Clinic Name _____ **Date of Review** _____

Reviewer _____

1. *Clinic Overview*

How long has this clinic been providing care for patients with HIV? _____ **years**

How long has this clinic been providing ART? _____ **years**

When did this clinic begin receiving PEPFAR funding _____/_____ **20** _____

2. *Staffing*

Indicator		0	1	2	3	4	5
a.	HIV Clinic Staff Score	There are no dedicated HIV Clinic Staff.	Staff come from an outside facility on a visiting basis.	Any available facility staff work in the HIV Clinic.	Facility staff work in the HIV Clinic on a rotational basis.	Some staff are committed to the HIV clinic; time committed is < 1 FTE per role.	Fully committed HIV Clinic staff; 1 FTE per funded role.
b.	Clinician to Patient Ratio Score	There are no dedicated clinicians assigned to the HIV Clinic.	Clinician to Patient Ratio is < 1:750 or 1 clinician for > 45 patient visits/ day	Clinician to Patient Ratio is 1:501 to 750 or 1 clinician per 30 - 45 patient vistis/ day and is loosely based on new patient enrollment	Clinician to Patient Ratio is 1:251 to 500 or 1 clinician per 15 - 30 patient visits/ day and is based on new and current patient enrollment	Clinician to Patient Ratio is 1:250 or 1 clinician for upto 15 patient visits/ day and is based on scheduled appointments per month	Clinician to Patient Ratio is > 1:250 or 1 clinician for <15 patient visits/ day and is based on scheduled appointments averaged on a weekly basis taking into account unscheduled walk ins.

Indicator		0	1	2	3	4	5
c.	Staff Training in HIV Care	Staff have received no HIV specific training.	Only staff in the HIV clinic have received training limited to basic HIV information.	Only staff in the HIV clinic have received training limited to the basics of HIV and HIV medicines.	Staff in the HIV clinic and senior leadership have all completed the National Guidelines training and ART training provided by the Government.	All staff at the facility have completed the National Guidelines training and the HIV clinic staff have completed the ART training provided by the Government; additional training/capacity building has been provided by a PEPFAR implementing partner.	All staff at the facility have completed the full National HIV Trainings; additional advanced training in HIV terapeutics, ART resistance, switching, OIs, side effects and toxicity have been completed by HIV Clinic Staff and Senior Leadership.
	Score						

2. *Leadership*

Indicator		0	1	2	3	4	5
a.	Medical Leadership Score	There is no dedicated medical leadership for the facility.	Medical leadership for the facility is provided from a separate facility (MOH, RH, DH) with minimal visits on site.	Medical leadership for the facility is provided from a separate facility (MOH, RH, DH) with semi-annual to quarterly supervision visits.	Medical leadership for the facility is provided from a separate facility (MOH, RH, DH) with quarterly to monthly visits including time spent in the HIV clinic providing care/treatment.	Medical leadership for the facility is provided by an on site Medical Director with additional support from the MOH, RH or DH. Medical Director has < 1FTE dedicated to in-clinic activities.	Dedicated Medical Leadership is provided on site by a HIV Services Medical Director with 1 FTE involvement in the clinic including a dedicated patient load; additional support form the MOH, RH or DH on a routine basis.
Indicator		**0**	**1**	**2**	**3**	**4**	**5**
b.	Nursing and Home-Based Care Score	There is no dedicated nursing or community HBC leadership.	Minimal nursing leadership; HBC services provided by a separate organization not affiliated or managed by the facility.	Moderate nursing leadership with minimal integration into clinical management systems; HBC limited to an on-site coordinator that communicates with outside agencies.	Moderate nursing leadership with integration into the clinical team; moderate ability to influence program services; HBC leadership on-site supervising an integrated community program; minimal time in the field.	Effective nursing leadership integrated into the clinical system management with strong ability to influence program services; integrated HBC on-site supervising HBC; < 50% of time in field providing community nursing.	Effective nursing leadership integrated into the clinical system management with strong ability to influence program services; Community nurse supervises community health workers; integrated HBC on-site with funded CHWs and strong network of CHVs; > 50 % of time in field providing community nursing.

3. *Level of Care*

	Indicator	0	1	2	3	4	5
a.	Opportunistic Infection Management Score	No on-site capacity to diagnose or treat Opportunisitic Infections. No cotrimoxazole prophylaxis offered	Basic prevention of OIs limited to cotrimoxizole; no STI treatment available; referral of sick patients to other centers for diagnosis and treatment of other OIs.	Basic prevention of OIs, treatment of STIs; continuation of treatment initated at other centers.	Diagnosis and treatment of OIs and STIs except TB and Cryptococcal Meningitis.	Diagnosis and treatment of OIs on site including TB; referral to other site for diagnosis and treatment of CM.	Diagnosis and treatment of OIs on site including TB and CM.
b.	ART Score	No ART offered on site, no linkages to ART sites.	VCT site only; refers patients to other sites for staging and ART.	VCT and PMTCT offered at site only; refers to other sites for ART.	1st Line ART only and PMTCT services; 2nd line patients referred off-site.	1st Line, Alternative and 2nd Line provided on-site; PMTCT integrated into ART clinic.	1st Line, Alternative; and 2nd Line ART, HAART for pregnant women; pediatric treatment offered.

4. *Facility*

	Indicator	0	1	2	3	4	5
a.	Exam Rooms Score	No exam rooms.	1 Exam room available; multiple patients seen at one time; inadequate sanitation, ventilation, lighting; no exam tables or privacy screens.	> 1 Exam rooms available; usually one patient per room; exam table present; inadequate sanitation, lighting, and/or ventilation.	Exam rooms available; only one patient seen at a time; adequate furnishing and lighting; no infection control between patients; basic exam equipment lacking.	Exam rooms available with adequte privacy; furnishings, sanitation; ventilation; lacking some diagnostic equipment or lighting; multi use equipment sanitized between patients.	Fully equiped exam rooms with adequate privacy; furnishing, sanitation, ventilation, lighting, and diagnostic equipment; multi use equipment and exam tables sanitized between patients.

Indicator		0	1	2	3	4	5
b.	Laboratory Diagnostics Score	No laboratory capabilities on site beyond rapid test for VCT.	VCT, Hematocrit and Pregnancy test only.	VCT, Hematocrit, pregnancy test, ALT/AST, CRT available; no stains or radiology.	VCT, Hematocrit, pregnancy test, ALT/AST, CRT; stains available.	Gram staining, VCT, Hct, ALT, CRT, malaria smears, parasitology.	Gram and ZN staining, Hct, ALT, CRT, CRAG, malaria, parasitiology, and CXR.
c.	Medical Records Score	No medical records or cards.	Patient held visit cards for individual services only.	Registers only, patient held visit cards for individual services and TB treatment.	Patient ART card held by the clinic; registers and patient logs kept by service; or patient chart with minimal current information; no file system.	Full patient chart with sections for each service kept up to date and adequately filled out. Secure filing system with dedicated records room.	Full patient chart with sections for each service kept up to date and adequately filled out. Secure filing system with dedicated records room. Electroinic data base routinely updated with each encounter to different services.
d.	Clinic Flow Score	No organized clinic flow.	Only intake flow is organized, other services not integrated into linear clinic flow.	Intake and assessment organized in clinic flow, no organized flow through rest of systems.	Intake, assessment and laboratory organized in a linear flow; no organized flow for pharmacy or speciality services.	Linear flow including all services; clinic still experiences bottle necks on overly busy days.	Linear and logical flow inclusive of all services; no bottlenecks regardless of patient load for the day.
e.	Patient-Provider Interaction Score	No documented interaction; refill services only.	Limited history taken.	Limited history; observational review of systems only.	Detailed history with cursory physical exam of patient.	Detailed history and focused physical examination; little explanation given to patient.	Detailed hisotory and focused physical examination with explanation to patient of intended course of action

5. *Assessment Score*

	<30	30 - 35	36 - 41	42 - 47	48 - 53	54 - 60
Indicator	**<50%**	**50 - 59%**	**60 - 69%**	**70 - 79%**	**80 - 89%**	**90 - 100%**
Total Score						

6. *Summary*

7. *Program Component Specific Work-Plan and Follow-Up Activities*

Objective	Activities	Target Date	Person Responsible

Clinic Name _____ **Date of Review** _____

Reviewer _____

1. *Clinic Overview*

How long has this clinic been providing care for patients with HIV? ☐☐☐ **years**

How long has this clinic been providing ART? ☐☐☐ **years**

When did this clinic begin receiving PEPFAR funding ____/____ **20** ____

2. *Nursing Integration*

Indicator		0	1	2	3	4	5
a.	Care and Treatment Team Score	There are no defined job descriptions for nursing staff. No roles and responsibilities are documented.	Roles of nurisng staff are not documented. Each nurse performs one specific task	Nursing roles and responsibilities are documented. Documentation directed at individual task performance.	Nursing roles and responsibilities are well defined and documented and include the roles of nurses as a care and treatment team. Nursing team functions as an independent team within the care delivery system.	Nursing roles and responsibilities are well defined and documented. The Nursing staff function as a team and are integrated into clinical care meetings and case conferences.	There are well defined and functioning nurse-physician teams providing comprehensive, continuity care to patients enrolled in HIV care and treatment.

3. *Task Shifting*

Indicator		1	2	3	4	5	6
a.	Clinic Flow Score	There is no nurse involvement in coordinating patient flow through the clinic.	There is a nurse designated as "in-charge", however they have limited influence in changing flow of patients through the clinic.	There is a Nurse In-Charge that implements changes in clinic flow based on recommendations of the medical director and physician staff.	There is a Nurse-in Charge that functions as the clinic coordinator. S/he participates in changes in clinic flow based on meetings with the clinical team and implements suggested changes.	There is a Nurse In-Charge that is also an independently functioning Clinic Coordinator. S/he independently identified potential bottlenecks in the clinic flow and implements strategies to prevent or minimize the bottleneck and the clinic has minimal to moderate congestion on most days.	There is a Nurse In-Charge that is also an independently functioning Clinic Manager. S/he independently identifies potential bottlenecks in the clinic flow and implements strategies to prevent or minimize them. S/he has the authority to implement change.

Indicator		0	1	2	3	4	5
b.	General Job Practice Score	Makes no independent decisions regarding patient care.	Makes minimal independent decisions regarding patient care limited to scheduling of patient appointments.	Makes minimal nursing diagnoses related to non-HIV related pateint problems (fever, cold). Makes some independent decisions regarding patient care. Develops a nursing casre plan maintained separately from the pateint chart.	Makes nursing diagnoses followed by the design and implementation of a nursing care plan. Records the plan in the patient chart.	Makes nursing diagnosis, designs and implements a nursing care plan that is recorded in the patient chart. Provides comprehensive general care for stable patients not yet on ARVs.	Independently provides comprehensive care to stable general care patients, stable patients eligible for ARVs and patients stable on ARVs. Appropriately refers unstable patients for further medical care.
c.	Patient History Score	The nurse does not participate in patient history taking.	History taking is limited to asking patients their identifying information.	History taking is limited to asking patients identifying information, their reason for coming to the clinic. Information is not recorded by the nurse in the patient chart.	History taking is linited to patient identifying information, reason for coming to the clinic and askiong patients about missed doses of medications. Information is recorded by the nurse in the patient chart.	Performs a comprehensive review of symptoms, assesses pregnancy status, assesses adherence, incluiding barriers, and resords information in the patient chart. Communicates significant findings to the MO.	Performs a comprehensive review of symptoms, assesses pregnancy status, adherence including potential barriers, signs and symptoms of treatment failure and/or worsening disease. Information is recorded by the nurse in the patient chart and the nurse communicates significant findings to the MO and other members of the health care team including community health workers and treatment support personnel.

Indicator		0	1	2	3	4	5
d.	Patient Triage Score	The nurse does not triage patients in this clinic.	Triage is limited to assessing airway, breathing, circulation and disability in patients who are obviously ill.	Uses established protocols to triage patients who present with a specific complaint. Makes suggestions to MO regarding who needs immediate attention.	Uses established protocols to triage patients who present with a specific complaint. Makes independent judgment to determine who needs immediate attention and ensures the patient is seen in a timely manner.	Prioritizes emergency patients for care based on problem identification and assessment (history, visual assessment, vital signs). Patients identified by the nurse with emergency/urgent signs and symptoms are seen by the MO within 60 minutes or if in the community within 48 hours.	Prioritizes all patients for care based on problem identification and assessment (history, visual assessment, vital signs). Patients identified by the nurse with emergency/urgent signs and symptoms are seen by the MO within 15 minutes or if in the community within 24 hours.
e.	Vital Signs Score	The nurse does not take vital signs of patients.	2 or fewer vital signs (temperature, pulse, respiration, blood pressure, weight) are taken only on patients on ARVs at scheduled visits. Vital signs are written on a separate piece of paper and recorded in the chart by the MO.	Two or more vital signs are taken only on patients on ARVs at scheduled appointments and are documented in the patient chart by the nurse.	At least two vital signs are taken on all ARV patients at both scheduled and non-scheduled appointments and recorded in the patient chart by the nurse.	All vital signs for adult patients are taken at each visit for both ARV and non-ARV patients and are recorded in the patient chart.	All vital signs, including those indicated for pediatric care and treatment (height, head circumference) are taken at each visit for both ARV and non-ARV patients and recorded in the patient chart.

Indicator		1	2	3	4	5	6
f.	Patient Education Score	Nurses do not participate in patient education.	Participation in patient education is limited to reminding patients to follow the MO's instructions at either the beginning or end of visits.	Ensures the patient understands the MO's instructions about medication, general healthy living, and reasons for tests at the close of the visit.	Ensures the patient understands the MO's instructions about medication, general healthy living, and reasons for tests at the close of the visit. Reminds patient of general symptoms to watch out for while at home.	Ensures the patient and family understands the MO's instructions about medications, lifestyle changes and reasons for any tests being given at the beginning and close of the visit. Reminds patients about assessing symptoms at home and ensures the patient and family are aware of signs/symptoms that require immediate attention and how to contact the clinic.	Ensures the patient, family and community health volunteer understands the MO's instructions about medications, lifestyle changes and reasons for any tests at the beinging, during and at the close of the visit. Offers suggestions about symptom assessment and management for the patient at home. Patient, family and CHV are aware of signs/symptoms that require immediate attention and how to contact the clinic.
g.	Prevention Activities Score	Nurses do not participate in patient specific prevention assessments or planning	Nurse participation in prevention with patients is limited to remind patients of general risks of transmission.	Provides counseling and education on behaviors that increase the risk of transmission.	Provides counseling and education on behaviors that increase the risk of transmission. Encourages patients to have family members and sex partners tested for HIV	Counsels patients on behaviors that increase risk of transmission and on re-infection and resistance. Refers for counseling on risk reduction. Records that prevention review/education occurred in the patient chart.	Identifies patient behaviors that increase risk of transmission to others. Counsels patients and their involved family on re-infection and resistance. Provides or refers for counseling on risk reduction. Records all information in the patient chart.

Indicator		0	1	2	3	4	5
h.	Patient Follow-up Score	Nurses do not participate in patient follow-up.	Patient follow-up participation is completely limited to ordering basic labs based on MO orders or established protocols.	Patient follow-up is mostly limited to ordering basic labs based on MO orders or established protocols. Nurse may order follow-up labs such as CD4 based on protocol driven time lines.	Patient follow-up includes ordering of basic labs based on MO orders and established protocols. Nurse may order follow-up labs based on recognition of abnormal values.	Patient follow-up includes ordering of basic labs based on established protocols. Nurse routinely orders follow-up labs based on the recognition of abnormal values or new presenting symptoms.	Nurse routinely orders follow-up labs based on the recognition of new presenting symptoms. Reviews results of lab assays at each visit, recognizes abnormal values and brings them to the attention of the MO. Arranges for patient follow-up as necessary.
I.	Home Based Care Score	Nurses do not provide home based care.	Communicates only urgent patient information to Community Health Volunteers.	Communicates routinely with CHVs regarding patient health and adherence to routinely scheduled appointments.	Communicates routinely with CHVs regarding patient health, adherence to scheduled appointments and pharmacy pick up. Refers new patients for Home Based Care.	Nurses supervise the implementation of Home Based Care and are responsible for a designated number of Community Health Workers who supervise the CHVs.	Nurses supervise the implementation of Home Based Care. Has nursing staff that supervise a designated number of CHWs and spend >50% of their time in the community and routinely review home based care plans and outcomes.

3. *Universal Precautions and Confidentiality*

Indicator		0	1	2	3	4	5
a.	Infection Control Score	Minimal standards for infection control including hand washing and multi-patient use equipment are not in place.	Thermometers are disinfected between each use.	Thermometers are disinfected between each use and MOs wash their hands between each patient.	Thermometers and stethoscopes are disinfected between each patient use and MOs and nurses wash their hands between each patient.	All health care providers wash their hands and disinfect shared equipment between each patient.	All health care providers wash their hands and disinfect shared equipment between each patient. Patient exam surfaces are wiped down with disinfectant between patients.
b.	Universal Precautions Score	Nurses have no standard UP protective equipment.	Latex gloves are available in each exam room.	Latex gloves and permeable gowns are available in each exam room.	Latex gloves and non-permeable gowns are available in each exam room.	Latex gloves, non permeable gowns and 90/10 water bleach solution is available in each exam room.	Latex gloves, non-permeable gowns, 90/10 solution and protective eye gear is available in each exam room.
c.	Confidentiality Score	There are no provisions for patient privacy/confidentiality in chart handling, exam rooms or waiting areas.	Volunteers and/or other patients have access to patient charts, registers with names are visible. More than one patient is usually in the exam room at a time. There is no door on the exam room or people routinely enter and exit the exam room while patients are present	Volunteers have access to patient charts. More than one patient is usually in the exam room at a time. The exam room door stays closed most of the time with minimal traffic in and out.	Only clinic staff or the patient handles the chart. The exam room is private and only one patient is seen in the room at a time.	Only the clinical team or the patient handles the chart. The exam room is private and only one patient is seen in the room at a time. Full names are not called in the waiting area. Registers are not visible to other patients.	Only the clinical team or the patient handles the chart. The exam room is private and only one patient is seen in the room at a time. Full names are not called in the waiting area. Registers are not visible to other patients. Confidentiality and privacy of the patients is part of routine staff and volunteer orientation and continuing education.

4. *Assessment Score*

	<32	32 - 38	39 - 44	45 - 51	52 - 57	58 - 65
Indicator	**<50%**	**50 - 59%**	**60 - 69%**	**70 - 79%**	**80 - 89%**	**90 - 100%**
Total Score						

5. *Summary*

6. *Program Component Specific Work-Plan and Follow-Up Activities*

Objective	Activities	Target Date	Person Responsible

Clinic Name _____ Date of Review _____

Reviewer _____

1. *CBTS Overview*

How long has this clinic been providing care for patients with HIV? _____ years

How long has this clinic been providing ART? _____ years

When did this clinic begin receiving AIDSRelief funding _____/_____ 20 _____

2. *Treatment Preparation*

Indicator		0	1	2	3	4	5
a.	Structured Treatment Preparation Score	No structured treatment preparation	Treatment preparation exists but is not structured for every patient	A structured treatment preparation exists and is documented but staff are not familiar with it	A structured treatment preparation exists, is documented but only some staff are aware and conduct it only if necessary	A structured treatment preparation exists, is documented, all staff are aware and it is implemented the majority of the time	A structured treatment preparation exists, is documented, all staff are aware and it is implemented consistently with each new patient
b.	Social Criteria for Starting ART Score	Nosocial criteria for starting ART	There are social criteria but they are not formally written down	There are formally written social criteria and most staff are aware	Formally written criteria known by all staff and used by all staff for difficult patients	Formally written criteria known by all staff and used by all staff for all patients most of the time	Formally written criteria known by all staff and used by all staff and required for all patients prior to starting ART
c.	Patient /Family Treatment Score	No room for treatment preparation	There is a room available if tx prep needs to be done	There is a dedicated room for tx prep	Treatment prep is done in the community on days when it cannot be done in the clinic	There is a dedicated room for tx prep used only for tx prep daily	Dedicated room for tx prep in the clinic and also designated space for tx prep in the community
d.	Post Pharmacy Counseling Score	No post pharmacy counseling	Post pharmacy counseling is not structured	Post pharmacy counseling is done only for difficult patients	There is a dedicated person for post pharmacy counseling for difficult patients	Dedicated staff conduct post pharmacy counseling for every patient for the first 2 weeks	Dedicated staff conduct post pharmacy counseling for every patient after every pick up visit

3. *Patient Community Support*

Indicator		0	1	2	3	4	5
a.	Patient Home Visit Score	No home visits	Home visits are done only to follow up those who miss appts	Home visits are done for new patients only within the first 2 weeks of tx	Dedicated staff to conduct home visits for all patients on tx	Dedicated staff to conduct home visits prior to and post ART	Continued home visits; spot checks; for patients on ART
b.	Patient Support Groups Score	No patient support groups	Hospital based patient support groups; meet occasionally	Hospital and community based support groups; meet occassionally	Community based support groups meet monthly	Community based support groups meet monthly; clinic staff visits with the support group to provide care and continued support	Targetted support groups meeting monthly in the community; with support from clinic staff
c	Use of Community Health Nurses Score	No use of community health nurses	No community health nurse; nurse in charge communicates with CHWs	No community health nurse; CHWs come to the clinic to file reports quarterly.	Community health nurse operates independently of the community care and treatment support program.	Community health nurses responsible to support CHWs in the filed < 50% of the time.	Community health nurses responsible to support CHWs in the field
d.	Use of CHW Score	No use of community health workers	Community health provided by an un-affiliated organization.	Community health provided through linkage with another organization.	Community health workers < 25% FTE	Community health workers < 50% FTE	Continued use of community health workers
e	Use of PLWHA Score	No use of PLWHA in the program	PLWHA groups provided by an un-affiliated organization.	PLWHA groups provided through linkage with another organization.	PLWHAs engaged as volunteers in loosely organized community based support groups.	PLWHAs engaged as volunteers in organized community based treatment support programs.	Graduation of PLWHA as staff members

4. *Continuity of Care*

Indicator		0	1	2	3	4	5
a.	Community Mobilization & Sensitization Efforts Score	No community mobilization & sensitization efforts	Community mobilization and sensitization efforts provided by an un-affiliated organization.	Community mobilization and sensitization provided thorugh linkage with another organziation.	Community mobilization and sensitization provided by volunteers only during campaign efforts	Community mobilization and sensitization provided by volunteers on a routine basis.	Comprehensive community mobilization & sensitization efforts
b.	Home based Testing Score	No home based testing	Referrals to testing sites provided during community mobilization activities.	Referrals to testing sites provided during home visits and support groups in the community.	Home based testing with referral to primary health facility for confirmatory test.	Home based testing with linkage to community programs.	Home based testing linked with community based programs to provide testing and linkage to care
c	Prevention for Positive Strategies Score	No prevention for positive strategies	Prevention for positives limited to brochures and posters.	Counseling on basic risk reduction provided as prevention for positives.	Prevention for positives direct counseling provided only based on patient provided information.	Prevention for positives counseling and behavior change counseling provided at each visit.	Comprehensive ABC programs

5. *Assessment Score*

	<30	30 - 35	36 - 41	42 - 47	48 - 53	54 - 60
Indicator	<50%	50 - 59%	60 - 69%	70 - 79%	80 - 89%	90 - 100%
Total Score						

6. *Summary*

Program Component Specific Work-Plan and Follow-Up Activities

Objective	Activities	Target Date	Person Responsible

Clinic Name _____ Date of Review _____

Reviewer _____

1. *Health Care Management Overview*

What is the title of the highest management officer of this facility? _____

How long has the current holder been in this position? _____ years

What role does this person play in the HIV care and treatment program? _____

2. *Strategic and operational/service planning*

Indicator		0	1	2	3	4	5
a.	Facility mission Score	The facility does not have a mission statement or concept.	Mission exists but is not clearly documented and has not been reviewed in the last 12 months. Very few staff can articulate the mission and it is not referred to in any documents.	Mission exists and is doucmented but has not been reviewed in the last 12 moths. While the mission is referenced in guiding documents few staff can articulate it.	Mission exists and is clearly documented and is up to date; some of the facility values are not reflected. Most staff are able to articulate the mission.	Mission is clearly articpulated, up to day and reflects the facility's values and purpose; all staff know the mission and it is used to prioritize programs.	Mission is clearly articulated, up-to-date and reflects the facility's values and purpose; all staff know the mission and it is used to prioritize programs. The mission is posted in areas of the facility frequented by patients.
b.	Available written strategic plan Score	There is no short or long term strategic plan.	Medium to long term strategic plan is unclear or incoherent; strategy has no influence over management	Medium to long term strategic plan is fairly clear; strategy put forth by management has little direct relation to the plan	Medium to long term strategic plan is clear; sartegy put forth by management addresses most of the plan's content.	Clear and cohert medium to long term strategic plan that is actionable and measureable is in place, strategy is broadly known, all services offered are clearly linked and strategy informs decion making. Routinely reviewed by a multi-disciplenary committee representing most of the clinic based care delivery system.	Clear, coherent medium to long term strategic plan that is actionable and measurable; strategy is broadley known; all services offered are clearly linked ; time frames for goals achievement are clear and strategy informs decision making. It is reviwed on a routine basis by a team comprised of reprsentatives from the entire care delivery system including patient representation.
c.	Operational Planning/services planning Score	Facility runs operations purely on a day-to-day basis with no short term or long term planning activities; no ability or experience to conduct data based operational planning	Facility runs operations based on short term planning usually in reaction to crises in staffing, funding, or reporting.	Facility runs operations based on short to medium term planning, however, plans often change due to competeing priorities.	Facility runs operations based on medium term planning, a loosely defined operational plan exists which takes the annual budget into account.	Facility runs operations based on a well developed and concrete opeational plan. The plan is reaslistic and linked to an annual budget as well as service and patient trend data. The plan is routinely reviewed by senior management and front line clinic leadership.	Facility develops and refines concrete. Realistic, and detailed operational plan linked to annual budget and trend data; has internal experience in operational planning; operational plans developed regularly; operational plan linked to strategic planned activities and is used to direct operations. Plan is routinely vetted through a community advisory board.

Indicator		0	1	2	3	4	5
d.	New program development and service integration Score	No new program development exists. All programs are vertically run with virtually no communcation between them.	No assessment of gaps in ability of current programs to meet needs of the catchment area; limited ability to create new programs and integrate them into existing ones; new programs created largely due to funding availability; most related programs operate vertically	Some assessment of gaps in current programs to meet needs of the catchment area occurs centered on reporting to current funding sources; minimal ability to create new programs; program integration only at the most senior level of the facility.	Assessment of gaps in current programs to meet needs occurs on a semi-routine basis; some abilit to create new programs exists; program integration occurs only between programs with established and related referral systems.	Assessment of gaps in the ability of current programs to meet needs occurs routinely; strong ability to create noew programs to meet needs of current service recipients; programs are integrated at the facility level and communicate on an established routine basis.	Continual assessment of gaps in the ability of current gaps to meet needs and adjustments always made; Ability to create new programs to meet needs of underserved or new populations; feedback from community groups served is routinely sought and integrated; established ability to integrate new programs and all facility operations run in a logical flow for related services
e.	Performance Targets Score	Targets are non-existent or too few to measure facility performance.	Existing targets are vague and not linked to a time period; staff unaware of targets; no management buy in to targets; little realtionship of targets to measuring facility goals	Targets exist for some program areas; are time linked; and staff is generally aware; too few to accurately measure achievement of facility or program goals.	Targets exist for most program areas; are time linked; staff are aware of individual program goals and management routinely tracks and reviews target achievment.	Specific, quantified targets exist for each program area; targets are linked to facility mission and strategy; program goals are both process and outcome fouced; all staff are aware of individual and over all facility targets.	Limited set of quantified, demanding performance targets in all areas; Targets are linked to strategy, program goals and are output/outcome focused; Have annual milestones; Staff consistently adopts targets and works diligently to achieve them; Overall board and management evaluates performance based on targets;
f.	Performance Management: benchmarking	Performance data is not used for program benchmarking.	Rarely compares performance data such as financial performance, patient demographics, service utilization in relation to program goals or between departments and with other facilities or any objective standard	Sometimes compares performance data in relation to program goals between departments; rarely compares with other facilities or national goals, no objective standard exists.	Often compares performance data in relation to program goals within and between departments; compares with national goals and other facilities; utilizes an established objective standard.	Rountinely compares performance data in relation to program goals within and between departments as well as externally using an established objective standard. Makes program changes based on performance data.	Comprehensive internal and external benchmarking is part of the culture and is done regulary - say on a quarterly basis; Performamce compared to objective standards such as bed occupancy, bed turnover, average length of stay at a district, province and national level regularly; Benchmarking is used by staff in setting targets and daily operations; High awareness of how all activities rate against intyernal and external benchmarks; Systematic practice of making adjustments and improvement on basis of benchmarking. Performance data is posted in areas frequented by patients.

Indicator		0	1	2	3	4	5
g.	Human resource planning	No human resource management policy; HR function does not exist; No job descriptions; no performance evaluation system	There is one person responsible for tracking HR issues in addtion to their other funcitons; no written policy exists; no job descriptions exist and there is no performance evaluation system.	There is one or two people involved in HR functions in addtion to their other tasks, some basic job descriptions exist; no written hiring or firing policy exists; there is no performance evaluation system.	There is a designated HR person with a defined set of functions; job descriptions exist for most positions; written hiring and firing policies exist and most staff are aware of them; no performance evaluation system exists.	There is a desinated HR office within the facility that reports to the facility director; job descriptions exist for all postions; written policies exist; new staff particpate in a planned orientation and receive copies of all policies; there is a minimal performance evaluation system.	A clear human resource management policy exists; appointment and promotion of staff follows an elaborate performance evaluation system; job descriptions exist for all technical and key staff; a system to gather patient input is in place.
h.	Organizational structure	There is no clear organizational structure; departments and fucntions at the facility not well defined; relations between different units/departments/functions are not clearly outlined; the role of senior management and the board in services planning for old and new services not evident	Little to no organizational strucure is in place; very few departments/units/funcitons are defined; relationhips between different functions are unclear; staff is unable to articulate the organizational structure within their program area.	There is minial organizatoinal structure in place; some departments/units/functions are defined; relationshiops between different funcitons are not formally outlines; few staff are able to articulate the organizational structure within their program area.	There is an organizational structure in place; several departments/units/functions are well defined; relationships between different functions are basically outlined; most staff is able to articulate the organizational structure within their program area.	There is an organizational structure in place; the majority of departments/units/functions are well defined; relationships between different functions is clearly outlined; role of senior management in service planning is clear and evident; staff is able to articulate the organizational structure of the facility.	There is an organizational structure in place; all departments/units/fucntions are well defined; relationships between different fucntions clearly outlined; role of the board and senior management in services planning is clear and evident. The board has a patient representative.
i.	Board governance	There is no board or other higher structure in place.	There is a board however it rarely engages in setting policy for facility governance; Roles and responsibilities of the governance structure (GS) not clearly understoon by key actors; GS does not review budgets, audits or set performance targets; GS members not trained in their role; GS membership rarely changes	There is a board which sometimes engages in policy setting and facility governance; there are roles and responsibilities but they are limited to signatory authority on annual budget and medical director selection. Board members never change.	There is a board which routinely engages in policy setting and facility governance; there are roles and responsibilites understodd by key actors; board responsibilities are limited to annual budget review and approval of requests for new funding. Board is trained in their functions at first appointment. Board members rarely change.	Board exists and its roles and responsibilities are well defined and clearly understood by key actors; GS works well with management; Medical Director is a non-voting member of the board; quarterly review of budgets and peroformance data; provides guidance for facilty operations; GS trained in their role; appointed for a set period of time.	GS exists and its roles and responsibilities are well defined and clearly understood by key actors; the GS works well with management; GS sets performance targets, reviews budgets and audits and provides overall policy guidance for facility operations; GS members trained in their role; GS membership changes regularly. At least one patient serves as a voting member of the board.

3. *Assessment Score*

	<22	22 - 26	27 - 30	31 - 35	36 - 39	40 - 45
Indicator	**<50%**	**50 - 59%**	**60 - 69%**	**70 - 79%**	**80 - 89%**	**90 - 100%**
Total Score						

4. *Summary*

5. *Program Component Specific Work-Plan and Follow-Up Activities*

Objective	Activities	Target Date	Person Responsible

Clinic Name _____ **Date of Review** _____

Reviewer _____

1. *Financial, Budget and Cost Management Systems*

Who is the accounting officer of this facility? _____

How long has the current holder been in this position? _____ **years**

2. *Financial Systems*

Indicator		0	1	2	3	4	5
a.	Operating Surplus	Facility unable to procdue fiscal records for more than the last year.	Revenues have not exceeded expenses in the last 3 years	Revenues have exceeded expenses in only 1 year out of the last 3 years with no net surplus	Revenues have exceeded expenses in two of the last year but with no net surplus	Revenues have exceeded expenses in all the last 3 years but there has not been a net surplus	Revenues have exceeded expenses in all of the past 3 years and there has been a net surplus
b.	Diversity of Revenue Sources	Facility has no source of funding for HIV services.	Facility dependent on government and one donor grants which make up more than 90% of total revenue; a limited amount (less than 10%) is from patient fees; HIV services funded through grants exclusively; Facility is prone to funding fluctuations of government and the main donor	Facility dependent on government and less than one donor for more than 75% of total revenue; Less than 30% of revenue is from patient fees or other income generating activities; HIV services funded from grants exclusively	Facility dependent on government and about two donors for more than 50% of total revenue; less than 50% of the revenue comes from patient fees and other income generating activities; More than 75% of HIV services are funded through grants	Facility dependent on government and a variety of donors for up to 50% of its revenue; Less than 50% of the revenue comes from patient fees and other income generating activities; About 50% of HIV services funding is through grants	Grants from government and donors make up less than 50% of the operating revenue; More than 50% of revenue is from patient fees and other sources such as other income generating activities; Diversity of funding sources provide insulation against fluctuation in grant funding

Indicator		0	1	2	3	4	5
c.	Financial planning and budgeting	Budget provided by an outside agency with no facility involvement.	Very limited financial forecasting; General budget developed and approved outside of the facility; Performance against the budget is either loosely/poorly or never monitored; Budgets developed on a basis of inputs and are not linked to outputs in the plan	Limited financial forecasting, ad hoc update; Annual budget not utilized as an operational tool; Budgets developed based on historical incrementarism	Occasional financial forecasting; Annual budget occasionally used as an operational tool: Some attempt to isolate divisional/unit/cost center budgets within the overall budget; Performance to budget tracked occasionally	Solid financial forecasts updated at least semi-annually and discussed with the management team, staff and the baord; Annual budget utilized in operations; Budget reflects organizational needs; Solid efforts made to isolate budget according to divisions/units/cost centers; Performance-to-budget tracked at least quarterly	Very solid financial forecasts continuously updated; Annual budget updated regularly; Budgets are reveiwed monthly by management and are utilized in daily operations; Budget developmment is part of the planning process and reflects organizational/program objectives; Budgets are allocated and managed at a service delivery level (cost center); Performance to budget is monitored on a monthly basis
d.	Use of financial and operations data/financial reporting	Facility does not report its finances.	No basic financial management reports such as budget-to-actual financial reports, cash flow, and account payables or receivables are produced;	Occasionally produces some basic financial management reports such as budget-to-actual financial reports, cash flow and/or accounts payable/receivable; Reports produced upon request and reviewed by the Medical/Executive Director only;	Regularly produces basic financial management reports such as budget-to-actual fianncial report, cash flow and/or accounts payable/accounts receivable; Occasionally produces some more sophiscated financial reports on request such as cost center reports, administrative/overhead, and/or cost reporting/cost reconciliation; Financial reports reviewed by the Executive Director at least quarterly and by the board at least twice per year	Facility produces at least quarterly financial management reports; Produces some more sophiscated reports such as financial/operational reports, cost cebter reports, inventory and personnel cost tracking; Reports include data from previous time period for comparison; Financial reports reviewed by Executive/Medical Director monthly and by the management team and board at least twice per year	Produces comprehensive financial management reports, cost center reports, admin/overhead cost reports; Reconcilaition of costs, inventory and personnel is done regularly; Trend analysis information is availed routinely and is discussed by management team on a monthly basis and shared with the board at least quarterly; Information from the reports feeds directly into planning, decision-making and adjustments in services and operations

Indicator		0	1	2	3	4	5
e	Cost management	There is no cost management system.	The facility does not analyse cost of operation; No specific cost management strategy in place; Costs not related to service outputs; Service costs not known no available information on individual service costs; Unit cost information not known	Facility analyzes some cost information once a year when developing budgets; no specific cost management strategy in place; costs not related to services; some unit costs known	Occasionally the facility analyzes cost information at the request of the Executive/Medical Director; Some costs are related to services provided; some unit costs are determined and are used in preparation of some reports for the Executive/Medical Director but are not discussed relative to operations	On a quarterly basis the facility analyses cost information; there is a cost management strategy in place but it is not comprehensive; Unit cost information is occasionally related to service operations; Unit cost information is prepared for management discussion on a quarterly basis but is not shared with the baord;	The facility monthly analyzes service cost of operations; Units costs known for all services; A clear cost management strategy in place; Costs managed at a cost center level; Facility knows what it costs to offer different services; Financial cost reports available; Cost information feeds into budgeting process; Cost reports prepared and discussed by management on a monthly basis and are shared with the board on a quarterly basis

3. *Assessment Score*

	<12	12 - 14	15 - 16	17 - 19	20 - 21	22 - 25
Indicator	**<50%**	**50 - 59%**	**60 - 69%**	**70 - 79%**	**80 - 89%**	**90 - 100%**
Total Score						

4. *Summary*

5. *Program Component Specific Work-Plan and Follow-Up Activities*

Objective	Activities	Target Date	Person Responsible

Clinic Name _____ **Date of Review** _____

Reviewer _____

1. *Pharmaceutical Management*

Is there a pharmacy department in this facility? _____

What are the qualifications of the person who heads it? _____

How many people work in the pharmacy and what are their qualifications? _____

2. *Supply management*

Indicator		0	1	2	3	4	5
a.	Drug Therapeutic/Formulary Committee	Facility has no DTC.	Facility has no DTC; Drug selection and ordering is based on a push system from a higher level such as a district or central medical store	Facility has no DTC; drug selection is done by the Medical Director but supply is based on a push system from the district and is not inititaed by the facility	Facility has a DTC but it does not meet regularly; The TOR for the DTC not clear; Drug selection and ordering is done by the Pharmacy-in-charge and the Medical Director;	Facility has a DTC and it meets on a quarterly basis; the TOR are clear although minutes of the DTC meetings are not regularly kept nor are they regularly disseminated; The DTC selects drugs to be used in the facility	The facility has a DTC; The DTC is fully constituted, meets regularly and makes all decisions on product selection; drug orders are made by the facility following the DTC recommendations
b.	Drug order process	Facility has no drug ordering process.	Drug orders deliveries are determined by the district; the concept of lead time in placing orders not adhered to at all times; Frequent stock out of tracer products for more than 4 weeks on average;	Some drug orders are made by the facility but most of the drugs come through a push process; lead time is not considered important in drug orders or requisitions from the district; the facility experiences stock out of key products frequently;	Drug orders are made by the facility but infrequently; lead time in placing orders is considered important but facility struggles to incorporate it in estimating drug quantities to order; the facility does not experience stock outs lasting more than a week	Drug orders are made by the facility on a quarterly basis regardless of stock levels; lead time consideration is made in the ordering process but not for all products; rarely does the facility have stock-outs due to internal circumstances but the facility has no contigency plan for unanticipated drug stock-outs; drug quantities ordered are not based on consumption patterns	Drug orders are made following lead time and inventory levels at all times; Drugs ordered based on what the facility needs (pull system); No reported stock outs of key tracer products; Facility has a contingency plan in case of unanticipated drug shortage

Indicator		0	1	2	3	4	5
c.	Pharmacy records and documents	There is no documentation available.	Facility does not keep stock cards for tracking inventory; Physical stocks not reconciled with stock card values; procurement/delivery related documents are not kept at the store/pharmacy; Receipts and issues in and out of the pharmacy are not well documented and authorized	Facility maintains inventory stock cards but they are not filled frequently; Physical stocking takes place but is rarely reconciled with records; Receipts in and issues out of the pharmacy not are sometimes authorized and recorded	Facility maintains stock cards and fills them most of the time; the stock cards are not always up to date; Physical stocking takes place on a semi-annual basis but reconciliation is not always done or accurate since some records are not updated regularly; Receipts in and issues out of the pharmcy are recorded; All delivery/procurement related records are kept at the store/pharmacy and are filed;	Facility maintains stock cards and fills them regularly; Stock cards are mostly updated; Physical stocking takes place on a quarterly basis; Records related to drug orders, receipts and procurement are safely filed and kept at the store/pharmacy;	Inventory stock cards regularly filled; Physical stocks reconcile with stock card values; Procurement/delivery documents are kept at the pharmacy; Receipts and issues in and out of the pharmacy are well documented and authorized; Full reconciliation is done after stock taking; inventory records are computerized and both paper and electronic records agree on stock status
d.	Inventory management system	Facility does not manage it's own inventory.	The facility does not adhere to a FEFO (First Expiry First Out) system; Drugs not arranged in the store according to a logical system; There are expired drugs mixed with other drugs in the pharmacy;no inventory standard operating procedures (SOPs);	The Facility follows a First In First Out (FIFO) policy which does not take into consideration expiry; drugs not arranged in the store according to some logical system; Class A drugs including ARVs are not safely locked away from easy of reach of anyone walking into the store or pharmacy; Some drug boxes rest on the floors and no pallets; expeired drugs stored in the same place as good drugs but are not mixed	Facility follows a FEFO policy; some drugs not well labeled and arranged; it is still hard to locate different products; Class A drugs including ARVs are not safely locked away and are within easy reach of anyone walking into the store; consideration for storage requirements for different products is not made a priority; not all drugs are on shelves or pallets for boxes; SOPs in place but have not updated in the last 1 year	Facility follows a FEFO policy in inventory management; Expired drugs separately stored; Standard Operating Procedures for inventory management available but sometimes not followed and are not regularly updated	The facility follows a FEFO system consistently in the use of drugs; Drugs are well arranged in the pharmacy following a logical system; Drugs are stored according to their classfication; following national regulations and policies; SOPs exist, are regularly updated, are followed and are easily accessed by all who staff who need to follow them; There is a system for storing and disposing off expired drugs

Indicator		0	1	2	3	4	5
e	Drug quantification system and capability	Facility does not maintain a drug store on site.	No quantification process for drugs in place; Supplies sent to the facility by the district or other higher level body following no known formula	The facility not able to quantify its drugs needs and bases requisitions whenever made to past inventory levels	The facility tries to quantify drug needs but lacks the internal skills/competences to do it; no specific formula followed in drug quantification	Facility is able to estimate/quantify its drug needs within 75% accuracy; Not all factors such as past consumption, future utilization expectation, lead tme, buffer stock are incorporated; The quantifcation done using either paper system or excel program	Facility is able to quantify its drug requirements accurately; Lead time, buffer stock, utilization patterns etc… factors are taken into consideration when quantifying needs; the facility uses a computer software program to quantify drug needs.

3. *Assessment Score*

	<12	12 - 14	15 - 16	17 - 19	20 - 21	22 - 25
Indicator	<50%	50 - 59%	60 - 69%	70 - 79%	80 - 89%	90 - 100%
Total Score						

4. *Summary*

Program Component Specific Work-Plan and Follow-Up Activities

Objective	Activities	Target Date	Person Responsible

Clinic Name _____ **Date of Review** _____

Reviewer _____

1. *Clinic Overview*

Is there a dedicated laboratory manager? (Yes or No) _____

If yes, how long employed? _____ **years**

How long has this laboratory been providing services? _____ **years**

2. *Infrastructure*

Indicator		0	1	2	3	4	5
a.	Facility Score	No dedicated laboratory space.	Small space; No separation between sections; Dusty; No electricity; No running water.	Adequate space; No separation between sections; Electricity 25% functional; Poor lighting; Dusty; No running water; No climate control.	Adequate space; Sections not clearly defined; Electricity 50% functional; Adequate lighting when electricity available; Running water 80%; No distilled water; No climate control; Dust not completely controlled.	Space meets needs of laboratory; Separated by sections; Electricity funcational and 80% stable; Good lighting; Running water 100%; No distilled water; Climate control 80%; Dust controlled.	Space meets needs of laboratory, including distinct areas for patient reception, phlebotomy, specimen reception, testing area, microbiology section, and staff eating/meeting area; Separated by sections; No power outages; Excellent lighting; Running and distilled water 100% available; Climate control 100% available; Dust controlled.

Indicator		0	1	2	3	4	5
b.	Storage (Room temperature, cold, and frozen) Score	No areas dedicated to storage in the laboratory.	Small area for room temperature storage; No monitoring or climate control; Non-conformances not recorded; No corrective action taken.	Small area for room temperature and cold storage; No monitoring or climate control; Non-conformances not recorded; No corrective action taken.	Adequate area for room temperature, cold, and frozen; No monitoring or climate control; Non-conformances not recorded; No corrective action taken.	Adequate area for room temperature, cold, and frozen; 80% monitored and climate controlled; Non-conformances not recorded; No corrective action taken.	Sufficient area for room temperature, cold, and frozen storage; Separate and distinct areas; Monitored and climate controlled daily; Non-conformances recorded and corrective actions are taken and recorded immediately.

2. *Testing Capacity*

Indicator		0	1	2	3	4	5
a.	Hematology/CD4 Score	There is no capacity for hematology or CD4.	Manual methods for hematology.	Manual and automated methods for hematology.	Manual and automated methods for hematology; Manual methods for CD4.	Automated methods for hematology; Automated methods for CD4.	Manual and automated methods for hematology; Manual and automated methods for CD4.

Indicator		0	1	2	3	4	5
b.	Chemistry Score	There is no capacity for chemistry.	Manual methods for kidney and liver function tests.	Semi-automated or automated methods for kidney and liver function tests.	Manual and semi-automated or automated methods for kidney and liver function tests.	Manual and semi-automated or automated methods to monitor all major ARV toxicty.	All necessary chemistry testing that is relevant to the clinic or hospital.
c.	Microbiology Score	There is no capacity for microbiology.	AFB and malaria tests.	AFB, malaria, and gram staining.	AFB, malaria, gram staining, and CRAG.	Separate room for microbiology; AFB, malaria, gram staining, and CRAG.	Separate room for microbiology; AFB, malaria, gram staining, CRAG, flourescent microscopy, cultures, sensitivities.
d.	Serology Score	There is no capacity for serology.	Two HIV rapid tests; Discordant rapid tests sent out for confirmation.	Three HIV rapid tests; Discordant rapid tests confirmed in laboratory.	Three HIV rapid tests; Discordant rapid tests confirmed in laboratory; Additional serologic tests such as CRAG and RPR.	Three HIV rapid tests; Discordant rapid tests confirmed in laboratory; All necessary serologic tests.	Three HIV rapid tests; Discordant rapid tests confirmed in laboratory; All necessary serologic tests; ELISA.

3. *Good Laboratory Practices*

Indicator		0	1	2	3	4	5
a.	General Good Laboratory Practices Score	No universal precautions; No separation between dirty and clean; No rotation of personnel; Eating, drinking, and storage of food routinely; Uncontrolled access.	Inappropriate use of universal precautions; No separation between dirty and clean; No rotation of personnel; Eating, drinking, and storage of food; Uncontrolled access.	Inappropriate use of universal precautions; Some separation between dirty and clean, but not well maintained; No rotation of personnel; Eating, drinking, and storage of food, but not routinely; Uncontrolled access.	Some inappropriate use of universal precautions; Some separation between dirty and clean, but not well maintained; No rotation of personnel; No eating, drinking, and storage of food; Attempts are made to control access.	Universal precautions used appropriately; Well maintained distinction between dirty and clean; Personnel rotated at least once per quarter; No eating, drinking, or storage of food; Access limited to laboratory staff, but not completely controlled.	Universal precautions always used appropriately; Clear distinction between dirty and clean; Personnel rotated at least once per month; No eating, drinking, or storage of food; Access limited to laboratory personnel only.
b.	Specimen Collection Score	Not safe for laboratory personnel or patients; Syringe draws only; No gloves; Specimens collected in laboratory or other inappropriate area; TB specimens collected near other patients; No communication with patients; Reusing supplies; Needles recapped and disposed of in regular waste; Specimens usually not labelled and never inspected for specimen integrity prior to testing; Poor quality specimens always used for testing.	Syringes draws only; Gloves not used; Specimens collected in laboratory or other inappropriate area; Little communication with patients; Some supplies re-used for patients; Needles recapped and never diposed of appropriately; Specimens usually not labelled and never inspected for specimen integrity prior to testing; Specimens of consistently poor quality tested.	Syringes draws routine; Gloves changed between every ten patients; Specimens collected in laboratory; Little communication with patients; Some supplies are re-used for patients; Needles recapped, but disposed of appropriately 80%; Specimens usually labelled poorly and not inspected for specimen integrity prior to testing; Specimens of both good and bad quality tested.	50% vacutainer draws (50% butterfly needles for peds); Gloves changed between every two patients; Collection in appropriate and separate areas; Little communication with patients; Some supplies re-used for patients; Needles not recapped and disposed of appropriately 80%; Specimens usually labelled properly and inspected prior to testing 50%; Specimens of both good and bad quality tested.	80% vacutainer draws (80% butterfly needles for peds); Gloves changed between each patient; Collection in appropriate and separate areas; Good communication with patients; New supplies for each patient; Needles not recapped and disposed of appropriately 100%; Specimens usually labelled properly and inspected prior to testing 80%; Mostly specimens of good quality tested.	100% vacutainer draws (100% butterfly needles for peds); Gloves changed between each patient; Collection in appropriate and separate areas; Good communication with patients; New supplies for each patient; Needles not recapped and disposed of appropriately 100%; Specimens always labelled properly and inspected prior to testing 100%; Only specimens of good quality tested.

Indicator		0	1	2	3	4	5
c.	Specimen Flow	There is no describable specimen flow procedure in the laboratory from the time that test is requested by the provider until the result is issued to the provider.	Provider calls laboratory to order test. Patient goes to the laboratory. Laboratory collects patient specimen. Specimens are transported to appropriate section of laboratory. Specimen is run and results are reported on the patient requisition form. Someone collects the results from the laboratory.	Provider issues requisition form to patient. Patient provides requisition form to laboratory. Laboratory collects patient specimen. Specimens are transported to appropriate section of laboratory. Specimen is run and results are reported on the patient requisition form and usually in the log books. Someone collects the results from the laboratory.	Provider issues requisition form to patient. Patient provides requisition form to laboratory. Laboratory collects patient specimen. Specimens are transported to appropriate section of laboratory. Specimen is run and results are reported in log book and on the patient requisition form. Results are issued to the patient or the doctor.	Provider issues requisition form to patient. Patient provides requisition form to laboratory. Laboratory collects patient specimen ensuring proper documentation. There is a separate phlebotomy area. Specimens are entered into master log. Specimens are transported to appropriate section of laboratory. Specimen is run and results are reported in log book and on the patient requisition form. Results are issued to the patient or the doctor.	Provider issues requisition form to patient. Patient provides requisition form to laboratory. Laboratory collects patient specimen ensuring proper documentation. There is a separate patient reception area and phlebotomy area. There is a separate specimen reception area where specimens are received after being drawn. Specimens are entered into master log. Specimens are transported to appropriate section of laboratory. Specimen is run and results are reported in log book and on the patient requisition form. Results are coordinated at the specimen reception area. A complete,verified result is sent to the doctor.
	Score						

Indicator		0	1	2	3	4	5
d.	Laboratory Organization Score	No organization; Not cleaned regularly; Only expired reagents; Sections, benches, shelving, cupboards, and other storage areas unlabelled.	Disorganized; Cleaned at least once a month; Greater than 80% expired reagents; Sections, benches, shelving, cupboards, and other storage areas unlabelled.	Disorganized; Cleaned at least once a week; Greater than 50% expired reagents; Sections, benches, shelving, cupboards, and other storage areas unlabelled.	Adequate organization; Cleaned at least once a week; Less than 50% expired reagents; Sections, benches, shelving, cupboards, and other storage areas unlabelled.	Adequate organization; Cleaned at least once a day; Less than 20% expired reagents; Some sections, benches, shelving, cupboards, and other storage areas labelled.	Well organized; Cleaned at least twice a day and when necessary; No expired reagents; All sections, benches, shelving, cupboards, and other storage areas labelled.
e.	Waste Management Score	Receptacles not available for waste; Trash not separated; Sharps containers not available for needles and sharps; Infectious waste not disinfected; Waste buried; No control over access to waste.	Receptacles available for waste; Trash not separated; Sharps containers not available for needles and sharps; Infectious waste not usually disinfected; Waste incinerated or buried; Little control over access to waste.	Receptacles available for waste; Trash not separated; Sharps containers available for needles and sharps and used 50%; Infectious waste not usually disinfected; Waste incinerated; 50% controlled access to waste.	Receptacles available for hazardous waste and regular trash; Trash correctly separated 50%; Sharps containers available for needles and sharps and used 80%; Infectious waste usually disinfected; All waste, after disinfection for infectious waste, incinerated; 80% controlled access to waste.	Receptacles available for hazardous waste and regular trash; Trash correctly separated 80%; Sharps containers available for needles and sharps and always used; Infectious waste disinfected; All waste, after disinfection for infectious waste, incinerated; 100% controlled access to waste.	Receptacles available for hazardous waste and regular trash; Trash always correctly separated; Sharps containers available for needles and sharps and always used; Infectious waste disinfected; Disinfected waste autoclaved; All waste, after disinfection and autoclaving for infectious waste, incinerated; 100% controlled access to waste.

Indicator		0	1	2	3	4	5
f.	Laboratory Maintenance: General, Preventative, and Service Contracts	No functioning equipment; Pipettes never calibrated; No proper training, preventative maintenance, or continuous education; No service contracts; No equipment connected to UPS; No actions, non-conformances, and corrective actions documented.	25% functioning equipment; Pipettes never calibrated; Proper training; No preventative maintenance or continuous education; No service contracts; At least 25% of equipment connected to UPS; No actions, non-conformances, and corrective actions documented.	50% functioning equipment; Pipettes never calibrated; Proper training; Limited preventative maintenance; No continuous education; Service contracts for 25% of equipment; At least 50% of equipment connected to UPS; 25% of all actions, non-conformances, and corrective actions documented.	80% functioning equipment; Pipettes calibrated at least once since purchase; Proper training and preventative maintenance; No continuous education; Service contracts for 50% of equipment; At least 80% of equipment connected to UPS; 50% of all actions, non-conformances, and corrective actions documented.	80% functioning equipment; Pipettes calibrated once per year; Proper training, continuous education, and preventative maintenance; Service contracts for 80% of equipment; All equipment connected to UPS; 80% of all actions, non-conformances, and corrective actions documented.	100% functioning equipment; Pipettes calibrated twice per year; Proper training, continuous education, and preventative maintenance; Service contracts for 100% of equipment; All equipment connected to UPS; All actions, non-conformances, and corrective actions documented.
	Score						

4. *Documentation*

Indicator		0	1	2	3	4	5
a.	Log Books and Operational Logs Score	No log books for any tests; Master log not used; No operational logs; QC, lot numbers, and expiration dates not recorded; Documentation not stored.	Log books for 25% of tests; Master log not used; No operational logs; QC, lot numbers, and expiration dates not recorded; Documentation stored inconsistently.	Log books for 50% of tests; Master log not used; All operational logs completed 25%; QC, lot numbers, and expiration dates recorded 25%; Documentation stored inconsistently.	Log books for 80% of tests; Master log not used; All operational logs completed 50%; All logs completed in pen; QC, lot numbers, and expiration dates recorded 50%; Documentation stored inconsistently.	Log books for all tests; Master log used; All operational logs are completed 80%; All logs completed in pen, neatly and clearly; QC, lot numbers, and expiration dates recorded 80%; Documentation stored inconsistently.	Log books for all tests; Master log used; All operational logs completed daily, or as appropriate; All logs completed in pen, neatly and clearly; QC, lot numbers, and expiration dates always recorded; Documentation stored for minimum time identified in SOP for document control.
b.	SOPs, Bench Aids, and Manuals Score	There are no SOPs, manuals, or bench aids in the laboratory.	SOPs present, but not accessible or used; Documentation never reviewed or updated.	SOPs and bench aids present, but not accessible and used by less than 50% of all staff; Documentation reviewed and updated at least every other year.	SOPs, bench aids, and Quality Manual present, accessible, and used by at least 80% of all staff; Documentation reviewed and updated at least once per year.	SOPs, bench aids, Quality Manual, and Safety Manual present, accessible, and used by all staff; Documentation reviewed and updated at least once per year.	SOPs, bench aids, Quality Manual, Training Manual, and Safety Manual present, accessible, and used by all staff; Documentation reviewed and updated at least once per year or when significant changes in procedure are made.

5. *Quality Assurance*

Indicator		0	1	2	3	4	5
a.	Internal	No written QC procedures for tests; No written QA and QC procedures for laboratory operations; No laboratory staff fully informed of procedures, policies, and need for adherence; Manufacturer QA/QC recommendations not followed; Quality Manual not present; Staff not measured for compliance; No continuous education or updates.	Written QC procedures for 25% of tests; No written QA and QC procedures for laboratory operations; <25% of laboratory staff fully informed of procedures, policies, and need for adherence; Manufacturer QA/QC recommendations not followed; Quality Manual not present; Staff not measured for compliance; No continuous education or updates.	Written QC procedures for 50% of tests; Written QA and QC procedures for 25% of laboratory operations; 25% of laboratory staff fully informed of procedures, policies, and need for adherence; 25% of manufacturer QA/QC recommendations followed; Quality Manual not present; Staff not measured for compliance; No continuous education or updates.	Written QC procedures for 80% of tests; Written QA and QC procedures for 50% of laboratory operations; 50% of laboratory staff fully informed of procedures, policies, and need for adherence; 50% of manufacturer QA/QC recommendations followed; Quality Manual present and used by at least 50% of staff; Staff not measured for compliance; Continuous education and updates at least once per year.	Written QC procedures for every tests; Written QA and QC procedures for 80% of laboratory operations; 80% of laboratory staff fully informed of procedures, policies, and need for adherence; 80% of manufacturer QA/QC recommendations followed; Quality Manual present, accessible, and used by at least 80% of staff; Staff measured periodically for compliance; Continuous education and updates at least twice per year.	Written QC procedures for every tests; Written QA and QC procedures for all laboratory operations; All laboratory staff fully informed of procedures, policies, and need for adherence; All manufacturer QA/QC recommendations followed; Quality Manual present, accessible, and used by all staff; Staff measured periodically for compliance; Continuous education and updates at least quarterly.
	Score						

Indicator		0	1	2	3	4	5
b.	External Score	No EQA or proficiency testing; Non-conformances not corrected; Non-conformances and corrective actions not documented; Laboratory not reviewed by an outside body.	Infrequent EQA and proficiency testing; Non-conformances infrequently corrected; Non-conformances and corrective actions documented 25%; Laboratory not reviewed by an outside body.	Annual EQA and proficiency testing; Non-conformances sometimes corrected; Non-conformances and corrective actions documented 50%; Laboratory not reviewed by an outside body.	Annual EQA and proficiency testing; Non-conformances often corrected; Non-conformances and corrective actions documented 80%; Laboratory not reviewed by an outside body.	Bi-annual EQA and proficiency testing; Non-conformances corrected; Non-conformances and corrective actions documented; Laboratory reviewed by an outside body and provided feedback.	Quarterly EQA and proficiency testing; Non-conformances corrected; Non-conformances and corrective actions documented; Laboratory reviewed by an outside body, provided feedback, and uses feedback for quality improvement.
c.	Non-conformances and corrective actions Score	No SOP; Never documented.	SOP present, but not accessible or used by staff; Never documented.	SOP present, but not readily accessible and used by 25% of all staff; 25% documented.	SOP present, accessible, and used by 50% of all staff; 50% documented.	SOP present, accessible, and used by 80% of all staff; 80% documented.	SOP present, accessible, and used by all staff; 100% documented.

6. *Laboratory Management*

Indicator		0	1	2	3	4	5
a.	General Laboratory Management Score	No organizational chart; Chain-of-command not defined or communicated; No workplan; No reports to hospital administration; Does not meet with hospital administration; Hours do not meet needs of hospital/clinic; Staff never present.	No organizational chart; Chain-of-command not defined or communicated; Oral workplan; No reports to hospital administration; Does not meet with hospital administration; Hours do not meet needs of hospital/clinic; Staff present only 50%, but only working 25%.	No organizational chart; Chain-of-command not defined or communicated; Oral workplan; Yearly report to hospital administration; Does not meet with hospital administration; Needs to expand hours to meet needs of hospital/clinic; Staff present, but only working 50%.	Organizational chart exists, but not posted; Chain-of-command defined, but not communicated; Oral workplan; Yearly report to hospital administration; Meets with hospital administration at least yearly; Needs to expand hours to meet needs of hospital/clinic; Staff present, but only working 50%.	Organizational chart exists, but not posted; Chain-of-command defined and communicated to all hospital/clinic personnel; Written workplan including roles and responsibilities for each employee; Quarterly reports to hospital administration; Meets with hospital administration at least quarterly; Hours address needs of hospital/clinic; Staff present and working during working hours.	Organizational chart posted; Chain-of-command well defined and communicated to all hospital/clinic personnel; Written workplan including roles and responsibilities for each employee; Monthly reports to hospital administration; Meets with hospital administration at least monthly; Hours address needs of hospital/clinic; Staff present and working during working hours.
b.	Staff Professional Development and Training Score	No training on techniques essential for quality laboratory testing; Staff performance not reviewed; Goals not set; No training manual; Certifications and resumes not kept.	Infrequent training on techniques essential for quality laboratory testing; Staff performance not reviewed; Goals not set; No training manual; Certifications and resumes not kept.	Some training on techniques essential for quality laboratory testing; Staff performance not reviewed; Goals not set; No training manual; Certifications and resumes not kept.	Training on techniques essential for quality laboratory testing; Staff performance not reviewed; Goals set when hired; Training manual present; Certifications and resumes not kept.	Training on techniques essential for quality laboratory testing; Staff performance reviewed at least once per year; Goals set at least once per year; Training manual present; Certifications and resumes kept in training manual.	Routine training on techniques essential for quality laboratory testing; Staff performance reviewed at least twice per year; Goals set at least once per year; Training manual present; Certifications and resumes kept in training manual.

Indicator		0	1	2	3	4	5
c.	Communication with laboratory staff, hospital staff, and patients Score	No communication protocols; Laboratory manager has no meetings with hospital management team.	Oral communication protocols with no adherence; Laboratory manager has no meetings with hospital management team.	Oral communication protocols with 50% adherence; Laboratory manager has annual meetings with hospital management team.	Written communication protocols with 50% adherence; Laboratory manager has quaterly meetings with hospital management team.	Written communication protocols with 80% adherence; Laboratory manager has monthly meetings with hospital management team.	Written communication protocols with 100% adherence; Laboratory manager has weekly meetings with hospital management team.
d.	Supply Chain Management Score	No reagents or only expired reagents; Reagents not stored properly; No inventory or forecasting system; Reagent lots not QCd.	Frequent stock-outs or expired reagents; Reagents not stored properly; No inventory or forecasting system; Reagent lots not QCd.	Frequent stock-outs or expired reagents; Reagents not stored properly; Inventory and forecasting system present, but not utilized; Reagent lots not QCd.	Few stock-outs or expired reagents; Reagents stored properly 50%; 50% functional and utilized inventory and forecasting system; Reagent lots not QCd.	Few stock-outs or expired reagents; Reagents stored properly 80%; 80% functional and utilzed inventory and forecasting system; Reagent lots >50% QCd.	No stock-outs or expired reagents; Reagents stored properly 100%; 100% functional and utilzed inventory and forecasting system; Reagent lots 100% QCd.

5. *Assessment Score*

	<52	52 - 62	63-72	73 - 83	84 - 93	94 - 105
Indicator	<50%	50 - 59%	60 - 69%	70 - 79%	80 - 89%	90 - 100%
Total Score						

6. *Summary*

7. *Program Component Specific Work-Plan and Follow-Up Activities*

Objective	Activities	Target Date	Person Responsible

Clinic Name _____ **Date of Review** _____

Reviewer _____

1. ***Pediatric Clinic Management***

Is there a pediatric department in this facility? _____

What are the qualifications of the person who heads it? _____

How many people work in the clinic and what are their qualifications? _____

#	Type	INDICATOR	SCORE 0	1	2	3	4	5	Definition or Source Documentation	Measurements: These relate to the period for which the review is being undertaken – last 3 months, last 6 months etc - as indicated	Best source of indicators – existing or perceived	Comments on capture methods and tools
PART 1: CLINICAL CARE SERVICES												
ANTENATAL TESTING SERVICES												
1A	OE PM	All pregnant women are screened for HIV with same day results	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of pregnant women booking in ANC receiving HCT tests	Number of women attending ANC Number of women attending ANC	ANC register ANC HCT register	All country facilities c
FAMILY TRACKING AND TESTING												
3A	OE	All partners of HIV+ pregnant women are provided HCT services	Not done	Testing offered but statistics not available or < 10% of partners tested	10-25% of partners tested	25-50% of partners tested	50-75% of partners tested	>75% of partners tested	Proportion of HIV + women for whom completion of partner testing or partner's previously known sero-positive status is	Number HIV+ pregnant women with their partners involved and tested Number HIV+ pregnant women	ANC HCT register ANC partner register	Captured in new S.Fo
3B	OE	All children of HIV+ pregnant women are provided HCT services	Not done	Testing offered but statistics not available or < 10% of women have their children tested	10-25% of women have their children <15 years of age tested or documented not to be exposed	25-50% of women have their children <15 years of age tested or documented not to be exposed	50-75% of women have their children <15 years of age tested or documented not to be exposed	>75% of women have their children <15 years of age tested or documented not to be exposed	Proportion of HIV+ women for whom there is completion of children's testing or children's previously known lack of exposure is	Number HIV+ pregnant women with documentation of family involvement and testing Number of HIV+ pregnant women	ANC HCT register Supplementary MCHC Forms	Captured in new S.Forms - Lists all children and intervention results
MATERNAL CARE												
4A	OE	All HIV+ pregnant women are promptly staged clinically	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV+ pregnant women who have HIV stage recorded within 1 month of diagnosis	Number HIV+ pregnant women with clinical stage recorded within 1 month of HIV diagnosis Number HIV+ pregnant women	ANC positive client register Supplementary MCHC data reports	While some ANC regi

4B	OE	All HIV+ pregnant women receive prompt CD4 count enumeration	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV+ pregnant women who have CD4 result recorded within 1 month of diagnosis	Number HIV+ pregnant women with CD4 result within 1 month of HIV diagnosis Number HIV+ pregnant women	ANC positive client register Supplementary MCHC data reports	While some ANC regi
5	OE	All HIV+ pregnant women meeting AR country criteria for treatment for their own disease are placed on full HAART.	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV+ pregnant women with indications for HAART who initiate HAART prior to delivery	Number HIV+ pregnant women with indications for Number HIV+ pregnant women with indications for HAART	Supplementary MCHC data reports	Captured in new S.Form Some ANC registers indicate the regimen a woman was placed on but none indicates whether she met the criteria for treatment
6	OE	All HIV+ pregnant women who do not meet AR country criteria for treatment are given the most aggressive antenatal PMTCT regimen allowed by guidelines	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV+ pregnant women without indications for treatment receiving most aggressive regimen provided for in guidelines – HAART included (see tool manual).	Number HIV+ pregnant women not meeting criteria for treatment receiving the most aggressive regimen Number HIV+ pregnant women not meeting criteria for treatment	Country Guidelines and protocols Supplementary MCHC data reports ANC positive client registers	Captured in new S.Fo
7	OE	All HIV+ pregnant women receive Viral load analysis at term	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV+ pregnant women who have VL performed and result recorded at term	Number HIV+ pregnant women Number HIV+ pregnant women	Supplementary MCHC data reports	Captured in new S.Fo
8	OE	All HIV+ pregnant women receive intrapartum antiretrovirals according to WHO 2006 standards	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV+ pregnant women who are administered 3 antiretrovirals during labor and delivery	Number HIV+ pregnant women administered 3 antiretrovirals during labor and delivery Number HIV+ pregnant women with that delivered in period under review	ANC Delivery register Post natal documentation from MCHC S. Form for clients that delivered outside facility	Exists in delivery regi

INFANT FEEDING COUNSELING AND SUPPORT												
11A	OE	All HIV+ pregnant women are counseled on infant feeding prior to delivery using IHV AR tools	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV+ pregnant women having 1 or more visits after diagnosis and before delivery who have documentation of	Number of HIV+ pregnant women with record of maternal infant feeding counseling Number of HIV+ pregnant women	Supplementary MCHC data reports Infant feeding counseling charts	**Appropriate counse
11B	OE	All HIV+ parturient women are counseled on infant feeding after delivery using IHV AR tools	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV+ women delivering in facility who have documentation of appropriate infant feeding counseling prior to discharge	Number of HIV+ parturient women with record of maternal infant feeding counseling before discharge Number of HIV+ pregnant women	Supplementary MCHC data reports Infant feeding counseling charts	**Appropriate counse
11C	OE	All HIV+ mothers with infants <12 months of age are provided appropriate counseling on infant feeding using IHV AR tools	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of exposed infants at and past 6 months of age who received and had documented appropriate infant feeding counseling whether or not child	Number of HIV exposed infants at or past 6 months of age with record of appropriate maternal infant feeding counseling Number of HIV exposed infants at or	Supplementary MCHC data reports Infant feeding counseling charts	**Appropriate counse
12 A	OE	Appropriateness of nutrition: Breastfed HIV exposed infants received appropriate counseling and scoring and are protected by evidence-based ARV prophylactic regimen (either maternal ART, infant NVP, or other)	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV exposed breast-feeding infants under 6 months of age who are appropriately scored and protected by maternal or infant antiretrovirals	Number of children under 6 months of age being breastfed under ARV regimen cover in mother and/or child Number of children being breastfed	Supplementary MCHC data reports Infant feeding counseling charts	Obtain from Infant fee
12 B	OE	Appropriate of nutrition: Non-breastfed HIV-exposed infants received appropriate counseling and scoring and have an assured supply of quality infant formula and accessories for guaranteeing healthy nutrition	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV exposed BMS-fed infants under 6 months of age who have a demonstrable consistent supply of a quality commercial formula and report adequacy of BMS accessories for ensuring AFASS.	Number of children under 6 months of age being formula fed who demonstrate consistent supply of quality formula and accessories Number of children being formula fed	Supplementary MCHC data reports Infant feeding counseling charts	Obtain from Infant fee

EXPOSED INFANT CARE												
13	OE PM	HIV exposed infants are given ARVs after delivery?	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of infants	Number of HIV exposed infants born who receive ART prophylaxis in the 1st week of life Number of HIV exposed infants born	Exposed infant register Delivery register Supplementary MCHC data reports	
14	OE PM	HIV exposed infants are given cotrimoxazole from 6-8 weeks of age (or upon presentation) until no further exposure and HIV definitively ruled out	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of infants	Number of HIV exposed infants prescribed CPT according to definition Number of HIV exposed infants born	Exposed infant register Supplementary MCHC data reports	
16A	OE	HIV-exposed infants are evaluated for TB risk with exposure risk investigated along with clinical screening	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of charts t	Number of HIV exposed infants with appropriate TB risk documentation as defined Number of HIV exposed infants	Supplementary MCHC data reports	Review of S Forms is necessary and not just the report Focus on the exposure data Also get the clinical screening
17	OE PM	HIV exposed children are monitored for growth	HIV-exposed infants are not monitored for growth.	Weight is recorded at > 80% of visits	Weight is recorded at > 90% of visits	Weight is plotted at > 90% of visits	Weight is plotted at > 90% of visits and length is recorded at > 90% of visits	>90% of visits have weight and length plotted AND indicate whether growth is appropriate	Proportion o f HIV ex	Number of HIV exposed infants with average number of visits as described during which vital signs were documented Number of HIV exposed infants	IQ Care generated reports – pediatric ART care	SF Weight and date

18A	OE	EID HIV exposed infants have DNA PCR results reported to family by 10 weeks of age, or within 4 weeks of initial visit if initial visit occurs >6 weeks of age.	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV exp	Number of HIV exposed infants with DNA PCR reported as described Number of enrolled HIV exposed infants	Only applies to sites with access to DNA PCR EID DNA PCR registers Supplementary MCHC data reports	Exists across all cour
20A	OE	HIV infected infants are initiated on ART immediately with age used to determine	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV-infe	Number of infants diagnosed with HIV Number of infants diagnosed with HIV infection	Supplementary MCHC data reports	Exposed child care fo
21	OE	HIV infected infants have CD4 percentage or counts measured and documented?	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV-infe	Number of infants diagnosed with HIV infection who got Number of infected HIV infants	Supplementary MCHC data reports	Exposed child docum
INFECTED CHILD CARE												
23	OE PM	HIV infected infants are given cotrimoxazole from period of exposure or initial diagnosis till 5 years of age or appropriate immune system reconstitution - as per national guidelines	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of infected	Number of HIV infected children under 5 prescribed CPT Number of HIV infected children under 5	Pediatric ART registers Monthly PEPFAR reports IQ care reports	Number of children on CPT is reported by all programs This number needs to be translated into the proportion of those eligible
24	OE	All children identified as HIV infected have accurate, confirmed diagnosis	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of infants	Number of HIV infected children and infants with definite Number of HIV infected infants and children	Pediatric ART registers IQ Care reports Chart review	

25	OE	All HIV infected children receive prompt CDD4 evaluation	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV-infe	Number of HIV infected children with Number HIV infected children	IQ Care reports Chart review	
26		All HIV infected children receive prompt clinical staging	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV-infe	Number of HIV infected infants with Number HIV infected children	IQ Care reports Chart review	
27	OE	All HIV infected children with indications for treatment are receiving ART Use IHV and / or national guidelines to determine appropriateness of treatment	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of children	Number of HIV infected children who are not on ART Number of HIV infected children with no indications for ART	Chart review IQ Care reports and queries	Measures population
28	OE	All children with indications for treatment are receiving ART	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of children	Number of HIV infected children with indications for ART who are on ART Number of HIV infected children with indications for ART	IQ Care reports	Measures population
29	OE	HIV infected children are evaluated for TB risk with exposure risk investigated along with clinical screening	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of charts t	Number of HIV infected children with appropriate TB risk documentation as defined Number of HIV infected infants	IQ care reports Chart review	TB screening involves

30	OE PM	HIV infected children are monitored for growth	HIV-exposed infants are not monitored for growth.	Weight is recorded at > 80% of visits	Weight is recorded at > 90% of visits	Weight is plotted at > 90% of visits	Weight is plotted at > 90% of visits and length is recorded at > 90% of visits	>90% of visits have weight and length plotted AND indicate whether growth is appropriate	Proportion o f HIV ex	Number of HIV infectedchildren with average number of visits as described during which vital signs were documented Number of HIV infected children	IQ care reports Chart review	
31	OE	Children receiving ART are monitored for treatment success with regular CD4 counts	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV-infe	Number of HIV infected children with appropriate CD4 frequency and results (at least 1 in 6 months) Number of HIV infected children on ART	IQ Care reports	
32	OE	Children receiving ART are monitored for treatment success with regular VL analysis	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of HIV-infe	Number of HIV infected children with appropriate VL frequency and results (at least 1 every year) Number of HIV infected children on ART	IQ Care reports	

PART 2. SYSTEM INTEGRATION & PATIENT RETENTION												
36A	OE	All HIV exposed infants are enrolled in exposed infant cohort and followed till 2 years of age	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of ALL HIV	Number of exposed infants over 2 with documentation of 4 clinic visits and 1 over 18 months of age Number of HIV exposed infants born over 2 years earlier		Records have to be r
37	OE	All HIV exposed infants have final infection status determined.	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of ALL HIV-exposed infants over 2 years of age who have final infection status documented and communicated to family.	Number of exposed infants born over 2 years earlier with final infection status determined and communicated to family Number of HIV exposed infants born over 2 years earlier	Exposed infant register IQ care generated reports	
38	OE	All HIV exposed infants have vital status at 12, 18 and 24 months of age determined.	<60%	60-80%	80-90%	90-95%	95-98%	>98%	Proportion of ALL HIV-exposed infants with vital status at 12, 18, and 24 months determined.	Number of exposed Number of HIV exposed infants at an age over the time period under review ie. 12, 18, 24 months	IQ care generated reports	??

3. ***Assessment Score***

	<52	52 - 62	63-72	73 - 83	84 - 93	94 - 105
Indicator	**<50%**	**50 - 59%**	**60 - 69%**	**70 - 79%**	**80 - 89%**	**90 - 100%**
Total Score						

4. ***Summary***

5. ***Program Component Specific Work-Plan and Follow-Up Activities***

Objective	Activities	Target Date	Person Responsible

Section:	**Quality Improvement Program ***
Hospital Name:	
Date of Review:	
Interviewer:	
Persons Interviewed:	
Key Participants:	
Estimated Time:	1-2 hours

Start Time
End Time

List of documents to review:

		Rating Scale (1 poor, 3 minimum level for sustainability, 5 very good)					
Indicator Category	**Data Source**	**1**	**2**	**3**	**4**	**5**	**Score**
Infrastructure/Equipment							
Clinical Information System	Observation; interaction with data management staff	Medical record and very basic manual system in place to collect data for external governing body purposes; externally reported program data is reviewed to assess program level data, i.e. # patients in care, # on ART.		Has functional information system (manual or electronic) to track patients and patient care; some data is collected and used for quality activities. Limited capacity to easily manage quality measurements with current system.		Fully functional clinical information system to track patient care, track core components of HIV program, and produce useful quality of care information reports from an electronic database or health record.	
Human Resources							
Committed Staff	Job Descriptions, Meeting minutes	Only one designated individual (quality coordinator, data manager) was responsible to perform or coordinate any efforts related to quality; quality was not part of other staff's job expectations *Caveat: This is not just capturing or producing data reports.*		Key staff members are formally expected to conduct or participate in quality activities, but no dedicated time is allocated.		Adequate time is allocated for key staff members to perform routine quality related activities in addition to being formally expected to conduct or participate in quality activities.	

Defined Roles and Responsibilities	Job Descriptions	Staff has vague idea about roles and responsibilities for quality program; no written documentation or activities described in job descriptions.		Key roles for quality program are clearly described; leadership and governance is established; staff is informed about different roles; QI team roles are described; follow-up responsibilities for quality activities is not clearly defined.		The staff roles and responsibilities are clearly described regarding involvement in HIV team structure, performance measurement, and quality activities; and follow-up responsibilities for quality activities is clearly defined; roles and responsibilities are noted in job descriptions.	
Practices (Activities)							
Organizational Structure	Meeting minutes	Quality structure is only loosely in place; a few meetings at which quality is purposefully discussed; some of the HIV staff participate; knowledge of quality assessment structure is limited to only a few people in HIV program.		Separate HIV quality committee may not exist but at least 4 meetings per year where quality activities is purposefully discussed; meetings include different disciplines in HIV quality discussions (e.g. nurse, doctor, pharmacist, administrator, records, other); staff knows about quality activities and committee meetings; documentation records of meetings are kept.		Formal HIV quality committee does exist; and meets more than 4 x per year; HIV quality meetings include written minutes and written follow-up; understanding of entire staff about quality structure and reporting mechanism; active support by overall institution.	

Written Quality Plan	Written plan, staff interview	HIV quality program has only a loose outline of a structured quality plan; a written plan does not reflect routine quality improvement activities.		The quality plan is reviewed and updated annually; the quality plan describes the quality committee structure and its frequency of meetings; key quality principles and objectives are outlined; the quality does not include all major components and is not routinely shared with staff.		The quality infrastructure includes a written plan reviewed and updated annually and includes all major components; the link to the institution's overall quality program (if there is one) is described; the quality committee oversees and provides feedback to quality improvement projects; staff is aware of the plan; staff is actively involved in reviewing and updating of the quality plan.	

Annual Goals	Quality Plan Document, meeting minutes	Goals only based on external requirements.		Annual quality program goals were discussed and agreed on by HIV quality team; goals were selected based on past performance and external requirements; a loose process is in place to update goals and selection of goals and prioritization process not clearly defined.		Annual goals were set to select quality projects and performance measures; selection and prioritization process was clearly defined; goals were relevant to HIV program; at least annual review and update of annual goals.	
Workplan	Work plan/care and treatment plan documents	No formal process for quality findings in place; follow-up of quality findings only as needed; workplan may be in place but is not reviewed and updated periodically.		Quality activities include moderate planning for the near future; workplan in place and reviewed and updated periodically.		Full workplan with timelines and individual roles and responsibilities in place; monitored by quality committee and staff aware of timelines and workplan activities.	

Patient Involvement	Meeting minutes, patient representative confirmed via interview	Patient concerns are only discussed as they arise; patients' satisfaction is not measured routinely; no structure in place to gather patients' feedback.		Patient needs and/or satisfaction are assessed; feedback of patients is discussed in quality committees.		Findings of consumer assessments are routinely integrated into the quality program; QI project reflected results of issues identified by consumers; structured input from consumers such as patients, family members, advocates, etc.; consumer feedback is incorporated in setting quality goals; results of quality activities are routinely communicated with patients and other consumers; patient centered quality activity is launched.	
Commodities/Supplies							
Record Keeping							
Documentation	Meeting minutes, observation	Minimal documentation of the quality plan and meeting minutes exist		A full quality plan and at least quarterly meeting minutes are available upon request		Improvement activities and results are documented and ongoing quality improvement activities and updates are posted in a public area in the clinic.	
						Total Score	0
						Average	0.00

**** QIP section adapted from HIVQUAL International-Organizational Quality Assessment Tool***

5. ***Assessment Score***

Indicator	<22	22-26	27-30	31-35	36-39	40-45
	<50%	50 - 59%	60 - 69%	70 - 79%	80 - 89%	90 - 100%
Total Score						

6. ***Summary***

7. ***Program Component Specific Work-Plan and Follow-Up Activities***

Objective			Activities		Target Date	Person Responsible

Clinic Name _____ **Date of Review** _____

Reviewer _____

1. *Clinic Overview*

How long has this clinic been providing care for patients with HIV? _____ **years**

How long has this clinic been providing ART? _____ **years**

When did this clinic begin receiving PEPFAR funding ____/____ **20** ____

2. *Benefits of Treatment*

Indicator	0	1	2	3	4	5
a. Quality of Life Score	Performance Status is not documented.	Staff has been trained to evaluate and document performance status at each visit.	Performance Status is documented at baseline and recorded at least once since initiation of ART.	Staff in the HIV clinic have been trained to refer patients with Performance Status decline or <80 for clinical evaluation.	Performance Status is documented at each visit but does not trigger clinical intervention.	85% of patients on ART have Performance Status >85% that enables them to return to pre-illness activities.

Indicator	0	1	2	3	4	5
c. End of Life Care Score	Staff have no training in how to recognize approaching end-of-life.	Staff has received basic end of-life training and clinic is investigating appropriate linkages and management protocols.	Clinic has developed end-of-life management protocols and established linkages with home-based care providers but patients are not being referred on a regular or timely basis.	Regular team conferences are held to discuss clinical management of sick patients; referrals are made to trained home-based care providers.	Patients with Stage 4 disease caused by 1)failure of viral control; 2)co-morbidities e,g, Hep B/C, cancer, or uncontrolled OI; or 3) pre-ART patients with active OI and 3 organ involvement are entered on established end-of-life protocols and regular re-assessment of treatment goals is implemented.	All patients with signs of approaching end-of-life receive appropriate symptom management, attention to life closure issues, and referral to clinically supervised home-based care services in time for end-of-life tasks e.g. wills and permanency planning to be completed.

2.	***Staff Sustainability***					**(Care for Providers)**																											
	Indicator					**0**					**1**					**2**					**3**					**4**				**5**			
	a.	**Stress Relief for Staff**				**No policies or practices are in place to recognize or relieve stress faced by staff in providing care for persons with HIV/AIDS.**					**Staff has received basic training in stress relief and methods of stress reduction are being investigated.**					**Staff members have been involved in development of stress relief methods for the workplace but no routine activities identified or policies in place.**					**Policies are in place for routine use of stress relief and other methods identified to encourage self-care and improve employee satisfaction with workplace but activities only take place sporadically.**					**Yearly inservice is offered on stress relief techniques and policies are in place to provide routine mechanism for stress relief and regular group activities are offered but few staff take part and no staff satsfaction survey performed**				**All staff are trained in self-care techniques and regular activities and policies are in place to provide varied types of staff counseling and support to be chosen by individuals and regular surveys are conducted regarding effectiveness of stress relief program.**				
		Score																															
	Indicator					**0**					**1**					**2**					**3**					**4**				**5**			
	b.	**HIV Care for Staff**				**No policies or practices are in place to provide confidential HIV counseling and testing, post-exposure prophylaxis (PEP), or ART for HIV clinic staff.**					**Post-exposure prophylaxis is offered on an individual basis; policies and practices are not clear.**					**Staff are informed regarding mechanisms for PEP at time of employment but no efforts are made to provide routine HIV testing to staff.**					**Policies are in place for PEP and staff informed on regular basis and encouraged to use service; no documentation re attempts to provide HIV care to potentially HIV+ employees.**					**Workplace exposure risks and need for routine HIV testing are discussed with staff at least annually. No efforts to assure that employees seek HIV care and treatment.**				**Clear policies for post-exposure prophylaxis, confidential mechanism for HIV counseling and testing for individual staff, and referral for care and treatment outside the workplace are in place and staff are regularly encouraged to use this mechanism of self-care.**				
		Score																															

3.	***Level of Care***					
	Indicator	**0**	**1**	**2**	**3**	**4**	**5**
	a	**Co-Trimoxazole Prophylaxis** **Score**	**Co-trimoxazole is prescribed but no follow-up is given to assure that patient is taking medication.**	**Clinical file contains space for documentation of adherence percentage to prophylaxis but no attempt is made to complete data.**	**Staff trained to determine cotrimoxazole adherence percentage but < 50% of patients are taking prophylaxis regularly.**	**>80% of charts have documentation of adherence percentage but medication is not consistently available**	**staff has been trained to discuss adherence with CoTrimoxazole prophylaxis with eligible patients and to report gaps in medication supply.**	**All eligible patients have >90% adherence to co-trimoxazole prophylaxis; it has been prescribed appropriately and medication is always available to patient.**
	b.	**TB** **Score**	**No screening for active TB.**	**TB screening questionnaire is used in clinic but no policy to assure that all patients are screened.**	**TB Screening polices and procedures are in place but no policies exist regarding what to do for positive patients.**	**Once TB screen is positive there is a clear procedure that is followed but mechanisms for isolation are not available.**	**>80% of patients are screened for active TB and TB positive patients are isolated but refferal mechanisms are unclear.**	**All patients are screened for active TB and TB positive patients receive appropriate treatment and follow up.Isolation techniques are clearly followed**
	c.	**Mental Health Issues** **Score**	**No screening for mental health issues or capacity for on-site mental health care.**	**Clinic is in process of identifying local resources for mental health care and staff receiving training regarding recognition of mental health issues across continuum of illness.**	**Local mental health resources identified and linkages made. Staff has received basic training in mental health needs of persons with HIV/AIDS.**	**Protocols developed for management of depression; recognition & referral for substance abuse and issues of personal violence.**	**Providers are trained in recognition of mental health issues and basic medical management with mental health clinical back-up established.**	**All patients receive baseline and follow-up mental health screening at each clinical stage of disease; providers are able to prescribe appropriate treatment & community linkages for additional counseling are in place if not available on site.**
4.	***Safety***					
	Indicator	**0**	**1**	**2**	**3**	**4**	**5**
	a.	**Prevention of malaria and il** **Score**	**No treated bednets or treatment for water safety available.**	**Staff investigating program for dispensing treated bednets and water treatment.**	**Program for maleria prophylaxis and water safety has been implemented but supplies are not consistent and materials not always available for dispensing.**	**Staff has been educated regarding importance of including malaria prophylaxis and water treatment methods messages in routine care and clinc has necessary supplies available.**	**Treated bednets and /or water treatment materials are dispensed without counseling or follow-up regarding use.**	**All eligible patients receive treated bednets and water treatment materials accompanied by personal instruction in use and routine follow-up reminders regarding use.**

5. *Assessment Score*

	<20	20 - 23	24 - 27	28 - 31	32 - 35	36 - 40
Indicator	**<50%**	**50 - 59%**	**60 - 69%**	**70 - 79%**	**80 - 89%**	**90 - 100%**
Total Score						

6. *Summary*

7. *Program Component Specific Work-Plan and Follow-Up Activities*

Objective	Activities	Target Date	Person Responsible

1. *Total Assessment Score*

Component Scores

Medical Clinic	Nursing	CBTS	Care & Support	Leadership & Management	Financial Systems	Pharmacy	Laboratory	QIP	MCH

Total Score						
	<50%	**50 - 59%**	**60 - 69%**	**70 - 79%**	**80 - 89%**	**90 - 100%**
	Service provider has significant programmatic and operational deficits that would make it unwise to initiate an ART program at this time. If an ART program exists it should not enroll new patients until significant improvements are made. Patients should be managed by another institution or a supervising agency placed at the clinic while improvement plans are developed and implemented. The agency providing financing should be notified immediately and administrative issues addressed.	**Service provider has significant programmatic and operational deficits that would make it unwise to initiate an ART program at this time. If an ART program exists it should not enroll new patients until significant improvements are made. A supervising team should be placed at the clinic while improvement plans are developed and implemented. The agency providing financing should be notified immediately.**	**Service provider has significant programmatic and/or operational deficits that would make it unwise to expand an ART program at this time. New patient enrollment should be suspended until the most significant deficits are addressed. The capacity building team or supervising agency should increase the amount of time it is spending at this provider and work closely with clinic leadership and teams to develop improvement plans immediately. Funding agency may or may not need to be notified.**	**Service provider has moderate programmatic and/or operational deficits currently. It may be wise to slow ART and care enrollment until the most significant issues are addressed if they directly compromise patient safety. The capacity building team or supervising agency should increase the amount of time at this provider and offer advance continuing education to the clinical team and community support programs.**	**Service provider has some programmatic and/or operational deficits currently. Increased opportunities for continuing education should be offered to the clinical team and the community support program.**	**Service provider has few or no programmatic and/or operational deficits. Clinical staff and community support programs should be rewarded with advanced training opportunities. Service provider should be considered as a possible local training site for this program area.**

2. *Summary*

3. *General Work Plan and Follow Up Activities*

Objective	Activities	Target Date	Person Responsible