaling up of prevention
$144 million for limited scaling up of Antiretroviral treatment
Nigeria needs to spend between 30-40% of health budget to cope

Monday, April 04, 2011
AIDS Prevention Initiative Nigeria
HIV/AIDS Financial Sources in 2007 and 2008

APIN Quality Management Programme

Introduction

- History
  - APIN was established as a program of HSPH in 2000 with a grant from the Gates Foundation
  - The Harvard PEPFAR (APIN Plus) Program 2004
  - APIN LLC was incorporated as a local NGO in 2007 to gradually assume HSPH’s work in Nigeria.

Governance

- Two tiered structure
- HRSA’s recommendations on governance
- New board Composition
  - More diversified board
  - Meeting transition guidelines (85% Nigerians)
  - Broadened scope of activities
    - E.g. Resource mobilization for sustainability

APIN/PEPFAR Sites: 2010

Adult numbers as at December 2010

<table>
<thead>
<tr>
<th>Service</th>
<th>Total</th>
<th>Harvard</th>
<th>APIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMTCT CT and results</td>
<td>66,503</td>
<td>46,783</td>
<td>19,720</td>
</tr>
<tr>
<td>Tested Positive</td>
<td>3,119</td>
<td>2,348</td>
<td>771</td>
</tr>
<tr>
<td>ART Cumulative</td>
<td>94,478</td>
<td>56,935</td>
<td>27,543</td>
</tr>
<tr>
<td>Current</td>
<td>57,996</td>
<td>39,187</td>
<td>18,809</td>
</tr>
<tr>
<td>CARE Cumulative</td>
<td>129,787</td>
<td>80,661</td>
<td>49,136</td>
</tr>
<tr>
<td>Current</td>
<td>63,128</td>
<td>48,752</td>
<td>24,376</td>
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<tr>
<td>HCT CT and results</td>
<td>101,430</td>
<td>73,249</td>
<td>28,181</td>
</tr>
</tbody>
</table>
**Pediatrics numbers as at December 2010**

<table>
<thead>
<tr>
<th>Service</th>
<th>Total</th>
<th>Harvard</th>
<th>APIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>ART</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cumulative</td>
<td>3,988</td>
<td>2,578</td>
<td>1,410</td>
</tr>
<tr>
<td>• Current</td>
<td>2,998</td>
<td>1,945</td>
<td>1,003</td>
</tr>
<tr>
<td>CARE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cumulative</td>
<td>6,089</td>
<td>3,867</td>
<td>2,222</td>
</tr>
<tr>
<td>• Current</td>
<td>3,898</td>
<td>2,565</td>
<td>1,333</td>
</tr>
<tr>
<td>HCT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• CT and Results</td>
<td>7,981</td>
<td>5,577</td>
<td>2,904</td>
</tr>
</tbody>
</table>

**QM Programme Background**

- **Goal:** Ensure programme sites to provide the best possible quality of care to HIV positive patients using evidence based methods.
- **Objectives:**
  - To assess quality of care provided to HIV/AIDS patients and promote accountability for patient care
  - To evaluate health outcomes of patients as related to clinical processes
  - To promote joint identification of strengths and weaknesses in clinical processes and systems
  - To constantly improve upon the quality of care delivered to patients by applying Continuous Quality Improvement (CQI) tools.

**QM Programme Background (2)**

- **Model**
  - Evidence Based Practice + Continuous Quality Improvement
  - Evidence based practice: treatment and care protocols in line with national and international guidelines
  - Continuous Quality Improvement: QI Infrastructure + Performance Measurement + Quality Improvement Activities

**History and Evolution**

- **John Snow International (JSI) QA visits**
  - Commissioned by HSPH in 2006 to assess the quality of care at some sites as part of its oversight functions.
  - Assessed the adult and pediatrics programme areas
  - 2 rounds of visits to 5 sites

- **Internal Quality Improvement Efforts:**
  - To provide on-going support to sites in identified areas of weakness, share strengths across sites and continuously monitor quality of care.
  - Started in 2007 with adult ART programme and expanded to include PMTCT and pediatrics ART in 2009.
  - Quality of care was evaluated during scheduled site assessment visits using a combination of methodologies including chart reviews and staff interviews.

**History and Evolution (2)**

- **Internal Quality Improvement Efforts contd.**
  - Chart review was done by entering data into a file maker based 'site assessment database' that allowed for rapid data analysis and immediate feedback.
  - Follow up action: individual trainings, programme area specific technical assistance and follow up assessment visits
  - Collaboration with Federal Government of Nigeria
    - The Nigerian government piloted a national QI system with support from HIVQUAL in 2007 and 2008
      - APIN/Harvard PEPFAR was actively involved in all the processes including indicator development, training, site visits and debrief meetings
      - 4 of our sites participated in the 1st and 2nd pilot phases
      - APIN was actively involved in the development of national QI indicators - January 2010

**History and Evolution (3)**

- **Harmonization of APIN QA indicators with the Federal Ministry of Health HIV Quality of care indicators**
  - To prevent double reporting and increased work load on the sites
  - Included all indicators plus the original APIN list and adopted the Federal Government indicators in areas of overlap.
  - Original APIN QA indicators (Viral Load assessment and outcome monitoring) not part of the Federal Government list were retained.
  - The harmonized indicators now serve as the minimum indicator set to be reported against every 6 months

- **Engagement with HEALTHQUAL (September 2010)**
  - Engaged by Harvard Clinical Oversight Committee to support APIN QI efforts
APIN Quality Management Structure

- Programme management level:
  - 2 Quality Assurance staff: QA Coordinator and QA officer
  - Central QA Committee: provides strategic direction to APIN’s QI efforts
- Site (health facility) level
  - Quality improvement committee: led by QI focal person who is usually a clinician
    - Has terms of Reference adopted from the central office generic document
    - Initiates on-site performance measurement, quality gaps analysis and improvement projects to address identified gaps
    - Reports to the head of the ART programme on site and the central office through the QA Coordinator

Approach to Capacity Building

- Trainings
- Regular assessment using the site QM programme status check list
- Tools development
- Coaching

Trainings

- Basic Quality Improvement Training
  - Target audience: All Site QI committee members
  - Purpose: provide introduction to QI concepts and methodologies
- Intermediate QI training/review meeting
  - Target audience: Site QI focal persons
  - Purpose: Provide additional training to on Continuous Quality Improvement tools
- Allow for periodic review of QM programme and peer learning
- Regional trainings
  - Uses basic QI training curriculum
  - Aims to increase the pool of healthcare workers with QI skills and competencies
- APIN/HealthQual TOT
  - To provide participants a solid understanding of quality improvement (QI) theory and methodologies
  - To increase the pool of qualified quality improvement trainers to further build site specific and zonal capacity for quality improvement

Regular assessment using the site QM programme status check list

- Purpose:
  - Help programme office to understand the state and functionality of sites’ QM programme so that the most appropriate form of support in the different thematic areas can be provided.
- Thematic Areas
  - Quality Improvement Infrastructure
  - Quality Management Plans
  - Internal Performance Measurement
  - Quality Improvement Activities
- Administered in 2009 and 2010

Tools Development

- Results from the 2009 administration of the status check list revealed that processes were not uniform across sites with resultant inability to compare results or share best practices.
- Tools developed to harmonize processes and enable demonstration of improvement and processes
- APIN QI Tool Kit
  - How-to document
  - Step wise approach to quality improvement
  - Contains both narratives and tools for each step
  - QI Committee: Generic TOR, meeting records template, agenda template
  - Quality Management Plan: Template
  - Quality Improvement activities: tools and tools for each step
  - Prioritization matrix, flow charts, tools for root cause analysis, improvement matrix, implementation plan template

QA Report Generation Tools

- Quality Indicators (QuIC) tool:
  - Automated, file maker based utility. Has replaced manual report generation for adult indicators, reduce reporting burden and turn around time.
  - Increases reliability and accuracy of QA reports
  - Can be run at the smallest clinics
  - Displays individual IDs of patients meeting certain criteria in addition to generating percentages helps with individual patient follow-up and care
- Quality Improvement indicators SOP
  - Stepwise instructions on generating QA indicators manually (in use for pediatrics and PMTCT)
Innovation in Implementation

- Existing electronic utilities assist the sites to generate outcome data for patients on care and treatment.
- Harvard and APIN site networking allows for best practices to be readily adopted. E.g.
  - Dedicated space or hours for pharmacy pickups
  - Verification of patient contact info at each visit
  - Inter-site training and assessment activities

Patient Monitoring and Management Tools

- Treatment Response Utility
- Pharmacy Pickups
- Laboratory Values
- CO2
- Lag of Viral Load

Each green triangle indicates one pickup of antiretroviral medications. Orange triangles indicate a change in regimen.

Quality Improvement Coaching

- **Purpose**
  - Serve as a bridge between didactic trainings and real life practice.
  - Tailored to the needs of individual sites and sometimes individual members of the QA project specific teams
  - Eligibility for coaching based upon scores from QM output assessment
  - Measures 5 domains:
    - QI Reporting, QM plan, QI committee structure, QI committee functionality and performance measurement
  - Maximum score is 20
  - Score bands 0-5, 6-10 qualify for coaching

Results

- 2 dimensions of results:
  - QM system building: changes in site QM programme status check list parameters
  - Improving quality of care indicators: selected indicators between July 2009 and December 2010

QI Status Checklist Findings

<table>
<thead>
<tr>
<th>Quality Improvement Infrastructure</th>
<th>December 2009</th>
<th>September 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing Committee</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Representative membership</td>
<td>74%</td>
<td>83%</td>
</tr>
<tr>
<td>Agenda Prior to QI team meetings</td>
<td>26%</td>
<td>53%</td>
</tr>
<tr>
<td>Appropriate content of agenda</td>
<td>33%</td>
<td>44%</td>
</tr>
<tr>
<td>QI Committee Terms of reference</td>
<td>22%</td>
<td>80%</td>
</tr>
<tr>
<td>Keeping meeting records</td>
<td>26%</td>
<td>53%</td>
</tr>
<tr>
<td>* Short term QA work plan</td>
<td>13%</td>
<td>60%</td>
</tr>
<tr>
<td>Evidence of work plan implementation</td>
<td>33%</td>
<td>27%</td>
</tr>
<tr>
<td>Work plan implementation on track</td>
<td>33%</td>
<td>40%</td>
</tr>
<tr>
<td>Additional 2010 indicator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>= Tangible meeting outputs</td>
<td>NA</td>
<td>19%</td>
</tr>
</tbody>
</table>

QI Status Checklist Findings (2)

<table>
<thead>
<tr>
<th>Quality Improvement Infrastructure</th>
<th>Dec 2009</th>
<th>Sep 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Performance Measurement activity</td>
<td>39%</td>
<td>43%</td>
</tr>
<tr>
<td>Appropriate indicators</td>
<td>44%</td>
<td>69%</td>
</tr>
<tr>
<td>Evidence based choice of measurement area</td>
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<td>69%</td>
</tr>
<tr>
<td>Quality Improvement Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past or current Quality improvement activities</td>
<td>22%</td>
<td>40%</td>
</tr>
<tr>
<td>Appropriate activities</td>
<td>40%</td>
<td>56%</td>
</tr>
<tr>
<td>Implementation tracking</td>
<td>0%</td>
<td>17%</td>
</tr>
<tr>
<td>Documentation of implementation</td>
<td>0%</td>
<td>17%</td>
</tr>
<tr>
<td>+ Prioritization Matrix</td>
<td>NA</td>
<td>82%</td>
</tr>
<tr>
<td>+ Root cause Analysis</td>
<td>NA</td>
<td>56%</td>
</tr>
<tr>
<td>+ Improvement Matrix</td>
<td>NA</td>
<td>50%</td>
</tr>
<tr>
<td>+ Process Indicators</td>
<td>NA</td>
<td>0%</td>
</tr>
</tbody>
</table>
Summary

- 2009: most sites were at comparable levels in understanding and implementation of QI, so a general approach could be employed: central training, QI tool kit etc
- 2010: sites are at different levels of implementation and understanding, hence a case by case approach is needed in 2011
  - QI committee strengthening
  - Support for QI processes at different levels
  - Support to develop QM plan

Changes in Quality of Care Indicators

- % of patients with at least 1 CD4 count in 6 months
- % of patients with CD4 ≤ 359 on ART therapy during the review period

Challenges

- Burden of work: quantity and type of work
  - Workload of site staff especially with respect to other primary responsibilities in the hospital impact on ability to meet and carry out QI activities
  - QI requires a different set of skills, most of which health care workers do not receive as part of pre-service training
- Funding for QI at Health Facility level
  - Basic needs like stationery, refreshments
  - Programme careful not to create a special QI budget
- Calls for 100% QI staff at Health Facilities
  - Concerns that it might undermine the team approach to QI
  - Documentation
- Absence of a strong National QI programme

Fitting into a National QM programme

- Treatment and care protocols in line with national guidelines
- Already using national QI indicators and reporting timelines
- Documented systems and processes that allow for comparison, sharing of best practices and alignments when necessary
- Pool of master trainers and coaches available who can support the national programme in its scale up

Thank You!
Ministry of Health and Social Services
Namibia

Our Experience with the HIV Quality Management Program

Dr Justice Gweshe
Chief Medical Officer
National AIDS and STI Control Program

Presentation Outline

1. HIV Program Current Organogram
2. Program Execution
3. Namibia Regional Quality Improvement Workshop model
4. Some program ingredients for building ownership and sustainability
   I. Team work, facility driven QI planning
   II. Facility Ownership, Communication and Recognition of Facility
      Driven QI processes
   III. Leadership, Motivation and Stakeholder involvement
5. Consumer Involvement in QI
6. Challenges
7. Successes
8. Way Forward

Program Activities

- Engagement and staffing
- Routine Measurement of Performance Indicators
- Improvement education and implementation
- Coaching and mentoring by country team
- Regional groups to share best practices
- Patient involvement
- Expansion geographically and to other service areas
Objectives of Regional Quality Improvement Workshops

The RQI Workshops are designed for sites who have been trained in the basic principles of Quality Improvement (HIVQUAL) and have completed at least a baseline performance measurement exercise and has the following objectives:
1. To promote peer learning
2. To provide a forum for ongoing QI skill building
3. To provide benchmarking reports

Development and use of regional groups

- Regional Quality Improvement Workshops convened following each of the 5 rounds of data collection conducted to date in 16 pilot sites.
- The phase 2 sites (18) have each conducted 2 rounds of data collection
- Participating sites grouped into 5 clusters around the 5 regional health training centres
- Each facility is represented by a team of QI stakeholders e.g. MD, Nurse, Data Person, Program Officer etc
- Workshops conducted over a period of 2-3 days

Topics Covered During the Meetings

The workshops are organized in a format of a mix of facilitator led didactic presentations, facility group discussion with plenary feedback and plenary open discussions. The topics covered include:
- Review of Performance Data by sites
- Development of QI projects and sharing of best practice
- Sites develop draft QI work plans which are then finalized once they return back to site
- Open forum for discussion on other topics covering QM and QI
- Quality program infrastructure discussed and Quality Management Action plans are developed/updated

Team work, facility driven QI planning

- Presentation of QI projects by each facility promotes learning by participants
- Challenges and best practices are discussed and this offers a platform of spread of the best practices across the participating sites
- Examples of peer learning at RQI workshops:
  - The procedures to maximize the provision of IPT and Cotrimoxazole through an integrated service approach
  - Development and sharing of standard M&E tools for Food Security and Alcohol Screening

Promotion of Peer Learning

- Promotion of Peer Learning
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Group Peer learning in action
“Results and sustainability”
Namibia’s experience

Motivation, Leadership and Stakeholder Involvement

This conference and Namibia’s vision for building a sustainable QM Program
- Hosting this conference has helped us to learn from all the countries and individual expertise represented here.
- To maximize on lessons from this conference, team Namibia represented by a variety of cadres each of whom will play a pivotal role in strengthening the QM program.

<table>
<thead>
<tr>
<th>Level in Health System</th>
<th>Cadres Representing</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Program Managers</td>
<td>-HIV Program Managers</td>
</tr>
<tr>
<td></td>
<td>-National Quality Assurance Managers</td>
</tr>
<tr>
<td>Regional Managers</td>
<td>-Representatives of Regional Health Directors</td>
</tr>
<tr>
<td></td>
<td>-Regional HIV Program Managers</td>
</tr>
<tr>
<td></td>
<td>-Regional Chief Medical Officers</td>
</tr>
<tr>
<td></td>
<td>-Regional Quality Assurance Officers</td>
</tr>
<tr>
<td>District or Facility level</td>
<td>-District Medical Officers (PMOs)</td>
</tr>
<tr>
<td></td>
<td>-Facility level medical doctors, nurses, patient representatives</td>
</tr>
</tbody>
</table>

Successes
- New skills (e.g. data analysis and interpretation, data use, QI skills) have been build among health care workers.
- RQI workshops have led to sharing of best practice of processes of care.
- Sharing of tools developed for evaluating food security and alcohol screening has helped to establish a new culture in most facilities where previously this element of HIV care was not being provided due to absence of screening tools.
- Improved processes of delivery of care have resulted in increased rates of PCP prophylaxis and provision of TB Isoniazid Preventive Therapy across most sites.
- The RQI workshop model has helped establish linkages between providers from different facilities which help to standardize HIV care across all sites in Namibia.
- Establishment of consumer involvement activities at some facility level.

Challenges
- Namibia is a huge country yet sparsely populated and this is a challenge in terms of providing field technical support to all participating sites timeously.
- Human resources constraints including rapid staff turnover at facilities impacts negatively on the capacity building process for quality management.
- The lack of capacity of quality management among program managers at district and regional level impacts negatively on their capacity to offer continuous supervision, mentorship and coaching to site level staff.
Lessons Learned

• Government leadership/ownership of program is important for sustainability of the QM program
  • “A leader’s first job is to create a thinking environment. Every subsequent act of leadership gains quality from there”. Nancy Kline
• Adequate site preparation is key to success for implementation
• “Taking the little steps approach works!!”
• Consumer involvement can help to facilitate QI

Way Forward

• MOHSS has begun restructuring the QA unit
  • Plans for TWG setting up
    • Consultative process on assessments of processes and needs for an expanded QM program
  • National QM Policy-standards, measures, structures
• Program to continue building QM capacity at all health care levels

Acknowledgements

1. Ministry of Health and Social Services
2. PEPFAR Namibia
  1. CDC Namibia
3. HEALTHQUAL International
4. ITECH Namibia
5. All participating sites
6. Consumers
Country Program Highlights: Ethiopia
Presenter: Abiyou Kiflie, MD, MPH

Quality Management in Ethiopia
HEALTHQUAL All Country Learning Network, Windhoek
By: Abiyou Kiflie, Alemayehu (MD, MPH) Federal MOH/Tulane University – UAE Quality Improvement Advisor
17 March 2011

Country Profile
Demography
- Population: 80 million
  - 86% rural; 14% urban
  - <5 children = 44.6%
  - TFR = 5.4
- Religion:
  - Christianity
  - Muslim
- Multicultural
- Language:
  - National: Amharic = 94.5%, Oromchi, Tigrinya
  - Regional and Local: >70
- Administration – Federal with 11 administrative regions

Country Profile
Health Status
- IMR = 77/1,000
- CMR = 50/1,000
- Under 5 MR = 123/1,000
- MMR = 673/100,000
- HIV Prevalence = 2.3%
Source: 2007 population census

Health System
- Federal Ministry of Health
  - Regulatory
  - EQCQI
  - RHQ
  - Woreda Health Office
  - Specialized Hospitals
  - General Hospitals
  - Primary Hospitals (rural)
  - Health Centers (both)
  - Health Posts (rural)

Quality Improvement
- Status of Implementation: Very Early
- Approach
  - Uses the model for improvement
  - Measurement linked with improvement
  - Aims for implementing across all services provided in the health facility
Responsibilities

- Principle: "Quality Improvement is the responsibility of every body"
  - Every body is responsible to improve the quality of service that it provides
    - Every unit, Every Individual needs to perform QI projects
      - A unit will be its own QI team: run QI cycles to improve its own functions

Development Process
- 2007/8: technical working group (QM for HIV) established to harmonize and guide activities by multiple partners that use different models
  - Framework developed
  - Baseline assessment done
- 2009/10: Reform undergoes within the ministry
  - Shift from disease specific approach to general service view
    - HIV specific QM transformed to general service QM (and the TWG too)
  - Though process gets delayed some steps are started ...

Current Status
- Materials prepared and standardized
- The materials are official documents of the ministry
- Refining the materials undergoing taking inputs from implementation process
- Initial 5 hospitals (pilot) gets training
  - Mentoring/Coaching process undergoing to get the hospitals implement as proposed

Responsibilities
- Practically:
  - Capacity?
  - Time?
  - Devotion/commitment?
- An over all QM committee
  - To advise the hospital management
  - To provide technical support to the lower units and capacity building
- Special QI teams to be organized for cross cutting issues (if no committee responsible)
HHS/CDC Track 1.0 Transition in Rwanda

March 2011

Principles Behind Track 1.0 Transition in Rwanda

- ICAP and AIDS Relief are transitioning programs to the Rwanda MOH as the local partner
- Emphasis on maintaining quality of care while increasing GOR ownership and management
- Technical support and capacity building from Track 1.0 partners during the whole transition process
- Gradual transition approach
  - Transition one-third of sites during each year (2010, 2011, 2012)

MOH Agencies’ Distribution of Responsibilities for Transition

<table>
<thead>
<tr>
<th>Implementing partners Activity</th>
<th>MOH Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentoring</td>
<td>TRACPlus</td>
</tr>
<tr>
<td>Supervision, AIDS and Reporting</td>
<td>UPDC</td>
</tr>
<tr>
<td>Health Facilities, Salaries</td>
<td>Districts (via UPDC)</td>
</tr>
<tr>
<td>Performance-Based Financing</td>
<td>CAAC</td>
</tr>
</tbody>
</table>

Transition Planning & Implementation Timeframe

**Planning phase**
- Establish Transition Task Force
- Conduct site readiness assessment
- Select 1st sites for transition
- Develop M&E

**Implementation phase**
- Transition 1st 24 sites
- Strengthen MOH capacity to manage and report according to USG requirements
- Monitor performance of transitioned sites in collaboration with GOR

Rapid assessment of site readiness, November, 2009

- Joint MOH, CDC, ICAP, AIDS Relief visits to 65/76 sites
- Completed rapid assessment tool (RAT)
  - Administrative, managerial, financial aspects with score
- Reviewed routine HIV program performance indicators collected quarterly
- Reviewed sites for transition based on criteria:
  - Transition district hospital with associated health centers
  - Clinical performance indicators: >75%
- Discussions within TTF on site selection
  - 18 sites selected for transition March 2010
  - 6 sites selected for transition October 2010

TTF functions

- Management: Conduct pre-award assessment, develop sub agreements, oversee the award application, provide award management support
- M & E: training, mentoring, data quality & data base management
- Clinical: mentorship, capacity building & Program evaluation
Monitoring and Evaluation of Track 1.0 Transition in Rwanda

- **Objectives:**
  - Establish baseline level of performance of sites
  - Monitor any changes in overall performance of sites
  - Evaluate the quality of clinical services and management capacity of sites throughout the transition process

- **Methods:**
  - Conduct comprehensive assessment of sites at baseline and at 6, 12 months after transition
  - Quarterly site visits aim to be integrated with routine supervision through MOH, use routinely collected indicators
  - Two components:
    - Capacity assessment survey to monitor overall management
    - Performance indicators approved by MOH to monitor clinical performance

Domains of Assessment

- Data is collected on 7 domains of management
- Data is also collected on clinical indicators.

Analysis Methods

- Score (or "grade") computed for each domain
- Overall score computed for each site, weighted domains
Dissemination of Baseline & follow up Data for Kibuye Districts

- These facilities were transitioned in May 2010.
- These were ICAP supported sites.
- Baseline assessment was done in May 2010.
- Follow up assessment was done in December 2010.

Overall Scores: Baseline and Follow-up

<table>
<thead>
<tr>
<th>Site</th>
<th>% HIV+ Women ART Proph.</th>
<th>% HIV+ Women ART for Life</th>
<th>% Partners Tested</th>
<th>% HIV-exposed Infants ART Proph.</th>
<th>% HIV-exposed Infants PCR at 6 wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubengera</td>
<td>100%</td>
<td>100%</td>
<td>53%</td>
<td>94%</td>
<td>85%</td>
</tr>
<tr>
<td>Kirambo</td>
<td>100%</td>
<td>67%</td>
<td>81%</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>Mukungu</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
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<tr>
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<td>100%</td>
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<td>100%</td>
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<tr>
<td>Birambo</td>
<td>100%</td>
<td>100%</td>
<td>82%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

PMTCT Clinical Indicators

- Proportion of Patients Newly Enrolled on Care and Treatment who Received CTX
- Proportion of Patients Newly Enrolled on Care and Treatment who Were Screened for TB
Next steps

- The quality team will harmonize the mentorship & supportive supervision tools.
- Pilot sites will be selected for QI projects
- QI plan is already developed
- Harmonized tools for QI will be produced from SOC ICAP & CQI tool of AIDS Relief.

Summary Results: Management

- HC average overall score increased (78%-84%)
- Domains with improved average scores:
  - Financial management
  - Supply chain management
  - Strategic information
- Domains with similar average scores:
  - Clinical management
  - Laboratory
- Domains with reduced average scores:
  - Human resources
  - Quality improvement

Conclusions & Next Steps

- Now almost all sites have been transitioned to MOH
- The last baseline assessment has been conducted in the first two weeks of March 2011 for 46 sites
- Follow up assessment will be done for the sites which are already transitioned.
- Special emphasis is given to these sites to maintain & improve quality of services through regular supportive supervision, frequent clinical mentorship & PBF.
- The site level quality improvement activities will be piloted in the transitioned sites.

Conclusion & next steps conti..

- Overall:
  - MOH owns the process because it builds on the existing MOH indicators
  - M&E with feedback to health facilities leads to identification of effective responses for areas that need improvement
  - Process is jump-starting integrated supervision, will be linked to PBF
  - Strengthen MOH financial and administrative capabilities
  - Address action points derived from dissemination workshop
  - Continue monitoring the quality of services
  - Define long term plans for technical support
Acknowledgments

• Health facilities
• MOH
• UPDC
• TRAC Plus
• ICAP
• AIDS Relief
• CDC-Rwanda transition team
Plenary Presentations
Towards an MTCT Free Kenya
Place of MBP

Dr Sirengo Martin, MD, MMed
PMTCT program manager
NASCOP

Outline
- Introduction
- PMTCT program status
- Country plan for elimination of MTCT
- MBP

Introduction

Background
- Kenya population: 38.6 Million (Census 2009)
- Estimated number of pregnancies: 1.5 Million per year
- HIV positive pregnant women: 106,500 (7.1% of 1.5M-Sentinel survey 2009)
- HIV exposed infants assuming all live births: 106,500
- HIV exposed: 42,600 assuming 40% transmission rate.
- Despite the alarming statistics, majority of pediatrics infections are preventable

History

- Started in a few pilot sites in late 1990s
- Small scale implementation by 2000
- Large scale implementation by 2002
- TWG formed in 2002
- 460 sites by 2003 and ≈1000 sites in 2005
- PMTCT sites 4,150

Achievements: DASH BOARD

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV testing rate</td>
<td>70.5%</td>
<td>81%</td>
</tr>
<tr>
<td>ARV delivery Mother</td>
<td>72.3%</td>
<td>78%</td>
</tr>
<tr>
<td>ARV delivery infant</td>
<td>49%</td>
<td>63%</td>
</tr>
<tr>
<td>EID testing</td>
<td>59%</td>
<td>80%</td>
</tr>
<tr>
<td>MTCT rate</td>
<td>10-15%</td>
<td>8%↑</td>
</tr>
</tbody>
</table>

Achievements
**eMTCT**
- eMTCT is now considered a realistic public health goal
- eMTCT initiatives can accelerate attainment of MDGs 4, 5 and 6
- 2010 WHO PMTCT recommendations could ↓ MTCT of HIV to <5% in BF pop and <2% in Non BF pop

**Model of improvement (eMTCT)**
- What are we trying to do?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

**Kenya MFI Goals and Target**

**GOALS**
- Elimination of MTCT by 2015
- Contribute to maternal health and child survival by achieving universal access to comprehensive PMTCT services

**TARGET**
Reduce MTCT rates to <5% by 2015

**The eMTCT implementation plan**
- 1st phase: Taking stock (2010)
  - Program data, PMTCT Formative research, Joint review mission (JRM), impact evaluation
- 2nd phase: Jan-Dec 2011
  - Pilot in 5 districts with M&E component
  - Rationale: High HIV burden, Option A, Strong CHS
  - District baselines
- 3rd phase: (2012 and beyond)
  - Roll out phase

**Proposed PMTCT Indicators for MFI**

<table>
<thead>
<tr>
<th>Prong 1</th>
<th>Prong 2</th>
<th>Prong 3</th>
<th>Prong 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTC and FP</td>
<td>Family planning among HIV +</td>
<td>ART and ARV PXP</td>
<td>Family centered interventions</td>
</tr>
<tr>
<td>Catchment Popn</td>
<td><a href="#">Unmet need for FP reduced</a></td>
<td><a href="#">ANC attendance rate</a></td>
<td><a href="#">1. Partner testing</a></td>
</tr>
<tr>
<td>1. Knowledge of HIV status</td>
<td><a href="#">WRA access to modern FP</a></td>
<td><a href="#">WHO staging and CD4</a></td>
<td><a href="#">2. Access to PCR</a></td>
</tr>
<tr>
<td>1. FP uptake</td>
<td><a href="#">1. ANC attendance rate</a></td>
<td><a href="#">ARV ppx (MBP)</a></td>
<td><a href="#">3. ART for +ve infants</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="#">Mother-baby pair</a></td>
<td><a href="#">4. PSSG</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="#">Skilled delivery</a></td>
<td><a href="#">Nutritional supplement support</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="#">Counseled on IYCF</a></td>
<td><a href="#">Retention rate and effective linkages to chronic care</a></td>
</tr>
</tbody>
</table>
eMTCT implementation framework

Effective partnerships

Community systems strengthening

Health systems strengthening

MBP

- Rationale: convenient packaging to address ARV commodity challenges. Based on WHO 2010 guidelines (Option A)
- Buy-in: Meetings with KEMSA, CHS, PHMTS/DHMTS, eMTCT steering sub-committee of TWG
- Implementation plan (draft framework)
  - PSM plan
  - MBP implementation plan- What, who, when, how etc
  - MBP M&E-routine vs enhanced

MBP contribution to PMTCT QI

- C-Coverage
- Q-Quality
- U-Utilization

MBP

<table>
<thead>
<tr>
<th>Period</th>
<th>Mother/Baby</th>
<th>Medicine</th>
<th>Dosage (WHO Rapid Advice Nov 2009)</th>
<th>Quantity in MBP (Feb 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>During Pregnancy</td>
<td>NVP 300mg</td>
<td>CTX 960mg</td>
<td>Start week 14</td>
<td>400 tablets (strips of 10)</td>
</tr>
<tr>
<td>Labour &amp; Delivery</td>
<td>NVP 200mg</td>
<td>AZT 300mg</td>
<td>Start week 14</td>
<td>200 tablets (strips of 10)</td>
</tr>
<tr>
<td>After delivery</td>
<td>NVP 200mg</td>
<td>CTX 960mg</td>
<td>Start week 14</td>
<td>1 tablet NVP + 4 tablets AZT/3TC</td>
</tr>
<tr>
<td>Baby</td>
<td>NVP syrup 10mg/ml</td>
<td>AZT 300mg</td>
<td>Start week 14</td>
<td>50 tablets (strips of 10)</td>
</tr>
</tbody>
</table>

Challenges of MBP

- National
  - Acceptability
  - Registration
  - F&Q. ? Place of regular supply of ARVs
  - Distribution
  - Data tools
  - Partner roles and resp & coordination
  - Slow start-up
- Regional, Facility and community
  - Capacity building
  - Support supervision
  - Criteria of issuance
  - LTFU and tracking
  - Data tools
  - Disclosure and stigma
  - Mama pack vs Family pack
Lessons learnt
- Need for clear operational plan
- Policy
- Logistics
- Service delivery
- Community engagement
- M&E

Anticipated benefits (QI) of MBP
- Reduce individual ARV commodity stock outs
- Improve ANC attendance (timing of 1st visit and retention upto 4 visits)
- Scale up of patient ART eligibility screening
- Promote patient counselling in available interventions

Anticipated benefits (QI) of MBP
- Promote disclosure, male involvement and HTC, SBA, safer IYCF, PNC and EID
- Promote pt follow-up
- Streamline PSM plans
- Strengthen support supervision
- Improve partner coordination (each partner assigned a task)
- Promotion of maternal/child health and reduction in MTCT rates

Perceived cons of MBP?
Patient:
- Promote stigma and discrimination
- Cause marital disharmony
- Contribute to LTFU - ↓ ANC attendance, SBA
- From MBP to Family pack/selling of drugs
- Mix up esp among the illiterate
Other:
- Complex repackaging logistics/wastage

Ahsante sana
Thank you
Title: Towards an MTCT Free Kenya  
Speaker: Martin Sirengo, MD, MMed  

Overview of presentation:  
• Strengthening of health systems through unique interventions – the Mother Baby Pack  
• Kenya is dedicated to eliminating mother to child transmission by 2015, with a goal of decreasing the rate to less than 5%  
• In achieving this goal, PMTCT is viewed as an entry point to improve overall maternal and child health  
• Implementation: partnerships, health systems strengthening, community systems strengthening  
• Why the Mother Baby Pack?  
  o Convenient packaging to address ARV commodity challenges  
  o Stakeholder buy-in  
  o Implementation plan (draft framework)  
    - MBP implementation plan- What, who, when, how etc  
    - MBP M&E-routine vs enhanced  
• The Mother Baby Pack is part of a comprehensive approach to PMTCT, to improve coverage, quality and utilization of medications for pregnant women and new born babies.  
• Challenges:  
  o National  
    - Acceptability  
    - Registration  
    - Place of regular supply of ARVs  
    - Distribution  
    - Data tools  
    - Partner roles and responsibilities & coordination  
    - Slow start-up  
  o Regional/Facility/Community  
    - Capacity building  
    - Support supervision  
    - Criteria of issuance  
    - LTFU and tracking  
    - Data tools  
    - Disclosure and stigma  
    - Mama pack vs Family pack  
• Lessons:  
  o Need for clear operational plan  
  o Policy  
  o Logistics  
  o Service delivery  
  o Community engagement  
  o M&E  
• Benefits:  
  o Disclosure  
  o Scale-up of ART eligibility screening and retention  
  o Partner coordination  
  o PMTCT services and outcomes, among others
What are Factors of Sustainability on the National HIVQUAL Program in Thailand?

All Countries Learning Network, Windhoek Namibia
March 14-18, 2011

Contents
- Context of HIV/AIDS program and quality management system in Thailand
- Elements for HIVQUAL-T national program sustainability

Country Statistics
- Total population 63,444,000
- Gross national income per capita (PPP international $) 7,440
- Life expectancy at birth m/f (years) 69/75
- Healthy life expectancy at birth m/f (years, 2003) 58/62
- Probability of dying under five (per 1000 live births) 8
- Probability of dying between 15 and 60 years m/f (per 1000 population) 264/155
- Total expenditure on health per capita (Intl $, 2009) 346
- Total expenditure on health as % of GDP (2009) 3.5

HIV/AIDS Program Expenditure

<table>
<thead>
<tr>
<th>Year</th>
<th>Total expenditure, million USD</th>
<th>Per capita population, USD</th>
<th>Per capita PLWHA, USD</th>
<th>As % of Total Health Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>204</td>
<td>3</td>
<td>351</td>
<td>2.7</td>
</tr>
<tr>
<td>2008</td>
<td>210</td>
<td>3</td>
<td>431</td>
<td>1.9</td>
</tr>
<tr>
<td>2009</td>
<td>218</td>
<td>3</td>
<td>415</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Source
- Domestic, % of total AIDS exp.: 83
- International, % of total AIDS exp.: 17

Expenditure profiles
- Care and treatment, % total AIDS exp.: 71.8
- Prevention, % total AIDS exp.: 14.1
- ART expenditure, USD per patient year: 300
HIV/AIDS Treatment and Care Expenditure

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total care and treatment, m USD</td>
<td>138</td>
<td>166</td>
</tr>
<tr>
<td>Antiretroviral therapy</td>
<td>45%</td>
<td>57%</td>
</tr>
<tr>
<td>Inpatient care</td>
<td>31%</td>
<td>19%</td>
</tr>
<tr>
<td>Outpatient care</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Specific lab monitoring</td>
<td>15%</td>
<td>7%</td>
</tr>
<tr>
<td>OI prophylaxis</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>All others</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Total %</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Thailand’s Health Infrastructure

- University hospitals, excellent medical centers and regional hospitals in each region
- General hospital in each province
- Community hospital in each district

ART Facilities

- Up to 200,000 PLHA are receiving ART in >900 hospitals in countrywide
- Most of pediatric cases (> 8,000) have received HIV care services from secondary and tertiary hospitals with pediatricians

- ART Centers
  - Government hospitals 927
  - Private hospitals 98
- Laboratory Facilities
  - CD4 103
  - Viral load 29
  - Viral genotyping 10
  - HIV PCR (government) 15

Technical support
- DDD, DOH, DMS, DMH
- HIV/ARV experts
- GAP/CDC

Financial support
- NHSO
- SSO
- Civil servant Fund

The Healthcare Accreditation Institute

- Established 8 April 1999
- The institute’s policy is
  - To have flexibility within the plan and be independent of management
  - Transparency and accountability institute
- Main functions
  - QM and QI training (formerly)
  - Accreditation by 4 standards of HA/HPH

Elements for HIVQUAL-T National Program Sustainability

Expansion of The Adults HIVQUAL Program
Expansion of The Pediatric Care Network

- Year 2005-2006
  - 3 Provinces
  - 47 Hospitals
  - 5.2% gov. hospitals

- Year 2007
  - 9 Provinces
  - 98 Hospitals
  - 10.8% gov. hospitals

- Year 2008-2009
  - 15 Provinces
  - 158 Hospitals
  - 17.5% gov. hospitals

- Year 2010
  - 30 Provinces
  - 200 Hospitals
  - 22.2% gov. hospitals

Elements for the sustainability

- Policy and leadership
- Quality structure and coordination on implementation
- Capacity building on HIVQUAL model
- IT and management and benchmarking
- Sharing information and stories
- Incentive and rewards
- Linkage to Hospital Accreditation

The 5 years National Strategies (2011-2015) and M&E Framework of HIV Care and Treatment

- Improve quality of life among PLHA
- Decrease morbidity rate
- Decrease mortality rate
- Mitigate Drug resistance
- Decrease stigma and discrimination
- Reduce risk behavior

Department of Disease Control

Mission: develop standard of HIV/AIDS care and transfer knowledge to the society

National Health Security Office

Strategy: Maintain quality of care and treatment services
Elements for the sustainability
- Policy and leadership
- Quality structure and coordination on implementation
- Capacity building on HIVQUAL model
- IT and management and benchmarking
- Sharing information and stories
- Incentive and rewards
- Linkage to Hospital Accreditation

Local committee
- 12 Regional QI committee
  Members consist of representatives from regional HSO, Provincial Health Offices, Regional Offices of Prevention and Disease Control, NGO, PHA network, hospitals
- Provincial QI committee
  Members consist of representatives from Provincial Health Offices, NGO, PHA network, hospitals

Network development
1. QI network
   - Establish regional and provincial QI committees to plan, facilitate, support, and monitor QI activities in hospitals
   - Support Group Learning meeting
     Main roles: Management and technical support
2. Pediatric HIV care network
   - Develop and expand pediatric HIV care networks to strengthen referral system and building capacity of health care providers
     Main role: Technical support

The Country HIVQUAL Committee
- Advisory committee
- Steering Committee
- QI Technical Committee
- Monitoring and Evaluation Committee
- Local Committee Regional/provincial

Committee meetings

Workshops on Pediatric Care Network
Elements for the sustainability

- Policy and leadership
- Quality structure and coordination on implementation
- Capacity building on HIVQUAL model
- IT and data management and benchmarking
- Sharing information and stories
- Incentive and rewards
- Linkage to Hospital Accreditation

Capacity building on Quality Improvement: QI training

Objective
1. To understand and describe quality improvement principles of HIV treatment and care and can apply to routine services
2. To increase knowledge and skills of quality improvement and quality management
3. To build network of health care providers

Target group
- Hospital Quality Management team
- Patient Care Team (PCT)
- Home Health Care team
- HIV Coordinator/HIV care team
- Staff of Office of Disease Prevention and Control
- Staff of Provincial Health Office

QI training

Setting Priorities

Satisfaction continuum

Red bead game

QI Memo

Elements for the sustainability

- Policy and leadership
- Quality structure and coordination on implementation
- Capacity building on HIVQUAL model
- IT and data management and benchmarking
- Sharing information and stories
- Incentive and rewards
- Linkage to Hospital Accreditation
Indicators
- 5 main groups
  - CD4 monitoring
  - ART
  - OIs
  - Disease screening
  - Health Promotion
- 12 core indicators
- 45 optional indicators

Computer-based report
- HIVQUAL-T program

Computer-based report (2)
- Pediatric HIVQUAL-T program

8 year Analysis of core HIVQUAL Indicators (1)
- CD4 testing
- Access to ARV
- ARV Adherence Assessment
- VL testing

8 year Analysis of core HIVQUAL Indicators (2)
- Cryptococcal Prophylaxis
- PCP Prophylaxis
- Cervical cancer screening
- TB screening

Benchmarking of service coverage between national values and hospital results
Elements for the sustainability
- Policy and leadership
- Quality structure and coordination on implementation
- Capacity building on HIVQUAL model
- IT and management and benchmarking
- Sharing information and stories
- Incentive and rewards
- Linkage to Hospital Accreditation

HIVQUAL Group Learning

Examples of CQI stories posted in website

Incentive and Rewards
Certification/shield
- Best quality improvement on HIV treatment and care
- Best coordination
Incentive payment to health facility
Recognition
- Best practice presentation
  - National HA forum
  - HIVQUAL forum
  - Group learning

HIVQUAL Thailand website
www.cqihiv.com
Elements for the sustainability
- Policy and leadership
- Quality structure and coordination on implementation
- Capacity building on HIVQUAL model
- IT and management and benchmarking
- Sharing information and stories
- Incentive and rewards
- Linkage to Hospital Accreditation

Linkage to Hospital Accreditation
- Policy advocacy to Institute of Hospital Accreditation (IHA)
  - Policy maker
  - HA Surveyors
- Develop tools which integrate HIVQUAL with HA standard
  - Clinical tracers highlight
  - Composite KPI
  - QI Memo and CQI story
- Integrate HA concept/standard into QI training
- Participate in the 11th national HA forum on March 2010

Clinical Tracer Highlight
- Matching of HIV treatment and care indicators with 4 parts (28 indicators) of HA standard
  - Indicators are from
    - HIVQUAL-T indicator
    - Organization assessment
  - Automatic generate from HIVQUAL –T software
Challenges

- Expand implementation of national HIV quality improvement project to all government hospitals
- Conduct HIV quality improvement continuously in hospitals (CQI)
- Maintain giving standard and quality HIV services in hospitals while the number of PHA receiving ART increases
- Integrate HIVQUAL indicators, including other HIV related indicators into National ARV Program database

Organizational Quality Assessment Tool (OA)
Title: What are Factors on Sustainability on the National HIVQUAL Program in Thailand
Speakers: Peeramon Ningsanond, MD; Cheewanan Lertpiriyasuwat, MD, MPH; Chitlada Utaipiboon, MD

Overview of presentation:

- Programmatic sustainability is multifaceted, including:
  - Policy and leadership
    - Department of Disease Control
    - National Health Security Office
  - Quality structure and coordination on implementation
    - National HIVQUAL Committee
    - Local Committee
      - 12 regional QI committees
      - Provincial QI committee
    - Network Development
      - QI network
        - Regional and provincial QI committees
        - Pediatric HIV care network
  - Capacity building on HIVQUAL model
    - QI training
      - Setting priorities
      - Satisfaction continuum
      - Red bead game
      - QI memo
  - IT and management and benchmarking
    - HIVQUAL Thailand software
    - Reporting
      - Benchmarking of service coverage between national values and hospital results
  - Sharing information and stories
    - HIVQUAL group learning
    - HIVQUAL Thailand website
  - Incentive and rewards
    - Certification
    - Facility-level financial incentives
    - Recognition
  - Linkage to Hospital Accreditation
    - Policy advocacy to Institute of Hospital Accreditation (HA)
    - Tools which integrate HIVQUAL with HA standard

- Challenges:
  - Expand implementation of national HIV quality improvement project to all government hospitals
  - Conduct HIV quality improvement continuously in hospitals (CQI)
  - Maintain giving standard and quality HIV services in hospitals while the number of PHA receiving ART increases
  - Integrate HIVQUAL indicators, including other HIV related indicators into National ARV Program database
Overview of the presentation

- Haitian health system
- Organization of HIV services
- Quality Improvement program into HIV services
  - Organisation
  - Key results (before and after the earthquake)
  - Key challenges
  - Perspectives

Demography of Haiti

<table>
<thead>
<tr>
<th>Population</th>
<th>10,085,214 habitants (est 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Density</td>
<td>370 hab./km²</td>
</tr>
<tr>
<td>Population growth rate</td>
<td>2.1 %</td>
</tr>
<tr>
<td>Median age (total population)</td>
<td>31.3 yrs</td>
</tr>
<tr>
<td>- Male</td>
<td>30.9 yrs</td>
</tr>
<tr>
<td>- Female</td>
<td>31.4 yrs</td>
</tr>
<tr>
<td>Age Structure</td>
<td></td>
</tr>
<tr>
<td>- 0-14 years</td>
<td>38.1% (males 1,735,317/ females 1,704,383)</td>
</tr>
<tr>
<td>- 15-64 years</td>
<td>58.5% (males 2,621,059/ females 2,665,447)</td>
</tr>
<tr>
<td>- 65 years and over</td>
<td>3.4% (males 120,040/ females 188,690)</td>
</tr>
<tr>
<td>Sex ratio (total population)</td>
<td>0.98 male/female</td>
</tr>
<tr>
<td>Urban population</td>
<td>47 %</td>
</tr>
<tr>
<td>Prevalence HIV/AIDS</td>
<td>1.2 %</td>
</tr>
</tbody>
</table>

Main Objectives before QI program

- To contribute to the 2-7-10 PEPFAR goals
  - Enroll patients on ARV
  - Enroll patients in care
  - Prevent new infections

General Background

- Generalized epidemic: 2.2%
  - High risk groups: CSW, MSM, Youths
  - More concentrated in big cities
- Very poor health care delivery system particularly in public facilities
- Very weak management systems of care (HMS, drug logistic, human resources management)
- High level of stigmatization towards HIV
- Two NGOs (PIH, GHESKIO) proffering integrated HIV treatment
Main focus

1) Build a comprehensive and integrated model of HIV care that could fit into the poor system of care to produce quality and sustained outcomes:

Main focus (continue)
Model of care

- To build this model a lot of effort and resources were invested:
  - To build infrastructure (Internet, EMR, MESI, etc)
  - To hire personnel
  - To support operational costs
  - To train in different domains: clinical and community care, psycho-social support etc
  - To provide technical assistance needed in different domains to build and maintain the system.

Main Focus (Continue)

3) This system is built around the creation of centers of excellence around which services are now rapidly expanded to peripheral centers.

- Major inputs are provided to the CE to make them capable of supervising, performing mobile clinic and being a referral center for HAART and other specialized services (advanced lab etc)
4) The program has been built through the development of networks that are given resources to support a number of sites delivering different mix of services:
- Five of them (GHESKIO, PIH, MOH, AIDSRelief, MSH) have integrated HIV care and treatment services in health facilities.
- Four have integrated HIV care in specialized institutions:
  - FOSREF in CSW and Youth clinics
  - POZ in community services and MSM clinics
  - ICC in TB clinics
  - I-TECH in pediatric clinics.

5) Although the program has been mainly managed through vertical networks, efforts are being made to decentralize the management of the program through the MOH departmental directorates to ensure better coordination and integration at departmental and local level.

6) The program is also built on continuous reinforcement of local ownership and leadership:
- Strong manager at site and departmental level (site managers)
- Reinforcement of indigenous organizations
- Emphasis on building the skill of local staff

### Key Results in HIV services in 2010

<table>
<thead>
<tr>
<th>Indicateurs</th>
<th>Résultat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre de personnes testées pour VIH</td>
<td>403773</td>
</tr>
<tr>
<td>Nombre de personnes dépistées VIH+</td>
<td>24076</td>
</tr>
<tr>
<td>Nombre de FE testées pour VIH</td>
<td>132781</td>
</tr>
<tr>
<td>Nombre de FE dépistées VIH+</td>
<td>3240</td>
</tr>
<tr>
<td>Nombre de nouveaux enrôlés en soins cliniques</td>
<td>15806</td>
</tr>
<tr>
<td>Nombre de personnes ayant initié la prise d’ARV</td>
<td>6093</td>
</tr>
<tr>
<td>Cumul de personnes ayant été enrôlées en soins cliniques VIH/SIDA</td>
<td>140802</td>
</tr>
<tr>
<td>Cumul de personnes ayant démarré la prise d’ARV</td>
<td>38968</td>
</tr>
</tbody>
</table>

### HIVQUAL Haiti History

- In 2007, the MSPP adopted the HIVQUAL methodology as a national program for monitoring and improving systems of care delivery for persons living with HIV.
- Ten performance indicators to measure the quality of HIV services covering adult and pediatric care and treatment, and PMTCT were developed through a National Advisory Committee of PEPFAR partners and stakeholders convened by MSPP in late 2007.
- 19 HIV clinics were selected to begin HQ-HT, representing a mix of regions, clinic types and degree of support by partners.
- Data collection was expedited by the incorporation of the indicators into the EHR.
**HIVQUAL- Haïti Organigram**

Ministère de la Santé Publique et de la Population (MSPP)  
Responsable: DG MSPP

- Comité National de Qualité  
  Lead: DG MSPP (Dr. Thimothé)  
  Representants: MSP, CDC, UNDP, WHO, AFRM, PIH, FHI, GHESKIO, PEPFAR, CDC, USAID, TDR, PATH, PIH, USAID, PIH, FHI, GHESKIO, PEPFAR, CDC, USAID, TDR, PATH
  Rôles: Surveillance de HIVQUAL Haïti, coordination de l'ouragan, suivi des activités, résolution des problèmes, coordination des données, suivi des activités, coordination.

- Secrétariat Technique  
  Resp: PNLS et UGP

- Core Team  
  Resp: Coordonnateur Soins et Traitements

- Coaching Team  
  Resp: Coordonnateur Soins et Traitements

- Comité Qualité de l'Hôpital  
  Resp: Directeur Médical, Site Manager, Case Manager ou autre personnel approprié

**Institutions using HIVQUAL**

<table>
<thead>
<tr>
<th>Institutions using HIVQUAL</th>
<th>new ART</th>
<th>new non-ART</th>
<th>new Total</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-07</td>
<td></td>
<td></td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>Dec-08</td>
<td></td>
<td></td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>Dec-09</td>
<td></td>
<td></td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>Dec-10</td>
<td></td>
<td></td>
<td>25</td>
<td>50</td>
</tr>
</tbody>
</table>

**HIVQUAL HAITI INDICATORS**

**INDICATEURS CLÉS**

- Retention en soins des patients sous ARV
- Enrôlement aux ARV
- Screening TB (PPD)

**AUTRES INDICATEURS**

- Surveillance immuno-épidémiologique (CD4)
- Evaluation nutritionnelle (IMC)
- Méthode PF chez la femme VIH+
- Vaccination des enfants VIH–
- Evaluation de l’adhérence

**HIVQUAL report is generated by the EMR**

- Indicateurs de l'efficacité de l'EMR
  - Retention des patients sous ART
  - Enrôlement aux ARV
  - Screening TB (PPD)
  - Surveillance immuno-épidémiologique (CD4)
  - Evaluation nutritionnelle (IMC)
  - Méthode PF chez la femme VIH+
  - Vaccination des enfants VIH–
  - Evaluation de l’adhérence
**Earthquake**

- January 12, 2010

**Impact of the Earthquake on the Processes of HIV Services (140 sites)**

<table>
<thead>
<tr>
<th>Process</th>
<th>Nb of sites with stop history</th>
<th>Nb of sites in stop 3 months after earthquake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing</td>
<td>51 (36%)</td>
<td>9</td>
</tr>
<tr>
<td>Supply material of testing</td>
<td>15 (29%)</td>
<td>13</td>
</tr>
<tr>
<td>Care Enrolment</td>
<td>25 (29%)</td>
<td>3</td>
</tr>
<tr>
<td>ART Enrolment</td>
<td>21 (42%)</td>
<td>5</td>
</tr>
<tr>
<td>Dispensation of drugs</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>CD4</td>
<td>37</td>
<td>15</td>
</tr>
</tbody>
</table>
SITUATION HIV-QUAL after earthquake on January 12

- 6 Health centers were destroyed in the western department.
- EMR was not available during 3 months in 8 health centers.
- After the earthquake, activities stopped for 6 months.
- Members of Core team, Coaching team and Health center quality committee leave their organization or went abroad.

PM: National average after earthquake

- After green light of the MOH
  - Organisational Assessment of the facilities into HIVQUAL conducted in June 2010
  - Revision of all tools for collecting QI project
  - Revision of all training material
  - Training on QI were conducted on site by the departmental coaches

Resuming HIVQUAL activities after the earthquake

PM: National average

Training on QI after the earthquake
**Key Results**

- Tremendous efforts of the local leadership for the resuming of services
- Strong partnership have been developed.
- Continuous expansion while focus on quality is maintained
- The national EMR facilitated the resuming of QI activities.
- Coordination and planning of the program at departmental level
- Strong leadership and ownership at local level (capacity to run the program with minimum technical assistance)
- Good impact on the overall health system.

---

**Innovation for sustainability**

- All departmental directorate integrated in their activity plan a QI part (training, coaching and mentoring)
- Reward of quality leader into institution with outstanding quality program
- Site QI leader facilitate on national quality training
- Site QI leader are invited to participate into international meeting on QI (3 leaders have or will attend the next meeting)
- The remarkable leader in sites and departmental directorate will receive specialized training in QI in NQC (4 leaders have already received)

---

**Future focus**

- Expansion of QI to all HIV clinics
- Development of a website for sharing QI project among sites
- Consumer national Committee

---

**Challenges**

- Poor lab infrastructure
- High turn over of the personnel
- Need to invest in long term training of young Haitian professionals
- Rebuilding of the destroyed health facilities
- Economic crisis has further deteriorated the health care system could affected the gain in QI
<table>
<thead>
<tr>
<th>Sources</th>
<th>Special thanks to:</th>
</tr>
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<tr>
<td>• <a href="http://www.mesi.ht">www.mesi.ht</a></td>
<td>• MOH PNLS</td>
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<td>• lhsi.ht</td>
<td>• CDC Haiti</td>
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<td>• emmus4</td>
<td>• NYSDOH AIDS Institute</td>
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<td>• <a href="https://sitesurveys.ugp.ht/survey">https://sitesurveys.ugp.ht/survey</a></td>
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<tr>
<td>• EMR MSPP, EMR PIH</td>
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</table>
Title: HIVQUAL - The Haitian Model
Speaker: Gabriel Thimothe, MD, MPH

Overview of presentation:

- Haiti's national quality management program is focused on three goals based on PEPFAR goals:
  - Enroll patients on ARV
  - Enroll patients in care
  - Prevent new infections
- The Haitian model is designed around building a comprehensive and integrated model of HIV care to produce quality and sustained outcomes, with a focus on:
  - Infrastructure
  - Workforce
  - Operational costs
  - Training domains: clinical and community care, psycho-social support
  - Technical assistance in different domains to build and maintain the system
- Centers of excellence for care supervision, mobile services and outreach, and as a referral center for HAART and other specialized services
- Development of networks and partnerships for integrated HIV care and treatment services
- Move toward decentralization
- Reinforcing local ownership
- Earthquake produced disruptions in service, but comprehensive electronic health record has been used to refocus services and monitor areas for continued support.
- This has led to revisions with tools for collecting QI information, training materials and clinic level QI training by QI coaches
- Improvement and the earthquake
  - 140 clinics experienced serious disruption or stoppage of service due to the earthquake, but most were back on line within 3 months.
  - All 11 indicators demonstrated sustained levels of performance despite the earthquake, with only slight decreases in rates.
  - 6 of 11 performance measures improved within the six month review period post-earthquake, between June ’10 and December ’10.
- Key improvement issues:
  - Local leadership and ownership as integral to continued QI efforts
  - Strong partnerships
  - Continued program expansion
  - National EMR has facilitated resuming of QI activities
  - Coordination and planning at departmental level
  - Visible impact on the overall health system
- Innovation for sustainability:
  - Integration of QI into departmental activity plan (training, coaching and mentoring)
  - Reward of quality leaders
  - Clinic level QI leaders facilitate national quality training
  - Clinic level QI leader participation in international meetings
  - Specialized training in QI
- Challenges
  - Poor lab infrastructure
  - Staff turnover
  - Training
  - Rebuilding of destroyed health facilities
  - Economic crisis and impact on health care system and QI efforts
- Future Focus
  - Expansion of QI to all HIV clinics
  - Development of a website for sharing QI project among sites
  - Consumer national Committee

Facility Mean Performance Scores

Source: HIVQUAL Haiti
HIV Prevention for People Living with HIV/AIDS: Indicators for HIV Care and Treatment Settings

Daniel Kidder, PhD
Pam Bachanas, PhD
Amy Medley, PhD

HEALTHQUAL All Country Learning Network (ACLN) Meeting
16 March 2011

Healthcare Providers

1. Give basic prevention recommendations (disclosure, partner testing, safer sex, and alcohol reduction)
2. Assess and support adherence
3. Provide family planning and safer pregnancy counseling
4. Assess and treat STI symptoms
5. Distribute condoms

Refer for behavioral counseling on prevention, positive living, adherence, and alcohol reduction

Lay Counselors

1. Conduct Group Education
   - Basic Education on HIV/AIDS
   - Protecting Your Partner
   - Protecting Your Children
   - Treatment Adherence
   - Positive Living
2. Provide Individual Counseling
3. Provide HIV Counseling and Testing, where permitted
   - Individuals: Walk-in and partner(s) of clinic patients
   - Couples: Concordant and discordant

Prevention with People Living with HIV (PwP)

- Prevention interventions with people living with HIV (PLHIV) improve their health and reduce the risk of transmission to partners/children
- Prevention is a critical part of the care of PLHIV throughout their illness

PwP in clinic settings

- Health care providers meet with patients regularly
  - Can deliver consistent, targeted prevention messages and strategies during routine visits
- Health care providers are considered authority figures and trusted sources of health information
- Prevention information on infection control is regarded as quality standard of care

PwP in clinic settings (2)

- Health care providers can address biomedical prevention strategies
  - E.g., family planning, STI management
- Given clinic burden and complexity of patients’ needs, many patients need more in-depth counseling on prevention issues
  - E.g., disclosure, condom use, alcohol use
  - Incorporating counselors into clinic settings is essential for comprehensive prevention activities

Outline

- Prevention with People Living with HIV (PwP) in clinic settings
- PwP PEPFAR indicator
- HEALTHQUAL prevention indicator
- Questions and discussion
Country PwP Activities

- Many countries developing and/or strengthening national policies and guidelines for PwP activities
- Integrating prevention services into routine care of PLHIV so prevention becomes a part of the continuum of care
  - Part of National Care and Treatment guidelines
  - National Prevention Strategies or Frameworks include PwP activities and services
  - Example countries include Ethiopia, Kenya, Namibia, Nigeria, Rwanda, Zambia

PwP Monitoring and Evaluation

- Need to be able to monitor and evaluate clinic-based PwP activities
- PEPFAR PwP Next Generation Indicator (released Aug 2009)
  - Essential/Reported indicator
  - Captures delivery of the minimum package of services for PLHIV
  - Will assist field in monitoring and evaluating coverage of prevention services for PLHIV

PwP PEPFAR Indicator

"Number of people living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions"
- To count for indicator, PLHIV must have received the minimum package at last visit
- In clinic/facility-based or community/home-based services

PwP Minimum Package

Assessment of:
- Sexual activity
  - provision of condoms/lubricant, risk reduction counseling
- Partner HIV status
  - provision of (or referral for) partner testing
- STIs
  - provision of (or referral for) STI treatment, partner treatment
- Family planning needs
  - provision of contraception, safer pregnancy counseling, or referral for family planning services
- Adherence
  - support or referral for adherence counseling
- Need for community-based services (e.g., home-based care, support groups, post-test clubs)
  - refer or enroll

Indicator Rationale

- Prevention is more than just condoms
- Minimum package is evidence-based for improving health of PLHIV and decreasing transmission risk
- Minimum package will help drive programming and improve services
  - Integrate prevention into continuum of care and treatment
  - ‘All or none’ indicator
  - Countries may not yet be doing all, but want to move toward that point

Why ‘at last visit’?

- Prevention services should be delivered routinely and not just at intake
- Life situations change over time
  - Prevention needs change and require ongoing attention
- Acknowledge that there are potential difficulties with capturing information
Where are clinics now?

- All services may not currently be delivered during routine care visits
- Services may be delivered but not currently documented
- Is there a component of the PwP indicator that could be targeted as a starting point to improve service delivery and documentation?
  - HEALTHQUAL prevention indicator

Prevention Indicator

- What is the priority prevention goal for PLHIV?
  - Get partners tested and identify discordant couples
  - Can then intervene to reduce transmission risk
- Steps to identify discordant couples:
  - Disclosure → Partner tested → Knowledge of partner status

Possible Indicators (1)

- Disclosure
  - Pros:
    - If mutual disclosure, may have less risky behavior and greater support/care of positive partner
  - Cons:
    - Don’t know for certain that partner has been tested
      - Patient may assume partner’s status based on patient’s status (“I am positive, so (s)he must be positive”)

Possible Indicators (2)

- Partner tested
  - Pros:
    - Documents that HIV test has occurred
  - Cons:
    - Patient may not know partner’s test outcome. If no disclosure, can’t identify concordant/discordant couples
    - Don’t know if negative partner has been retested as needed (e.g., every 6 months)
    - If partner not tested in clinic or don’t have documentation of results, then can’t be certain of results

Possible Indicators (3)

- Knowledge of partner HIV status
  - Pros:
    - Identifies discordant couples and can prioritize for interventions
  - Cons:
    - Don’t know if partner was actually tested
    - Don’t know if mutual disclosure has occurred
    - Don’t know when partner was last tested (negative partners need routine retesting)

Questions and Discussion

- If there can be only one HEALTHQUAL indicator for PLHIV, what would it be?
- What about other possible indicators?
  - Risk behavior (e.g., consistent condom use, # of partners)
  - STIs
  - Family planning
  - Adherence
- Can the indicator include multiple questions?
  - E.g., partner tested (Y/N), test date, HIV status
Title: HIV Prevention for People Living with HIV/AIDS: Indicators for HIV Care and Treatment Settings
Speaker: Daniel Kidder, PhD

Overview of presentation:

• Prevention interventions with people living with HIV (PLHIV) improve their health and reduce the risk of transmission to partners/children
• Prevention is a critical part of the care of PLHIV throughout their illness
• Importance of prevention in a clinic setting
  o Family planning
  o STI management
  o Disclosure
  o Condom use
• Many countries developing and/or strengthening national policies and guidelines for PwP activities
• Integrating prevention services into routine care of PLHIV so prevention becomes a part of the continuum of care
• Capacity to monitor and evaluate prevention efforts
• Prevention indicator development
  o Minimum package of activities
    - Sexual activity
    - Partner HIV status
    - STIs
    - Family planning needs
    - Adherence
    - Community based services
• Prevention services should be delivered routinely and not just at intake
• What is the priority prevention goal for PLHIV?
  o Get partners tested and identify discordant couples
  o Can then intervene to reduce transmission rates
• Potential Indicators
  o Disclosure
  o Partner tested
  o Knowledge of partner HIV status
What’s New in TB?

HEALTHQUAL All Country Learning Network Annual Meeting Windhoek, Namibia March 14-18, 2011

Bess Miller, M.D.
Associate Director, TB/HIV Prevention and Care
Division of Global HIV/AIDS
Centers for Disease Control and Prevention
Atlanta, GA

Outline of presentation

• Why focus on TB in PLHIV?
• Are we making progress in reducing TB?
• What’s new with the 3 I’s plus?
  – INTENSIFIED TB case finding
  – Isoniazid preventive therapy
  – Infection Control
  – ART in TB/HIV patients
• What’s most important to measure?

Why do we focus on TB in PLHIV?

• TB is the most common life-threatening OI and a leading cause of death.
• 21% of 1.8 mil deaths in PLHIV in 2009 were due to TB.
• The risk of developing TB is 30 times greater in PLHIV.
• Rates of TB are enormously high at initiation of ART (15-30%).
• TB is treatable and preventable in PLHIV and early diagnosis and treatment affect mortality.

Are we making progress in reducing TB, worldwide? In Africa? In Asia?

TB Incidence Rates - 2009

• Highest burden in Asia (55% of 3.4 million cases)
• Highest rates in Africa, due to high HIV infection rate ~80% of HIV+ TB cases in Africa
Not enough TB patients are being diagnosed.
Of those diagnosed, not enough start and complete treatment.
Of those with no TB, not enough are receiving IPT.
Of PLHIV with TB, not enough are on ART and ART is not started early enough.
So, how can we do a better job?

- Intensified TB case finding (ICF)
- Isoniazid preventive therapy (IPT)
- Infection control
- Early initiation of ART

Key Recommendations of new WHO ICF/IPT Guidelines

- Screen all PLHIV for TB using this algorithm:
  - any current cough, fever, weight loss or night sweats
  - If no symptoms, offer IPT.
  - If yes symptoms, evaluate for TB & other causes.
  - PLHIV who have unknown or + TST and unlikely to have active TB should receive 6 months IPT.
  - Consider using 36 months of IPT.
  - TST is not a requirement for initiating IPT, but those with a + TST benefit more from IPT.

Isoniazid Preventive Therapy (IPT) for HIV-infected adults

- Clinical trials of 6 months IPT in TST+ Ugandan & Zambian PLHIV showed a 70% efficacy.
- However benefit lost within 6-30 months after stopping IPT.
- Molecular epidemiologic studies in Africa have demonstrated high rates of re-infection with TB.
- Hypothesis of Botswana IPT RCT: continuous IPT will better prevent TB than 6 month short course.

Samandari et al., in press

Botswana IPT trial (36 months INH vs 6 months INH) in PLHIV

- The benefit of 6 months of IPT was lost in less than 6 months after treatment completion in Botswana.
- Continuous IPT (36 months) prevented TB in TST+ with 92% efficacy.
- ART's effect on TB prevention was smaller than IPT but additive for TST+.
- In TST negatives, 36 months of IPT did not prevent TB any better than placebo.
- Only ART benefited TST negatives with a 50% reduction in TB incidence.
- TST negatives may be unnecessarily exposed to harm from IPT.

Samandari et al., In press
When should you start ART in TB patients and when, to prevent TB in PLHIV?

- Treat all patients with CD4 counts of < 350.
- Treat all patients with WHO clinical stage 3 and 4 irrespective of CD4 count.
  For prevention of TB:
- Identify HIV infection early.
- Start care and initiation of ART early.

When should you start ART during TB treatment?

- Final data from SAPIT* (#39LB, Karim et al, U of KZN) and ACTG 5221 (#38, Havlir et al) on when to start ART. Starting ART within 2 weeks of starting TB treatment in patients with CD4 less than 50 reduces mortality and prolongs AIDS-free survival. For TB patients with CD4 greater than 50, can wait for 2 months to start ART.

*Starting Anti-retroviral therapy at 3 points in Tuberculosis Treatment.

What should we be doing about preventing TB transmission in outpatient facilities?

2009 WHO TB infection control policy
Health Care Facility Measures

- Managerial activities
  - Administrative controls
    - Triage, separation, cough etiquette, minimize time in health care settings
- Environmental controls
  - Ventilation systems, UVGI
- Personal protective equipment
  - Respirators, masks

Facility-level Managerial activities

- Identify or strengthen a local infection control committee
- Develop a comprehensive and budgeted facility plan
  - Address human resources, policies and procedures
- Ensure health facility design, construction or renovation addresses TB infection control
- Conduct surveillance for TB disease among HCWs
- Promote timely and quality lab services
- Address advocacy, communication and social mobilization
- Conduct continuous quality improvement and monitoring and evaluation activities

Changes in Focus of New Policy

- Minimizing time spent in health facilities = less hospitalization
- Greater focus on design of buildings and use of space
- Importance of protecting health care workers and community from contracting TB in health facilities
- Encourages health care workers to receive TB and HIV prevention and care services and to reduce exposure to TB
- Emphasizes community involvement and education to reduce stigma of TB and TB infection control practices

What is Xpert MTB/Rif?

- A new fully automated molecular diagnostic test for TB, designed for use close to the point of patient care.
- Based on DNA polymerase chain reaction, done in a closed-system to detect the presence of M. tuberculosis as well as rifampicin resistance directly from sputum samples.
- Presents minimal biosafety risk to lab staff.
- Results available within 100 minutes.

What are potential benefits of Xpert MTB/RIF?

- Increased sensitivity over smear microscopy (91% vs. 29% in HIV-infected individuals)
- Early initiation of TB treatment - reduced transmission, morbidity, and mortality
- Early ability to separate MDR TB patients from others
- Suitable for use at district and sub-district level
- Minimal training needed
- Minimal biosafety concerns
GeneXpert MTB/RIF – a game changer?

- Mean time to detection of disease
  - Xpert MTB/RIF – 100 minutes
  - Microscopy – 1 day
  - Liquid culture – 17 days
  - Solid culture – > 30 days
- Mean time to detection of rifampin resistance
  - Xpert MTB/RIF – 100 minutes
  - Phenotypic DST – 75 days

WHO Guidance, Dec 2010

- Xpert MTB/RIF should be used as the initial diagnostic test rather than conventional microscopy, culture, and DST in individuals suspected of MDRTB or HIV-associated TB.

So much to monitor…how should we prioritize?
You are already monitoring and improving the quality of TB services!

- You have indicators for:
  - TB clinical symptom screening
  - TB diagnostic evaluation
  - Referral to TB clinic
  - TB medication registration
  - Latent TB infection screening
- You have developed specific TB screening forms.
- You have initiated IPT, placed a red sticker on patient records, and developed an INH register to track patients.
- You have developed methods of tracing patients LTFU.

Top ten recommendations for improving quality of TB services in HIV care and treatment programs.

1. Know the TB epidemic in your community.
2. Develop a TB suspect register.
3. Monitor turn-around-time for lab results.
4. Monitor triage and separation of coughers.
5. Do simple cohort review on a periodic basis
   - Number of PLHIV screened for symptoms of TB
   - Number screened positive
   - Number diagnosed
   - Number on treatment
   - Number completing treatment

Top ten recommendations for improving quality of TB services in HIV care and treatment programs.

1. Do clinic register reviews—compare practices across clinics.
2. Hold joint monthly meetings with HIV and TB clinic staff to identify barriers and solutions to effective service delivery.
3. Conduct surveillance of new cases of TB disease in facility health care workers and staff.
4. Identify personnel dedicated to TB/HIV

Top recommendation for improving quality of TB services in HIV care and treatment programs.

- One! Do TB symptom screen on all PLHIV at every visit to HIV care and treatment services.
Title: What's New in TB?
Speaker: Bess Miller, MD

Overview of presentation:

- Tuberculosis (TB) is the most common life-threatening opportunistic infection
- It is a leading cause of death among people living with HIV/AIDS (PLWHA)
- The risk of developing TB is 30 times greater in PLWHA.
- TB is both treatable and preventable in PLWHA and early diagnosis and treatment affect mortality outcomes.

Review of current statistics of tuberculosis world-wide reveal the following trends: (1) under-diagnosis of TB; (2) challenges with the initiation and completion of treatment; (3) under-use of IPT for TB(-) patients; (4) slow/late initiation of ART for PLWHA with TB.

- A review of new strategies, technologies, and WHO recommendations to improve these aspects of TB care:
  - Intensified TB case finding (ICF). The new WHO ICF/IPT guidelines recommend screening of all PLWHA for TB with any current cough, fever, weight loss, or night sweats. If no symptoms are identified, IPT should be offered. If symptoms are identified, the patient should be evaluated for TB. PLWHA who have unknown or positive TST and are unlikely to have active TB should receive six months of IPT. Those with a positive TST benefit more from IPT. Children living with HIV who have poor weight gain, fever, current cough, or contact history should be evaluated. If evaluation shows no TB, children should be offered IPT, regardless of age.
  - Isoniazid prevention therapy (IPT). Samandari et al. recently conducted a randomized control IPT trial which found that continuous IPT (36 months as proxy for life-long) significantly reduced TB incidence as compared to 6 months of IPT. ARTs effect on TB prevention was smaller than IPT but additive.
  - ART initiation. In PLWHA with TB, ART should be initiated in all patients with CD4 counts under 350 and all patients with WHO clinical stage 3 and 4 (irrespective of CD4 count). To prevent TB in PLWHA, identify HIV infection early and start care/initiation of ART early.
  - Infection Control. Strategies to address infection control include measures to be taken at the (1) health care facility; (2) facility-level management; (3) policy level.

- New technology will play an important role in addressing TB.
  - The Gene Xpert MTB/Rif is a new, fully automated molecular diagnostic test, designed for use close to the point of patient care.
  - This technology decreases the mean time of detection of disease and rifampin resistance.
  - It has the potential to allow for early initiation of treatment and requires minimal training/biosafety concerns.
  - Current challenges associated with this new technology include the cost of the device/test and existing systems of treatment.

Review of the top ten recommendations for improving the quality of TB Services in HIV care and treatment programs.

1. Know the TB epidemic in your community.
2. Develop a TB suspect register.
3. Monitor turn-around-time for lab results.
4. Monitor triage and separation of coughers.
5. Conduct simple cohort review on a periodic basis.
6. Conduct clinic register reviews-compare practices across clinics
7. Hold join monthly meetings with HIV and TB clinic staff to identify barriers and solutions to effective service delivery.
8. Conduct surveillance of new cases of TB disease in facility health care workers and staff
9. Identify personnel dedicated to TB/HIV
10. Do TB symptom screen on all PLWHA at every visit to HIV care and treatment services.
Measuring for Improvement: Can QI Facilitate Retention in HIV Care?

Bruce D. Agins, MD MPH
Director, HEALTHQUAL International
Medical Director, NY State Dept of Health
March, 2011
ACLN II - WINDHOEK

Overview
- What do we hope to accomplish through implementation of QI?
- Measuring retention
- Improvement work and its challenges
- Challenges and conclusion

Continuum Engagement in Care

Unaware of HIV Status (not tested or never received results)
Know HIV Status (not referred to care; didn't keep referral)
May Be Receiving Other Medical Care But Not HIV Care
Entered HIV Primary Medical Care But Dropped Out (lost to follow-up)
In and Out of HIV Care or Infrequent User
Fully Engaged in HIV Primary Medical Care

Health Resources Service Administration (HRSA)

What can QI contribute?
- Focus on systems of care delivery
- Organization level vs. patient-level
- Systematize processes of measurement
- Routinize improvement of retention and manage it at the clinic level
- Innovative (thinking "out of the box") interventions

What does it really mean to be retained?

- The patient is engaged in care
  - OR
- The clinic has the patient on its active roster

At what level do we measure retention?

- A) The patient
- B) The clinic
- C) The district
- D) The region/state
- E) The nation
- F) All of the above

Clarifying some issues of meaning

- Retention is to adherence as....
  - HIV care is to ART care?

![Diagram of numerator and denominator with eligible patients/samples and case management steps]

**Step 1: Create a Case List**
- Identify all active patients that visited the clinic during a given time interval
- Example: all patients that visited Clinic A in the year between January 2009 and January 2010

**Step 2: Define a Measure**
- Pick an item such as Retention Rate and define it
- Example: Retention Rate is the number of active patients visiting Clinic A in each half of the year

**Step 3: Analyze Ways to Improve the Performance of the Measure**
- Example: Account for all patients who were not retained and brainstorm improvements
  - Attempt to account for all patients: Did they die or transfer care?
  - Analyze the list of those not accounted for and identify common characteristics
  - Develop interventions to target these populations

**Step 4: Incorporate improvements and repeat**
- Example: Perform common retention interventions and update case list the following year
  - 1. Remove all patients who have since died or transferred care
  - 2. Add new patients
  - 3. Recalculate retention rate
Measurement: After the first cycle

- Refresh your active case list
- Maintain cohort to monitor retention over longer periods of time

Four Retention Measures

- Missed visit
- No visit within 3 months
- At least 2 visits in the year separated by at least 3 months
- 2 visits during the year, at least one in each six month half of the year
**Measurement: Challenges**

- Arbitrariness of time interval
- Gathering data from community interventions
- Integrating the tracking into routine operations
- District level data about retention
- and Data Quality...

**Uganda Longitudinal Results (n = #patients / # clinics)**

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<tr>
<th>Country</th>
<th>Round</th>
<th>Numerator</th>
<th>Denominator</th>
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<tr>
<td>Uganda</td>
<td>1-4</td>
<td>n=1,972</td>
<td>n=1,160</td>
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**Namibia Longitudinal Results (n = #patients / # clinics)**

<table>
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<tr>
<th>Country</th>
<th>Round</th>
<th>Numerator</th>
<th>Denominator</th>
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<tbody>
<tr>
<td>Namibia</td>
<td>1-4</td>
<td>n=1,507</td>
<td>n=1,082</td>
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**Haiti Longitudinal Results (n = #patients / # clinics)**

<table>
<thead>
<tr>
<th>Country</th>
<th>Round</th>
<th>Numerator</th>
<th>Denominator</th>
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<tbody>
<tr>
<td>Haiti</td>
<td>1-3</td>
<td>n=6,752</td>
<td>n=6,004</td>
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**Namibia Visits Indicator Definition**

- **Definition**: Regular clinical visits
- **Numerator**: Number of patients with at least 1 visit in the past 6 months
- **Denominator**: Number of patients with at least 1 visit in the past 6 months

**Haiti Visits Indicator Definition**

- **Definition**: Regular clinical visits
- **Numerator**: Number of patients with at least 1 visit in the past 6 months
- **Denominator**: Number of patients with at least 1 visit in the past 6 months
Model for Improvement

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

Model for Improvement

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

QI Model

1. Measure
2. Test changes
3. Apply changes
4. Remeasure

Categories of Interventions

- Chronic care model
  - Redesign care delivery
  - Decision support
  - Improve patients’ abilities to manage their own illness
  - Improving community support and linkages
  - Improving longitudinal record-keeping
  - Organizational support

Fishbone analysis: root causes for missed appointment and LTFUs

Source: NHDPQUAL 2010
Chronic Care Model

Decision Support
- Informed, Activated Patient
- Prepared, Proactive Practice Team
- Improved Functional and Clinical Outcomes

Productive Interactions
- Delivery System Design
- Organization of Services
- Clinical Information Systems

System Design
- Community Resources and Policies
- Self-Management Support

Client
- HCW
- Systems

- Adverse drug effects
- Staff motivation
- Facility hours

- Client satisfaction
- Staff attitude
- Space

- Clinic location
- Lack of knowledge
- Infrastructure

- Stigma/Disclosure
- Ethics/Professionalism
- Patient flow

- Sociocultural
- Waiting Time

- Feeling Better
- Ratio of HCW/patients

- Misconception/Lack of understanding
- Lack of integrative services

- Staff retention
- Staff Shortages

- Stock-outs

Quality Enhancing Interventions


Patient-Focused Interventions

Quality Enhancing Interventions

- Health literacy
- Shared clinical decision-making
- Self-care
- Safety
- Access
- Patient experience

Regulatory

Quality Enhancing Interventions

- Health care institution
  - Accreditation
  - Inspection
  - Target Setting
  - Standard Setting
- Professions
  - Licensure
  - Certification
  - Credentialing
- Markets
  - Patient protection
  - Capacity and supply
  - Managed competition
Incentives
Quality Enhancing Interventions
• Financial
  – Individual provider
  – Organizational
  – Patient
• Non-financial
  – Autonomy
  – Reputation
  – Developmental opportunity

Data-driven & IT
Quality Enhancing Interventions
• Public reporting
• Performance monitoring and feedback
• Information knowledge and management
  – EMR
  – Decision support for clinician/patients

Organizational Interventions
Quality Enhancing Interventions
• Organizational Change
  – QI
  – Culture change
  – Professional behavior change
• Care Processes
  – QA
  – Safety and risk management
  – Performance measurement and reporting

Health Care Delivery Models
Quality Enhancing Interventions
• Disease or population groups
  – Prevention
  – Health promotion
  – Primary care
  – Acute/chronic/palliative care

Leatherman: What’s missing?
• Community level interventions

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<thead>
<tr>
<th>Community Level</th>
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<tbody>
<tr>
<td>Community Partnership and Resources</td>
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<tr>
<td>• Community Health Workers</td>
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<td>• Outreach Workers</td>
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<td>• Home Care Workers</td>
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<td>• TX Supporters</td>
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<td>• Clinic Reminders</td>
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<td>• DIO Workers</td>
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<td>• PHIA Involvement</td>
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<td>• (e.g., Mothers to Mothers)</td>
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<td>• Patient Networks</td>
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<td>• Community Councils and Leaders</td>
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<td>• Radio Outreach</td>
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<td>• Involvement of CBOS/NGOS</td>
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<td>• Location of services within the community</td>
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<td>• TX Distribution Points</td>
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<td>• SMS Reminders</td>
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<td>• Education</td>
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### Community Level Innovation


### Interventions: Challenges

- **Classification**
  - Is a treatment supporter the same as a DOT worker as an outreach worker as a navigator?
- **Standardization**
  - Are all reminder calls and messages the same?
  - Who did it? Timeframe before or after visit? Content of intervention messages/patient education?
- **Bundling and Unbundling**
  - Are interventions conducted simultaneously? If multiple are counted, does sequence really matter?
- **Coordination**
  - Implementing multi-agency interventions, involving community organizations and clinics

### QI: Limitations

- Documentation of improvement work
- Linking interventions to causality

### Lessons from the US

- Information systems make it easier
- Multiple interventions usually necessary
- Specific interventions don’t necessarily transfer from clinic to clinic
- Frequent contact with clinic team makes a difference
- Early retention seems to correlate with long-term retention and better outcomes

### What can we do now?

- Promote retention work at all levels
- Foster better record-keeping systems to keep accurate case lists of active patients
- Conduct improvement projects to learn what works in each setting
- Link tested interventions to barriers identified during process investigation
- Document details of interventions and rethink classification scheme
- Strengthen community interventions and involve peers
- Ask patients now why they don’t come back as part of QI work process investigation

### What can we do now?

- Routinely measure and improve retention in all HIV ambulatory clinics
- Start linking retention work, including measurement, with community systems
Conclusions and Way Forward

- Need standardized measurement scheme
- Common taxonomy for interventions for communication
- Consider multiple sources of care within a community or region
- Go to the community:
  - They know...
  - Multiple interventions can be linked
  - Stigma reduction
  - Cultural appropriateness
- Involve peers
- Prepare for retaining youth in care
- Use data for improvement...and measure improvements

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HEALTHQUAL Teams in Uganda, Mozambique, Namibia, Nigeria, Haiti, Guyana, Kenya, Botswana, Swaziland, Thailand, Rwanda
Title: Measuring for Improvement: Can QI Facilitate Retention in HIV Care

Speaker: Bruce D. Agins, MD, MPH

Overview of presentation:

- Retention of PLWHA in HIV primary medical care, especially those who are disengaged and sporadic users, is a major priority for both providers and public health.
- Retention in medical care and adherence to HAART is associated with patient clinical outcomes, including health-related quality of life, transmission behavior, and changes in CD4/VL count.
- Efforts to improve retention often lack a systematized process to allow for sustainable gains and face specific client/HCW/system-level challenges.
- Using QI, retention can be addressed at the organization, clinic, and patient level. The improvement process and the associated interventions can help establish systems to continually measure and improve retention. When investigating retention, the quality improvement cycle includes four steps: (1) create a case list; (2) define a measure; (3) analyze ways to improve the performance of the measure; (4) incorporate improvements and repeat.
  - Create a Case List
    The first step of this process, creation of an accurate case list, is extremely important and involves the following steps: (1) identify all your active patients; (2) determine how many of these patients are still engaged in care; (3) account for those patients not in care; (4) calculate new case lists. It is important to continually refresh your active case list and maintain a patient cohort (clinic based or system based) to monitor retention over time.
  - Define a Measure
    Current measures of retention vary across the literature and the HEALTHQUAL International countries. Examples of measures include: missed visits, # of visits within a specific time period, and time period with no visits. HEALTHQUAL participants have varied their definitions of retention by duration between clinic visits and ART status. Overall, challenges to performance measurement include: (1) arbitrariness of time interval; (2) gathering data from community interventions; (3) integrating tracking into routine operations; (4) obtaining/utilizing district level retention data.
- Improvement interventions can target different areas/categories.
  - When approaching retention using the chronic care model, areas for intervention include: care delivery redesign, decision support, patient self-management, community support, organizational support, and longitudinal record keeping.
  - Retention interventions identified by HEALTHQUAL countries at the 2010 ACLN were categorized under three levels: (1) Ministry of Health-increasing access and availability; (2) Clinic; (3) Community-community partnership and resources.
    - Community partnerships have important benefits: local knowledge, multiple interventions can be linked, stigma reduction and cultural appropriateness.
  - Categories of quality enhancing interventions identified by Leatherman include: patient focused, regulatory, incentives, data driven/IT, organizational, and health care delivery models. A component not addressed in this review is community level interventions.
- Challenges to implementing quality improvement work include:
  - (1) standardization and classification of interventions;
  - (2) conducting interventions simultaneously;
  - (3) coordination of interventions.
- Limitations to this work include documentation and linking interventions to causality.
- Based on retention work from the United States, early retention seems to correlate with long-term retention and better outcomes.
- Frequent contact with clinic teams is also associated with improved outcomes.
- To better sustain QI work, information systems make measurement and improvement easier.
- To further retention work among the HEALTHQUAL countries, the following next steps were identified.
  - (1) Promote retention work at all levels and foster better record-keeping systems to maintain accurate case lists.
  - (2) Conduct improvement projects and link tested interventions to barriers identified during process investigation.
  - (3) Strengthen community interventions and involve peers and consumers in the process to investigate and improve retention rates.
OBJECTIVES:

- To provide a forum for the exchange of information and ideas to advance all country programs.
- Strategies to build a sustainable framework for communication between countries.
- To learn what works (and what does not work).

Communications Tools

- Newsletter
- Emails
- HEALTHQUAL.ORG
- Project Space
- Posters
- Abstracts
- Manuscripts

HEALTHQUAL Publications

**Newsletter**

1. Quality improvement case studies.
   - ACLN
   - Retention
   - QI Highlights

**Briefs**

2. A series of regular, brief, concise QI narratives and related PM data.
   - TB and QI
   - Partners' corner
   - CD4 monitoring

**EMAIL UPDATES**

- Newsletter
- Resources
- Programmatic updates

"site-to-site / nation-to-nation"

-Leatherman et al.

Joshua Bardfield, MPH
Program Communications Manager
HEALTHQUAL International

Building Cross Country Communication

Joshua Bardfield, MPH
Program Communications Manager
HEALTHQUAL International
Collection and dissemination of QI information is essential.

To share successful strategies and barriers that have been overcome

To build a compelling website about quality in each of your countries.

Promoting communication between countries

Regular QI updates as a centerpiece on our homepage

QI tools and resources:
- QI narratives
- Presentations
- Publications
- Video

Prominence of QI resources, tools and publications

Unique country pages with QI projects and data

What is Project Space?

- A password protected, web-based resource for storing and sharing program documents.
- Includes a calendar, discussion board and listserv.
- You decide who the users are and the level of access they have –
  - guests
  - content editors
  - administrators who can invite new users and make changes to the space itself

Project Space

Comprehensive warehouse of program documents and QI resources

All presentations, discussion notes and resources from the 2010 and 2011 ACLN

Newsletters, conference posters, organizational forms, presentations
Project Space

Why Project Space?

- Online file storage, sharing and collaboration tools are increasingly seen as a key programmatic resource across professional fields.

  - This becomes critical as:
    - the volume of programmatic information grows
    - the level of documentation increases and becomes more complex
    - geographic spread increases

- Project space has the potential to be a powerful program tool.

Challenges

- Internet connectivity
- Branding/ownership issues
- Users and user rights
- Ease of use
- What else?

Next Steps

Workplan

- Use feedback from ACLN to develop a work plan to reinforce cross country communication

Test and Implement

- Test and implement strategies identified.

Ongoing Feedback

- Your opinion is critical.

THANK YOU!
Open Space

HEALTHQUAL International
All-Country Learning Network
Windhoek, Namibia
14 March, 2011

What is Open Space?

- Open Space is not rocket science.
- A self-organizing method to facilitate participant-driven learning sessions.
- No pre-planned agenda. The sessions are developed and conducted by the participants and reflect what is important to them.
- Open Space ≠ Optional Space

The 4 Principles of Open Space

- The participants who come are the right people
- Whatever happens is the only thing that could have happened (present centered)
- When it starts is the right time to start
- When it’s over, it’s over.

The 1 Law of Open Space

The Law of 2 Feet

Go to where you can contribute and be engaged the most

Developing The Agenda

1. Participants choose topics for sessions that they will facilitate and own.
2. Topics with facilitators’ names are posted on the agenda wall.
3. Participants sign up for sessions.
4. HQ staff will develop the schedule.
5. New sessions can be added at any time.
6. Short report back session at the end of each day.

The Theme

- Whatever helps you do the work and grow the program.
Role of HEALTHQUAL Staff

- Answer technical questions if they arise.
- Keep the conversation focused on quality if it goes off track.
- Take notes at each session.
Open Space Topic: Customer Satisfaction

Facilitator: Tim Chadborn
March 15, 2011

Key Questions Raised

- What do we mean by customer satisfaction and how does this relate to quality services?
- Does awareness need to be raised among patients, policy makers, and general public of service standards, (what services are available)?
- Are customer expectations of services in line with perceptions of services to be provided (perhaps patients need to be referred to where services exist)?
- Do we need to balance service standards and client expectations (perhaps involve consumers in developing service standards)?
- Is satisfaction linked to consumer involvement?

Issues to Monitor Customer Satisfaction

- Patient flow/waiting times
- Healthcare worker staffing and attitudes
- Clinic environment
- Services available including medication
- Distance
- Accessibility
- Fees
- Opening Times
- Location
- Provider/patient interactions
- Knowledge expertise
- Safety of services/adverse events
- Confidentiality

Methodologies to assess customer satisfaction (quantitative vs. qualitative)

- Written exit questionnaires
- Interviews
- Consumers Forums
- Focus groups
- Suggestion Boxes
- Patient Help-Line
- Technology
- For all above, sample size should be based on patient flow rates, how many questions to ask, and actual time period to administer/collect/analyze surveys?

Challenges Raised

- Customer bias/subjectivity
- Staff influencing process
- Having representative enough sample size
- Resources/cost
- Skills (How to conduct consumer satisfaction)
- Literacy/language issues
- What types of rating processes to use (ex: likert scale, )

Outcomes

- Attitude of health care workers affects utility of services (difficult to measure impact)
- Clients have completed exit surveys to address waiting times, patient flow, questions about reception, counseling/testing, and how patients feels about services offered (all which can be used to improve service delivery).
- Suggestion boxes may not work if staff don’t follow policy/procedures for use of suggestion boxes
- Client satisfaction (qualitative/quantitative approaches) study concluded that patients are not aware of rights/service standards.
- Who administers surveys may have impact on information provided by patients (peers, contractors, students, interns, other trusted community stakeholders)
Topic: Customer Satisfaction Surveys
Facilitator: Tim Chadborn

Issues Discussed:

- What do we mean by customer satisfaction and how does this relate to quality services?
- What is customers expectation of service and what is perception of service? What did survey find. Is expectation in line with perceptions?
- What is provider expectation? Need to balance service standards and client expectations? Perhaps involve consumers in developing service standards
- If customer expectations are different than service standards, consumers should understand that sometime expectations may be outside of service standards? Perhaps patients need to be referred to where that service exist?
- Raise awareness among patients, policy makers, and general public of service standards, service availability
- Prior to conducting client satisfaction study, address gaps you know about first. First When issues are unknown, conduct satisfaction

Define/Brainstorm Issues to Track/Monitor:

<table>
<thead>
<tr>
<th>Facility staffing</th>
<th>Distance/Accessibility/Fees/Opening Times/Location</th>
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<tbody>
<tr>
<td>Patient flow/waiting times</td>
<td>Provider/patient interactions</td>
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<tr>
<td>Health Care Worker Attitudes</td>
<td>Knowledge expertise</td>
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<td>Environment</td>
<td>Safety of services/adverse events</td>
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<tr>
<td>Services Available including medication</td>
<td>Confidentiality</td>
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</table>

Examples of customer satisfaction:

- Kenya: Impact Evaluation (Qualitative aspects including focus groups). Health care workers need to be patient-friendly. Provides feedback for QI. Attitude of health care workers affects utility of services. Difficult to measure impact.
- Survey looks at waiting time, flow of patient through site. Exit survey looks at things like waiting time.
- Exit Survey ask questions about reception, counseling, how patients feel about all services which can be used to improve service delivery.

Study to look at client satisfaction (qualitative/quantitative approaches). Study concluded that patients are not aware of rights/standards. Services are good, raised awareness of client rights – Patient Awareness!

Methodologies (quantitative vs. qualitative) customer satisfaction surveys?

<table>
<thead>
<tr>
<th>Written exit questionnaires</th>
<th>Interviews</th>
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<tr>
<td>Focus groups</td>
<td>Suggestion boxes</td>
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<td>Patient help line</td>
<td>Consumers forum</td>
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<td>Technology</td>
<td>Random sampling</td>
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<tr>
<td>Patient flow</td>
<td>Likert scales</td>
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</tbody>
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For quantitative quality improvement methodologies:

- Use combination of consumer forums, written questionnaires and exit interviews conducted by staff or someone else

Challenges with conducting consumer forums, written questionnaires and exit interviews:

- Bias/Subjectivity
- Staff influencing process
- Representative enough sample
- Resources/cost
- Skills – How to conduct consumer satisfaction, Literacy/language issues

Ideas to implement consumer forums, written questionnaires and exit interviews:

Peers, Contractor, Students, Interns, Community Members who are trusted brokers
Open Space Topic: Healthcare Financing in QI Activities
Facilitator: Micah Anyona

Three Issues Discussed
• Funding at various levels and from different sources: public and private
• Resource planning, mobilization and allocation
• Resource accountability

Three Outcomes Discussed
• Cost benefit analysis: cost effectiveness and savings resulting from QI activities.
• Need to build capacity among all staff in management of financial resources.
• Achieve more quality with less!
Topic: Healthcare Financing in QI Activities
Facilitator: Micah Anyona (Kenya)

Aim of session: Need to define an essential package which is seen as an entry point for governments to commit to funding for improvement activities.

Issues discussed:

Funding:
- QI needs to be quantified in terms of dollars, i.e., savings by investing in treatment. Money spent up front is money later saved.
- Healthcare financing issues to be examined at the national level and the clinic level.
- How will we sustain the program? Who is initiating? Is it the government or is it at the grassroots level filtering up?
- There may be a national budget for health, but there are a lot of things throughout the health sector that require financing and this complicates the budget.
- Need to identify the various funding sources at the national level?

What are the broad areas that we must look at for HCF in QI?
- Ministry of health, private-public partnerships
- Resource utilization and ensuring those resources are used appropriately
- Need to evaluate the quality of a project against resources utilized
- Allocation of funds to relevant issues
- Limitations of funding imposed by donor agencies
- The need for good planning: work plan and budgeting – prioritization
- Coordination at the local and national levels to prevent duplication or competition
- Motivation to seek out and apply for available funds
- Need for a strong financial auditing system
- Development of skilled personnel to implement the proposed work
- Staff planning and training in financial management as part of QI
- Financial reporting mechanisms – need to demonstrate cost savings generated by QI
- Application of best practices to financial management
- Ensuring the flow of financial resources to support activities – cutting waste, preventing stockouts of commodities which impact service delivery
- Accountability, cost-effectiveness, analysis
- Technical and financial sustainability

Achieve more with less!
Open Space Topic: QA/QI
Facilitator: Catherine Herzog

Three Issues Discussed
1) Defining QA and QI
2) Can QA and QI indicators be integrated?
3) The roles at the facility, local, and national, and international level for defining QA/QI and working on potential integration

Three Outcomes Discussed
1) QA is based on meeting defined standards; individuals responsible; used for auditing and accreditation. QI is based on continuous improvement; teamwork and facility-wide process; feeds back into the system
2) Need a set of national core indicators and many local, optional indicators
3) Training materials need to cover both QI and QA, even if they are often done separately in practice
Topic: QA/QI
Facilitator: Catherine Herzog
Issues Discussed:

Defining QA and QI
- QA is based on meeting defined standards; individuals responsible; used for auditing and accreditation.
- QI is based on continuous improvement; teamwork and facility-wide process; feeds back into the system.

Can QA and QI indicators be integrated?
- Need a set of national core indicators and many local, optional indicators
- QA is based on guidelines and policies and can’t be changed. QI is how you’re getting there—would need to know if these are handled by different people and how to get these groups to talk to each other
- Challenges with reporting; HIVQUAL is every 6 months, national QA is due quarterly
- Need to merge the tools themselves, not just the timelines
- Some funders and donors have their own required indicators, need to merge them for QA. For QI, each site runs a program and has unique challenges. Based on QA report, clinics develop QI projects and indicators for the QI projects. Each site develops their own indicators for their QI project and the project is linked to improving quality of care and meeting national QA standards

The roles at the facility, local, and national, and international level for defining QA/QI and working on potential integration
- Training materials need to cover both QI and QA, even if they are often done separately in practice
- Uganda QA dept. oversees guidelines and develops standards. QI has developed separately in the HIV program, trying to pull it into the QA program
- People doing QA need to be pulled into QI
Four Issues Discussed

- Challenges
  - Not understanding purpose or goals
  - Staff issues: competency, turnover, extra workload, demotivation, problems with change
  - Lack of political commitment
  - Computers and other IT

Four Issues Discussed (cont.)

- Way Forward
  - Create culture of quality in all areas of practice
  - Build staff capacity in QI, QM, and IT
  - Include quality as part of school curriculum
  - Advocacy to leadership: ensure political commitment
- Indicators
  - Use national guidelines to select indicators
  - Prevention
  - Treatment
  - Care and support

Four Issues Discussed

- Sustainability
  - Ensure that countries can take over programs when funders are not there
  - Create a quality culture
  - Information systems
  - Policymaker commitment and advocacy

Two Outcomes Discussed

- Monitoring and Evaluation of QI Progress/Outcomes
  - Continuous quality management and improvement
- Successful integration of quality into all levels of education
Topic: Integrating QI Into Primary Care  
Facilitator: Ernest Ekong, MD, MPH, FACP  

Issues Discussed:

Challenges
- Purpose/goals  
- Computers  
- Staff turnover, demotivation (capacity), attrition  
- IT competency  
- Extra work load  
- Change → problem  
- Misunderstanding of program  
- Political commitment/advocacy  
- Need to incorporate into all service areas  
- Different funders/programs – funding base  
- Information systems  
  - The needs of different programs will be different, and QI must be integrated into all units (not just HIV/AIDS). Does one overall program work for all types of units?  
  - Different funders require different things. How can we integrate those requirements?  
  - Higher funding means better quality. Are there other programs that will provide money for QI in other areas, like primary care?  
  - Moving from HIVQUAL to HEALTHQUAL, looking at primary health care, we're expecting one person to provide quality care.  
  - Information systems are necessary to track quality over time.  
  - Policymakers have to be engaged in the process. These are country programs, the focus should be on what the country needs.  
    - Example: When HIVQUAL came to Guyana, Minister of Health wanted to use it to strengthen primary care, which is how HEALTHQUAL was born.

How do we integrate primary care and quality?
- Create a culture of quality at all levels of staff  
- QI training in all pre-service training (as part of curriculum)  
- Involve administration to get support  
- There is already a model in place; we should learn from it. We can use the skills that have already been developed via HIVQUAL.  
- Working with primary care/non-HIV colleagues  
- Train staff on QI basics according to their level

Primary care indicators
- Select indicators based on national guidelines  
- Important indicators to include:  
  - Prevention/education  
  - Treatment  
  - Care support  
- Determine whether disease-specific indicators are appropriate, or whether general indicators are more appropriate  
- The goal is to reach a point where countries can take over. PEPFAR has created the culture, but now countries are moving towards standing on their own.  
- When PEPFAR goes, will the same indicators still remain?  
- Evaluate what was present before donor money came in and use that infrastructure  
- Continued investment in producing buy-in to the QI culture
Open Space Topic: Can we improve the quality of care without improving staffing levels?

Facilitator: Dr. Mahwire

Three Issues Discussed

- Yes We Can!
- Strategies to use QI to address issues associated with staffing shortages
  - Working smarter not harder
  - Patient triage and patient flow
  - Improving documentation
    - Show improvements
    - Task shifting
      - Role of peer volunteers and patient experts

Three Outcomes Discussed

Successful Quality Improvement (QI) Work Can have specific benefits for staff:
- Improved skills/knowledge (data analysis)
- Empowerment
- Improves moral and motivation
- Prevent burnout
- Working in a team
- Recognition:
  - newsletters/presentations/storyboard
  - nonfinancial awards
  - Performance base/quality based rewards

Other Areas Addressed

- Quality at the facility/regional/national level
  - Idea of developing/implementing indicators at higher levels to assess their role in quality management/administration
    - Set specific goals for these levels and ensure accountability
    - Use of benchmarking data
Topic: Healthcare Staffing and Quality Improvement

Facilitator: Dr. Mahwire

Aim of Session: “Working smarter, not harder:” using quality improvement when confronting staff shortages.

Issues Discussed:

Successful Quality Improvement (QI) work can have specific benefits for clinic staff:
- Improved skills, e.g. data analysis
- Learning options/staff development
- Staff empowerment
- Improves moral and motivation
- Prevents staff burnout
- Enhances team building
- Gain recognition through different outlets (e.g. newsletters/presentations/storyboards)

Using Quality Improvement (QI) to address staffing issues:
- Address/analyze patient flow and work through with all staff (organize flow/space)
- QI Strategies
  - Engage all members of the team in the QI process
  - Streamline patient flow. Examples of interventions: (1) Use color coded paper to track patient’s needs; (2) triage patients; (3) task shifting
    - Task shifting: change adapt roles within the clinic to improve quality and reduce unnecessary workload burdens
    - Utilizing expert patients-help guide the patient through the healthcare system
      - Areas to address: (1) confidentiality; (2) legality; (3) remuneration/rewards

Quality improvement at the national level /regional level/ facility level:
- Ensuring quality improvement work from higher levels (regional/national/administrative)
  - Review facility-level data
  - Support and provide assistance for regions to develop regional quality management plans
  - Review the frequency of quality trainings
  - Logistic support of testing/campaigns/systematic improvements
  - Create and review indicators as appropriate to regional/national level
  - Identify challenge areas across facilities
  - Benchmarking across programs-identify region-wide/national priorities
    - Identify common challenge areas and areas of improvement
  - Support local and regional committees to establish the quality roles/responsibilities to ensure accountability

Awarding facilities for quality work:
- Grants: Investigate those grants that support quality work
- Performance Based Financing:
  - Associated Concerns
    - Sometimes the one doing the worst-needs the most help
  - Works if there is an established standard of quality (based on facility-type)
Three main issues discussed

- **TB screening**
  - Not routinely done/ lack of resources (TST, X-ray, low coverage of sputum analysis)/lack of coordination between the TB/HIV programs

- **IPT uptake** is very low in most countries, why? How do we engage clinicians in putting those HIV+ on IPT?
  - Challenges: rule out of TB, monotherapy, resistance, no systems in place

3 Outcomes

- **TB screening**:
  - Accommodate the screening to the available resources
  - Reinforce the coordination between the programs
  - Motivate providers and patients about the importance of having this screening done.

- **IPT**:
  - Commitment of the system
  - Information on the benefits/evidence to the providers
  - Patient involvement/education
Topic: TB and HIV
Facilitators: Marie Lina Excellent, MD and Paula Samo Gudo, MD, MPH

Issues Discussed:

Screening for TB
- Participants discussed relative merits and difficulties of TB screening.
  - Based on resources, some clinics screen all patients with a PPD or TST, while some clinics use a symptom screening only.
    - **TST:** In high-prevalence countries, TST is not recommended because it screens for latent TB. TST also has a downside in that patients must return to the clinic 48-72 hours later for test result. TST also requires maintaining a cold chain.
    - **Symptom screen:** A quick series of questions screening for symptoms which might be associated with TB. This is faster and requires fewer resources than TST, but is highly non-specific to TB and requires more follow-up lab tests like sputum sample or chest x-ray.
  - Tools discussed for screening
    - Haiti has developed a starter package which includes TST, chest x-ray, and sputum analysis offered to all new patients, based on clinical exam and TST.
    - Mozambique: a screening form. Where the form is not available, clinician report screening in the patient chart. Often the screening is done but not documented in the chart, especially when no screening form is available.
    - Kenya: screening form which captures history-taking questions. If any question on the screening was indicative of TB, the clinician should do a detailed physical examination and take a sputum sample.
- In busy clinics, TB screening and in-depth physical examination are often missed. A patient who only sees their provider twice a year does not get the recommended three screenings per year.
- For diagnosis, the decision about whether to diagnose on sputum analysis or chest x-ray was based on resources.
- Co-location of clinic & lab increases feedback to provider. Increasing communication is important for coordinating HIV/TB care.
- Screening in children is particularly difficult. Children often can’t produce good sputum samples, so a chest x-ray is suggested.
- Some countries are trying to expand their TB screening beyond the clinic into the community, w/o being specific to HIV status.
- Creating a standard protocol using HIVQUAL methodology can improve screening rates at the national level. Participants specifically mentioned staff training, management of resources, and screening tools.
- TB screening must be done, regardless of the tool used and while managing limited resources.

Challenges of Isoniazid Prophylaxis
- Excluding active TB in PLWHA: issue of putting a patient with TB on IPT leading to resistance, and that those who would benefit most from IPT (those with low CD4 and latent TB) are those the most at risk for resistance.
- If a patient develops INH-resistant TB, it is hard to say for certain that prophylaxis created that resistance.
- Integrating IPT into the ART system can improve adherence for those who are co-infected and already on ART.
- Guidelines for starting IPT must be made clearer.

Integration of TB/HIV Services
- There is still much separation between TB and HIV programs.
- Chart reviews can identify areas where cooperation opportunities are being missed.
- Participants suggested that any patient coming into TB clinic who is not already known to be HIV positive be referred for an HIV test.
- At every HIV clinical visit, the provider should screen for TB and perform a physical exam.
- Countries have tried different approaches to increase coordination between HIV and TB.
  - Guyana has tried to embed ART into TB clinics by training TB doctors in ART.
  - Namibia has started an initiative where patients referred for sputum sample analysis have an HIV test done as well.
  - Mozambique has piloted a “one-stop shop” model where all information is requested together. First doses of ART are started by the HIV clinician after TB and HIV care are both complete, but otherwise the programs are integrated.
- There are some issues with infection control for co-located services, as you are sending someone with a highly infectious, very serious disease (TB) into a population with compromised immune systems (HIV clinic).
Open Space Topic: Validating Quality Improvement

Facilitator: Dr. Martin Sirengo

Issues Discussed
Two main issues:
• Validation of Performance Measurement Data and processes
• Validation of Quality Improvement Interventions
  – Association/attribute of a specific intervention to an improvement

Validation of Performance Measurement
The “Dos” of Performance Measurement
• The right sample
• Ensure uniform indicator definitions across programs
  – Clear definitions of numerator/denominator
  – Indicator reflective of overall improvement goal
• Right baselines

Why QI Validation?
• Performance Measurement
  – Ensure no over/under reporting
  – Ensure linkage to improved outcomes
• QI project
  – Identifying strong interventions
  – Plans for up-scaling QI activities are systematic
  – Ensure linkage to improved outcomes
• Allows for reproducibility

How to Validate
• How should validation be done?
  – Internal quality audit
  – External
    • Client satisfaction
  – Strategies
    • Test of data tools (multiple reviewers)
    • Validation tool-use checklist to guide process
      – Sample Size
      – Tool
    • Quality control checks

Who and When
Who is responsible?
– Internal: QI Teams
– External: QI Teams from other clinics/levels to review and provide feedback
When?
– As part of reporting requirement
Topic: Validating Quality Improvement
Facilitator: Martin Sirengo, MD

Aim of Session: Discuss the validation processes of performance measurement (PM) data and the validation of quality improvement (QI) interventions.

Issues Discussed:

Elements of Performance Measurement Validation
- Review significance of data
- Reproducible (across sites/across programs)
- Ensure PM processes reflect a thought-through scientific approach
- Ensure uniform indicator definitions across programs
  - Clear definitions of numerator/denominator
  - Indicator reflective of overall improvement goal
  - Address both process and outcomes
- Establish accurate baseline data
- PM data to drive improvement work

Elements of Quality Improvement Validation
- Association/attribution of a specific intervention with an improvement
  - Ensure linkage to improved outcomes
  - Concerns: confounding factors/attribution of a single intervention to an improvement
- Identify strong improvement interventions and apply to a larger scale
- QI methodology is not the same as scientific research

Methods of Validation
- Internal quality audit of PM processes
  - Test of data collection tools
  - Validation tool-Use checklist to guide process
  - Establish quality control checks
- External review-client satisfaction with quality of services

Responsibility for Quality Validation
- Internal: QI Teams
- External: QI teams from other clinics/levels to review and provide feedback
**Open Space Topic:**
Is performance based financing (PBF) a motivation for quality improvement (QI)?

**Facilitator:** Dr. Paula Samo Gudo

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**Issues Discussed**

- Creates unhealthy competition between staff
- It can also be demotivating
- Promotes “gaming” in the system
- Does not look at processes but only the results
  - Results could be completely disconnected from the processes. For example, vaccination rates.
- Not sustainable over time
- Should quality be rewarded with money?

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**Outcomes Discussed**

- PBF should be used to improve the working conditions and general health facility (HF) environment
  - Transparency in rewarding
- Others ways to motivate
  - Good leadership, respect to staff, offering holidays instead of money, participation in conferences, accreditation.
- The processes need to be checked that lead to the results
Is PBF a motivation for QI?

What is PBF? For example, Rwanda has been implementing a PBF project since 2002. They have established a set of results indicators. Health facilities are then paid based on the indicator performance. Funds get transferred to health staff like a bonus. Would a system like this work as motivation for quality management staff to work towards quality improvement?

What are the main problems with using PBF to motivate QI?

- PBF rewards for results and not necessarily the processes.
- It can promote unhealthy competition and demotivate those that do not get paid
- It can promote “gaming” the system.
- Quality should not have a prize. It should be part of the culture.
- Sustainability: Funding for PBF programs may not always be available.
- Other intrinsic factors affect how facilities perform such as different overall patient populations. One facility might just see sicker patients.
- It can create an unhealthy cycle where you have to pay people to do more.

What are other ways to motivate QI?

- Recognition of the facility that does good quality improvement work. The facility would then recognize the staff.
- Sometimes if people feel that their work is valuable is enough motivation.
- Accreditation programs (independent from government). For example, insurance programs only pay hospitals that have been accredited.
- Provide other incentives to staff that perform well such as extra vacation days, participation in international conferences
- The best system might be a combination of many things

If PBF is used, how should the funds be used?

- Rewards could be used towards improving working conditions and general working environments of staff instead of individuals.
- Usage of money should be transparent
- PBF programs should be designed based on the country structure and culture
Open Space Topic: Evaluation of HEALTHQUAL

Facilitator: Matthew Rosenthal

Three Issues Discussed

• How do we evaluate HEALTHQUAL?
• What do we want to ask?
  – Are the services being offered meeting the objectives of HEALTHQUAL?
    • Build capacity for quality management: PM, QI, QMP
• Evaluating changes in the process versus higher level impacts due to confounding factors

Outcomes Discussed

• Develop a logic framework for evaluation
  – Input, Process, Output, Outcome, Impact
  – Identify specific area for evaluation within this framework
• To evaluate capacity building, account for both qualitative and quantitative components within this framework
Topic: Evaluation of HEALTHQUAL
Facilitator: Matthew Rosenthal
Aim of Session: Discuss strategies for evaluating HEALTHQUAL and its impact
Issues Discussed:

Identify objectives of HEALTHQUAL:
- Funded objectives of HEALTHQUAL
  - Build capacity for quality through…
    - Performance Measurement
    - Quality Improvement
    - Quality Management Program (infrastructure)

The Null Hypothesis:
- Without HEALTHQUAL, there would be improved capacity for quality management
- Establishing a Control
  - Compare outcomes in sites implementing HEALTHQUAL to those not implementing HEALTHQUAL
- Associated Concerns
  - Confounding factors may affect comparison between control and HEALTHQUAL sites
  - Building capacity for improvement vs. actual improvement may be evaluated differently
  - Attribution
  - New field of impact evaluation when investigating capacity building
    - What are the appropriate indicators for capacity building? (also, training)

Logic Model-Used to determine areas of the process to evaluate (Output or Outcome)

<table>
<thead>
<tr>
<th>Input</th>
<th>Process</th>
<th>Output</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Human Resources/ Staff appropriation</td>
<td>- Training</td>
<td>- # of staff trained</td>
<td>- Competency of Quality team (measure through…)</td>
</tr>
<tr>
<td>- Financial Support</td>
<td>- Creation of Quality Committees</td>
<td>- # of quality committees/teams established</td>
<td>- Clinics utilization of data to drive improvement of care</td>
</tr>
<tr>
<td>- Partner v. government contribution</td>
<td>- Implementation of policies of quality</td>
<td>- # of facilities collecting data/data quality</td>
<td>- Team approach utilized</td>
</tr>
<tr>
<td>- Increasing national budget</td>
<td>- Development of tools</td>
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<td>- Improvement in performance?</td>
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<tr>
<td></td>
<td>- Coaching/mentoring</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Strengthening partnerships with stakeholders</td>
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<td></td>
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<tr>
<td></td>
<td>- Technical assistance</td>
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<td>- Data collection</td>
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<tr>
<td></td>
<td></td>
<td>- # of successfully implemented projects</td>
<td></td>
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<td></td>
<td></td>
<td>Qualitative Aspect: perceptions/discussions on quality (how speak/document quality/involvement of key government stakeholders/ownership)</td>
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</tbody>
</table>

*Note: Be careful on whose point of view you are looking at this model from. Components may change categories. Impact is also a part of this model, but was not addressed in this specific Open Space discussion.
Open Space: Promoting Adherence in Children
Facilitator: Witaya Petdachai, MD & Ake-Chittra Sukkul, MD

Open Space Topic:
Promoting Adherence in Children
Facilitator:
Witaya Petdachai & Ake-Chittra Sukkul

Three Issues Discussed
1) Barriers to adherence in children
   - Stigma, disclosure, family support, children not knowing why they need to take medications or get blood tests
1) Transitioning adolescents to an adult clinic
   - Introduce children to adult physician
3) Age specific tools
   - Calendar, medication cards, diaries, storybooks, games, painting, unit dose

Three Outcomes Discussed
1) Disclose to children as early as possible (age 7-9), but also make sure they are old enough to understand.
2) Find a family member or someone else who can help the child take their medication and teach them how to take their medication on their own
3) Use of teaching tools to help children understand about illness, why medications are important, and how to be adherent
   - Make sure teaching tools are culturally appropriate and do not support local myths
Topic: Promoting Adherence in Children
Facilitators: Witaya Petdachai, MD & Ake-Chittra Sukkul, MD
Issues Discussed:

Barriers to adherence in children
- Stigma in community or family
- Child not aware of his/her HIV status
- Lack of family support- no one to help the child take medications. If children’s parents passed away, guardians may not know the child is HIV infected
- Children not knowing/understanding why they need to take medications or get blood tests and therefore do not understand the importance
- Exposed infants information is in mothers book, so during review they don't have their own chart.
- Clinic can interfere with school

How to use age specific tools, examples of successful tools
- Calendar, medication cards, diaries, storybooks, games
- Use of teaching tools to help children understand about illness, why medications are important, and how to be adherent
- Make sure teaching tools are culturally appropriate and do not support local myths
- Disclose to children as early as possible (age 7-9), but also make sure they are old enough to understand.
- Find a family member or someone else who can help the child take their medication and teach them how to take their medication on their own
**Open Space Topic:** Giving Consumers Feedback

Facilitator: Martin Mukulu

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**Three Issues Discussed**

- Addressing individual vs. general complaints systematically
- Feedback works both ways (consumers and providers must work together to improve services)
- Different methodologies exist for giving and receiving feedback

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**Three Outcomes Discussed**

- Staff training on how to give honest and clear feedback (perhaps identify a focal person)
- Give feedback based on existing policies and procedures or develop new ones
- Channels of communication need to be clear for both consumers and providers
Topic: Giving Consumers Feedback
Facilitator: Martin Mukulu

Issues Discussed:

How do providers communicate back with consumers? Is it a two way processes?

- Are the processes the same to provide feedback to consumers?
  - Helpline, suggestion box, and interviews.

- Select key issues to give feedback, need to decide how often do you give feedback? Qtrly, Monthly.

- In terms of QI, it is important to give feedback to consumers.

How do we give personal feedback to consumers? Is there a systematic way for staff to give feedback?

- May not be able to solve individual problems, but should be documented by staff. However, for example, determine most common complaints weekly and implement strategies to address?

- It takes building good relationships between staff and patients in order for honest feedback to be provided by patients.

- Focus group discussion is similar to open space and issues can be raised as well as providers explaining back how systems work.

- Suggestion boxes are anonymous, so it may be difficult to give feedback. Consumers put complaints in suggestion box, opened weekly, discussed with staff. How do you ensure communication back to patients.

- Incorporate individuals from networks or support groups. Staff from institutions can go to support groups. From our suggestion box, we noticed that there are issues which we can bring forward with support groups.

- Different methodologies to give feedback (coaching to peers).

- Involving consumers in QI, do you want to have a representative to attend team? Support groups are small segment of population.

- People are homogenous, different levels, different domains. Looking at QI from public health point of view w/minimum standards of quality of care. It should be from public health perspective, not individually.

- Some may use suggestion box, some will use meetings, some will use other methods. Are you able to bring it together analyze it and address the issues. When you address, what is the forum you will use to communicate feedback.

- Give feedback through newsletter, to show how an issue was addressed.

- Ex: Clients talking about a long waiting time, ques, limitation of staff. An institutional staff that can address awareness of why waiting times exist – Explain flow of process so consumers understand.

- Post information for patients, they check what information exists, what is new?

- Many times staff who give feedback are not the individuals who should be making the final decision about feedback. Train staff how to give honest and clear feedback.
What do we want to accomplish?

- High quality care
- Efficiency in QM of all programs. The sum is greater than its parts
- Standardization of tools
- Effective communication between stakeholders
- Sharing of best practices so all benefit

Who are the stakeholders in the partnership?

- Ministry of health
- Development partners/Funders
- Implementing partners
- Consumers

How will we know that we have made a change for the better?

- Process is owned by the ministry at every level of the healthcare system
- National standards of care and quality management structure
- Partners are all using one set of principle, standards, tools and reporting mechanisms despite different quality models or brands
- Stakeholders are meeting regularly to share ideas, accomplishments, barriers and challenges

What changes will we need to make?

- Quality of care is integrated into national strategic plans
- Ministry leads the way in bringing partners together for an initial briefing on standards of care and quality management brands and methodologies
- All partner activities must be in alignment with national strategic quality plan.
- Identify a unified set of quality principles
- Standardize indicators, tools, and data reporting
- Integrate routine data collection with improvement activities
- Meet regularly as a collaborative, workgroup or learning network
Topic: Harmonizing Quality Management Across Partners
Facilitators: Carla Johnson and Shobha Vakil, MD
Issues Discussed:

- Country ownership is key to the success of transition for PEPFAR-supported programs.
- It is vital that partner quality management and performance improvement activities be aligned with those at the national, regional/provincial, district, and local levels of government.

Here are some aspects to consider:

- There are at least several implementing partners (IP’s) in most countries, and there may be more as new NGO’s compete for funds. It’s a good time to be talking about harmonization.

- Quality models and partners abound, and although principles are similar, not everyone uses the same language. Some IP’s subcontract to quality specialists and some integrate QM and QI into their programs.

- Indicators, patient monitoring systems, and data collection methodology may also differ. Sometimes, there is resistance to change when it comes to alignment with national systems.

- Some countries have well-developed plans and infrastructures, as we learned during our week in Namibia, and some do not.

- Some countries are integrating HIV/AIDS quality standards into the existing quality infrastructure and some are using HIV/AIDS QM infrastructure as a framework for developing an integrated healthcare approach.
Open Space Topic:
QI in Hospitals
Facilitator: Abiyou Kiflie

Three Issues
• Structure...
• Implementation... &
• Monitoring of QI in hospitals.

Three Outcomes
• Development of a high-level QM committee to advise hospital administrators
• The QM committee will lead different units or sub-QM teams within each department
• Departmental approach vs. committee approach for QI within a department
Topic: QI in Hospitals
Facilitator: Abiyou Kifle, MD, MPH
Issues Discussed:

Areas to examine in a hospital-wide QI approach: Structure, Implementation, Monitoring

Structure:

- Examine structure in the hospital, then how the structure should happen, then how this can be better organized.
- Previously we looked at HIV specific QI activities in different settings, but a hospital is not only meant for HIV. We are trying to build sustainability and program integration.
- You have an administrative structure in each department. Each disease or service area needs to define steps and indicators. But since this is bigger and wider, each department does their own process, defines expectations and feeds back to the quality committee.
- What should the structure be? Should we have a quality committee? How many?
- It varies from hospital to hospital. In some hospitals there are already people looking at infection control, infection control as part of QI.
- So the infection prevention committee would become the QM committee to address IP and other areas.
- In a hospital you have a hospital-wide QM committee, then committees for each unit/department that get more specific.
- HIV, pediatric, surgical, etc…Lab, pharmacy…How many committees and would they be manageable?
- I think each of those departments would select 1 or 2 members to form the hospital-wide committee.
- The committee should be multi-disciplinary and always cross-cutting.
- You might have a committee for internal medicine that will interact with the pharmacy, lab, and depend on these other areas.
- Since HIV patients have other conditions, why don’t we broaden the HIV committee to deal with other conditions, because these QM committees are already dealing with other areas of care since they are hospital staff.
- There are different structures in each hospital, and I think the main focus is to think about an institution with different services and a committee designed to make sure all of the pieces fit together.
- An overall QM committee that oversees the entire hospital, and within this structure there will be individual committees.
- If one unit is established, it is there to provide and improve a service. And there is no need to establish a separate committee.

Implementation:

- Drive the process with the quality committee to examine all processes.
- In Namibia, HIVQUAL is implemented in the hospital, and some hospitals have existing ART committees.
- Hospitals serve different services: outpatient; HIV non-HIV, acute, chronic, etc…
- Every department should implement QI.
- In the hospital there are ART clinics which started before HIVQUAL was introduced. They are there, looking at QM and infection control throughout the hospital.
- If I were starting a data driven QI program in a hospital, the first thing is to define quality indicators and be able to extract data and look at data to see what needs to be improved.
- For example, in a hospital one would look at occupational bed percentage, length of stay, infection control, it is very complex. What is happening in pediatric wards is different from adult wards.

Monitoring:

- In a hospital, we are looking at different programs and we do not focus on one disease. If someone wants to apply QI in a hospital setting, we have to take it step by step. For example, first we take diabetes, and we need indicators, measurement, etc…
- We use data to develop improvement projects and the hospital should begin with quarterly meetings to discuss data and identify areas for improvement and those data will guide which areas to focus on.
- Each department should sit down and develop indicators and measure baseline and start from there.
- Where is the accountability? Especially in a large hospital.
- The QM team will act as an advisor group for the hospital management, and the medical unit will be running QI on its own
Open Space Topic: Prevention Indicators
Facilitator: Dr. Daniel Kidder

Three Issues Discussed
• Prevention indicators used by countries
• If limited number of indicators could be implemented, what would they be?
• Should indicators be more process or outcome focused or both?

Three Outcomes Discussed
• Understanding the importance of including prevention indicators
• No single ideal prevention indicator
• Countries need to have internal discussions to determine which prevention indicators will be implemented
Topic: Prevention Indicators
Facilitator: Daniel Kidder, PhD

Issues Discussed:

How can care be integrated in prevention settings?

- In Kenya, all prevention efforts happen in clinic, not in communities
- HHS would like countries to establish lay counselors within clinics, not in communities.
- Linking prevention and care is difficult and not part of PEPFAR indicator. Once persons are diagnosed positive, they should be linked to care and prevention with positive activities should be included in care settings
- Prevention to care continuum is not about just providing care, but also providing prevention services. You can’t just do HIV medications. Consumers may need STI, TB screening, and Family Planning Services. Prevention is Care to be incorporated in every visit.

PWP tools or indicators used in countries?

<table>
<thead>
<tr>
<th>ARV adherence assessment - Thailand</th>
<th>Family planning education - Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner testing - Uganda</td>
<td>PMTCT - Namibia</td>
</tr>
<tr>
<td>STI screening - Thailand</td>
<td>Partner disclosure - Thailand</td>
</tr>
<tr>
<td>Alcohol screening - Namibia</td>
<td>Male circumcision</td>
</tr>
<tr>
<td>Prevention education - Mozambique</td>
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</tbody>
</table>

What do you think about implementing additional prevention indicators and what they be?

- Identification of sero-discordant couples and collecting information may be challenging due to other factors.
- Need to balance all prevention strategies and come up with an endpoint
- If there was an endpoint, what would it be? A Process is needed to reach the endpoint.
  - Do you now your partners HIV status? What is HIV status?

People may not really know partner’s status.

- Selection of indicators will vary from site to site - A form is put in patients file and at every visit, PLWHA are asked if they have a partner and was partner tested. Analysis suggested that there are a lot of sero-discordant partners. As a result interventions implemented (circumcision, prevention education, family planning).
- HEALTHQUL should help us understand processes to get to an outcome measure. What are some mid-point processes to get us to the point of increasing sero-discordant couples over time?
- Adherence not good strategy for Primary Prevention
- Importance of partner testing combined with prevention measures
- Multiple and concurrent partners comes up
- Building disclosure skills and advocacy for condom use
- Counseling and behavior change
- Evaluation research (18 clinics, 200 people followed/clinic). Less than 5% have less than 5 partners (self-reported).
- It’s up to countries to prioritize indicators.
- Staff feel they would need to speak with staff that do prevention on a daily basis to get their input to determine prevention with positive indicators.
- Worried about some of the indicators at some sights and settings (ex: sites not offering family planning information, services, and medications)
- PEPFAR would like to see integrated system at ARV clinics to provide one-stop shop so consumers can get family planning information and then referral to MCH if commodities cannot be provided on-site.
Open Space Topic: Sustaining QI in Low Resource Settings
Facilitator: Godfrey Kayita and Peeramon Ningsanond

Three Issues Discussed
- How to Define Sustainability of a QM program
  - Ownership
  - Routine and repeatability
  - Over what length of time?
  - Local resources
- Processes of creating sustainable programs
  - Integration (existing systems vs. creating a new system)
  - Community/consumer involvement
  - Creating a culture of quality
  - Mentoring
  - Needs assessment

Three Issues Discussed (continued)
- Challenges to Sustainability
  - Funding
    - Donor issues
    - Government not able to match NGOs
    - Maintenance (of CD4 machines, computers, etc.)
  - Workload
  - Staff turnover, attrition, and movement
  - Interventions to address those challenges

Three Outcomes Discussed
- Involvement of consumers
- Include quality into pre-service, in-service, and continuing training
- Take context into account – know your needs
Topic: Sustaining Quality Improvement in Low Resource Settings
Facilitators: Godfrey Kayita, MD and Dr. Peeramon Ningsanond, MD

Issues Discussed:

Creating a definition of sustainability

A sustainable program will:

- Continue despite financial setbacks or decreases in budget
- Integrate into governmental or other pre-existing structures
- Have support from political figures and those in power
- Be marked by routine – but “routine with happiness”
- Establish a “culture of quality,” including attitudes and expectations of quality
- Be able to continue, without extra infusions of capital, over a sufficiently long term
- Rely on local resources
- Include ownership by all involved, both staff and consumers/community
- Continue irrespective of the forces that brought it there

Processes to create sustainable programs:

- Mentoring: Create a system where new generations learn the process you’re trying to sustain
- Create ownership by involving stakeholders in the process from early stages.
  - Ownership must occur at multiple levels: government, facility, those running the system, staff, consumers, and community.
- Integration with primary care
  - Dedicated HIV programs are not sustainable over time. Integration of HIV care with primary care is crucial.
  - Maintaining the same level of funding and donor interest will be difficult. We must be prepared to do more with less.
  - Integrating the systems built up around HIV into primary care and other programs can spread QI activities into those areas.
  - Integration can go two ways: HIV integrated into larger system, or additional things can be added into the HIV system.
- Integration into government systems
  - Few examples of large, free-standing health programs maintained outside the government structure (outside of HIV).
  - Crucial shift away from quality as an extra budget item; rather, quality is an intrinsic expectation of each budget item.
  - Depending on the structure of government and health systems, use the national or local context for integration platform.
- Meeting needs: pressing needs must be met first even if not the original plan of the donor establishing the intervention.
- Share experiences, gathering and communicating information
- Establish training on QI methods for staff
  - Pre-service training: Medical students, nursing students; continuous in-service training; and training/re-training in QI and QM as someone moves into management

Challenges to Establishing Sustainable Programs

- Donor funding issues
  - Governments can’t match levels of donor funding.
  - Creating local knowledge about how to fix new technology, or resources must be diverted to creating lower-tech systems.
  - Donors funds should fit existing needs/framework; the needs/framework should not have to shift to meet available funds.
  - Some countries have established a focal person at MOH to manage NGOs. This person can match NGOs to need.
  - Important to stress that it is better to offer a comprehensive package for fewer facilities than to do less for more clinics.
- Data collection and reporting burden
- Staff issues: turnover requiring training and retraining; limited full-time staff for QI; lure of NGOs or private sector; transfer of staff within country can move all trained personnel out of a facility
- Different definitions of quality, weighing technical quality against consumer satisfaction
- Difficult to gauge whether a program is sustainable, especially given potentially volatile sources of funding
Open Space Topic: QI and VCT
Facilitator: Ake-Chittra Sukkul and Chitlada Utaipiboon

Three Issues Discussed
• VCT System of each country (Namibia, Thailand, Mozambique)
• Different indicators for counseling and testing
  – Pre-test counseling
  – Post-test counseling
  – Testing
• Counselor qualifications

Three Outcomes Discussed
• Information systems change
  – Make sure everyone has the same information
• How to increase coverage of post-test counseling
  – Expand use of same-day testing
  – Written vs. verbal consent
• Different methods of qualifying counselors: lay vs. professional
Topic: Quality Improvement and Voluntary Counseling & Testing (VCT)
Facilitators: Ake-Chittra Sukkul and Chitlada Utaipiboon
Issues Discussed:

Indicators of Counseling & Testing

- Different countries use very different indicators for counseling and testing.
- Thailand: Use chart abstraction based only among those who received a test.
  - Pre-test counseling: among those who received a test, how many received pre-test counseling? What did this test include?
  - Post-test counseling: among those who received a test, how many returned for post-test counseling?
  - Referred to care: among those with a positive result on an HIV test, how many were referred to care?
  - Thailand does not have widespread availability of rapid testing, so the patient has to return for results several days later. There is a large drop-off between those who receive the test and those who return for result and are post-test counselled.
  - Thailand requires written, rather than verbal, consent to be tested.
- Namibia:
  - Pre-test counseling: Cue cards are used like a checklist to document what is discussed in pre-test counseling.
  - Reporting forms are standardized.
  - The biggest problem in Namibia was with information transfer. Facilities are required to send their information directly to the Ministry, so the regional center often lost touch with what was going on. The system was not installed regionally.
  - A new form was developed covering statistics of VCT which goes to the regional level. However, this increases the data burden by adding an extra form.
  - VCT is a standalone unit, so it is rare that someone is tested without pre-test counseling. However, hospitals and social work units have their own testing units as well.
- Mozambique:
  - Pre-test counseling: two counseling sessions are given before testing: one group session, and one individual session.
  - Post-test counseling: Post-test counseling is supposed to happen regardless of status. In case of a positive test, results are given to the doctor.
  - A major problem in Mozambique was a lack of continuity across different areas of the facility. There is no one standard form, so tests done in one area are reported by a different form than tests done in another.
  - There is very little follow-up after the test is done to see if patients who tested positive ever connect to a doctor.
- Participants agreed that widespread use of rapid testing increases the number of those who get tested and who receive their results and go through post-test counseling.
- Participants also discussed how stockouts of testing materials (rapid tests, reagents, etc.) made it difficult to successfully measure how the testing service is actually doing.

Criteria to be a counselor:

- Countries have different standards for becoming a counselor based on availability of trained personnel.
- Thailand: Most stringent requirements, longest time to train. In addition to having a bachelor’s degree (at least), you have to be a nurse, doctor, or social worker. You also have to go through additional training to be qualified as a counselor. Requirements are so high that many people do not want to become counselors.
- Namibia: Counselors must have finished through grade 10, at least 25 years old, and must go through a 6 month training program (3 months in classroom, 3 months practical experience).
- Mozambique: Counselors must have finished grade 10 or up, be at least age 18, and go through a 15-day training course.
- There was a discussion about the relative benefits of intensive training and restricting training only to those with further degrees. Relative benefits of less intensive training and lower restrictions on who could counsel were an increased number of counselors, decreased cost, and decreased effects of brain drain when foreign health care workers left. Relative benefits to higher standards for training were an increased ability to deal with psychosocially complicated cases and better maintenance of confidentiality.
- “Community counselors” were only trained in HIV VCT, and so were not as flexible in what they could do, but could cover the needs of HIV VCT more efficiently.
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