Quality Standards and Indicators for Advanced HIV Disease Service Delivery

Respondent(s):

1. Honorific: _____
2. Name: _____
3. Phone Number: _____
4. Email: _____
5. Position: _____
6. Program / Department: _____
7. Organization: _____
8. Country: _____

Indicate Level of Assessment:

☐ National Level
☐ Health Facility Level
    ☐ Hub
    ☐ Spoke
☐ Community Level

National Level Indicators
Health Facility Level Indicators – Hub and Spoke
Community Level Indicators

Check or circle the appropriate response and provide additional information where indicated.

1.1 AHD Clinical Standards and Indicators

[Assessed at the health facility level]

Quality Standard 1: All people at risk of Advanced HIV Disease (newly diagnosed initiating ART, presenting with an illness requiring admission, children under five diagnosed with HIV, viremic, and returning to treatment) should be promptly* assessed for AHD using a CD4 cell count test in addition to a comprehensive review of the clinical history and physical examination		
Process Indicators		
1.1	Which of the following best describes the availability of SOPs to guide assessment of at-risk PLHIV for AHD? 1. The HF has written SOPs, a physical copy is available on the day of the visit, and the SOPs include (a) guidance that people in all five at-risk groups should be assessed for AHD, (b) clearly defined criteria for AHD diagnosis (including elements from history and physical examination), and (c) the timeframe** for AHD assessment 2. The HF has written SOPs that are available on the day of visit, but they do not include all three elements (A, B & C) above 3. Written SOPs are not available on the day of visit *Data source = direct observation of clinic SOPs.*	1= Dark Green 2 = Yellow 3 = Red
1.2	Which of the following best describes the HF's capacity to provide CD4 testing? 1. The HF has the functional equipment, supplies, and staff required to provide on-site CD4 testing today, either via rapid test or onsite laboratory services 2. The HF can collect a blood specimen for CD4 testing today and has SOPs and systems to guide specimen transport and results return with an average monthly TAT of 72 hours 3. The HF can collect a blood specimen for CD4 testing today and has SOPs and systems to guide specimen transport and results return with an average monthly TAT of 1 week 4. The HF has systems and SOPs in place to refer clients to an off-site location for CD4 testing 5. The HF does not have any CD4 testing capability (i.e., any of the above services) *Data source = interview of clinical and laboratory staff; review of specimen referral SOPs if needed; review of CD4 / sample collection register*	1 = Dark Green 2 – Light Green 3= Yellow 4 = Orange 5 = Red
Outcome Indicators		
1.3	Proportion of PLHIV at risk of AHD (newly diagnosed initiating ART, presenting with an illness requiring admission, CLHIV <5 years, viremic, and returning to treatment) presenting at this health facility assessed for advanced HIV disease	> 90% = Dark Green

	Data source: Patient files / medical chart / EMR *Numerator = Number of PLHIV at risk of AHD assessed for advanced HIV disease using CD4 cell count in the last 12 months prior to assessment.* *Denominator = Number of PLHIV at risk of AHD in the last 12 months prior to assessment.*	80-90% = Light Green < 80% = Yellow If unavailable = Red

*This refers to the nationally agreed upon timeline to initiate the service described

**This refers to the time from when someone is identified be in a risk group (or the time someone in a risk group presents to clinic) to the time when they are assessed for AHD

Quality Standard 2: All people with AHD should receive prompt* diagnostic testing for TB with rapid molecular tests (TB-LAM and Xpert MTB/rif assay)		
Process Indicators		
2.1	Which of the following best describes the availability of written SOPs to guide TB screening and diagnosis? 1. The HF has written SOPs, a physical copy is available on the day of the visit, and the SOPs include (a) guidance that all clients with AHD should receive diagnostic testing for TB with rapid molecular tests; (b) instructions for how and where the testing should be performed; and (c) a timeframe** in which the testing should be completed 2. The HF has written SOPs that are available on the day of visit, but they do not include all three elements (A, B & C) above 3. Written SOPs are not available on the day of the visit *Data source = direct observation of clinic SOPs.*	1= Dark Green 2 = Yellow 3 = Red
2.2	Which of the following best describes the HF's capacity to provide rapid molecular testing for TB? 1. The HF has the functional equipment, supplies, and staff required to provide on-site rapid molecular testing today 2. The HF can collect a specimen for testing today and has SOPs and systems to guide specimen transport and results return within 48 hours 3. The HF has systems and SOPs in place to refer clients to an off-site location for TB-LAM and Xpert MTB/rif assay with an average monthly TAT of 1 week 4. The HF does not have any access onsite or off-site to TB molecular testing capability (TB-LAM and Xpert MTB/rif assay)	1 = Dark Green 2 = Light Green 3 = Yellow 4 = Red

	Data source = interview of clinical and laboratory staff; review of specimen referral SOPs if needed.	
Outcome Indicators		
2.4	In the past 12 months what proportion of people with AHD have a documented result of a TB rapid molecular test within 24 hours of AHD diagnosis *Data source = clinic records.* *Numerator = Number of people with AHD identified in the last 12 months with a TB test done within 24 hours of AHD diagnosis.* *Denominator = Number of people with AHD identified in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

*This refers to the nationally agreed upon timeline to initiate the service described

**This refers to the time from when someone is identified to have AHD to the time a sample is collected for testing with TB-LAM and Xpert MTB/rif assay

Quality Standard 3: All people with AHD should be screened for TPT eligibility, and if eligible, should be offered TPT		
Process Indicators		
3.1	Which of the following best describes the availability of written SOPs to guide assessment of TPT *eligibility*? 1. The HF has written SOPs, a physical copy is available on the day of the visit, and the SOPs include (a) a definition of which AHD clients are eligible for TPT including contraindications; (b) screening guidance, including required elements of medical history review, clinical assessment, psychosocial assessment, and laboratory testing (if required) 2. The HF has written SOPs that are available on the day of visit, but they do not include both elements (A & B) above 3. Written SOPs are not available on the day of the visit *Data source = direct observation of clinic SOPs.*	1= Dark Green 2 = Yellow 3 = Red
3.2	Which of the following best describes the availability of written SOPs to guide TPT *delivery*? 1. The HF has written SOPs, a physical copy is available on the day of the visit, and the SOPs include (a) guidance for TPT regimen, dosing, and duration; (b) guidance for providing TPT adherence support to clients; and (c) guidance for adverse events/side effects monitoring 2. The HF has written SOPs that are available on the day of visit, but they do not include all three elements (A, B & C) above	1= Dark Green 2 = Yellow 3 = Red

	3. Written SOPs are not available on the day of the visit *Data source = direct observation of clinic SOPs.*	
3.3	Which of the following best describes the HF's capacity to provide TPT? 1. The HF has had no stockouts AND has initiated all eligible RoC on TPT in the last 3 months 2. The HF has had stockouts AND has not consistently initiated all eligible RoC on TPT in the last 3 months 3. The HF can refer eligible clients to an off-site location for TPT 4. The HF cannot provide TPT to RoC *Data source = TPT register and pharmacy register; interview of clinical and pharmacy staff, review of client referral SOPs if needed*	1 = Dark Green 2 = Yellow 3 = Orange 4 = Red
Outcome Indicators		
3.4	Proportion of PLHIV with AHD eligible for TPT who were initiated on TPT in the last 12 months *Data source = TPT register.* *Numerator = Number of people with AHD eligible for TPT initiated on TPT within the last 12 months* *Denominator = Number of people with AHD eligible for TPT in the last 12 months prior to assessment.*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

Quality Standard 4: All people with AHD and diagnosed with TB disease, should receive immediate* TB treatment		
Process Indicators		
4.1	Which of the following best describes the availability of written SOPs to guide TB treatment? 1. The HF has written SOPs, a physical copy is available on the day of the visit, and the SOPs include guidance for (a) assessing treatment readiness; (b) screening for contraindications; (c) optimal treatment regimen, dosing, and dispensing intervals; (d) clinical follow up, including screening for side effects and adverse events; (e) adherence counselling and support. 2. The HF has written SOPs that are available on the day of the visit, but they do not include all five elements (A-E above) 3. Written SOPs are not available on the day of the visit *Data source = direct observation of clinic SOPs.*	1= Dark Green 2 = Yellow 3 = Red
4.2	Which of the following best describes the HF's capacity to provide TB treatment? 1. The HF has had no stockouts AND has initiated all eligible RoC on TB treatment in the last 3 months	1 = Dark Green 2 = Yellow

	2. The HF has had stockouts AND has not consistently initiated all eligible RoC on TB treatment in the last 3 months 3. The HF can refer eligible clients to an off-site location for TB treatment 4. The HF cannot provide TB treatment to RoC *Data source = TB register and pharmacy register; interview of clinical and pharmacy staff, review of client referral SOPs if needed*	3 = Orange 4 = Red
Outcome Indicators		
4.3	Proportion of RoC diagnosed with TB who were initiated on TB treatment within 24 hours of diagnosis in the last 12 months. *Data source = clinic records.* *Numerator = Number of RoC diagnosed with TB and initiated on TB treatment within 24 hours of diagnosis in the last 12 months.* *Denominator = Number of RoC diagnosed with TB in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

* TB treatment should be initiated as soon as TB diagnosis is confirmed

Quality Standard 5: All people with AHD should be promptly* screened for cryptococcal meningitis (CM) using serum CrAg		
Process Indicators		
5.1	Which of the following best describes the availability of written SOPs to guide screening with serum CrAg? 1. The HF has written SOPs, a physical copy is available on the day of the visit, and the SOPs include (a) guidance that all clients with AHD should be screened for CM using serum CrAg; (b) instructions for how and where the testing should be performed; and (c) a timeframe** in which the testing should be completed 2. The HF has written SOPs that are available on the day of visit, but they do not include all three elements (A, B & C) above 3. Written SOPs are not available on the day of the visit *Data source = direct observation of clinic SOPs.*	1= Dark Green 2 = Yellow 3 = Red
5.2	Which of the following best describes the HF's capacity to provide serum CrAg screening? 1. The HF has the functional equipment, supplies, and staff required to provide on-site serum CrAg testing today 2. The HF can collect a blood specimen for serum CrAg testing today and has SOPs and systems to guide specimen transport and results return within 48 hours 3. The HF has systems and SOPs in place to refer eligible clients to an off-site location for serum CrAg screening with an average monthly TAT of 1 week	1 = Dark Green 2 = Light Green 3 = Orange 4 = Red

	4. The HF does not have any serum CrAg testing capability (i.e., any of the above services) *Data source = interview of clinical and laboratory staff, review of client referral SOPs if needed*	
Outcome Indicators		
5.3	Proportion of people with AHD that were promptly screened for CM using serum CrAG. *Data source = clinic records.* *Numerator = Number of people with AHD that were screened for CM within 24 hours of AHD diagnosis in the last 12 months* *Denominator = Number of people with AHD identified in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

*This refers to the nationally agreed upon timeline to initiate the service described

**This refers to the time from when someone is identified to have AHD to the time a sample is collected for screening for CM using serum CrAg

Quality Standard 6: All PLHIV with a positive sCrAg should receive prompt* diagnostic testing with CSF CrAg		
Process Indicators		
6.1	Which of the following best describes the availability of written SOPs to guide CSF CrAg testing? 1. The HF has written SOPs, a physical copy is available on the day of the visit, and the SOPs include (a) guidance that all clients with AHD and a positive serum CrAg should receive diagnostic testing with CSF CrAg; (b) instructions for how and where the testing should be performed; and (c) a timeframe** in which the testing should be completed 2. The HF has written SOPs that are available on the day of visit, but they do not include all three elements (A, B & C) above 3. Written SOPs are not available on the day of the visit *Data source = direct observation of clinic SOPs.*	1= Dark Green 2 = Yellow 3 = Red
6.2	Which of the following best describes the HF's capacity to provide CSF CrAg screening? 1. The HF has the functional equipment, supplies, and staff required to provide on-site CSF CrAg testing today 2. The HF has systems and SOPs in place to refer eligible clients to an off-site location for CSF CrAg screening 3. The HF does not have any serum CrAg testing capability (i.e., any of the above services) *Data source = interview of clinical and laboratory staff, review of client referral SOPs if needed*	1 = Dark Green 2 = Yellow 3 = Red

Outcome Indicators		
6.3	Proportion of PLHIV with a positive serum CrAg who received prompt diagnostic test of CSF CrAg *Data source = clinic records.* *Numerator = Number of people with AHD with a positive serum CrAg who had a CSF CrAg test within 24 hours in the last 12 months* *Denominator = Number of people with AHD with a positive serum CrAg in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

*This refers to the nationally agreed upon timeline to initiate the service described

**This refers to the time from when someone is identified to have a positive sCrAg to the time a sample is collected for CSF CrAg testing

Quality Standard 7: All people with AHD with a positive sCrAg and a negative CSF CrAg should receive prompt* pre-emptive CM treatment as part of standard of care. This should be initiated within 24 hours		
Process Indicators		
7.1	Does the facility have written SOPs to guide pre-emptive CM Treatment? *If a physical copy of SOPs is available on the day of visit, score = Y. If not, score = N.*	Y N If "No" score Red If Y, score Dark Green
7.2	Does the facility have enough medicines for all clients needing pre-emptive CM treatment? *Check available stocks on the day and calculate against monthly consumption, score = Y if enough for 3 months or more. If not, score = N.*	Y N If "No" score Red If Y, score Dark Green
7.3	In the past 6 months has the pre-emptive treatment of people with AHD, with sCrAg positive and CSF CrAg negative been delayed or deferred due to lack of medication/medication stockout?	Y N If "No" score Dark Green If Y, score Red
Outcome Indicators		

7.4	Proportion of people with AHD, with sCrAg positive and CSF CrAg negative, receiving pre-emptive CM treatment *Data source = clinic records* *Numerator = Number of people with AHD with sCrAg positive and CSF CrAg negative on pre-emptive CM treatment in the last 12 months* *Denominator = Number of people with AHD with sCrAg positive and CSF CrAg negative in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

*This refers to the nationally agreed upon timeline to initiate the service described

Quality Standard 8: All people with AHD with a positive sCrAg and a positive CSF CrAg should receive prompt* CM treatment as part of standard of care. This should be initiated within 24 hours		
Process Indicators		
8.1	Which of the following best describes the availability of CM treatment? 1. The facility provides CM treatment on site. [If yes, answer 8.2 and 8.3] 2. The facility has functional referral systems for people diagnosed with / suspected to have CM to receive CM treatment elsewhere. 3. The facility does neither 1. nor 2. *Data source = direct observation of clinic SOPs.*	1 = Dark Green 2 = Light Green 3 = Red
8.2	Does the facility have written SOPs to guide CM Treatment? *If a physical copy of SOPs is available on the day of visit, score = Y. If not, score = N.*	Y N If "No" score Red If Y, score Dark Green
8.3	Does the facility have enough medicines for all clients needing CM treatment? *Check available stocks on the day and calculate against monthly consumption, score = Y if enough for 3 months or more. If not, score = N.*	Y N If "No" score Red If Y, score Dark Green
8.4	In the past 6 months has CM treatment been delayed or deferred due to lack of medication/medication stockout?	Y N If "No" score Dark Green

		If Y, score Red
Outcome Indicators		
8.4	Proportion of people with AHD, with sCrAg positive and CSF CrAg positive, receiving CM treatment *Data source = clinic records* *Numerator = Number of people with AHD with sCrAg positive and CSF CrAg positive on CM treatment in the last 12 months* *Denominator = Number of people with AHD with sCrAg positive and CSF CrAg positive in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

1.2 Training & Mentorship:

[Assessed at the health facility level]

Quality Standard 1: All health facilities providing care to recipients of care (ROCs) with AHD should have a minimum of two healthcare workers formally trained (certified) and skilled (experienced) to provide AHD services and who routinely manage people with AHD		
Process Indicators		
1.1	Is there a standard national AHD training curriculum for health care workers (clinicians, nurses, pharmacists, and laboratory technicians)? *If a physical copy of the AHD training curriculum is available on the day of visit, score = Y. If not, score = N.*	Y N If "No" score Red If Y, score Dark Green
1.2	Did the health care providers attending to people with AHD receive refresher training following the latest guideline revisions? *Data source = Health facility records and/or key informants (e.g., ask facility manager if HCW's have been trained, ask providers present on day of visit if they have been trained in AHD management)*	Y N If "No" score Red If Y, score Dark Green
1.3	Does the facility have a standard tool/checklist to assess the competency of AHD service delivery skills among health care workers? *If a physical copy of a standard tool/checklist is available on the day of visit, score = Y. If not, score = N*	Y N If "No" score Red If Y, score Dark Green
1.4	Are there AHD guidelines in the clinic where AHD is provided? *If a physical copy of the AHD guidelines is available on the day of visit, score = Y. If not, score = N*	Y N If "No" score Red If Y, score Dark Green
Outcome Indicator		
1.5	Does the facility have at least two HCWs providing HIV services trained in AHD? *Data source = Health facility training records and individual training certification*	None score RED 1 HCW score Yellow

		2 or more score Dark Green

Quality Standard 2: All providers of AHD services should receive routine mentorship support (routine in-person, virtual, or online courses on AHD) from district, county, provincial or regional AHD mentors on a monthly/quarterly basis		
Process indicators		
2.1	Does the district, county, provincial or regional AHD mentors have a routine schedule (and funding?) for providing AHD mentorship at the facility level? *Check for a physical copy of the schedule for mentorship, score = Y. If not, score = N*	Y N If "No" score Red If Y, score Light Green
2.2	Do these mentors have an AHD mentorship checklist/assessment tool? *If a physical copy of AHD mentorship is available on the day of visit, score = Y. If not, score = N*	Y N If "No" score Red If Y, score Light Green
Outcome Indicators		
2.3	Proportion of health care providers attending to people with AHD that received mentorship support focussed on AHD in the last 12 months. *Data source = Mentorship records* *Numerator = Number of health care providers attending to people with AHD that received mentorship support focussed on AHD in the last 12 months* *Denominator = Number of health care providers attending to people with AHD in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

Quality Standard 3: All facilities providing AHD services should have SOPs to guide AHD service delivery		
Process Indicators		
3.1	Does the facility have AHD SOPs? *If a physical copy of AHD SOPs is available on the day of visit, score = Y. If not, score = N*	Y N If "No" score Red If Y, score Light Green
3.2	Are the SOPs available in the room where AHD services are provided? *If a physical copy of AHD SOPs is available and clearly displayed in the room on the day of visit, score = Y. If not, score = N*	Y N If "No" score Red If Y, score Dark Green

Quality Standard 4: All facilities providing AHD services should conduct regularly - weekly - scheduled clinical case review meetings (content should include morbidity and mortality review information)
Process Indicators

4.1	Does the facility have a schedule for AHD clinical review meetings? *If a physical copy for AHD clinic review meetings is available on the day of visit, score = Y. If not, score = N*	Y N If "No" score Red If Y, score Light Green
4.2	Does the facility have an individual assigned to lead AHD clinical review meetings? *Data source = Health facility records and/ or key informants (e.g., ask facility manager, ask providers present on day of visit)*	Y N If "No" score Red If Y, score Light Green
Outcome Indicators		
4.3	Proportion of scheduled clinical case review meetings focused on / including AHD conducted in the past 6 months *Data source = AHD clinic review meeting minutes* *Numerator = Number of clinic review meetings focused on / including AHD held in the last 12 months* *Denominator = Number of clinic review meetings held in the last 12 months*	> 90% = Dark Green 80-90% = Light Green 60-80% = Yellow < 60% = Red

1.3 Hub and Spoke Model:

[Assessed at the national level]

Quality Standard 1: All HF providing ART should routinely screen all recipients of care at substantial risk of HIV disease progression (newly diagnosed initiating ART, presenting with an illness requiring admission, children under five diagnosed with HIV, viremic, and returning to treatment) for AHD using a CD4 test		
Process Indicator		
1.1	Does the Ministry of Health national HIV program have a system in place to track health facilities that are routinely screening PLHIV at substantial risk of AHD using a CD4 test? *Data source: DHIS or National electronic data repository*	Y N Yes = Dark Green No = Red
Outcome Indicator		
1.2	Proportion of health facilities that routinely screen PLHIV at substantial risk of HIV disease progression for AHD using a CD4 test *Data source: DHIS or National electronic data repository* *Numerator = Number of health facilities that screened PLHIV at substantial risk of HIV disease progression for AHD using a CD4 test in the latest reporting period* *Denominator = Current number of health facilities nationally*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow Data not available = Red

Quality standard 2: All HF should have systematic processes (such as referral SOPs and an updated national directory of AHD services) to aid in referral to AHD services that are not available on site

Process indicator		
2.1	Does the Ministry of Health national HIV program have a national directory of AHD services system in place with referral SOPs to aid in referral to AHD services that are not available on site? *If a physical copy of SOPs is available on the day of visit, score = Y. If not, score = N.*	Y N Yes = Dark Green No = Red
2.2	Does the Ministry of Health national HIV program have a system in place to track health facilities that are routinely referring people with AHD to higher level health facilities for services that are not available onsite? *Data source: DHIS or National electronic data repository*	Y N Yes = Dark Green No = Red
Outcome indicator		
2.3	Proportion of HF with functional referral systems for AHD services *Data source: DHIS or National electronic data repository* *Numerator = Number of health facilities that referred people with AHD who needed a referral in the latest reporting period* *Denominator = Current number of health facilities nationally*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow Data not available = Red
2.4	Proportion of people with AHD who needed referrals and were successfully referred to the appropriate HF *Data source: DHIS or National electronic data repository* *Numerator = Number of people with AHD who needed referrals and were successfully referred to the appropriate HF in the last 12 months* *Denominator = Number of people with AHD who needed referrals identified in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow Data not available = Red

[Assessed at the HF level]

Quality standard 3: All HF providing AHD services should have systematic processes (such as clinical algorithms) to assess and identify ROC who develop medical conditions requiring management beyond the HF level of care (referral to secondary and tertiary HF)		
Process indicator		
3.1	Is there a system in place to assess and identify ROC who develop medical conditions requiring management beyond the HF level of care (referral to secondary and tertiary HF)? *Data source = Check if the facility has SOPs, patient charts helping to identify patients who need more intensive services.* *Score YES if any of these documents are available.*	Y N If "Yes" = Dark Green If "No" = Red
Outcome Indicators		
3.2	Proportion of people with AHD who develop medical conditions requiring management beyond the HF were successfully referred *Data source: Referral register / HTS /ART / Viremic / Appointment registers*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow

	Numerator = Number of people with AHD who develop medical conditions requiring management beyond the HF successfully referred to the appropriate HF in the last 12 months *Denominator = Number of people with AHD who develop medical conditions requiring management beyond the HF in the last 12 months*	Data not available = Red

Quality Standard 4: All HF providing AHD services should have systematic processes to assess, identify and support ROC with AHD requiring additional care (such as adherence to treatment and psychosocial support) in the community (community service delivery)		
Process Indicator		
4.1	Is there a system in place to assess, identify, and support ROC with AHD requiring additional care (such as adherence to treatment and psychosocial support) in the community (community service delivery)? *Data source = Check if the facility has SOPs, HTS /ART / Viremic / Appointment registers, patient charts helping to identify ROC with AHD requiring additional care.* *Score YES if any of these documents are available.*	Y N If "Yes" = Dark Green If "No" = Red
Outcome Indicator		
4.2	Proportion of ROC with AHD requiring additional care and are successfully referred to community support services *Data source: VCT / ART / Viremic registers,* *Numerator = Number of people with AHD requiring additional care and are successfully referred to community support services in the last 12 months* *Denominator = Number of people with AHD requiring additional care at home in the last 12 months.*	Record percentage If unavailable = Red

Quality Standard 5: All HF providing AHD services should promptly refer identified complex cases to an appropriate treatment centre (referral to secondary and tertiary HF)		
Process Indicator		
5.1	Is there a system in place to identify complex cases (unsuppressed VL, treatment failure, new OIs, pregnancy, young age) who need special care? *Data source = Check if the facility has SOPs, VL registers, patient charts helping to identify complex cases.* *Score YES if any of these documents are available.*	Y N If "Yes" = Dark Green If "No" = Red
5.2	Does the facility have referral SOPs and an updated national directory of AHD services to aid in referral of complex cases to an appropriate treatment centre? *If a physical copy of SOPs is available on the day of visit* *Score = Y. If not, score = N.*	Y N If "Yes" = Dark Green If "No" = Red

5.3	Is there a system in place to track prompt referral of identified complex cases to an appropriate treatment centre (referral to secondary and tertiary HF)? *Data source = Referral logbook, tracking tool, national directory of AHD, referral forms*	Y N If "Yes" = Dark Green If "No" = Red
Outcome Indicator		
5.4	Proportion of complex cases referred to an appropriate treatment centre. *Data source: Referral register / HTS /ART / Viremic / Appointment registers* *Numerator = Number of complex cases successfully referred to the appropriate treatment centre in the last 12 months* *Denominator = Number of complex cases identified at the HF in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

Quality Standard 6: All HF providing in-patient care to PLHIV with AHD should have comprehensive discharge / downward referral SOPs		
Process Indicator		
6.1	Does the facility have a system in place to comprehensively discharge / ensure downward referral for people with AHD? *Data source = Check if the facility has SOPs, in-patient / internal referral registers, patient charts helping to identify PLHIV with AHD. Score YES if any of these documents are available.*	Y N If "Yes" = Dark Green If "No" = Red
Outcome Indicator		
6.2	Proportion of people with AHD discharged / downward referred from in-patient department *Data source: Internal referral register / patient chart* *Numerator = Number of people with AHD discharged / downward referred from in-patient department in the last 12 months* *Denominator = Number of people with AHD admitted at the HF in the last 12 months*	Record percentage If unavailable = Red

1.4 Advocacy Communication and Social Mobilization

[Assessed at the health facility level]

Quality Standard 1: All AHD service delivery demand creation activities should be developed in partnership with recipients of care		
Process Indicators		
1.1	Does the facility have a hospital management team (HMT) and a multi-disciplinary team (MDT) that reviews HIV service delivery including AHD service delivery and demand creation? *Data source: HMT and MDT minutes that include discussions on AHD service delivery and ROC participation*	Y N If "Yes" = Dark Green If "No" = Red
1.2	Is a recipient of care part of the membership of the HF HIV / AHD multidisciplinary team? *Data source: Minutes of the HF AHD multidisciplinary team including the ROC participation*	Y N If "Yes" = Dark Green If "No" = Red
Outcome Indicators		

1.3	Proportion of HF HMT and MDT meetings detailing a review the AHD services including demand creation activities *Data source: HMT minutes, MDT minutes, AHD register* *Numerator = Number of HMT and MDT meetings focused on AHD including demand creation activities held in the last 12 months* *Denominator = Number of HMT and MDT meetings focused on AHD held in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

Quality Standard 2: All HF providing AHD services should have tailored ROC demand creation activities for AHD services provided in partnership with ROC (AHD Peer educators).		
Process Indicators		
2.1	Are the ROCs involved in the HF AHD service delivery demand creation activities such as health talks, peer to peer counselling sessions, adherence support? *Data source: Health talks schedule, counselling scheduling rota, service delivery rota*	Y N If "Yes" = Dark Green If "No" = Red
Outcome Indicators		
2.2	Proportion of people with AHD linked to a peer educator for support and routine follow-up *Data source: ART registers and Peer Educator registers* *Numerator = Number of people with AHD linked to a peer educator for support and routine follow-up in the last 12 months* *Denominator = Number of people with AHD identified in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

[Assessed at the community linked to a HF – hub or spoke]

Quality Standard 3: All community AHD awareness programs should be provided in partnership with ROC		
Process Indicators		
3.1	Do the CSOs linked to the HF conduct community HIV awareness programs that incorporate AHD awareness in partnership with the ROC? *Data source: CSO report*	Y N If "Yes" = Dark Green If "No" = Red
Outcome Indicators		
3.2	Proportion of community HIV awareness programs that incorporate AHD awareness held *Data source: CSO report* *Numerator = Number of community HIV awareness programs that incorporate AHD awareness held in the last 12 months* *Denominator = Number of community HIV awareness programs held in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red
3.3	Proportion of ROCs engaged in community HIV awareness programs that incorporate AHD awareness *Data source: CSO report* *Numerator = Number of ROCs engaged in community HIV awareness programs that incorporate AHD awareness held in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow

	Denominator = Number of ROCs engaged in community HIV awareness programs held in the last 12 months	If unavailable = Red

Quality Standard 4: All community led monitoring programs should include monitoring of AHD service delivery		
Process Indicators		
4.1	Do the CSOs linked to the HF conduct community led monitoring that includes monitoring of AHD service delivery? *Data source: CLM report*	Y N If "Yes" = Dark Green If "No" = Red
Outcome Indicators		
4.2	Proportion community led monitoring programs that incorporated AHD monitoring held *Data source: CLM report* *Numerator = Number of community led monitoring programs that incorporated AHD monitoring held in the last 12 months* *Denominator = Number of community led monitoring programs held in the last 12 months*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

1.5 Supply Chain Management Systems:

[Assessed at the national level]

Quality Standard 1: All HF providing AHD services should have adequate stocks of AHD pharmaceutical commodities (particularly TB and CM management and prophylactic commodities) to cover the course of OI treatment		
Process Indicators		
1.1	Does the Ministry of Health national HIV program have a national system in place to track AHD pharmaceutical commodities that are routinely used to manage people with AHD? *Data source: DHIS or National electronic data repository or HIV Commodity management system*	Y N If "Yes" = Dark Green If "No" = Red
Outcome Indicators		
1.3	Proportion of health facilities that routinely track AHD pharmaceutical commodities used to manage people with AHD *Data source: DHIS or National electronic data repository or HIV Commodity management system* *Numerator = Number of health facilities that submitted an HIV commodity consumption report that included data on AHD pharmaceutical commodities used to manage people with AHD in the latest reporting period* *Denominator = Current number of health facilities nationally*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

Quality Standard 2: All HF managing PLHIV with AHD should have adequate stocks of AHD laboratory commodities (particularly CD4 testing as well as TB and CM diagnostic and monitoring commodities)
Process Indicators

2.1	Does the Ministry of Health national HIV program have a national system in place to track AHD laboratory commodities that are routinely used to screen and diagnose AHD and the associated comorbid conditions? *Data source: DHIS or National electronic data repository or Laboratory information management system*	Y N If "Yes" = Dark Green If "No" = Red
Outcome Indicators		
2.2	Proportion of health facilities that routinely track AHD laboratory commodities used to screen and diagnose AHD and the associated comorbid conditions *Data source: DHIS or National electronic data repository or HIV Commodity management system* *Numerator = Number of health facilities that submitted an HIV laboratory report that included data on AHD laboratory commodities used to screen and diagnose AHD and the associated comorbid conditions in the latest reporting period* *Denominator = Current number of health facilities with laboratories nationally*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

Quality Standard 3: All AHD HF hubs managing people with AHD should have functional laboratory equipment to support AHD services (specifically CD4 test, TB LAM, Xpert MTB/rif assay, CrAg, Biochemistry)		
Outcome Indicators		
3.1	Proportion of AHD HF hubs managing people with AHD with functional laboratory equipment (specifically CD4 test, TB LAM, Xpert MTB/rif assay, CrAg, Biochemistry) to support AHD services *Data source: DHIS or National electronic data repository* *Numerator = Number of AHD HF hubs managing people with AHD having functional laboratory equipment (specifically CD4 test, TB LAM, Xpert MTB/rif assay, CrAg, Biochemistry) in the latest reporting period* *Denominator = Current number of AHD hubs nationally*	> 90% = Dark Green 80-90% = Light Green < 80% = Yellow If unavailable = Red

1.6 Monitoring and Evaluation for AHD:

[Assessed at the health facility level]

Quality Standard 1: M&E for AHD includes data collection and reporting of necessary patient information at facility level and strategic use of data to review program performance		
Process Indicators		
1.1	Does the facility collect and report at least one element of the AHD package, such as diagnostic tests for key OIs[1] (i.e., CD4 testing, Xpert MTB/Rif assay, TB LAM, CrAg), their prophylaxis[2] and treatment?	Y N If "Yes" = Dark Green

[1] Key OIs include TB and CM

[2] OIs prophylaxis [prevention services] include CTX, TPT and CM prophylaxis as prescribed in the national guidelines

	Data source: Health facility records [paper and/or electronic]	If "No" = Red
1.2	Does this facility offer the comprehensive AHD package onsite and, if so, does the facility capture population- and age-disaggregated data to allow for all populations at high risk of AHD [i.e., newly diagnosed initiating ART, presenting with an illness requiring admission, children under five diagnosed with HIV, viremic, and returning to treatment] to be tracked separately? *Data source: Health facility records [paper and/or electronic]*	Y N If "Yes" = Dark Green If "No" = Red
1.3	Does this facility capture age-disaggregated data on the AHD package, including diagnostic tests for key OIs, their prophylaxis and treatment in both the paper and electronic Health Information System [HIS]? *Data source: Health facility records [paper and/or electronic]*	Y N If "Yes" = Dark Green If "No" = Red
Outcome Indicators [Aggregate data]		
1.4	Proportion of health facilities collecting and reporting at least one element of the AHD package, including diagnostic tests, prevention, and treatment for key OIs *Data source: Health facility records [paper and/or electronic]*	> 90% = Dark Green 80-90% = Light Green 60-80% = Yellow < 60% or no data = Red
1.5	Proportion of health facilities capturing age-disaggregated AHD package, including diagnostic tests, prevention, and treatment for key OIs in both the paper and electronic Health Information System [HIS] *Data source: Health facility records [paper and/or electronic]*	> 90% = Dark Green 80-90% = Light Green 60-80% = Yellow < 60% or no data = Red