

**Kingdom of Cambodia  
Nation King Religion**



**Ministry of Health**

**Standard Operating Procedure (SOP)  
For the Continuous Quality Improvement of HIV Care and  
Treatment Program in Cambodia**

**Second Revision 2021**



**National Center for HIV/AIDS Dermatology and STD**

## PREFACE

Cambodia is one of only seven countries worldwide to have achieved the 90-90-90 targets which translates into 73% of all people living with HIV being virally suppressed. Cambodia has gone even further by setting a national goal of getting 95% of PLHIV diagnosed, 95% of diagnosed PLHIV on treatment, and 95% of PLHIV on treatment virally suppressed by 2025.

At the end of 2019, there are 68 ART clinics where HIV/AIDS care and treatment have been providing to 61,299 patients countrywide. Although the estimated annual number of new infections is declining, there were 3,831 patients reported newly registered in care and treatment in 2019. National Center for HIV/AIDS, Dermatology, and STD in collaboration with all partners working on the HIV area in Cambodia assure the provisions of all HIV-related services have high quality. The quality of care at ART facilities, the quality of laboratory services, the quality of HIV-related data, and the uses of the quality data to continuously improve the quality of the continuum of care at all levels and point of services are the main focus of the standard operational procedure.

The Ministry of Health would like to congratulate NCHADS and all development partners who were actively participating in developing and updating this Standard Operational Procedure (SOP) for Continuous Quality Improvement for Continuum of Care for People Living with HIV/AIDS in Cambodia. The SOP is important and helpful to guide our health care providers at all points of care of the HIV program to maintain and improve their performance, quality of services, quality of data and uses; hence to improve the quality of life of HIV infected patients.

Ministry of Health officially approves the SOP and expects that all involving stakeholders will implement the continuous quality improvement effectively to improve quality of life of the people living with HIV/AIDS and help the country reach its 95-95-95 goals by 2025. *-NB*

Phnom Penh, ... *03 June* ... 2021

  
**Minister of Health**  
*[Handwritten signature]*  
**Prof. ENG HUOT**  
SECRETARY OF STATE

## ACKNOWLEDGEMENT

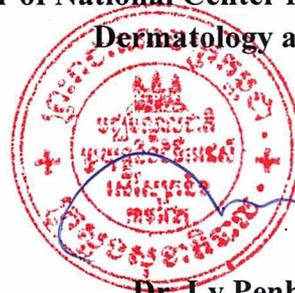
On behalf of NCHADS, I would like to express my sincere appreciation and gratitude to all who contributed to the development of this standard operational procedure, working group members, and representatives from WHO, UNAIDS, US-CDC, FHI360(EpiC), AHF, CRS, CHAI and others who dedicated their valuable time and efforts to provide inputs and successfully create and update this important document.

NCHADS also would like to special thanks to Dr. Samreth Sovannarith, Dr. Ouk Vichea, deputy director of NCHADS, Dr. Ngauv Bora, chief of technical bureau of NCHADS, Dr. Khol Vohith, chief of Research Unit, Dr. Sau Sokunmealiny, vice chief of Research Unit, Mr. Tep Romaing, Mr. Phal Sophat, Mr. Nhim Dalen, technical officers of EpiC project and Dr. Chan Sodara, Public Health Specialist of US-CDC who significantly contributed to the update of the latest version of the SOP.

Phnom Penh, 25 May 2021

**Director of National Center for HIV/AIDS**

**Dermatology and STD**



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## ABBREVIATIONS

ACU	AIDS Care Unit
ART	Anti-Retroviral Therapy
CAA	Community Action Approach
CENAT	Centre National Anti-Tuberculosis
COC	Continuum of Care
CQI	Continuous Quality Improvement
FEW	Female Entertainment Workers
HBC	Home-Based Care
M&S	Monitoring and Supervision
MCH	Maternal and Child Health
NMCHC	National Center for Maternal and Child Health Center
MMD	Multi-Months Dispensing
MMM	Mondul Mith Chuoy Mith (Friend Help Friend Center)
MSM	Men who have Sex with Men
NCHADS	National Center for HIV/AIDS, Dermatology, and STD
OD	Operational District
OD-CoC-CC	Operational District- Continuum of Care-Coordination Committee
OI	Opportunistic Infection
PASP	Provincial AIDS and STI program
PDCA	Plan Do Check Act
PHD	Provincial Health Department
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PSF	Patient Satisfaction Feedback
PWID/PWUD	People Who Inject Drugs/People Who Use Drugs
SOP	Standard Operating Procedure
TG	Transgender
TLD	Tenofovir Lamivudine Dolutegravir
TPT	TB Prophylaxis Therapy
TWG	Technical Working Group
VCCT	Voluntary Confidential Counselling and Testing

## 1. Background and Rationale

Cambodia was congratulated for reaching the global target of 90-90-90 in 2017 three years before the world's deadline. Reaching the global 90-90-90 targets is an important feature of Cambodia's national AIDS response: that's 90% of people knowing their HIV status, 90% of people who know their status accessing treatment and 90% of people on treatment being virally suppressed.

Given the promising national progress in scale-up of treatment services, Cambodia has set a national goal of getting 95% of PLHIV diagnosed, 95% of diagnosed PLHIV on treatment, and 95% of PLHIV on treatment virally suppressed in order to eliminate new HIV infections as a public health problem by 2025.

Preparing to reach the 95-95-95 targets, NCHADS employs a strategy that has already had proved in the HIV response for more than two decades – uniting diverse stakeholders, integrated approach, and using quality data to ensure accountability for results. Various essential guidelines, protocols, and standard operational procedures were developed, updated, or adopted from WHO or other international guidelines such as, but not limited to following documents:

- National HIV clinical management guidelines for adults and adolescents (2015, revised 2020)
- Same-day ART guidelines (2019),
- Operational guidelines for implementation of HIV viral load routine testing (2017),
- Guidance to enhance ART adherence, viral load monitoring, and regimen optimization to improve HIV viral suppression among PLHIV on ART (2017),
- Standard operational procedure for data quality assurance (2019),
- Standard operating procedure for Clinical mentoring (2014),
- Standard operating procedure for the continuous quality improvement for continuum of care for people living with HIV in Cambodia (2012, revised 2018),
- User guides for CQI dashboard indicators.

So far, the implementations of these various guidelines/SOP are undertaken by various units of NCHADS and partners independently. Some new initiations and updated tools, guidelines and implementation guidance have recently taken place. Therefore, the update of roles and responsibilities for all components involve are needed; and update the list of indicators will facilitate all stakeholders to implement and measure successes of HIV program in providing quality services to reach the 95-95-95 goals.

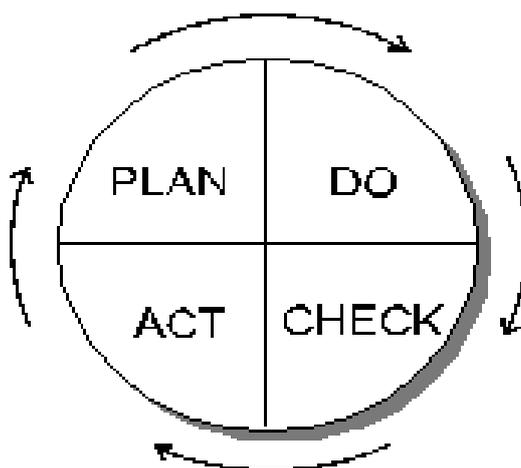
## 2. Origin of Continuous Quality Improvement from W. Edwards Deming

W. Edwards Deming began working in Japan in 1950 and was instrumental in building the Japanese industry into an economic world power. His strongly humanistic philosophy is based on the idea that problems in a production process are due to flaws in the design of the system, as opposed to being rooted in the motivation or professional commitment of the workforce. Under Deming's approach, quality is maintained and improved when leaders, managers and the workforce understand and commit to constant customer satisfaction through continuous quality improvement (CQI).

Deming and his colleague, Shewhart, promoted the PDCA cycle -- Plan, Do, Check and Act.

**PLAN** to implement a policy to improve quality and/or decrease the cost of providing services. After the plan is developed, we **DO** it by putting the plan into action and then **CHECK** to see if our plan has worked. Finally, we **ACT** either to stabilize the improvement that occurred or to determine what went wrong if the gains we planned for did not materialize. PDCA is a continuous cycle; any improvement realized by carrying out one PDCA cycle will become the baseline for an improvement target on the next PDCA cycle. The process of improvement (PDCA) is never ending, although the dramatic improvements of initial PDCA efforts may be hard to sustain.

Figure 1: The PDCA Cycle



CQI is a problem-solving method.

CQI focuses on system problems; rather than people problems.

CQI examines processes to identify areas for improvement; defects are analyzed using statistical principles and, when identified, are considered to be opportunities for improving the process.

In CQI, standards are based on best-practice models and national guidelines that are emulated throughout the system.

### 3. Objectives

Overall objective

To maintain high quality of HIV program services across the continuum of care for PLHIV in Cambodia.

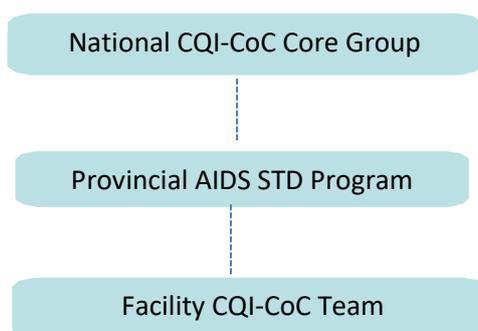
Specific objectives:

1. To obtain quality data of HIV care and treatment and its efficacy,
2. To assure the quality of HIV care and treatment services including related laboratory services,
3. To build the culture of using of quality data to improve the quality of services,
4. To maintain high performance of ART clinics in providing care and treatment related services to PLHIV.

## 4. Structure, Role and Membership

### 4.1 Structure of CQI-CoC

Figure 2: Structure of CQI-CoC



There are three levels for the implementation of the CQI-CoC activities – the National Core Group, the Provincial AIDS and STD office, and the onsite CQI-CoC team (Figure 2). The National CQI-CoC Core Group builds the capacity of facility CQI-CoC Team to implement CQI and provide quality services to PLHIV; and PASP such that PASP can continuously and directly support, monitor, facilitate and coordinate the facility CQI-CoC teams. The facility CQI-CoC team members are the critical players responsible for implementing CQI such that the full PDCA cycle occurs and translates into improved quality of care.

The skills at all three levels necessary to implement CQI include but are not limited to:

- Clinical skills, clinical competency, and understanding of patient care and treatment services including viral load, CD4 and other necessary laboratory related tests.
- Knowledge on obtaining and producing quality data,
- Knowledge and skills on data management, data analysis, and use of data,
- Knowledge and skills on problem solving, and planning.

### 4.2 Members and Responsibility of CQI Team at each level

#### 4.2.1 Members and Responsibility of National CQI-CoC Core Group

##### 4.2.1.1 Members of National CQI-CoC Core Group

- Director of NCHADS
- Chief of Data Management Unit, NCHADS
- Chief of AIDS Care Unit, NCHADS
- Chief of Research Unit, NCHADS
- Chief of Surveillance Unit, NCHADS
- Chief of laboratory Unit, NCHADS
- Representative from PLHIV

- Representatives from development partners
- Representative from CENAT
- Representative from NMCHC who is responsible for PMTCT.

#### **4.2.1.2 Responsibilities of National CQI-CoC Core Group**

- Develop and review the annual plan for CQI
- Develop and amend the Standard Operation Procedure (SOP) of the CQI
- Monitor and evaluate the implementation of CQI
- Support sub-national level include PASP and ART teams to solve any problems or issues encountered
- Builds capacity of PASP and train PASP to train sub-national teams through teaching sessions, onsite coaching, or peer-learning
- Analyze data collected from sub-national level, generate results and provide feedback to the PASP, ART sites for quality improvement on a timely and regular basis
- AIDS Care Unit (ACU) of NCHADS is the point of contact of the National CQI COC Core Group to oversight the implementations of the national guidelines, concept notes, and all other national documents related to HIV care and treatment in Cambodia to assure the quality of care and treatment and its efficacy by building, maintaining, updating, or improving the clinical capacity and clinical competency of ART teams in a regular manner.
- Research Unit (RU) is the point of contact of National CQI COC Core Group to oversight the development of culture of uses of up-to date evidence-based, to document the advantages or disadvantages of the newly introduced interventions/regimens in the healthcare settings. RU also reports patients' satisfactions of quality of HIV care and treatment services to the National CQI COC Core Group.
- Data Management Unit is the point of contact of the National CQI COC Core Group to oversight the data management and quality of HIV program data, to keep up to date the CQI dashboards according to the update of care and treatment guidelines.

#### **4.2.2 Members and Roles of OD-CoC-CC (Onsite CQI-CoC Team)**

##### **4.2.2.1 Members of OD-CoC-CC (Onsite CQI-CoC Team)**

- Director of OD
- Chief of ART site
- ART team
- Representative from laboratory unit
- Representative from TB unit
- Representative from MCH unit
- Representative from Drug unit
- Data person
- CAA team
- Representative from development partners.

##### **4.2.2.2 Responsibilities of OD-CoC-CC**

- Supports the implementation of CQI for HIV program according to the SOP at OD level.
- Conducts quarterly CQI meetings to monitor and update the team on HIV program performance and follows the cycle of P-D-C-A to assure the quality of care and treatment

services.

- Conducts supportive supervisions to low performance sites (if OD has more than one ART sites) to follow-up and support the implementations of the improvement developed during the quarterly meetings.
- Attends technical forums, meetings, and CQI-related trainings...etc.
- Collaborates with the National CQI-CoC Core Group to document the outcomes of any initiatives or interventions as required.

#### **4.2.2.3 Responsibilities of onsite CQI-CoC Team**

- Ensures the quality of data so that they are complete, correct, consistent, and timely
- Collects, enters, and sends the data, to the PASP on a regular basis and in a timely manner
- Regularly monitors and reviews site performance through use of CQI dashboards and team meetings
- Collaborates with PASP to conduct supportive supervisions to identify problems, causes of the problems, develop, or modify improvement plan as appropriate following the processes of P-D-C-A
- Attend technical forums, meetings, and CQI-related trainings...etc.
- Collaborates with the National CQI-CoC Core Group to document the outcomes of any initiatives or interventions as required.

#### **4.2.3 Coordination Roles of PASP**

PASP has an important role in coordination of the onsite CQI-CoC teams to develop CQI implementation plans and to implement CQI smoothly.

The coordination role of PASP is as follows, but not limited to:

- Incorporates the CQI plan from each site into the PASP's CQI plan at provincial/city level
- Coordinates with the national program and all ART sites in their province to solve problems or issues such as poor data quality, lack of supplies, or resource issues
- Ensures data collected and sent to province from site level are correct and timely to national level
- Assists and builds capacity of staff at ART sites to use CQI dashboards and analyzes information for both program improvement and individual patient care improvement
- Advocates and facilitates stakeholder collaboration to ensure evidence-based technical and resources allocation to CQI activities
- Facilitates in conducting technical forum or meetings, such as CQI quarterly workshops, CQI TWG meetings...etc., to promote use and triangulation of CQI data with other data sources (e.g., B-IACM, TB program, etc.) for programmatic improvement
- Provides appropriate supports for data management to HIV program staff at OD level to ensure the quality of data management (data collection, data entry, and data analyzes) and data use for CQI implementations,
- Collaborates with and facilitates the national CQI-CoC Core Group to document the outcomes of any initiatives or interventions as needed.

### **5. Implementation of Continuous Quality Improvement**

The standard operational procedure defines continuous quality improvement (CQI) and describes how to implement it in HIV care and treatment program, particularly in the ART sites, at operational district, at provincial ADIS, and STD program, and at the national program levels.

Continuous quality improvement of the continuum of care is very important not only for the quality of life of the people living with HIV, but also to limit ARV drugs resistance, to prevent new infection, and to maximize the retention of patients in care across the whole HIV cascade.

ART sites in Cambodia have been implementing CQI concepts in order to maintain and improve quality health care services, and these practices become a routine practice for all health care providers.

The implementation of CQI follows the concept of P-D-C-A. P – Plan: health care providers plan their intentions (objectives), indicators, and targets of what they want to achieve; and activities of what they will do to reach the targets they plan. D – Do: health care workers do activities they planned. C – Check: after implemented the activities, health care workers have to check whether the targets in their objectives reached or not. To be able to check, health care workers have to document the outcomes from their activities by collecting, recording, entering, and analyzing the data from their documentations. A – Act: health care workers take necessary actions to improve the outcomes. To be able to take the right actions, health care workers identify the problems, prioritize them (section 4.4) and do the root cause analyze. Figure 3 outlines steps in implementation of CQI activities.

Figure 3: Steps in implementing continuous quality improvement



## 5.1 Data collection

Patient information including general information, clinical information and laboratory information are routinely collected by health care providers from each individual patient visits the ART clinic, then the data are entered and saved in the ART database. Health care providers who collect the data include clinicians, nurses, counselors, laboratory technicians, and CAA team that works in the health facilities.

Data of all patients that the health care providers collect during the day should be daily computerized (entered) by the data entry clerk at ART site.

## 5.2 Quality check and clean electronic database

### 5.2.1 Data quality assurance by data entry clerk

Data entry clerk should enter all information for all patient records on the day of ART service provision into the database. Data quality control can be done at this stage by the data entry clerk. At a minimum, she/he should perform the following activities in order to ensure data quality:

- Before starting to enter the data, the data entry clerk should count the number of patients charts the service completed that day and compares with the list of appointments on that day. The number of patient charts can be:
  - o The same as number of appointments,
  - o More than number of appointment if some patients come for visit earlier,
  - o Less than number of appointment if some patients did not come for visit.
- Enters all required fields according to data entry guidance stated in the Data Quality Assurance SOP.
- During data entry, if noting any missing data (i.e., not ticked, blank, etc.), unclear script, or inconsistent data, she/he must note all of these in a notebook and get clarifications immediately, or at the any convenient times as soon as possible. These corrections should be made immediately before starting data entry of the next cohort of patients.
- After completing entry all patient charts of the day, she/he should check the completeness of the records and some selected required variables as discussed with the ART team, for example, clinic ID, ART number, date of confirmatory test, date start ART, date of visit, date of next appointment, and viral load test.

In addition, the ART team will meet on a weekly basis to discuss problems that arise while entering data containing in patient records into the database, such as unclear script, unclear number, no data were recorded/written in the patient file, etc. These problems will be recorded in the notebook of data entry clerk, with a comment about how the problems encountered were overcome.

The weekly meeting is important to ensure that the highest quality data are gathered, processed, maintained and used.

The data entry staff will save the dataset on a regular basis on an external hard drive as a backup file following the instructions from the Data Management Unit of NCHADS.

### 5.2.2 Validation of electronic data using patients' charts

The site managerial team should perform the following steps to validate the data quality:

- Obtains a 5% random samples of patient records in the database.
- Checks the data against the charts.

- For each field, check the number of discrepancies between the paper record and the electronic record.
- Records the discrepancies, verifies, finds out the cause and make correction so that they reflect the actual information in the patient files and prevent repeated errors in the future.

The data quality validation should be done on a regular basis (for example, monthly) by comparing the data in the electronic file and data in patient files.

The PASP officer should control the quality of data at least quarterly basis following the DQA SOP of NCHADS. The Team should perform the data quality check, including completeness (make sure there is no missing data for each variable of interest in each patient record and there is no missing records), code consistency (make sure the entered code is the same as the one recorded on paper), and accuracy (for example, date when IPT is stopped should never be the same as date when IPT is started). The data should be collected and reported in timely manner.

5.2.3 NCHADS will check the data quality while compiling data sets from all ART sites, looking for missing or illogical or the completeness and accuracy of selected key CQI variables, such as clinic ID, ART number, date of confirmatory test, date start ART, date of visit, date of next appointment, and viral load tests.

### **5.3 Analysis and interpretation of the CQI indicators**

Data analysis is a process of transforming data into information. Data analysis does not necessarily mean using a complicated computer analysis package such as STATA, SAS, Excel, or other software. It means taking the data that we collect and looking at them in the context of the questions that we need to answer. For example, ART team may ask what is the percentage of same-day ART among today's patients? Or how many patients are prescribed ART for 6 months of the total patients today? There are several different methods that CQI data should be routinely reviewed.

ART sites should review their daily performance on key CQI indicators routinely, for example, the number of patients who need viral load test, number of new patients enrolled, number of patients putting on MMD (for example, 6 months by verifying the date of visit and date of next appointment), number of patients receive same-day ART, etc. since this is just a count number.

The summary analysis of CQI indicators should be also done on a regular basis, at least every quarter. The onsite CQI-CoC team is encouraged to analyze, interpret and use the results from their own data to monitor their services quality with appropriate supports from PASP and development partners in the province. At a minimum ART site should monitor their own performance on some important indicators, including:

- % of ART patients who died
- % of ART patients who were lost to follow-up
- % of ART patients come for visits "on time"
- % of PLHIV known to be on treatment 12 months after initiation of ART
- % of ART patients completed TPT course
- % of ART patients with viral load results at 12 months after initiating antiretroviral therapy
- % of ART patients tested for viral load with level <1000 copies/mL at 12 months after antiretroviral therapy initiation

- % of ART patients have received MMD  $\geq$  3 months
- % of ART patients are on TLD regimen
- % of SDART among new ART patients.

The CQI quarterly analysis dashboard can also be used by the province (PASP), and relevant Units at NCHADS, for example, Research Unit, and AIDS Care Unit to review sites' performance, develop action plans, or identify relevant interventions to support sites to continuously improve the quality of HIV care and treatment services.

## **5.4 Problem Analysis, Prioritization, Proposed Solution and Action Plan**

### 5.4.1 Identify problems indicated by key indicator analysis

Using the daily report generated by data entry clerk and the team as mentioned early, each week the onsite CQI-CoC team should generate a list of patients who require immediate follow-up. For example, patient who did not initiate ART within 07 days, patients who missed last appointment, patients who missed viral load testing appointment, patients with viral load greater than 1,000 copies/ml, or patient with missing critical data, etc. These lists can be reviewed to determine if it is a data-related problem, a problem related to the facility system, a problem related to health providers' practices, or a problem related to the patients. An action plan should then be developed accordingly for improvement purposes (see examples in Annex 4).

Each quarter, after reviewing the CQI quarterly onsite dashboard, the facility director, site manager and PASP will organize a meeting to review the results and identify "alarm points" for flagging problems when there is a failure to meet a pre-defined threshold for a desired outcome or when a pre-defined threshold for a negative outcome has been exceeded.

It is important to improve the communication between clinician team, other health service provider team, CAA team and data management team to ensure productive participation in this CQI process.

### 5.4.2 Problem analysis and development of the action plan to solve the identified problems

The onsite CQI-CoC team will work together to identify the root causes of problems and identify appropriate solutions to solve these problems. There may be many problems occurring during the quarter, so the team should prioritize them based on such as magnitude of the problem, how strong it impacts on the quality of services, potential to cause death, potential to result in another problem, or feasibility of solving the problem, etc. Three minimum criteria have been used in prioritizing a problem: **important, urgent, and feasible**.

After selecting the most prioritized problem(s), the team will further analyze to look for its causes by simply asking what caused the problem. Onsite CQI-CoC team with technical support from PASP and/or appropriate partners will then develop an action plan to address the causes of the problem. The action plan should be developed based on criteria below:

- Relevance to the defined problem
- Feasibility of implementation
- Integration with existing activities
- Effectiveness
- Ease in targeting
- Cost effectiveness

- Ease in evaluation.

The action plan should be specific about the steps necessary to ensure improvement in the indicator in question and should give a timeline for the sequence of actions planned. The team is encouraged to use the problems solving matrix attached in Annex 3 (see examples in Annex 4). Below are several examples of the causes associated with a particular problem.

**Example 1:** If low percentage of patients are on MMD for 6 months, the team should ask if it is due to a lack of understanding the SOP for MMD implementation or a lack of drugs in stock at site, site has plan for MMD or not, for example. Depending on the findings of investigation, staff from PASP can provide targeted refresher training or on-site coaching, or logistics management, staff can review where the forecasting and supply processes could be improved, or ART team meets to develop a work plan for MMD.

**Example 2:** If poor client appointment keeping is identified, the team should discuss whether or not this is due to poor adherence counseling, or healthcare providers set the appointment date by error, or this is really from patient side, for example. Training of facility counsellors or set up a system/flow to ensure the appointment date is correct, can then be conducted as indicated.

**Example 3:** If a low percentage of patients receiving viral load testing is identified, then the team should discuss the possible causes, such as failure of the physician to be aware when to request the test, VL test supply chain interruption, etc. Similarly, the first case would benefit from refresher training, or clinical mentoring, whereas the second issue would respond better to addressing supply chain barriers.

At any situation that needs support from the PASP or the National CQI-CoC Core Group should be brought to their attention as soon as possible to guide a more in-depth analysis of the CQI indicators and related problems, and together with the PASP and site team develop action plan to address the identified problems.

### 5.5 Implementation of the proposed action plan

Once the action plan is developed, the onsite CQI-CoC team shall implement the plan accordingly with facilitation, coordination and appropriate support from PASP and involved stakeholders.

### 5.6 Monitoring and evaluation of action plan

The onsite CQI-CoC team, PASP and involved partners should monitor the implementation of the action plan (improvement plan) to see whether they have had an impact on the identified problem(s).

- The impact of the action plan should be reflected in the following quarters. If the plan and its proposed activities are effective, the CQI team at site should note improvements in the indicators of concern.
- If the action plan was not effective, and if the indicators continue to show a plateau or a deteriorating trend, it may be necessary to share the concerns with national CQI-CoC Core Group and to modify the action plan in consultation with the team accordingly (see Annex 5: Follow-up report).
- Onsite CQI-CoC team should record and report the outcomes of action plan routinely every quarter.

## 5.7 Key Indicators

The following list of indicators will be used to assess and monitor the quality of the Continuum of Care (CoC) services being provided to PLHIV at ART clinics.

### 5.7.1 Mortality indicators and re-engage into care

- 1 Percentage of ART patients who died
- 2 Percentage of ART patients who were lost to follow-up
- 3 Percentage of ART patient with no clinical contact or ARV pick up for within 28 days since their last expected contact reengaged in care.

### 5.7.2 Quality of service indicators

- 4a Percentage of late visits beyond ARV supply buffer date
- 4b Percentage of late visits within ARV supply buffer date
- 4c Percentage of visits on schedule among ART patients
- 4d Percentage of early visits among ART patients
- 5a. Percentage of new ART patients have ART initiated on same-day as diagnosed date
- 5b. Percentage of new ART patients have ART initiated 1-7 days after diagnosed date.
- 5c. Percentage of new ART patients have ART initiated greater than 7 days after diagnosed date
- 6a Percentage of patients with CD4 count less than 350 receiving prophylaxis with Cotrimoxazole
- 6b Percentage of patients with CD4 counts less 100 c/mm<sup>3</sup> receiving prophylaxis with Fluconazole
- 7 **Percentage of ART patients received MMD for 3 months or more**
- 8 Percentage of PLHIV known to be on treatment 12 months after initiation of antiretroviral therapy
- 9 Percentage of ART patients received TPT (cumulative)
- 10 Percentage of ART patients completed the TPT course (cumulative)
- 11a Percentage of PLHIV on ART for at least 12 months received at least one viral load test in the past 12 months
- 11b Percentage of ART patients tested for viral load with level <1000 copies/mL at 12 months after antiretroviral therapy initiation [WHO: VLS.1]
- 11c Percentage of PLHIV receiving ART who have suppressed viral load [WHO VLS.3]

- 11d Percentage of PLHIV receiving ART with viral load  $\geq 1000$  copies/mL who received a follow-up viral load test within six months after enhance adherence counselling
- 11e Percentage of PLHIV receiving ART with two documented viral load test results  $\geq 1000$  copies/mL switching to second-, or third-line ART regimens
- 11f Percentage of viral load tests results returned to sites within 14 days of the sample being taken
- 12 Percentage of months in the past 12 months in which there were no ARV drug stock outages
- 13 Percentage of new ART patients prescribed TLD as 1<sup>st</sup> line regimen
- 14 Percentage of eligible ART patients on TLD as 1<sup>st</sup> line regimen (cumulative)
- 15 Percentage of clients reported satisfied with service they received
- 16 Percentage of clients reported the waiting time is acceptable
- 17 Percentage of clients received adequate counseling
- 18 Percentage of providers rated their health facility's services for KPs with low and very low

### 5.8 Update or revision of CQI indicators

- The National CQI-COC working group is responsible for updating or revising CQI indicators.
- Any indicator that is no longer be calculated from the patient records should either be removed, or patient databases and data collection tools should be modified.
- New indicators or revision of indicator definitions should occur as necessary to ensure that CQI reflects current national standards and guidelines.

### 6. Link with other services

Although Continuous Quality Improvement for ART patients is primarily focused on the quality of services for patients registered within these clinics, it can also be applied to other aspects of the Continuum of Care, for example, hospitalization, VCCT, Community Action Approach (CAA), TB, PMTCT, laboratory and drug store. Below are several examples of linkages:

#### 6.1 Community action providers

The ART clinic sees nearly all identified PLHIV on a periodic basis. However, community action providers can collaborate with ART to provide feedback and improvement in these services. Collaboration with community action providers can address problems with:

- Loss to follow-up: CAA team is needed to gather data on what has happened to the individuals who missed clinical appointment or lost, and to help carrying out interventions to reduce this missing or loss to follow-up.
- Adherence to treatment: Some measures to improve adherence can take place at the ART

clinic, but others may require CAA team to assess and organize household and community support for better adherence.

## **6.2 Hospitalizations**

An investigation of the rate of hospitalization of ART patients may require data from in-patient services if this is not routinely recorded in ART patient charts, for example, cryptococcus meningitis. In addition, review of hospital records may reveal gaps in HIV testing services. It may find, for example, that many patients had a hospitalization or TB treatment in several years prior but no HIV test. In this case the provider-initiated counseling and testing in the hospital may need strengthening.

## **6.3 VCCT**

Recency testing provides insight into the timeline of an individual's HIV infection. This information is important to public health because of the ability to use such data from VCCT services for targeted interventions and connect to ART clinic to start treatment earlier and have viral load suppressed that can prevent new infections and intervene before HIV is transmitted further.

## **6.4 PMTCT**

All pregnant women newly identified as HIV+ under the PMTCT program should be registered and placed quickly on ART. These services may best be evaluated in ANC and delivery facilities.

## **6.5 Boosted Integrated Active Case Management (BIACM)**

All new cases, whether found in the community or at a health facility, should be linked from the initial reactive testing to the confirmatory process then finally enrollment at the ART service. Active case management working group meet regularly to review the cascade to ensure the high rate of retention in the HIV program services from reactive to the enrollment in care and treatment.

The listing above is intended to provide possible examples of linkages between CQI for ART and other services. As experience with CQI in the ART setting, other examples of the linkage between ART and other services are likely to be found. While many CQI activities can take place completely within the ART clinic, CQI-CoC teams should recognize the opportunities for linking CQI with other services.

## **7. Monitoring, Supervision, Reporting and Training**

### **7.1 Monitoring & Supervision:**

The main objectives of monitoring and supervision are to support the onsite CQI-CoC team to maintain the quality of data and quality of health services.

PASP should schedule M&S at least once every quarter to the onsite CQI-CoC team at the early stage of CQI implementation. Once the onsite CQI-CoC team is more familiar with the process (e.g., has participated in a CQI orientation workshop, and is knowledgeable about how to use the quality data at site, PASP should conduct supportive supervision for every six months.

The national CQI-CoC Core Group should schedule joint M&S with PASP and development partners working in the area on an as needed basis.

During the M&S, the team should provide necessary support, including:

- Ensure completeness of data: all required data from each patient are collected, and they are collected from all registered patients at every visit,
- Ensure consistency of data between the patient paper record and the electronic database,
- Ensure availability and use of logbooks for problems faced during data entry,
- Ensure that each level is able to analyze, interpret and use the data.

## **7.2 Reporting:**

The Team Leader at the ART site should send electronic data to the PASP who checks and analyzes the data from all ART sites in the province. PASP should perform analysis of the indicators that are needed for the quality improvement at site and send the feedback to site on a quarterly basis prior quarterly workshop.

PASP sends data to the Data Management Unit at NCHADS, who regularly shares the data with AIDS Care Unit (ACU) for the following-up and quality of care purposes, and other relevant units within NCHADS. Providing feedback about the analysis results to onsite CQI-CoC team is necessary to promote data uses by local health care providers.

On a quarterly basis, the onsite CQI-CoC team should report to PASP on the progress of selected CQI indicators, follow-up activities for problem solving in the preceding quarter, problems and challenges, and an action plan for the next quarter. The progress reports should be posted on the NCHADS website, so that all relevant stakeholders can learn from CQI implementation, and sites can learn from each other.

Sites are encouraged to print out and post in a prominent place the progress of their CQI performance, problem analyses, and follow-up activities.

## **7.3 P-D-C-A Regional workshops to review core indicators of HIV care and treatment**

At a quarterly basis AIDS Care Unit collaborates with Research Unit, and Data Management Unit, organizes regional review workshops in which all ART clinics in the country participate. The inputs, processes, and expected outcomes of the regional review workshop is separately developed by AIDS Care Unit in consultation with Research Unit and Data Management Unit.

## **7.4 Evaluating the Effectiveness of the Continuous Quality Improvement Program**

- PASP will meet with the members of the CQI-CoC team from each ART site in a joint yearly meeting in order to evaluate the overall progress of the CQI program at each site.
- Each site will present the performance of CQI indicators from the preceding four quarters, a quality overview of the action plans developed and the outcomes and effectiveness of the action plans.

In the light of this overall report from the sites, PASP will evaluate how the accomplishments of the program compare with the overall and specific objectives of the CQI-CoC. They will discuss any quality issues that arise with implementation of the CQI plan, such as data collection, data entry and aggregation, calculation and appropriateness of the indicators used for monitoring quality as well as any modifications or additions to indicators that may become necessary. PASP will communicate with the national core CQI-CoC team about any issues they cannot resolve without national engagement.

Research Unit of NCHADS will document best practices of CQI nationwide focusing on cycle of PLAN-DO-CHECK-ACT: do ART clinics have proper plan to achieve CQI indicators? Do ART sites implement their plan? Do ART site use data to analyze the results of their performance and determine whether it made a difference? Do ART clinics take actions to maintain or improve their performance? In addition, the documentation should include qualitative information on enabling and hindering factors to implement CQI routinely at ART clinics.

## **7.5 Training & Capacity Building**

Human resource is the most important resource to implement CQI program. The workforce can be *empowered* and *enabled* to develop and use their full potential to achieve their local agency and regional or nationwide system vision for the future. For this to occur, the organization must provide opportunities for performance excellence, as well as for personal, professional and organizational growth.

### 7.5.1 SOP orientation workshop

To implement CQI-CoC effectively, relevant staff members who involve with CQI activities at all levels, must take a 2-day training about the Standard Operational Procedures of the CQI. At the end of the training, participants will be able to:

- Understand the objectives of the CQI program,
- Understand the cycle of CQI and steps to implement CQI,
- Apply the procedures stated in the SOP,
- Develop provincial site specific plan for the implementation of the CQI following the P-D-C-A cycle.

### 7.5.2 Data management training

Selected members of the CQI-CoC teams whose work associating with data shall take a 3-day training which will provide the basic knowledge and skill for them to work with data. At the end of the training, participants will be able to:

- Understand the key elements of data quality include completeness, accuracy, consistency, timeliness, precision, integrity, and confidentiality.
- Apply the concepts of data quality in collecting, processing, analyzing, and using the data,
- Use the set database layout to entry and backup the data,
- Know how to protect the data,
- Cite the rules, regulations and/or policies related to the use of data, or working with data,
- Understand advantages and disadvantages of using quality data,
- Analyze the data to get the answer for their queries related to their daily activities at the ART site,
- Develop a plan to manage their own data,
- Develop a data quality control mechanism for their own dataset.

## ANNEX I: CQI Indicators

### I. The Mortality Indicators and re-engagement into care and treatment

<b>1. Percentage of ART patients who died</b>	
<b>Definition</b>	Number of patients on ART who died divided by total number of patients on ART at the clinic in the reporting period and multiplied by 100.
<b>Purpose</b>	To monitor the mortality rate of patients who are on ART
<b>Method of Measurement</b>	Count all dead patients in the reporting period and compute for percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Total number of patients on ART who are known to have died as of the end of the reporting period
<b>Denominator</b>	Total number of patients registered in care as of the end of the reporting period (active patients + LTF + died + transfer out)
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female ART status: non-ART, on ART
<b>Source of data</b>	The facility ART electronic database
<b>Interpretation</b>	<p>Action point. National average figure will be used as a reference for the comparison purpose, as well as trends over time for each facility. Appropriate actions should be taken to understand the cause of the death, and then preventing them accordingly when the analysis result exceeds the national average figure or if mortality is increasing. PLHIV mortality rate should be as low as &lt;1%.</p> <p>Interpretation. The ultimate goal of HIV management is to preserve the lives of the patients. While not all patients can be saved, facilities should strive to provide good quality care that keeps deaths to a minimum.</p> <p>Intervention. The facility should review the reasons for mortality among ART patients, what changes in the system could reduce the chance of death and implement those that appear feasible.</p>

<b>2. Percentage of ART patients who were lost to follow-up</b>	
<b>Definition</b>	Number of patients in the reporting period who were classified as “Lost to follow up” according to the national definition divided by total number of patients on ART at the clinic in the reporting period and multiplied by 100. The patients are not classified as dead, transferred out, or stopped.
<b>Purpose</b>	To monitor the proportion of HIV infected patients on ART who were lost to followed-up, and actively follow up by ART clinics.
<b>Method of Measurement</b>	Count number of registered patients at the ART site in the reporting period who lost to follow-up, then compute for percentage using numerator and denominator below.  “Lost to follow up” is defined by the National HIV Program as all PLHIV who come for a visit late more than 28 days after appointment date.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Total number of patients who were lost to follow up during the reporting period.
<b>Denominator</b>	Total number of patients on ART at the end of the reporting period (active patients + LTF + died + transfer out)
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Source of data</b>	The facility ART electronic database
<b>Interpretation</b>	<p>Action point. National average figure will be used as a reference for the comparison purpose, as well as trends over time for each facility. Appropriate actions should be taken to understand the cause of the lost, and then preventing them accordingly when the analysis result exceeds the national average figure or is increasing over time. Percentage of LTFU should not exceed 9%.</p> <p>Interpretation. The ultimate goal of HIV management is to preserve the lives of the patients. While not all patients can be saved, facilities should strive to provide good quality care that keeps loss to follow up to a minimum.</p> <p>Intervention. The facility should review the reasons for loss among ART patients, what changes in the system could keep the patients adhere to the treatment.</p>

**3. Percentage of ART patient with no clinical contact or ARV pick up within 28 days since their last expected contact reengaged in care**

<b>Definition</b>	Number of ART patients who did not come for the visit or ARV pick up within 28 days since their last expected contact then who were re-engaged/returned in care divided by total number of ART patients who did not come for the visit or ARV pick up within 28 days since their last expected contact date, multiplied by 100.
<b>Purpose</b>	To monitor the proportion of HIV infected patients on ART who were re-engaged into care after missing clinical appointment.
<b>Method of Measurement</b>	Count number of patients who missed clinical appointment within 28 days, and those who returned into care after their missing, then compute for percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Number of patients who were missed clinical appointment within 28 days then re-engaged/returned into care during the reporting period.
<b>Denominator</b>	Total number of patients on ART who missed clinical appointment within 28 days in the reporting period.
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Source of data</b>	ART electronic database or “Tracing and Re-engagement” tool.
<b>Interpretation</b>	<p>Action point. National average figure will be used as a reference for the comparison purpose, as well as trends over time for each facility to re-engage missing clinical appointment patients.</p> <p>Appropriate actions should be taken to understand the cause of the missing, and then preventing them accordingly.</p> <p>Intervention. The facility should review the reasons for missing among ART patients, and re-engagement rate. If the re-engagement rate far below the missing, review what changes in the system could keep the patients adhere to the treatment.</p>

## II. Quality Service Indicators

<b>4a. Percentage of late visits beyond ARV supply buffer date</b>	
<b>Definition</b>	Number of all visits that came late beyond ARV drug supply buffer date divided by total visits in the reporting period and multiplied by 100.
<b>Purpose</b>	To promote counseling services and encourage patients to follow the physician's recommendations in order to avoid care and treatment interruption. This indicator is to be used as a proxy for measuring adherence to ART.
<b>Method of Measurement</b>	Count number of visits that are beyond ARV buffer supply date. Calculate for the percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Total number of visits beyond ARV buffer supply date during the quarter.
<b>Denominator</b>	Total number of visits during the quarter.
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Source of data</b>	Facility ART electronic database
<b>Interpretation</b>	<p>Action point. Facilities should limit the late beyond ARV buffer supply date to less than 2.5%.</p> <p>Interpretations. High percentage of late beyond ARV buffer supply shows that the adherence of the patients to ART is not good and likely lead to drug resistance.</p> <p>Interventions. The facility should review the cause of late beyond buffer, what problems may exist in the system and how these can be corrected to reduce the rate of missed appointments.</p>

<b>4b. Percentage of late visits within ARV supply buffer date</b>	
<b>Definition</b>	Number of all visits that came late but still in ARV drug supply buffer date divided by total visits in the reporting period and multiplied by 100.
<b>Purpose</b>	To promote counseling services and encourage patients to follow the physician's recommendations in order to avoid care and treatment interruption. This indicator is to be used as a proxy for measuring adherence to ART.
<b>Method of Measurement</b>	Count number of appointments that are within ARV buffer supply date. Calculate for the percentage using numerator and denominator below.  ARVs buffer should be given for 5 days (Ref. NCHADS letter 0146)
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Total number of visits within ARV buffer supply date during the quarter.
<b>Denominator</b>	Total number of visits during the quarter.
<b>Source of data</b>	Facility ART electronic database
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Interpretation</b>	<p>Action point. Facilities should limit the late within ARV buffer supply date to less than 10%.</p> <p>Interpretations. High percentage of late within ARV buffer supply likely lead to late beyond buffer and show that the adherence of the patients is not good, and this type of visit also add additional burden for daily work of health care providers.</p> <p>Interventions. The facility should review the cause of late within buffer, what problems may exist in the system and how these can be corrected to reduce the rate of missed appointments.</p>

<b>4c. Percentage of visits on schedule among ART patients</b>	
<b>Definition</b>	Number of all visits that came on schedule divided by total visits in the reporting period and multiplied by 100.
<b>Purpose</b>	To promote counseling services and encourage patients to follow the physician's recommendations in order to avoid care and treatment interruption. This indicator is to be used as a proxy for measuring adherence to ART.
<b>Method of Measurement</b>	Count number of visits that are on schedule. Calculate for the percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Total number of visits on schedule during the reporting period.
<b>Denominator</b>	Total number of visits during the reporting period.
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Source of data</b>	Facility ART electronic database
<b>Interpretation</b>	<p>Action point. Facilities should encourage the visits on schedule more than 85%.</p> <p>Interpretations. High percentage of visit on schedule is likely to keep the patients on adherence.</p> <p>Interventions. The facility should encourage patients to keep their visit on schedule.</p>

<b>4d. Percentage of early visit among ART patients</b>	
<b>Definition</b>	Number of all visits that came earlier than schedule divided by total visits in the reporting period and multiplied by 100.
<b>Purpose</b>	To promote counseling services and encourage patients to follow the physician's recommendations in order to avoid care and treatment interruption. This indicator is to be used as a proxy for measuring adherence to ART.
<b>Method of Measurement</b>	Count number of visits that are early than the appointment date. Calculate for the percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Total number of visits that are earlier than the appointment date during the quarter.
<b>Denominator</b>	Total number of visits during the quarter.
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Source of data</b>	Facility ART electronic database
<b>Interpretation</b>	<p>Action point. Facilities should limit the early visits at less than 10%.</p> <p>Interpretations. High percentage of early visits will burden daily work of health care providers.</p> <p>Interventions. The facility should encourage patients to keep their visit on schedule.</p>

<b>5. Percentage of new ART patients have ART initiated on same-day as diagnosed date</b>	
<b>Definition</b>	Number of new ART patients who have ART initiated on the same day as their HIV confirmatory test divided by the total number of new ART patients at the ART clinic in the reporting period, multiplied by 100.
<b>Purpose</b>	To monitor the timeliness of the initiation of ART treatment and to ensure that this is in line with the national guidelines on ART.
<b>Method of Measurement</b>	Count the number of patients who have ART initiation date the same as HIV confirmatory test date, then compute for percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Number ART patients who have ART initiation date the same as HIV confirmatory date in the reporting period.
<b>Denominator</b>	Total number of new ART initiated patients in the reporting period.
<b>Disaggregation(s):</b>	0 days (same-day) 1-7 days >7 days
<b>Source of data</b>	ART electronic database
<b>Interpretation</b>	Of the total patient load, how many percentages of clients have initiated same-day ART?

<b>6a. Percentage of patients with CD4 count less than 350 cells per cubic millimeter of blood receiving prophylaxis with cotrimoxazole</b>	
<b>Definition</b>	Number of HIV infected patients with CD4 cell counts < 350 cells/mm <sup>3</sup> received cotrimoxazole divided by number of all patients whose CD4 < 350 cells/mm <sup>3</sup> , multiplied by 100.
<b>Purpose</b>	To monitor the appropriate management of patients registered for OI/ART care in terms of OI prophylaxis
<b>Method of Measurement</b>	Count number of patients whose most recent CD4<350 cells/mm <sup>3</sup> and who receive a new or ongoing prescription for cotrimoxazole. Compute for percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Number of patients with most recent CD4 levels of less than 350 c/mm <sup>3</sup> who received a new or ongoing prescription for cotrimoxazole at the most recent visit in the selected quarter.
<b>Denominator</b>	Total number of patients whose most recent CD4 count was below 350 cells/mm <sup>3</sup> and had a patient visit during the selected quarter.
<b>Disaggregation(s):</b>	Sex: Male, Female
<b>Source of data</b>	The electronic database
<b>Interpretation</b>	<p>Action point. All patients with CD4&lt;350 cells/mm<sup>3</sup> must receive cotrimoxazole for opportunistic infections prophylaxis.</p> <p>Interpretation. Failure to provide prophylaxis significantly increases the risk that patients will suffer from opportunistic infections and so is an indicator of sub-optimal quality of care.</p> <p>Interventions. The facility should review reasons for not starting prophylaxis, determine what interventions would help to reduce these delays, and adopt program changes to correct the problem.</p>

<b>6b. Percentage of patients with CD4 count less than 100 cells per millimeter of blood receiving prophylaxis with fluconazole</b>	
<b>Definition</b>	Number of HIV infected patients with CD4 cell counts < 100 c/mm <sup>3</sup> received fluconazole divided by number of all patients whose CD4 < 100 c/mm <sup>3</sup> , multiplied by 100.
<b>Purpose</b>	To monitor the appropriate management of patients registered for OI/ART care in terms of opportunistic infections prophylaxis
<b>Method of Measurement</b>	Count actual number of patients whose most recent CD4<100 c/mm <sup>3</sup> and who receive a new or ongoing prescription for fluconazole. Compute for percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Number of patients with most recent CD4 levels of less than 100 c/mm <sup>3</sup> who received a new or ongoing prescription for fluconazole at the most recent visit in the selected quarter.
<b>Denominator</b>	Total number of patients whose most recent CD4 count was below 100 c/mm <sup>3</sup> and had a patient visit during the selected quarter.
<b>Disaggregation(s):</b>	Sex: Male, Female
<b>Source of data</b>	The electronic database
<b>Interpretation</b>	<p>Action point. All patients with CD4&lt;100 c/mm<sup>3</sup> must receive Fluconazole for OI prophylaxis.</p> <p>Interpretation. Failure to provide prophylaxis significantly increases the risk that patients will suffer from opportunistic infections and so is an indicator of sub-optimal quality of care.</p> <p>Interventions. The facility should review reasons for not starting prophylaxis, determine what interventions would help to reduce these delays, and adopt program changes to correct the problem.</p>

<b>7. Percentage of ART patients receiving multi-months dispensing <math>\geq 3</math> months</b>	
<b>Definition</b>	Number of ART patients dispensed ARV and next clinical appointment for <b>03 months or more</b> divided by all active ART patients at the end of reporting period, multiplied by 100.
<b>Purpose</b>	To monitor the coverage of MMD among all active ART patients in the clinic.
<b>Method of Measurement</b>	Count actual number of patients who have next clinical appointment for <b>03 months or more</b> . Compute for percentage using the numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Number of patients who have been dispensed ARV and next clinical appointment for <b>03 months or more</b> at the end of reporting period.
<b>Denominator</b>	Total number of active ART patients at the end of reporting period.
<b>Disaggregation(s):</b>	< 3 months 3 months 4-5 months $\geq 6$ months
<b>Source of data</b>	ART electronic database
<b>Interpretation</b>	MMD $\geq 3$ months should be 90%. Higher percent of ART patients on MMD means more patients are stable with less complex medical needs; more medical resources are free up for people who are sicker, those starting treatment and those with more complex needs.

<b>8. Percentage of patients on ART who are retained on treatment, annualized</b>	
<b>Definition</b>	Number of PLHIV who continue on ART after they initiated ART excluding those who are falling out of TX_CURR in a quarter or in a year.
<b>Purpose</b>	This indicator helps determine how many HIV+ adults and children are being retained in treatment.
<b>Method of Measurement</b>	<p>Retention<sub>quarter</sub> = <math>(1 - (\text{TX\_CURR}_{\text{prior quarter}} + \text{TX\_NEW} - \text{TX\_CURR}_{\text{current quarter}}) / \text{TX\_CURR}_{\text{prior quarter}})</math></p> <p>where:</p> <ul style="list-style-type: none"> <li>- TX_NEW = Number of adults and children newly enrolled on antiretroviral therapy (ART)</li> <li>- TX_CURR<sub>prior quarter</sub> = The number of adults and children receiving ART in the <b>previous</b> quarter</li> <li>- TX_CURR<sub>current quarter</sub> = The number of adults and children receiving ART in the <b>current</b> quarter</li> </ul> <p><b>How to Calculate the Annual Total</b> Annual rates can be calculated using <b>Q4 data from the current and previous year</b>. Quarterly rates should be annualized to ensure consistent comparison to target information that is based only on annual targets.</p>
<b>Frequency</b>	Quarterly
<b>Numerator,</b>	<p>The numerator is calculated by adding the TX_CURR results from the previous quarter to the TX_NEW results, and then subtracting the TX_CURR results from the current quarter: <math>(\text{TX\_CURR}_{\text{prior quarter}} + \text{TX\_NEW} - \text{TX\_CURR}_{\text{current quarter}})</math></p> <p>Alternatively, the numerator can also be calculated as TX_NEW – NET_NEW</p>
<b>Denominator</b>	<p>The number of adults and children receiving ART in the previous quarter TX_CURR (Previous quarter)</p> <p>The denominator is taken directly from the TX_CURR results for the previous quarter</p>
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Source of data</b>	Electronic ART database. Quarterly report.
<b>Interpretation</b>	<p>Action point. Retention rate &lt;90% of ART patients required action to improve the service quality and follow up mechanism.</p> <p>Interpretation. Retention rates above 100% would generally suggest that patients who had previously fallen out of care were re-enrolled in care, or that facilities that didn't report TX_CURR results in previous quarters began reporting.</p>

<b>9. Percentage of PLHIV received TB preventive therapy (TPT) (cumulative)</b>	
<b>Definition</b>	Number of PLHIV patients have received TPT at the end of reporting period divided by total PLHIV patients at the end of reporting period, multiplied by 100.
<b>Purpose</b>	To monitor the proportion of registered PLHIV who received TPT to prevent the development of active TB which is the leading cause of dead among HIV patients.
<b>Method of Measurement</b>	Count the number of registered patients at ART site at the end of reporting period who have received TPT (ongoing or completed). Compute for the percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Number of PLHIV patients who have received TPT (ongoing or completed) at the end of reporting period.
<b>Denominator</b>	Total number of PLHIV patients at the end of reporting period.
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Source of data</b>	ART electronic database
<b>Interpretation</b>	<p>Action point. All HIV infected patients have to receive one course of TPT.</p> <p>Higher TPT coverage lower expected rate of active TB.</p> <p>Interventions. The facility should review reasons for not providing TPT for preventing active TB, determine what interventions would help to optimize TPT, and adopt program changes to correct the problem.</p>

<b>10. Percentage of PLHIV patients completed the TPT course (cumulative)</b>	
<b>Definition</b>	Number of PLHIV patients have completed TPT course at the end of reporting period divided by total ART patients at the end of reporting period, multiplied by 100.
<b>Purpose</b>	To monitor the successful completion rate of patients taking a TPT course.
<b>Method of Measurement</b>	Count number of patients who have completed a course of TPT at the end of reporting period. Compute for the percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	The number of PLHIV patients who have completed a course of TPT at the end of reporting period.
<b>Denominator</b>	Total number of PLHIV patients at the end of reporting period.
<b>Source of data</b>	ART electronic database
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Interpretation</b>	<p>Action point. All HIV infected patients have to receive one course of TPT.</p> <p>Higher completion rate of TPT lower expected rate of active TB.</p> <p>Interventions. The facility should review reasons for low completion rate of TPT for preventing active TB, determine what interventions would help to optimize TPT, and adopt program changes to correct the problem.</p>

<b>11a. Percentage of ART patients receiving at least one viral load test in the past 12 months</b>	
<b>Definition</b>	Number of PLHIV receiving ART with at least one viral load test result in their medical record (ART database) in the past 12 months divided by number of PLHIV receiving ART for at least 06 months, multiplied by 100.
<b>Purpose</b>	To monitor viral load test coverage/access among PLHIV in the past 12 months.
<b>Method of Measurement</b>	Count number of patients who have viral load test result within the last 12 months. De-duplicate records to avoid double counting of the numerator. The denominator should exclude patients who died, transferred out to another clinic or been classified as lost to follow-up. Compute for the percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly and annually
<b>Numerator</b>	Number of PLHIV receiving ART with at least one viral load test result in their medical record (ART database) in the past 12 months.
<b>Denominator</b>	Number of PLHIV receiving ART for at least 06 months.
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Source of data</b>	ART electronic database
<b>Interpretation</b>	High proportion of viral coverage/access reflects high quality of HIV care and treatment.  Interpretation. The facility should review reasons for low viral load coverage and determine what interventions would help to increase the rate.

**11b. Percentage of ART patients tested for viral load with level <1000 copies/mL at 12 months after antiretroviral therapy initiation [WHO: VLS.1]**

<b>Definition</b>	Number of PLHIV receiving ART with viral load <1000 copies/mL at 12 months after initiating ART divided by number of PLHIV receiving ART with a viral load test result available at 12 months, multiplied by 100.
<b>Purpose</b>	To monitor viral load suppression rate among ART patients 12 months after initiating ART and to estimate the percentage of PLHIV who have suppressed viral load.
<b>Method of Measurement</b>	These data are based on a cohort of patients alive and receiving ART who have suppressed viral load 12 months after initiating treatment. The denominator should exclude patients who died, transferred out to another clinic or been classified as lost to follow-up. Compute for the percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly and annually
<b>Numerator</b>	Number of PLHIV receiving ART with viral load <1000 copies/mL at 12 months after initiating ART.
<b>Denominator</b>	Number of PLHIV receiving ART with a viral load test result available at 12 months.
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Source of data</b>	ART electronic database
<b>Interpretation</b>	High proportion of viral load <1000 copies/mL reflects treatment success rate. Interpretation. The facility should review reasons for low viral load suppression rate and determine what interventions would help to increase the rate.

<b>11c. Percentage of PLHIV receiving ART who have suppressed viral load [WHO VLS.3]</b>	
<b>Definition</b>	Number of PLHIV receiving ART who have a suppressed viral load (<1,000 copies/mL) divided by number of PLHIV receiving ART who have a viral load test in the past 12 months, multiplied by 100.
<b>Purpose</b>	To monitor suppression of viral load achieved among all those currently receiving treatment who received a viral load test, regardless of when they started ART.
<b>Method of Measurement</b>	The denominator should exclude patients who died, transferred out to another clinic or been classified as lost to follow-up. Compute for the percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly and annually
<b>Numerator</b>	Number of PLHIV receiving ART who have a suppressed viral load (<1,000 copies/mL)
<b>Denominator</b>	Number of PLHIV receiving ART who have a viral load test in the past 12 months.
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Source of data</b>	ART electronic database
<b>Interpretation</b>	<p>High proportion of viral load suppression (&lt;1000 copies/mL) reflects treatment success rate. It corresponds to the third 95 of the 95-95-95 targets (95% of the people receiving antiviral therapy have suppressed viral loads).</p> <p>Interpretation. The facility should review reasons for low viral load suppression rate and determine what interventions would help to increase the rate.</p>

<b>11d. Percentage of PLHIV receiving ART with viral load <math>\geq 1000</math> copies/mL who received a follow-up viral load test within six months after enhance adherence counselling</b>	
<b>Definition</b>	Number of ART patients received a follow-up viral load test within six months after a viral load $\geq 1000$ copies/mL divided by number of ART patients with viral load $\geq 1000$ copies/mL during the reporting period, multiplied by 100.
<b>Purpose</b>	To monitor the efficacy of the current regimen the persons with non-suppressed viral loads is currently receiving.
<b>Method of</b>	This is ideally a cohort-based indicator that measures the proportion of

<b>Measurement</b>	people who were due to and actually received a follow-up test in the reporting period. Compute for the percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Number of ART patients received a follow-up viral load test within six months after a viral load $\geq 1000$ copies/mL
<b>Denominator</b>	Number of ART patients with viral load $\geq 1000$ copies/mL
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Source of data</b>	ART electronic database and/or enhance adherence counselling register, high viral load logbook.
<b>Interpretation</b>	High proportion of viral load follow-up reflects good monitoring of treatment efficacy and help clinicians for on time clinical decisions.  Interpretation. The facility should review reasons for low proportion of viral load follow-up testing and determine what interventions would help to solve the problem.

<b>11e. Percentage of PLHIV receiving ART with two documented viral load test results <math>\geq 1000</math> copies/mL switching to second-, or third-line ART regimens.</b>	
<b>Definition</b>	Number of ART patients with two consecutive viral load test results $\geq 1000$ copies/mL (at least 7 months apart) switching to second- or third-line antiretroviral therapy regimens divided by number of PLHIV receiving ART with two consecutive viral load test results $\geq 1000$ copies/mL during the reporting period, multiplied by 100.
<b>Purpose</b>	To measure clinical follow-up and case management. It may help to inform forecasting and budgeting for procuring second- and third-line regimens.
<b>Method of Measurement</b>	These data are based on a cohort of patients alive and receiving ART who have viral load $\geq 1000$ copies/mL. The denominator should exclude patients who died, transferred out to another clinic or been classified as lost to follow-up. Compute for the percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Number of ART patients with two consecutive viral load test results $\geq 1000$ copies/mL switching to second- or third-line antiretroviral therapy regimens
<b>Denominator</b>	Number of PLHIV receiving ART with two consecutive viral load test

	results $\geq 1000$ copies/mL during the reporting period.
<b>Disaggregation(s):</b>	Age/Sex: <15 Male, 15+ Male, <15 Female, 15+ Female
<b>Source of data</b>	ART electronic database
<b>Interpretation</b>	Interpretation. The facility should review reasons for not switching regimens according to the national guidelines for HIV care and treatment and determine what interventions would help to manage cases properly.

<b>11f. Percentage of viral load results received at site within 14 days between date of sample collection and date of results received.</b>	
<b>Definition</b>	Number of viral load results received at site within 14 days between date of sample collection and date of results received divided by total number of results expected to receive in the reporting period, multiplied by 100.
<b>Purpose</b>	To measure the duration in days from date of VL test request to the date the results were received in the facility how fast is it.
<b>Method of Measurement</b>	We used the date the test was requested as a proxy for the date sample was collected. To measure date difference in days by subtracting date of receipt of viral load result and date request of viral load tests.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Number of viral load results received at site within 14 days between date of sample collection and date of results received in the reporting period.
<b>Denominator</b>	Total number of viral load results expected to receive in the facility in the reporting period.
<b>Disaggregation(s):</b>	<15 days $\geq 15$ days
<b>Source of data</b>	ART electronic database
<b>Interpretation</b>	The early the viral load results return to site, the better case management.

<b>12. Percentage of months in the past 12 months in which there were no ARV drug stock outages</b>	
<b>Definition</b>	Number of months that there were no ARV drugs stock outages divided by 12 months, multiplied by 100.
<b>Purpose</b>	To measure ARV drug supply continuity.
<b>Method of Measurement</b>	ART sites report stock-outs of essential ARVs to the PASP and NCHADS. A stock-out is when any essential ARV is not available at an ART site.
<b>Frequency</b>	Yearly
<b>Numerator</b>	The number of months in the year in which there was no ARV drug stock outage reported for any ARV in the national standard regimens.
<b>Denominator</b>	Number of months in a year (12)
<b>Source of data</b>	Pharmacy stock records
<b>Interpretation</b>	<p>Monitoring this indicator is important to ensure that the logistic supply system functions well. ARV treatment gaps can be dangerous to patients on ART, resulting in HIV DR and limiting treatment options.</p> <p>Movement of borrowing essential ARVs between ART sites within a province or between provinces in order to prevent stock-outs in ART sites with low stock of essential ARVs is not considered a stock-out, as long as an uninterrupted supply of essential ARVs remains available to meet patient treatment regimen needs and essential ARVs are defined as Antiretroviral drugs listed in the National ARV guidelines for adults and children. In addition, it will not be considered as a stock out in case when one essential ARV is out of stock, but its alternative drug is still available, thus there is no interruption on the treatment for patients.</p>

<b>13. Percentage of new ART patients prescribed TLD as 1<sup>st</sup> line regimen</b>	
<b>Definition</b>	Number of new ART patients prescribed TLD as 1 <sup>st</sup> line regimen divided by total number of new ART patients in the reporting period, multiplied by 100.
<b>Purpose</b>	To monitor the use of TLD regimen as the first line regimen among new ART patients according to the national guidance.
<b>Method of Measurement</b>	Count number of new ART patients who were prescribed TLD during the reporting period. Compute for percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	New ART patients who were prescribed TLD as the first line regimen in the reporting quarter
<b>Denominator</b>	All new ART patients in the reporting quarter
<b>Source of data</b>	ART database.
<b>Interpretation</b>	Action point. There should be 100% of new ART patients prescribed TLD regimen as 1 <sup>st</sup> line regimen.  Site should review reasons for low rate of TLD prescription for new ART patients and solve the problem accordingly.

<b>14. Percentage of ART patients prescribed TLD as 1<sup>st</sup> line regimen (cumulative)</b>	
<b>Definition</b>	Number of ART patients have been on TLD regimen at the end of reporting period divided by total number of all first line ART patients in the reporting period, multiplied by 100.
<b>Purpose</b>	To monitor the use of TLD regimen as the first line regimen among all ART first line regimen patients according to the national guidance.
<b>Method of Measurement</b>	Count number of all ART patients who have been prescribed TLD at the end of reporting period. Compute for percentage using numerator and denominator below.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	All ART patients who have been prescribed TLD as the first line regimen at the end of reporting quarter
<b>Denominator</b>	All first line ART patients in the reporting quarter
<b>Source of data</b>	ART database.

<b>Interpretation</b>	<p>Action point. There should be 90% of ART patients prescribed TLD regimen as 1<sup>st</sup> line regimen.</p> <p>Site should review reasons for low rate of TLD prescription as 1<sup>st</sup> line ART regimen and solve the problem accordingly.</p>
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<b>15. Percentage of clients reported satisfied with service they received</b>	
<b>Definition</b>	Number of ART client who participate in patient satisfaction feedback (PSF) who reported satisfied with overall service they received at ART site during the reporting period
<b>Purpose</b>	To monitor the level of satisfaction to the quality of service that PLHIV received.
<b>Method of Measurement</b>	The data will be extracted from the PSF database on number of clients who reported satisfied with the overall service they received during the reporting period. The PSF system is being used routinely at ART facilities by using online tablet-based data collection tool and the data is automatically import to the PSF database.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Number of clients participating in PSF who reported satisfied with the overall service they received
<b>Denominator</b>	All ART clients who participated in PSF during the reporting period
<b>Source of data</b>	PSF database.
<b>Interpretation</b>	Action plan. There should be 90% of ART client satisfied with ART service and solve the problem accordingly PSF report finding.

<b>16. Percentage of clients reported the waiting long time is acceptable</b>	
<b>Definition</b>	Number of ART clients reported the waiting time to received care and treatment services is acceptable based on their own judgement during the reporting period.
<b>Purpose</b>	To monitor the quality of services related to timeliness from the perspective of clients.
<b>Method of Measurement</b>	The data will be extracted from the PSF database on number of clients who reported the waiting time is acceptable during the reporting period.
<b>Frequency</b>	Quarterly

<b>Numerator</b>	Number of clients participating in PSF who reported that the waiting time is acceptable during the reporting period
<b>Denominator</b>	All ART clients who participated in PSF during the reporting period
<b>Source of data</b>	PSF database.
<b>Interpretation</b>	Action plan. The data will be used to improve the timeliness and responsiveness of service provision at ART. There is an expectation of at least 90% of clients reported the waiting is acceptable.

#### 17. Percentage of clients received adequate counseling

<b>Definition</b>	Number of ART clients reported receiving adequate counseling at the end of reporting period
<b>Purpose</b>	To monitor the quality of services related to counseling services from the perspective of clients.
<b>Method of Measurement</b>	The data will be extracted from the PSF database on number of clients received adequate counseling during the reporting period.
<b>Frequency</b>	Quarterly
<b>Numerator</b>	Number of clients participating in PSF who reported receiving adequate counseling service at ART site during the reporting period
<b>Denominator</b>	All ART clients who participated in PSF during the reporting period
<b>Source of data</b>	PSF database.
<b>Interpretation</b>	Action plan. There should be 90% of ART client reported receiving adequate counseling service they received. The data will be used to improve the quality of counseling at ART site.

#### 18. Percentage of providers rated their health facility's services for KPs with low and very low quality

<b>Definition</b>	Number of health care provider rated their health facility's service for KPs with low and very low quality during the reporting period
<b>Purpose</b>	To monitor the self-evaluation of the ART service among service providers at ART site.
<b>Method of Measurement</b>	The data will be extracted from the PSF database on number of providers rated their health facility's service for KPs with low and very low quality during the reporting period.

<b>Frequency</b>	Quarterly
<b>Numerator</b>	Number of providers participating in PSF who reported their health facility's service for KPs with low and very low quality during the reporting period
<b>Denominator</b>	All providers who participated in PSF during the reporting period
<b>Source of data</b>	PSF database.
<b>Interpretation</b>	Action plan. There should be less than 10% of health care provider rated their health facility's service with high quality service for KPs. The data will be used to discuss and find the solution to improve quality of care at ART site.

## **ANNEX II: Budget plan for three necessary inputs for CQI implementation**

NCHADS should budget for at least three necessary inputs listed below in order to implement the CQI-COC activities effectively:

1. CQI orientation workshop which covers:

- The revise CQI SOP including the problem-solving approaches,
- Data management: data quality, data collection, data processing, data analysis and data use.

2. Quarterly review workshop of HIV care and treatment performance following the P-D-C-A cycle. The review should be conducted quarterly or at least twice per year to continuously review the quality of ART services performance that reflect the achievement of the 16 indicators listed in the SOP. The review will identify the gaps, then plans and acts accordingly.

3. CQI dashboards. The dashboard can help ART team and PASP to monitor their daily activities and their monthly or quarterly performances complementing to the use of data at ART clinic.

### ANNEX III: Problem Solving Matrix

<b>(1) Problem (Prioritized problem)</b>	<b>(2) Cause (Causes of the problem)</b>	<b>(3) Proposed solution (Counter measures to the problem)</b>	<b>(4) Responsibility</b>	<b>(5) Timeline</b>	<b>(6) Follow-up</b>
Discuss and prioritize the indicators based on how important, urgent and feasible. List all indicators considered as priority.	Discuss about all possible causes that lead to the problem. List all causes from patients, health care providers and system point of view.	Discuss about possible solution. List all counter measures to the problem.	Who will be responsible for each proposed solution, individual or group	Set timeline to complete the proposed solution	State the status of the proposed solution, whether it was done, not done, or in progress.

#### ANNEX IV: Example use of Problem-Solving Matrix

<b>(1) Problem (Prioritized problem)</b>	<b>(2) Cause (Causes of the problem)</b>	<b>(3) Proposed solution (Counter measures to the problem)</b>	<b>(4) Responsibility</b>	<b>(5) Timeline</b>	<b>(6) Follow-up report</b>
% of late beyond ARV supply buffer date high	<b>Patient's side:</b> - Lack of support for travelling to the clinic - Working far from home	(not selected for problem solving)			
	- Forget the appointment date	- Counselor-CAA team have appointment list, set up reminder, remind the patients 2 days prior appointment date	- CAA team	- Today	In progress
	- Rely on drugs borrowing from others	- Clearly and repeatedly inform the patients during any meeting, there is no borrowing or lending drugs.	- Health care providers	- At next meeting on ... (date)	Not start yet. Will be followed-up (follow-up report)
	- Don't care about ART, too poor - Being late many times, don't dare to see doctor - Feel healthy	- Counselor/CAA team provide counseling, health education focused more on related topics (health care, adherence, how to maintain your good health) and conduct home visit more often.	- Counselor, CAA team	- Within this week	Not start yet. Will be followed-up (follow-up report)
	<b>Provider's side:</b> - Make appointment coincide with holidays	Post visible holiday schedule at physician, counselor and CAA desk	Site manager	Today	In progress

	- Next appointment was not made (Dr. forgot or he was absent)	Counselor/CAA team reviews and sets up reminder for next appointment (as above)	CAA team	Starting from today	In progress
	- Few health care providers but many patents/visits per day	(not selected for problem solving)			
	- Lack of patient appointment book	Update and regularly share information regarding inventory (at any meeting). Make request on time.	Site manager	Next meeting	Not start yet. Will be followed-up (follow-up report)
	- CAA team was not allowed to visit patient's home	- Counselor/CAA team provides counseling, health education focused more on related topics (health care, adherence, how to maintain your good health) in health education sessions. Clearly stated the objective of home visit	Counselor, CAA team	Next health education sessions.	Not start yet. Will be followed-up (follow-up report)
	- CAA team has limited resource for transportation support - Incentive comes late - Lack of medical consumables	(not selected for problem solving)			
	<b>System side:</b> - Lack of system to	Further investigation should be conducted to identify specific	Health facility director and site manager	October	Not start yet. Will be followed-up

	monitor patient's visit	component in the "system" which is absent.			(follow-up report)
	- lack of communication between doctor-CAA team	Revitalize weekly (or monthly) meeting among health care providers, data management clerk, CAA team	Site manager	Next weekly/monthly meeting	Not start yet. Will be followed-up (follow-up report)
	- IT does not maximize the use of data for patient monitoring	Further investigation should be conducted to identify specific what we want	PASP, HF director, site manager and IT	Next week	Not start yet. Will be followed-up (follow-up report)
	- Fund disbursement to CAA team was late or interrupted - Lack of coordination when planning for community activities.	(not selected for problem solving)			

**ANNEX V: Follow-up report (the solutions and outcomes of the previous quarter are reviewed in the current quarter)**

Proposed solution number ...: Further investigation should be conducted to identify specific component in the “system” which is absent.	
1. Initiated	Yes (or No).
2. When is it completed?	On 28 September 2012
3. What are the results?	The specific components were identified. They are ....
4. Are there constraints, challenges in completing the proposed solution?	No
5. Are there good things to learn from completing the proposed solution?	Yes, they are: - -
6. What can we conclude from “ACTING” the proposed solution?	A specific component which is absent in the system to monitor patient’s visit was identified and solutions are proposed in the recommendation below.
7. What do we recommend from the above conclusion?	..... .....
Proposed solution number ...: Revitalize weekly (or monthly) meeting among health care providers, data management clerk, CAA team	
2. Initiated	
2. When is it completed?	
3. What are the results?	
4. Are there constraints, challenges in completing the proposed solution?	

5. Are there good things to learn from completing the proposed solution?	
6. What can we conclude from “ACTING” the proposed solution?	
7. What do we recommend from the above conclusion?	

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