UNITED REPUBLIC OF TANZANIA

Ministry of Health, Community Development, Gender, Elderly and Children

National Guidelines on Quality Improvement of the HIV and AIDS Services

National AIDS Control Programme (NACP)

January 2017

National Guidelines on Quality Improvement of the HIV and AIDS Services

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FOREWORD

In 1993 the Ministry of Health (MoH) embarked on Health Sector Reforms (HSRs) aiming at improving the quality of the services provided at health facilities (HFs) and developed the Tanzania Quality Improvement Framework (TQIF) as a guiding document for Quality Improvement (QI) of health service provision. In recognition of the need to improve the quality of health services, many stakeholders undertook initiatives geared towards the improvements at HF level. Much of the impetus for this initiative focused on improving the quality of HIV and AIDS services in the country.

The QI initiatives have greatly been implemented through an Improvement Model and different approaches in design, process, monitoring and reporting structure with a lead provided by the National Guidelines on Quality Improvement of the HIV and AIDS Services.

However, between the development of this National guidelines and now, new interventions as well as various challenges in delivery of the HIV and AIDS Services have emerged. The resultant of that emerging is a need to revise the National Guidelines on Quality Improvement of the HIV and AIDS Services as well as its training package. The major goal of this revision is to integrate the new interventions and the new developments in the implementation of the other existing HIV and AIDS Interventions.

Upon completion of the revision process, the National Guidelines on Quality Improvement of the HIV and AIDS Services and its training package shall be used by Managers, Programmers and Researchers of the HIV and AIDS prevention, care and treatment and social support services as well as Facilitators and participants attending to the Training on Basic Quality Improvement of the HIV and AIDS Services country-wide.

Accompanying the National Guidelines on Quality Improvement of the HIV and AIDS Services is the training package consisting of the participant manual and the facilitators guide as well as facilitation slides. The learning is based on adult learning principles, which means that it is interactive, relevant and practical. Moreover, it requires that the trainer facilitates the learning experience rather than serving the more traditional role of a teacher or lecturer. It also involves the use of behaviour modelling to facilitate a competency-based learning in a standardized way of performing a skill or activity.

Through structured exercises and mini-lectures providing the need-to-know facts, the participant manual is meant to help users to reflect in their local settings, the processes in routine health service delivery and stimulate innovations and creativity as users think how to design strategies to further improve the health services.

The MoHCDGEC urge HIV and AIDS service Managers, Programmers, Planners and providers to use this manual consistently and continuously offer critical comments for improving future editions of this document.

Dr. Mpoki Ulisubisya,
PERMANENT SECRETARY

ACKNOWLEDGEMENT

Following the development of the National Guidelines on Quality Improvement of HIV and AIDS Services in November 2010, there was a need for a training package to facilitate and harmonize the training of health service providers (HSPs) at all levels of the health system to enable them to follow the national guidelines to implement and sustain Quality Improvement (QI) activities at HF level country-wide. This training package that consists of a Facilitators Guide, Participants Manual and training's facilitation slides is intended to serve as a guide for trainers of trainees (ToTs) with or without prior QI experience in enabling trainees to acquire appropriate knowledge and skills in the implementation of QI activities at the respective level of health service delivery.

The revision of the National Guidelines on Quality Improvement of the HIV and AIDS Services and its training package bases on the Tanzania Quality Improvement Framework (TQIF). In addition, the guidelines and the package has been customized to the Tanzanian situation by drawing lessons from experience gained during the field implementation of QI of HIV and AIDS services, in collaboration with members of the RHMTs, CHMTs and HFs providing HIV and AIDS services.

The process of reviewing the National guidelines and its training package has been coordinated by the National AIDS Control Program (NACP). The review process had two major pillars of financial and technical parts. The MoHCDGEC would like to register its appreciation to the University Research Company (URC) through USAID/ASSIST project under the support of the USAID's Bureau for Global Health, Office of Health Systems. Cooperative Agreement Number AID-OAA-A-12-00101 and the International Training and Education Center for Health (I- TECH) through the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under U91HA06801, International AIDS Education & Training Center for effectively covering the financial and technical support of the review of the package.

The Ministry of Health, Community Development, Gender, Elderly and Children would like to thank the Regional and Council Health Management Teams (R/CHMTs), Health Facilities including Mbeya Zonal Referral Hospital and Lugalo Military Hospital, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Management and Development for Health (MDH), Tanzania Health Promotion Services (THPS), Ariel Glazer Pediatric AIDS Healthcare Initiative (AGPAHI), Henry Jackson Foundation Medical Research Institute Walter Reed Project (HJFMRI – WRP), Lugalo Military Hospital who participated in the series of reviews of this training package.

Special note of appreciation go to the National Tuberculosis and Leprosy Program (NTLP) for accepting to organize a training that was used to field test the revised training package and for the very useful inputs that were obtained from the field testing training.

The MoHCDGEC would like in an exceptional way to recognize the Program Manager, Dr. Angela Ramadhani and the Heads of Units at the NACP led by Head of Quality Improvement Unit, Dr. Patrick Mwidunda for their active participation, contributions, coordination and guidance that they provided throughout the review process.

Since it is not possible to mention everyone by name, the MoHCDGEC would like to thank all those who contributed in one way or another to the review of the National Guidelines on the Quality Improvement of the HIV and AIDS Services and its training package.
The list of names of these experts even if in no particular order is attached hereto and I need it to be taken as part of this guideline.

Prof. Muhammad Bakari,
CHIEF MEDICAL OFFICER

LIST OF ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
AMSTL	Active Management of Third Stage of Labor
ANCs	Antenatal Clinics
ART	Anti-Retroviral Therapy
ARVs	Antiretroviral drugs
CBHS	Community Based HIV and AIDS Services
CBOs	Community Based Organizations
CCHPs	Comprehensive Council Health Plans
CHMT	Council Health Management Team
CHW	Community Health Workers
CQI	Continuous Quality Improvement
CQIT	Council Quality Improvement Team
CQI-TQM	Continuous Quality Improvement -Total Quality Management
CRHPs	Comprehensive Regional Health Plans
CTC	Care and Treatment Clinic
DACC	District AIDS Control Coordinator
DMO	District Medical Officer
EPI	Expanded Program on Immunization
FBOs	Faith Based Organizations
GBV	Gender Based Violence
GPA	Global Program on AIDS
HBC	Home Based Care
HBTC	Home Based Testing and Counselling
HF	Health Facility
HIV	Human Immunodeficiency Virus
HSHAS	Health Sector HIV and AIDS Strategy for Tanzania
HSHSP	Health Sector HIV AIDS Strategic Plan
IEC	Information Education and Communication
IPOs	Implementing Partner Organizations
IPs	Implementing Partners
I-TECH	International Training Education Centre for Health
KP	Key population
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MoHCGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MoHSW	Ministry of Health and Social Welfare
MTP	Medium Term Plan

MVC	Most Vulnerable Children
NACP	National AIDS Control Program
NCTP	National Care and Treatment Plan
NGO	Non-Governmental Organization
NMSF	National Multi-sectoral Strategic Framework
NQITWG	National Quality Improvement Technical Working Group
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PBCAs	Performance Based Contractual Agreements
PDSA	Plan Do Study Act
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
QA	Quality Assurance
QI	Quality Improvement
RACC	Regional AIDS Control Coordinator
RHMTs	Regional Health Management Teams
RIP	Regional Implementing Partner
RMO	Regional Medical Officer
RQIT	Regional Quality Improvement Team
RTC	Regional Technical committee
STIs/RTIs	Sexually Transmitted Infections/Reproductive Tract Infections
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
ToR	Terms of Reference
ToT	Training of Trainers
TQIF	Tanzania Quality Improvement Framework
TQM	Total Quality Management
TWG	Technical Working Group
URC	University Research Co., LLC
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WIT	Working Improvement Team
ZHRCs	Zonal Health Resource Centers

Section 1: Background

1.0 Background of National HIV and AIDS Response

Tanzania, being one of the Sub-Saharan countries most affected by the HIV and AIDS epidemic, has been taking a number of control measures since the first AIDS case was detected in 1983. The first institutional mechanism in responding to the epidemic was the establishment of a task force by the Ministry of Health (MoH) to implement a Short Term Plan in 1985. In 1988, the MoH established the National AIDS Control Programme (NACP) to coordinate the national response and took responsibility for the formulation and implementation of the three Medium Term Plans (MTPs I-III 1987-2002). Through the Global Programme on AIDS (GPA) based at the World Health Organization (WHO) headquarters in Geneva and the international community, Tanzania was able to mobilize resources to implement most of the strategic plans and interventions contained in the MTPs.

During MTP-I (1987- 2006), the main focus was to intensify the social mobilization processes at community level (decentralization) through education campaigns on the epidemic. Several coordinators for different interventions including the Regional and District AIDS Control Coordinators (RACCs and DACCs), STI Focal Persons (FPs), TB and HIV Coordinators, Community and Home Based Services (CHBS) Coordinators were appointed to assist the Regional and Council Health Management Teams (RHMTs and CHMTs) under the leadership of the Regional and District Medical Officers (RMOs and DMOs) respectively, to champion the response at these levels.

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

1.1 Background of National HIV and AIDS Quality and Quality Improvement

Despite detecting the first case of HIV infection in 1983, it was not until 1988 when the MoH started to provide the HIV and AIDS services upon the establishment of NACP. Because of the number of limitations, the HIV and AIDS service provision was not widely available and its quality was not the best given that HSPs had no knowledge of HIV and AIDS, diagnostic services were limited and drugs were not widely available. Only those who were economically and financially sound could afford getting drugs from outside the country.

Realizing those shortfalls, the Ministry of Health (MoH) took initiatives to improve the quality of HIV and AIDS services. Among the initial actions was regionalization of the Implementing Partners (IPs) so as to bring the services closer to the People Living with HIV and AIDS (PLHIV). Later, with support of different donors, the MoHSW developed national guidelines for different interventions, conducted different training to HSPs and conducted assessments of health facilities (HFs) to ensure quality in provision of HIV and AIDS services.

In 2010, the Ministry of Health and Social Welfare (MoHSW) developed the National Guidelines on Quality Improvement of HIV and AIDS Services, Manual of the Comprehensive Supportive Supervision and Mentoring of the HIV and AIDS Services as well as its training packages.

As demand for quality of HIV and AIDS services increased, the documents mentioned above were revised in 2014 to accommodate different developments in the delivery of the HIV and AIDS services. Together with guidelines and training packages, the MoHSW through NACP formulated a forum where QI stakeholders meet quarterly to deliberate on HIV and AIDS QI matters. At the HFs, formulation of the Work Improvement Teams (WITs) at the Care and Treatment Clinics (CTCs) facilitated introduction and implementation of the QI agenda.

1.2 Introduction to early HIV and AIDS Services

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

- Health education to the general public using various Information Education and Communication (IEC) approaches
- Training of health workers in specific skills such as management of STI/RTIs, laboratory tests, counselling, HIV Testing and communication for behaviour change
- Procurement and distribution of commodities and supplies, including condoms
- Printing and distribution of IEC materials
- Development of guidelines and dissemination for various interventions
- Disease monitoring and surveillance (establishment of sentinel sites, data collection, analysis and reporting)
- Screening of donated blood and Antenatal Clinic (ANC) attendees for HIV and syphilis for both routine and surveillance purposes

During this period, most activities conducted were preventive in nature. As such, very little change could be seen in most health facilities since services offered did not differ from the existing routine health services except in scope and linkage to HIV and AIDS services.

Following scientific advances in development of antiretroviral drugs (ARVs) and a global initiative to provide ARV at subsidized cost, the focus of HIV and AIDS interventions shifted from being predominantly preventive to include care and treatment.

Realizing this paradigm shift, two main national strategic approaches were developed at the beginning of 2003 namely: the Health Sector HIV and AIDS Strategy for Tanzania 2003 - 2006[1] (HSHAS) under the leadership of MOH and the National Multi-sectoral Strategic Framework on HIV and AIDS[2] (NMSF) spearheaded by the Tanzania Commission for AIDS (TACAIDS). These strategies signified an important departure from the previous preventive approaches to more comprehensive approaches, with NACP focusing on health and medical issues of the epidemic while TACAIDS provided a framework for other non-health players in the multi-sectoral response to develop their own sectoral strategies. The vision of NMSF was to unite the national efforts to reduce the spread of HIV infection and to provide the best available services for those infected by the HIV within a human rights and empowerment framework.

[1] Health Sector HIV and AIDS Strategy for Tanzania. Ministry of Health, 2003.
[2] National Multi-sectoral Strategic Framework. TACAIDS, 2003.

In a nutshell,. NMSF (I) (2003-2007) dealt with HIV epidemic response, NMSF (II) (2008-2012) focused on guiding the approaches, interventions and activities implemented by all actors in the country, linking national and international programmes and declaration focus on the 3 in 3 by 5 initiatives and universal access. NMSF (III) (2009-2015) aimed to achieve the MDGs and provided a comprehensive overview of the initiatives for the improvement of the health sector.

Currently, the country is implementing a five-year NMSF (IV) (July 2015-June 2020) which focuses on reaching all households with quality HIV and AIDS health services.

1.3 The National HIV Care and Treatment Plan

A paradigm shift occurred in 2003 with a major focus on care and treatment for PLHIV). By this time only about 2,000 PLHIV were receiving ARVs from private health facilities. None of the public sector HFs was providing ARVs. Therefore, MOH developed a comprehensive National Care and Treatment Plan for the five years[3] (2003-2008) which aimed at providing ARVs to as many eligible PLHIV as possible, with an initial target of 400,000 by the end of 2008. This required massive training of almost the entire HSPs on National guidelines for management of Anti-Retroviral Therapy (ART).

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

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

It was expected that HFs that met minimum criteria during assessment would proceed to provide HIV care and treatment services and those not meeting criteria would be encouraged to implement an improvement plan based on each assessment. However, almost all of the HFs assessed did not meet the criteria set. Given the urgent need for scaling up ART, 36 hospitals started providing ARVs in 2004, gradually increasing to over 200 hospitals by the end 2006. At the moment, all specialized, national, zonal, regional referral and district hospitals are providing ART services. Scaling up to primary HFs has resulted into more than 527 HFs providing ART in the country.

The involvement of primary health facilities in the provision of HIV and AIDS care and treatment services has contributed much to the increase in number of PLHIV enrolled into care and treatment services as more than 1,366,402 clients are currently registered to CTCs and more than half of them (54%) are on ARVs.

Involving primary health facilities in the provision of HIV and AIDS care and treatment services is a strategic decision by the MoHSW to improve access particularly in rural areas where distance to the district hospital was a critical factor influencing availability of service.

[3] National Care and Treatment Plan 2003 - 2008. Ministry of Health, 2003.

1.4 Current HIV Prevention, Care, Treatment and Support Services

Currently, TACAIDS is implementing the fourth five-year National Multi-sectoral Strategic Framework on HIV and AIDS (NMSF IV 2013 – 2018) from which the MoHCDGEC has developed a third Health Sector HIV and AIDS Strategic Plan 2013 – 2017 (HSHSP III 2013 - 2017).

The main goals of HSHSP III are: to achieve universal access to comprehensive HIV prevention, treatment, care and support services in order to significantly minimise the transmission of new HIV Infections; reduce HIV related mortality, elimination of HIV related stigma and discrimination; and to strengthen the capacity of the health system to support quality HIV and AIDS interventions and foster integration of the HIV and AIDS services within the health sector.

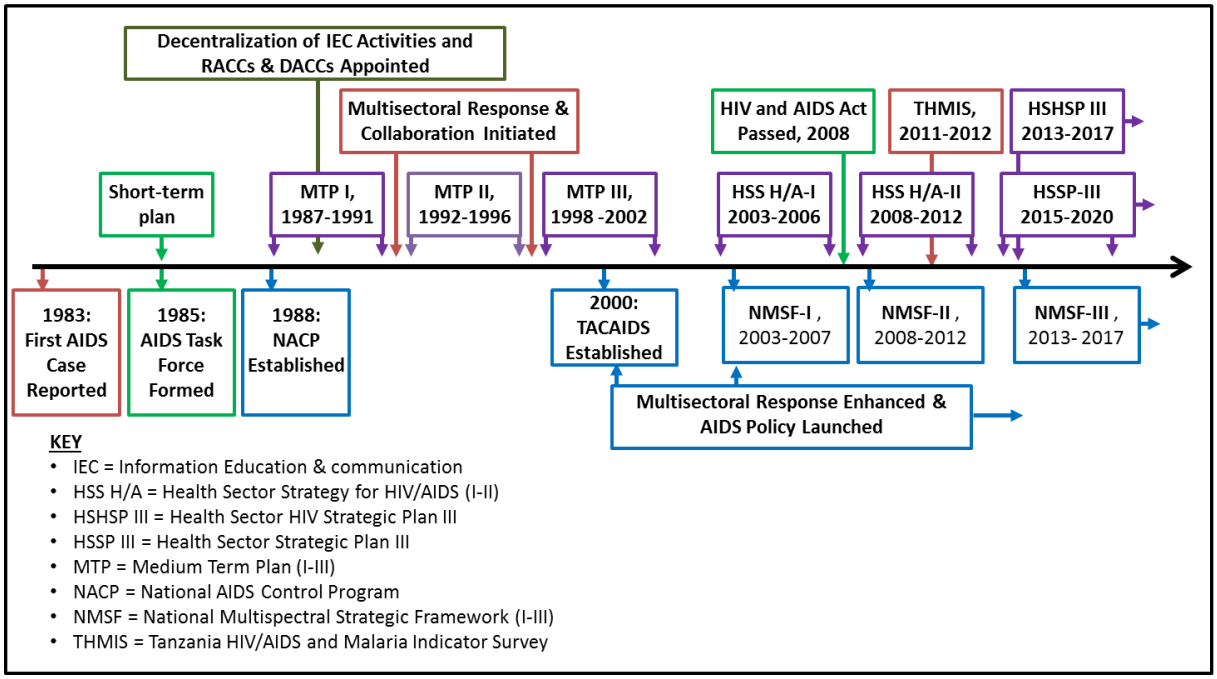
HSHSP III focuses on interventions that have proven to be cost effective as recommended by the World Health Organization's "Investment Framework". Also, the HSHSP III indicators have been carefully chosen to measure implementation at all levels. The use of a results-based approach in the HSHSP III is a very important development as it is both the national and global focus towards the post MDGs era (Sustained Development Goals). The HIV and AIDS interventions were developed to address the outcomes and hence this strategy is in harmony with the national and global health development agenda.

While the results-based interventions are, as stipulated in the HSHSP II, focused on the three thematic areas of Prevention, Care and Treatment and Crosscutting issues, the HSHSP III focuses on three impact results of eliminating new HIV Infections, reduction of HIV related deaths, and elimination of HIV related stigma and discrimination in health care settings.

Strategies that will contribute towards the achievement of the overarching impact results mentioned above are organised in three groups of optimising HIV prevention, treatment, care and support; building smart, strong and sustainable systems to support health sector HIV/AIDS response; and making smart and innovative investments.

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

Figure 1: History of the HIV and AIDS National Response in Tanzania (1983 -2017)



Section 2: Rationale

2.0 Rationale

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

Between 2004 and 2011, the MoHSW developed and revised the Tanzania Quality Improvement Framework (TQIF)[4,5] to mainly encourage the HSPs at all levels and other stakeholders in the sector to develop a culture of quality improvement in health service provision. The TQIF also outlines critical steps in improving and institutionalizing quality of healthcare in the country using available resources.

One of the three goals of the HSHSP II was to improve the quality of HIV and AIDS services for the general public, PLHIV, HSPs and other vulnerable populations.[5] Emerging of new interventions and the urgent need to scale-up interventions aiming at mitigating the impact of the HIV and AIDS epidemic have resulted in concerns regarding the quality of services.

Given the unsatisfactory quality of the services that were provided, the essence of achieving HSHSP II goals and realizing the implementation of the TQIF, it was therefore important to develop the national QI guidelines so as to spearhead the improvement in quality of the HIV and AIDS services in the country.

Referring to the HSHSP III, a number of new interventions including Gender Based Violence, Key Populations and Voluntary Medical Male Circumcision have emerged. Again, a number of challenges still exist that hinders the delivery of quality HIV and AIDS services such as declining of the funding for HIV and AIDS Service and a shortage of the human resource.

Based on the context of the HSHSP III and the need to overcome the challenges and improve the quality of the HIV and AIDS services, the MoHCDGEC / NACP decided to revise the National Guidelines on Quality Improvement of the HIV and AIDS Services in order to achieve improved HIV and AIDS services. It is therefore expected that the national QI guidelines will result in achievement of eliminating new HIV Infections, reduction of HIV related deaths and elimination of HIV related stigma and discrimination in health facilities and communities.

[4] Tanzania Quality Improvement Framework, Ministry of Health and Social Welfare, September 200
[5] Health Sector HIV and AIDS Strategic Plan II 2008 – 2012, Ministry of Health and Social Welfare, February 2009.

Section 3: Goal, Objectives and Target Audience

3.1 Goal

The National Guidelines on Quality Improvement of the HIV and AIDS Services aims to provide guidance to HSPs, managers and policy makers at all levels on improving the quality of HIV and AIDS services.

3.2 Objectives

The National Guidelines on Quality Improvement of the HIV and AIDS Services has the following objectives:

a) Institutionalise client-centred quality improvement as an integral part of HIV and AIDS service provision
b) Integrate HIV and AIDS interventions into the general health services
c) Capacitate HSPs to identify, analyse and develop alternative ways of improving quality of services at all levels of health service delivery
d) Facilitate the operationalization of supportive supervision and mentoring at all levels
e) Strengthen the capacity of HSPs, managers and policy makers to manage data for evidence based decision making to improve quality of service

3.3 Target Audience

The National Guidelines on Quality Improvement of the HIV and AIDS Services are intended to be used by the MoHCDGEC/ NACP policy makers, planners, RHMTs, IPs, CHMTs, Programme Managers, HSPs, teaching/academic institutions, partners in public and private sectors, FBOs, NGOs and CBOs involved in delivery of HIV and AIDS services.

Section 4: Dimension and Principles of Quality and Concept of Quality Improvement

4.0 Introduction

The HSPs need to understand the basic concepts of QI that include the terms quality, standards, quality assurance and quality improvement. The HSPs can improve health service delivery through understanding the dimensions of quality that contribute to the framework on which the service provision can be assessed. The improvement of quality in health services is a central issue globally including Tanzania.

It is important for the HSPs to familiarise with the principles and tools of QI that provides an opportunity for the continuously improving quality of services by improving processes within local settings while maintaining standards to ensure needs of clients are met.

4.1 Concept of Quality Improvement

The fundamental concepts of QI in health service delivery have evolved since few centuries, and address the following issues:

- QI brings an opportunity that aims to solve problems prevailing in the system that do not depend on one individual
- QI provides the reduction in the variation of performance, and therefore allowing the continuous delivery of the best services
- QI improves the health services delivery system that leads to better outcomes
- QI enhances collecting data from HFs, which is the key to identify health service delivery challenges and to measure effects of the introduced changes
- QI focuses on the performance measurement and improvement, and hence stimulating provision of high quality services
- QI helps to create team-based problem solving ways that also lead to better HIV related services and promote a better working environment.
- QI tests changes that result into better solutions.

The overall goal of the concept of QI to develop specific, sound and merit ideas and approaches that lead to an improvement of health service.

4.2 Dimensions of Quality

In health service delivery, dimensions of quality refer to aspects of health services provided to clients which; individually or collectively contribute to the framework on which the quality of services provided can be judged. Various dimensions of quality have been developed from the technical literature on quality and synthesize ideas from various QI experts. They provide a useful framework that helps teams to define, analyse, and measure the extent to which they are meeting facility standards for clinical and administrative services.

The following are nine dimensions of quality, which when applied in delivery of health services contributes to better client outcomes as well as satisfaction:

a) Technical performance
b) Effectiveness of care
c) Efficiency of service delivery
d) Safety
e) Access to service
f) Interpersonal relations
g) Continuity of services

h) Physical infrastructure and comfort
i) Choice of services

While all of these dimensions are relevant in health service delivery, not all of them deserve equal weight in every health service interventions. They are applicable in different levels of the health service delivery.

4.3 Principles of Quality

Principles are broad statements that provide a framework of general rules to shape organizational thinking. Fundamental decisions affecting health service delivery should be tested against principles of quality, and rejected when found to be in violation of those principles. The level of performance is a characteristic of any given system of work in improving quality of health services delivery.

Principles of quality offer the basis for identifying unnecessary, redundant, or incorrect parts of, and guide changes of processes in ways believed to yield improvements. A successful HIV service delivery always incorporates the following key principles:

a) Focus on clients' needs and expectations
b) Focus on communication and feedback
c) Focus on team and teamwork
d) Focus on measurements
e) Focus on systems and processes

4.3.1 Focus on Clients' Needs and Expectations

Health services need to be comprehensive enough to meet common needs and expectations of the clients and surrounding community. A client is a person or organization using services of a professional person or organization. There are two types of clients; external clients being individuals accessing a facility to receive services (e.g. patients) and internal clients being individuals involved in the delivery of service (e.g. doctors, nurses and administrators in the same health facility). Knowing the needs (both felt and unfelt) of clients is important for a health facility or institution in identifying issues related to quality improvement. Felt needs are those that a client is aware of, while unfelt needs are those that the client is unaware of. For a QI programme to succeed, it has to carefully identify its clients and learn their needs and expectations and then find ways to meet such needs and expectations.

4.3.2 Focus on Communication and Feedback

Communication is the transfer of information from one person to another for the purpose of sharing the idea or information. The transfer may be verbally or non-verbally (via speech, writing or physical signs/ gestures).

Communication occurs at several levels of interaction -clients within the health service delivery system. Effective communication builds a relationship of trust, understanding and empathy with the client and shows humanism, sensitivity and responsiveness, therefore the HSPs should apply communication skills to ensure quality service and client satisfaction.

Barriers to communication such as language channel used to convey message and content of message can affect the quality of service. It is very important to be aware of these barriers in health service delivery as they can severely affect the quality of health service delivered and client satisfaction.

Feedback is an important component of communication in health service delivery as it opens channels for clients to express opinion on the service provided. Providing feedback is important for fostering communication with clients and working towards ensuring clients' satisfaction. The approach used to provide feedback might cause barrier and hence service providers shall ensure feedback is provided in through an appropriate approach. After obtaining clients feedback, the HSPs need to devise improvement plans to address the clients' suggestions.

4.3.3 Focus on Team and Teamwork

Improving quality of the system requires people working in different parts of the system to work together in a coordinated manner and focusing on realization of the same main goal. When people work in teams, they are able to combine their talents, skills and efforts to accomplish results that individually they would not be able to achieve.

Having an effective teamwork requires leadership, participation of team members in analysing system deficiencies, agreeing on changes to be made and meeting regularly to evaluate the progress. The team should also be able to convince, sensitize, and share information with others on what they are doing and to get leadership support for incorporation of the QI initiatives into overall plan of the health facility.

4.3.4 Focus on Measurements

Measurement is critical to QI initiatives because it provides information about how the objective for improvement is being achieved. The collected data on a particular process of service delivery under assessment shall be compared with the desired standards to reveal the performance gap that needs to be improved. Measurements provide objective information that allows the development and testing of changes as well as monitoring progress after a change has been implemented.

In implementing QI, it is important to use data to measure components of a system that include inputs, processes and outcomes. Data are needed to determine the baseline performance, and provide appropriate information for decision-making, planning, monitoring and evaluation. Quality improvement efforts shall focus on evidence based practice using accurate, complete and latest data.

Measuring quality requires the development and application of performance measures (indicators) to make conclusion on the quality of service provided. Indicators are based on agreed standards and are evidence-based, and they provide a quantitative basis for achieving improvement in health services and the processes by which health services are provided. Indicators for QI shall be related to inputs, processes and outputs (monitoring) as well as outcomes and impact (evaluation) of health services' delivered.

4.3.5 Focus on Systems and Processes

Quality improvement views all health services offered as a product of interactions of dependent and interdependent part of a system made up of three components; input, process and output. Health service delivery involves a number of processes occurring simultaneously, each affecting the quality of services offered. Inefficiencies in providing health services are directly related to systems and processes. Therefore, it is essential that HSPs understand systems and processes so as to narrow gaps in quality and improve services provided to clients.

Every system is perfectly designed to achieve results that it achieves. A system left unchanged can only be expected to continue achieving the same results. To achieve a different result, it is essential to change the system in ways that enable it to achieve a desired different level of performance.

Each system has its own processes that are often based upon its needs. Processes can cause inefficiencies due to problems during execution or transition from one step to the other. In designing and implementing QI activities, a system view (inputs, processes and outputs) should be considered and deliberately avoid fragmented approach.

Section 5: Quality Improvement Model and Approaches

5.0 Introduction

The use of quality improvement model is effective for categorizing potential changes to a system and identifying changes that worked in other similar settings. Opportunities for performance improvement shall be identified through the management of data. Thereafter HSPs can make changes in the inputs and processes using the quality improvement model. There are various QI models that exist focusing on processes. The common model implemented in Tanzania is **"The Model for Improvement**".

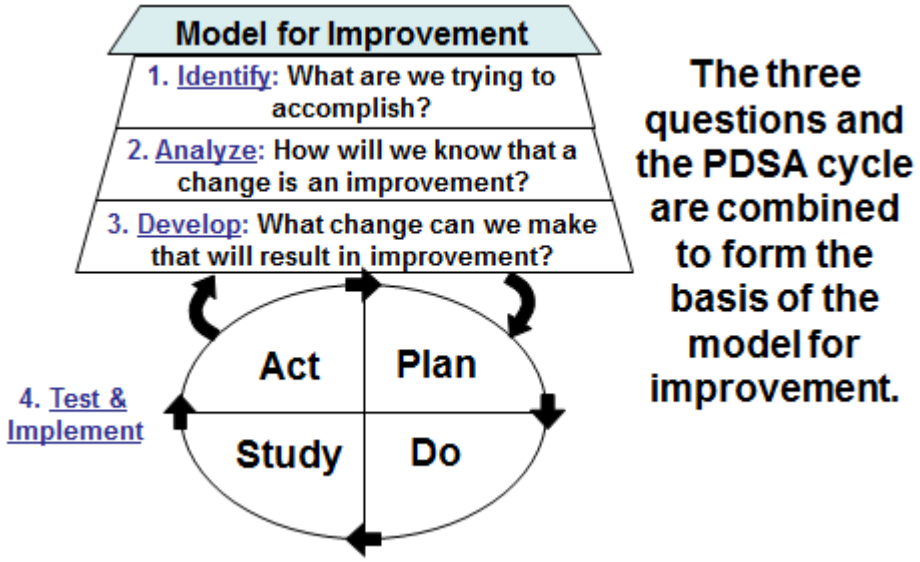
5.1 The Model for Improvement

The model for improvement is a strategy to systematically and effectively manage change. It has four steps that are interdependent:

Step 1. Identify: What are we trying to accomplish?
Step 2. Analyse: How will we know that a change is an improvement? and
Step 3. Develop: What changes can we make that will result in an improvement?
Step 4. Implementation: This step of the improvement model is constituted by four sub steps of Plan, Do, Study, Act (PDSA) cycle to test and implement changes.

The model is applicable for both simple and complicated situations and applied efforts may differ depending on the complexity of the product or process to be improved.

Figure 2: The Model for Improvement



5.2 Quality Improvement Approaches

The Model for Improvement described above can be implemented using different approaches. For QI of the HIV AIDS services the MoHCDGEC has opted to use two QI approaches the 5-S and the Improvement Collaborative.

5.2.1 Five-S (5-S)

The Five-S is a management tool, used as a basic approach for productivity, quality and safety improvement in all types of organizations. It is a philosophy and a way of organizing and managing the workspace and work flow with the intent to improve efficiency of work by removing things which are not in the right place, improving flow and reducing/ removing unreasonable processes.

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

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

5.2.2 Improvement Collaborative Approach

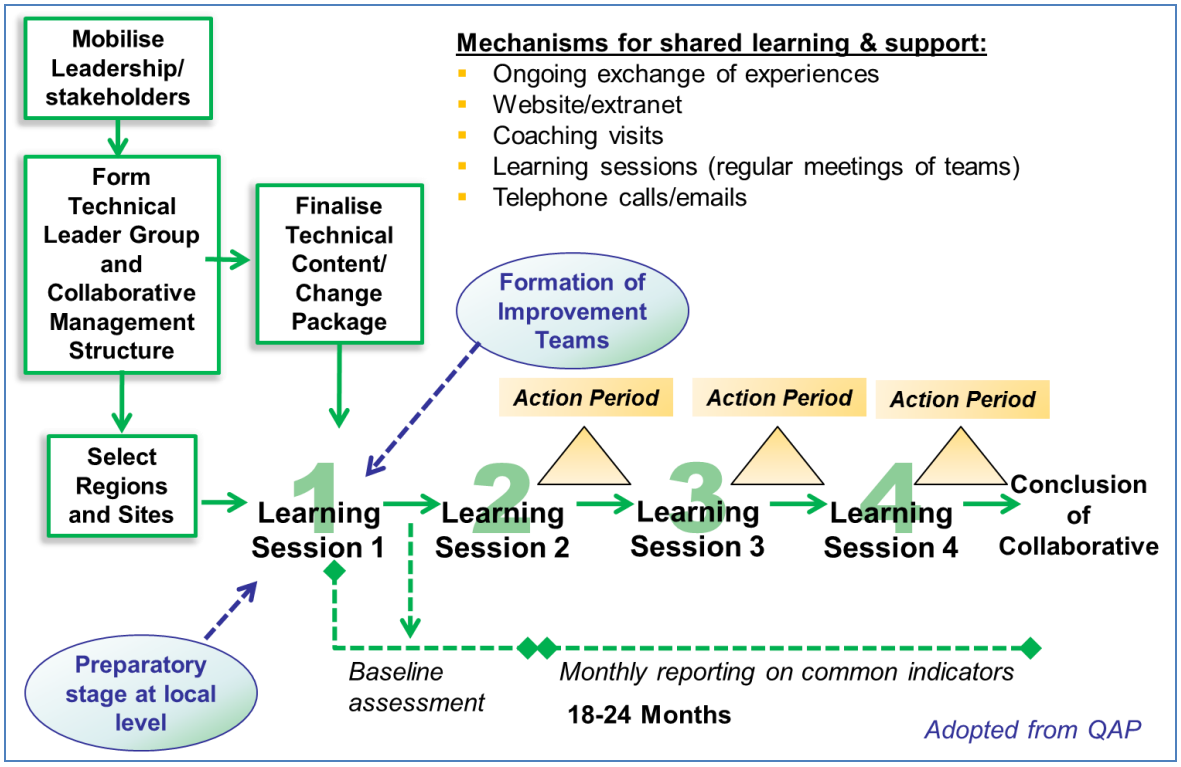
An Improvement Collaborative" is a shared learning system that brings together a number of teams to work together to rapidly achieve significant improvements in processes, quality, and efficiency of a specific area of service delivery, with an intention of spreading these methods to other sites. The teams work together for a limited period of time, usually 9 to 24 months, to rapidly achieve significant (often dramatic) improvements in a focused topic area through shared learning and intentional spread methods.

The approach uses the rapid team problem solving approach during the action periods which tailors the problem solving process to the situation at hand and minimizes activities just to ones necessary to make improvements.

During learning sessions, teams receive updates on the technical content and evidence based standards of the problem identified and develops common improvement indicators. In between learning sessions, teams go into action periods to analyse processes of service and design process changes to implement evidence based standards with the help of the coaches/ mentors.

The supervisors act as leaders and QI champions. During the learning sessions, teams exchange results and learn about the changes. If a team is poorly performing, they can learn from another team that found a change that worked well and they feel the competition to keep up with the other teams. These elements of sharing, competition and rapid follow-up, help maintain energy and momentum. A particular strength of improvement collaborative is that peer-to-peer learning that occurs during the learning sessions is often more powerful than top down technical assistance.

Figure 3: Improvement Collaborative Approach as Adapted by QAP



Section 6: Roles and Responsibilities

6.0 Roles and Responsibilities

Health services in Tanzania are organized in four levels: National, Regional, District and Community levels. The national and regional levels are involved in policy, coordination and guidance, while the regional, district (council) authorities and facility levels are responsible for direct implementation of the QI strategies. Each level has a critical role in ensuring efficient and effective running of the QI initiatives. This section describes the level specific roles and responsibilities to be undertaken in the implementation of guidelines as stipulated in the Tanzania Quality Improvement Framework (TQIF).

6.1 National Level

The MoHCDGEC aims at strengthening of Prevention, Care and Treatment and support services to PLHIV. As RHMTs, CHMTs and implementing partners increasingly scaling up applications of QI models and approaches for HIV and AIDS services, the coordination of implementation of QI activity remains important.

6.1.1 Roles and responsibilities of MOHCDGEC in QI of HIV & AIDS services:

- Review and set QI policies, guidelines and standards based on available evidence and best practices
- Develop strategies and guidelines for implementing all core HIV & AIDS interventions with clear targets and monitoring indicators
- Strengthen and revise a QI coordination mechanism, monitoring and evaluation system, and supportive supervision tools
- Mobilize financial and technical resources for QI implementation and oversight
- Develop and update the tools that are linked with the QI interventions: measurements/ assessment, supportive supervision, mentoring and M&E
- Identify training needs on QI and develop appropriate capacity building and update the existing programme
- Prepare and review the respective QI training curriculum for the national ToTs, ZHRC and RQIT/ CHMT and health service providers.
- Disseminate QI guidelines and tools to regions and relevant stakeholders
- Provide regular technical support to regions in improving the quality of HIV and AIDS services and monitoring of its implementation
- In collaboration with National, Referral and Specialized hospitals provided support and coordination to referral regional hospitals in terms of provision of specialized laboratory testing, clinical mentoring and disseminating evidence based management of HIV and AIDS
- Ensure availability of essential medicines and necessary supplies countrywide by facilitating efficient procurement, storage and distribution to all levels of health service delivery.
- To ensure there is a functional quality improvement (technical) committee
- Conduct operational research for QI HIV and AIDS interventions

6.1.2 Health Quality Assurance (HQA) Division

- Develop strategies and guidelines for implementing at regional and district health authorities and health institutions
- Organize training of trainers on QI initiatives in collaboration with partners

- Coordinating supportive supervisions to all levels regarding QI
- Collection and dissemination of national and international experiences technique data and references with regards to quality.
- Review of relevant MoHCDGEC guidelines and publications to ensure adequacy of standards and compliance with policies.
- Coordination of external recognition programme
- Coordination of the zonal health resource centres with regard to quality improvement initiatives
- Manage QI experts ,national facilitators/trainers information
- Coordination of stepwise certification towards accreditation system and oversee its implementation

6.1.3 Roles and responsibilities of QI Technical Working Group

- Formulate and update periodically a national QI framework and enhance its implementation
- Conduct QI activities at MOHCDGEC Headquarter
- Formulate national standards of services and processes and enhance compliance.
- Ensure that appropriate QI mechanisms are established at different levels
- Supportive supervision and monitor of QI activities at National and consultant hospitals
- Establishment of technical sub-committee
- Develop functional QI structure
- Coordinate sub-committee activities

6.1.4 Roles of National and Zonal Health Resource Centres

- Development of QI strategies and business plan
- Development of organisations vision and mission statement on QI
- Dissemination of health facilities strategies and business plans, vision and mission statement on QI
- Ensure effective top-bottom, bottom-top communication.
- Ensure proper allocation of resources for QI
- Provide technical expertise in QI activities
- Conduct researches on QI issues

6.1.5 Roles and responsibilities of Zonal Health Resource Centre in QI of HIV and AIDS services provision

- Support training of RHMTs and CHMTs in QI
- Provide technical support to RHMTs and CHMTs
- Dissemination of QI guidelines and information
- Conduct supportive supervision and mentoring of QI activities in collaboration with RHMTs
- Evaluation of QI activities in collaboration with RHMTs

6.2 Regional Level

At the regional level, the RHMT and HIV and AIDS Implementing Partner Organizations (IPOs) will work together on QI initiatives in their region. The RHMT, being the Government arm, will provide leadership to all stakeholders in QI activities connected to policy,

coordination, advocacy and communication. The RHMT in collaboration with relevant stakeholders will accomplish the following QI tasks:

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

- Training of regional referral hospital and CHMT in QI in collaboration with ZHRC.
- Provide technical support to regional referral hospital management team and CHMTs
- Dissemination of QI guidelines and information
- Supportive supervision and mentoring of QI activities in collaboration with RHMTs
- Evaluation of QI activities in collaboration with RHMTs
- Identify the regional QI focal person who will be part of the Regional Technical Committee
- Coordinate and provide leadership in the implementation of the QI guidelines in the region
- Provide linkage between MoHCDGEC, Local Government Authorities (LGAs) and relevant stakeholders in QI activities for HIV and AIDS services
- Mobilize key stakeholders to join implementation of the QI guidelines at regional and district levels
- Monitor and supervise performance of districts on priority QI targets and indicators
- Provide regular technical support to districts in implementation of the QI guidelines
- Receive district reports, aggregate and analyse for decision making, planning and management purposes
- Submit reports to national level and share with relevant stakeholders
- Ensure integration of QI activities for HIV and AIDS into all Comprehensive Regional Health Plans (CRHP)
- Distribute and enforce the use of HIV and AIDS intervention guidelines in the districts
- Establish a forecasting and monitoring system of essential medicines and supplies through better supply management systems

6.2.2 Roles of Regional Referral Hospital

The regional hospital, being the referral level within the region, shall provide:

- Clinical services to inpatients and outpatients referred to by district hospitals
- Curative specialist services in the region
- Expert and technical support to district, faith-based and private hospitals as well as primary health facilities on HIV and AIDS services
- Mentorship to district hospitals
- Support scale up e-health and connect to lower health facilities for better referral.

6.3 Council Level

The implementation of the Tanzania health policy has been decentralized to LGAs. The day-to-day implementation of health services including QI is therefore the responsibility of CHMTs. In this regard, LGAs has the responsibility of ensuring availability of adequate resources for provision of quality health services. The following are specific responsibilities of CHMTs in relation to QI activities:

6.3.1 Roles and responsibilities of the CHMT:

- Identify the council QI focal person who will be part of the Council Technical Committee
- Implement HIV and AIDS QI activities in line with QI guidelines at the council level

- Provide a link between CHMT and RHMT, implementing partners, district hospital and other health facilities on QI activities for HIV and AIDS services
- Facilitate training needs of QI teams at facility level in collaboration with in-charges of health facilities
- Strengthen procurement systems to ensure uninterrupted supply of HIV and AIDS commodities
- Provide technical support to Hospitals, and Primary Health Facilities (PHFs) on HIV and AIDS QI related activities in public, faith-based and private facilities
- Conduct supportive supervision to, PHFs in the district on QI activities using approved Comprehensive Supportive Supervision and (CSS) tools
- Oversee QI implementation in the district by conducting review meetings regularly with all health facilities and relevant partners in the district
- Support functioning of the existing system for data collection, analysis, reporting and utilization in all facilities
- Receive facility reports, aggregate and analyse for decision making, planning and management purposes
- Submit monthly and quarterly reports to the region
- Advocate, sensitize and promote HIV and AIDS QI activities at all levels within the district
- Monitor performance of health facilities on priority QI targets and indicators for HIV and AIDS services
- Conduct regular assessments of health facilities in the district to identify priority areas for improvement
- Integrate QI activities for HIV and AIDS services into Council Comprehensive Health Plans (CCHP)
- Disseminate and enforce the use of various National guidelines for HIV and AIDS interventions in health facilities within the district

6.3.2 District Hospital

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

6.3.2.1 Roles of District hospital

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

- Establish and activate functioning of WITs and facility QIT
- Provision of clinical services to inpatients and outpatients referred from primary health facilities and other hospitals within the district
- Provision of curative services at the district hospital
- Providing expert and technical support to primary health facilities; public, faith-based and private facilities on HIV and AIDS services
- Mentoring of HIV and AIDS services to primary Health facilities Improve and scale up e-health and connect to lower health facilities for better referral.

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

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

6.4.1 Roles of Health Facility Management

- Incorporate QI activities for HIV and AIDS services in the health facility plan
- Allocate resources for QI
- Development of organizational vision and mission statement on QI
- Supervise implementation of QI activities
- Promote effective top-bottom and bottom-top communication.
- Establish QI team and WITs
- Describe roles and responsibilities of WITs and QIT members
- Ensure clean and safe working environment (for internal and external clients)
- Collect, compile, validate, analyse, utilize and timely submission of data to the CHMTs.

6.4.2 Roles of the Health Facility Quality Improvement Teams (QIT) and Work Improvement Teams (WITs)

- Identify quality gaps through analysing processes of care within the facility and propose changes for improvement to facility management
- Develop improvement work plans and set targets based on defined national indicators using Standard Evaluation System (SES)
- Test and evaluate proposed changes and innovations using the QI model /PDSA cycles
- Collect, aggregate, present, analyse, utilize , and share data for decision making at facility level
- Submit reports to facility management
- Share QI experience through existing internal and external forums including community health committee on HIV and AIDS
- Liaise with the facility management during implementation of improvement strategies and activities

6.4.3 Roles and responsibilities of Community and Household Levels

Health services at this level encompass Health Promotion, Preventive, Curative, Palliative and Rehabilitative services, all adapted to the needs of the communities and based on public health concerns. With respect to health promotion, it is imperative to note that in order to address the community comprehensively, there is a need to categorise them by age groups e.g. children, youth, adults and the elderly. In addition, because of the society's tendency to overlook the welfare of special groups, more attention has been focused on social protection of marginalised groups e.g. persons with disability and vulnerable children. Implementation of different HIV and AIDS interventions at community level shall adhere to quality improvement model and its approaches.

6.4.3.1 Interventions at Community and Household Levels

The following are the interventions at Community and Household Levels:

- Carry out campaigns on various Community issues guided by National or Global events.
- Tailored individual follow up through home-based care e.g. chronic and long standing illnesses including PLHIV, cancer patients and those under TB-DOTS.
- Specific services such as pregnancy and child growth monitoring or first aid
- Creating awareness through conducting education sessions for the whole community or for targeted groups such as the women and the school children.

- Conduct information, education and communication/behavioural and social mobilisation through community resource persons such as school teachers and other community health professionals
- Training of CHWs including community influential leaders such as religious, traditional and political leaders
- Provision of commodities used for health promotion, prevention, curative and rehabilitative.
- Addressing social determinants of health such as taking environmental actions related to water, latrines and wastes
- Rehabilitation services to people such as those with disability, mental health and those affected with drugs.
- Access to health, nutrition and social services to children, youth, elderly, OVC, MVC, PLHIV and Gender Based Violence (GBV).
- Psychosocial support such as to people with long standing illnesses including those living with HIV and AIDS, cancer and after violence.
- Educating communities on their rights and responsibilities for quality health care
- Empowering them to demand for quality health services
- Involve community in assessing quality of health care and developing community health action plans

6.4.3.2 Roles of Community Members

- Managing resources of health facilities
- Demand for quality health services
- Respond to actions by health workers
- Assess quality of health services

Section 7: Operationalization of Quality Improvement Activities Across Levels of Care

7.0 Operationalization of Qi Initiatives Across Levels of Care

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

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

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

7.1 Assessment of Health Facilities

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

- Determine the availability and quality of the essential elements to start and/ or expand HIV and AIDS services
- Identify areas that needs strengthening and improvement to upgrade health facilities to a level that they will be able to provide comprehensive HIV and AIDS care, treatment and support services.

Assessment is an ongoing process through which areas for improvement are identified and strengthening plans developed. Assessment of the HFs using approved Facility Assessment tool is the responsibility of RHMTs in collaboration with CHMTs and Implementing Partners working in the respective region/ council. Areas of assessment in a health facility include:

- Organization of HIV and AIDS services
- Human resource capacity
- Training and guidelines
- Clinical HIV and AIDS services
- Patient records and reporting systems
- Continuum of care and treatment service
- HIV Testing and counselling services
- Laboratory services
- Pharmacy services
- Finances

7.2 Service Provision and Quality Improvement

Implementation of all HIV and AIDS interventions are guided by the national guidelines (see annex I). For harmonization and standardization of practice, stakeholders involved in service provision shall adhere to these national guidelines. In addition, principles and dimensions of Quality that are described in section 4 and the Improvement Model and approaches that are described in section 5 shall be applied to improve quality of HIV and AIDS services.

7.3 Supportive Supervision

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

Supportive Supervision of HIV and AIDS services is guided by the manual of comprehensive supportive supervision and mentoring of HIV and AIDS services and its tools.

7.4 Clinical Mentorship

Mentorship is a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality health outcomes. It is an integral part of the continuing education process taking place at the facilities where HSPs manage clients. Clinical mentorship visits shall be done after the supportive supervision visits have been completed.

Effective mentorship on HIV and AIDS services to HSPs involves regular visits by regional and council mentors who spend time with HSPs at lower levels of service delivery, providing regular on-job-training on various aspects of HIV and AIDS interventions.

7.4.1 Differences and Similarities between Mentorship and Supportive Supervision

There exist some differences and similarities between supportive supervision; and mentorship as outline in the table below:

Table 1: Differences and Similarities between Supportive Supervision and Mentoring[12]

Supportive supervision	Similarities of SS and Mentoring	Clinical mentoring
• Space, equipment, and forms • Supply chain management • Training, staffing and other human resource issues • Entry points • Patient satisfaction	• Patient flow and triage • Clinic organization • Patient monitoring and record keeping • Case management • Observation • Team meetings • Review of referral decisions	• Clinical case review • Bedside teaching • Journal club • Morbidity and mortality rounds • Assist with care and referral of complicated cases • Available via distance • Communication

7.5 Monitoring & Evaluation

Monitoring is a systematic and routine periodic collection of information from projects and programs for the purposes of learning from experiences, improving practices and activities in the future, having internal and external accountability of resources used and the result obtained, taking informed decisions on the future of the initiatives and promoting empowerment of beneficiaries of the initiatives (*sportanddev.org*).

Evaluation: Is assessing as systemically and objectively as possible a completed project or program with the purpose of drawing a conclusion about interventions which are relevant, effective, efficient, impact leading and sustainable. (*sportanddev.org*)

A monitoring and evaluation (M & E) system for HIV and AIDS services is made up of forms, cards, registers, records (electronic and paper) and procedures to collect and report information on indicators used to track programme activities and examine whether the programme is meeting its goals.

An Indicator is a variable used to measure progress towards the stated goals objectives and target of the programme, allowing managers to assess progress towards benchmarks. It is a specific measure of programme performance that is tracked over time by monitoring system. The value of an indicator in itself is usually of limited use however, unexpected values or changes in the indicator value suggested the need for further investigation.

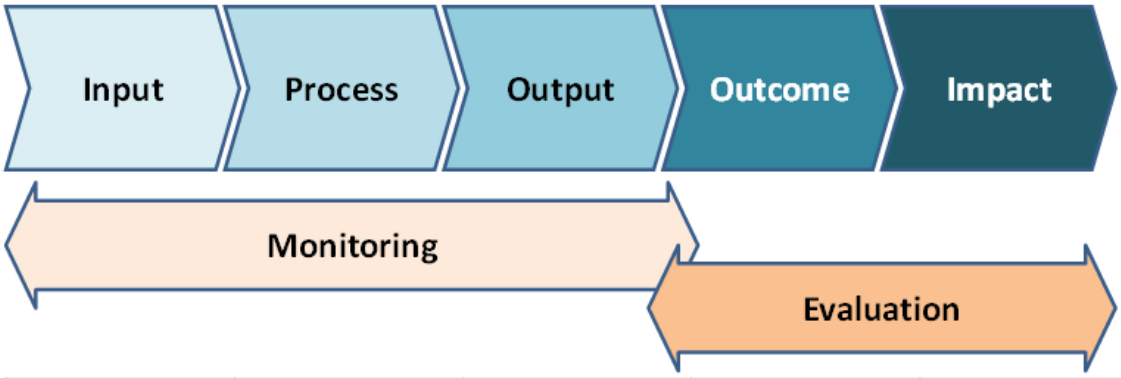
Indicators are usually selected and target set during the process of programme planning. The choice of indicators will also depend on what services are being offered and the capacity of programme to carry out monitoring and evaluation.
(WHO A guide to M&E for collaborative of TB/HIV activities, 2015 Rev)

Monitoring and Evaluation Framework

The commonly M&E framework used in Tanzania composes of:
Inputs: All recourses that are put into a system to obtained a desired output eg; people, finances, infrastructure
Processes: These are series of actions or changes that brings about a result e.g. training, procurement.
Outputs: the materials that are produced or result of a process.eg. Number of HCPs trained
Outcomes: These are changes that occur both immediately and sometime after activities are completed e.g. Changes in knowledge, behavior, altitudes and skills.
Impact: The wider effect of the program on long term result e.g. Decreased in HIV transmission rates, Decrease maternal mortality rates.

M & E Framework

Figure 4: M & E Framework



Input	Process	Output	Outcome	Impact
• Fund • HSPs • Trainers •Training facility	Training on PMTCT services	Increased # of trained HSPs on PMTCT	Increased % of HIV+ pregnant women received PMTCT services	Increased % of HIV- infants born from HIV+ mothers

Objectives of the M&E framework are:

- Monitoring of implementation progress of National HIV and AIDS interventions
- Timely identification of constraints hindering the implementation process and measures taken to address gaps
- Demonstration of programme effectiveness and impact.
- Evaluation of programme performance
- For the M & E system to function properly, managers at all levels need to ensure that monitoring tools are available and HSPs are oriented in the use of tools. HSPs should also ensure that data are collected, stored compiled, aggregated, analyzed, interpreted, presented, utilized within the HF and shared to the relevant authorities in line with prescribed deadlines. Furthermore, HSPs shall use the collected data for improvement of the quality of the services.

Data Quality:

Quality data is the data that is reliably and accurately represent the measure it was intended to present. This also refers to the degree of excellence exhibited by the data in relation to the description of the actual phenomena or totality of features and characteristics of data that bears on their ability to satisfy a given purpose; the sum of the degrees of excellence for factors related to data. High levels of data quality are achieved when information is valid for the use to which it is applied and when decision makers have in and rely upon the data.

Guiding principles on quality data

The guideline to ensure quality data is collected, reported and utilized is founded on the seven dimensions of quality data:

Accuracy:
The data collected and reported should be accurate or valid. This means it is shall be correct and measure what they are intended to. Accurate data is recorded from appropriately selected means for data generation.

Reliability:
The data recorded and reported must be reliable. This means it shall be collected based on protocols and procedures which does not change among the users in time and frequency.

Completeness:
All data tools used for recording and reporting shall be completed. This means all variables in either reporting or recording tools must be and not left

Precision:
The data collected must be precise. This means it must have all the parameters and details needed to produce the required information.

Timeliness:
The reports submitted to any level must be timely. This implies all the reports produced shall be submitted to the next level within the recommended timeframe.

Integrity:
All data must ensure Integrity. This means data generated by a program is protected from deliberate bias or manipulation for any reason be it political or personal.

Confidentiality:
All data must be kept. This means data collected is maintained and prevented from any access by unauthorized person. The data shall not be exposed to any person until permission from the relevant is obtained.

Data Quality Assurance
This is the process of verifying the reliability and effectiveness of data. Maintaining data quality requires going through the data periodically and scrubbing it. Typically this involves updating it, standardizing it, and de-duplicating records to create a single view of the data, even if it is stored in multiple disparate systems

Data Quality Control:
This is the process of controlling the usage of data with known quality measurement -for an application or a process.

Data Quality Assessment:
This is a procedure for determining whether or not a data set is suitable for its intended purpose.
Data Quality Assessments involve checking data against- Validity, Integrity, Reliability, Timeliness, Precision and Assessments help us determine areas of poor data quality and potential solutions. Data quality improvement is done through the following - Training Implementers, Mentorship, Supportive Supervision, Spot Check, Data Review in data collections tools (e.g. Registers and Monthly Reporting forms) and preparation of standard operations procedure in every level.

Annex 1: List of Contributors

The following individuals deserve a special mention for the efforts they put in updating the national guidelines for quality improvement of the HIV and AIDS services:

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Annex 2: A List of HIV and AIDS Interventions-Specific Guidelines

S/N	Name of Guidelines	Year Published
1.	National Guidelines for the Management of HIV and AIDS	2015
2.	National Guidelines for HIV Testing and Counseling in Clinical Settings	2013
3.	National Guidelines on Prevention of Mother to Child Transmission of HIV	2007
4.	National Guidelines for Management of Sexually Transmitted and Reproductive Tract Infections	2007
5.	National Comprehensive Guidelines for HIV Testing & Counseling	2013
6.	Guidelines for Home Based Care Services	2005
7.	National Guidelines for Comprehensive Package of HIV Interventions for Key Populations	2014
8.	National Policy on Collaborative TB and HIV services	2007
9.	National Standard Operating Procedures for Management of HIV and AIDS	2016
10.	National Training Manual for Health Care Providers on KP HIV and Health Friendly Services	2014
11.	National Training Package for Comprehensive Management of HIV and AIDS	2015
12.	Pharmacy Module Data Base Training Package	2014
13.	Standard Operating Procedure for Managing ARVs and OIs Drugs	2012
14.	National Guidelines for the Management of HIV and AIDS Data Quality	2012
15.	National HIV and AIDS Patient Monitoring System	2014
16.	The Tanzania Quality Improvement Framework in Health Care 2011-2016	2011
17.	National Guidelines for Quality Improvement of HIV and AIDS Services	2016
18.	National Essential Health Sector HIV and AIDS Interventions Package	2010
19.	A Manual for Comprehensive Supportive Supervision of HIV and AIDS Services	2016
20.	A Tool for Comprehensive Supportive Supervision of HIV and AIDS Services	2016
21.	Tools for Mentoring of HIV and AIDS Health Services	2016
22.	National Guideline for Voluntary Medical Male Circumcision (VMMC) and Early Infant Male Circumcision (EIMC)	2015

23.	National Health Sector HIV and AIDS Strategic Plan III	2013
24.	National Multi-sectoral Strategic Plan IV	2013

Annex 3: Tanzania HIV and AIDS Patient Care and Treatment Indicators

sn	Indicators or other aggregated data	Rationale	Reporting Obligation
1	Percentage of clients who are alive and on ART X months after start of ART (X= 12,24,36 and 48 months) **(Retention)**	Assesses progress in providing ART to every person with advanced HIV infection. Monitors trends in coverage	National, UNGASS, UA , EWI
2	Percentage of persons started first-line ART who are still on first-line ART X months later **(Retention)**	Early warning indicator for HIV drug resistance	National EWI
3	Number of persons enrolled into HIV care: (a)new and (b)cumulative ever at the facility by age and sex **(Access)**	Identifies gross numbers of patients enrolling in HIV care, contributing to national targets and progress of scale-up	National
4	Number of persons started on ART: (a)new and (b)cumulative ever started at the facility by age, sex and pregnancy status (**Access)**	Identifies gross numbers of patients starting on ART, contributing to national targets and progress of scale-up	National
5	Number of persons receiving HIV care during period by age and sex **(Access)**	Identifies reach and accessibility of HIV care during scale-up, informs facility-level planning	National Global fund
6	Number of persons currently on ART at the facility by age, sex and 1st-line or 2nd-line regimen (Numerator for UNGASS and National Core 7) **(Access)**	Assesses progress in providing ART to every person with advanced HIV infection	National Global Fund
7	Number of persons medically eligible for ART but not yet started by age and sex. **(Access)**	Identifies reach and accessibility of ART during scale-up	National
8	Number of persons currently enrolled in care receiving Cotrimoxazole (**Access)**	Allows monitoring of Cotrimoxazole use, drug supply management.	National
9	Number of persons currently on ART receiving Cotrimoxazole (**Access)**	Allows monitoring of Cotrimoxazole use	National

sn	Indicators or other aggregated data	Rationale	Reporting Obligation
10	Percentage of patients currently on ART whose status is (working, ambulatory, bedridden) **(wellness)**	Patient productivity, quality of life, and therefore ART success	National
11	Percentage of health facilities that offer ART (UA) **(Access)**	Measures access to Care and Treatment services	UNGASS
12	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy. **(Access)**	The indicator measures coverage of ART among those who need it.	UNGASS
13	Percentage of individuals starting ART who are prescribed a standard regimen.**(Access)**	**Numerator:** Number of individuals initiating first-line ART at the site who are prescribed an appropriate first-line regimen during the selected time period **Denominator:** Number of individuals starting ART during the selected time period ***Set target: 100%***	National EWI
14	Percentage of persons lost to follow-up during the 12 months after starting ART. **(Retention)**	**Numerator:** Number of individuals starting ART during a selected period of time in the previous year who were subsequently classified as "LOST TO FOLLOW UP"* during the first 12 months of ART **Denominator:** Number of individuals starting ART during the selected time period in the previous year ***Set target: < 20%*** ******"Lost to follow up" is defined as having missed three consecutive months of drug pick-ups and clinical appointments.*	National EWI
15	Percentage of persons starting first-line ART who are still on first-line ART 12 months later**. (Retention)**	**Numerator:** Number of individuals starting ART during a selected period of time in the previous year who are (12 months from ART start) still on first-line ART (this includes substitutions of one standard first-line regimen for another). **Denominator:** Total Number of individuals starting ART during a selected time period in the previous year ,minus the number of individuals starting ART in that time period who were transferred out during the 12	National EWI

sn	Indicators or other aggregated data	Rationale	Reporting Obligation
		months after starting ART. However, individuals who died, stopped ART, switched to second-line ART, or were lost to follow-up must be included in the denominator. ***Set target: > 70%***	
16	Percentage of persons who attended all appointments during a year. **(Retention)**	**Numerator:** number of individuals who were on ART at the end of the previous year or who started ART at some time during the present year who kept all appointments on time in the year up until the time they were classified as lost to follow-up, dead, transferred out, or stopped ART **Denominator:** number of individuals who were on ART at the end of the previous year or who started ART at some time during the present year **Set target**: 80%	National EWI
17	Percentage of HIV positive persons who were screened for TB in HIV Care or Treatment setting **(Access)**	**Numerator** **Denominator**	New national indicator for TB/HIV collaborative activities
18	Percent of HIV positive persons in HIV Care or Treatment (pre ART or ART) who started TB treatment **(access)**	**Numerator** **Denominator**	New national indicator for TB/HIV collaborative activities
19	Number of HIV positive persons who are clinically malnourished who received therapeutic and or supplementary food **(wellness)**	**Nutritional support**	New national indicator

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