HIV Program Minimum Package Service Quality Assessment Standard Operating Procedures

A QUALITY ASSESSMENT TOOL

Contents

The CQUIN HIV Program Minimum Package Service Quality Assessment Tool

Introduction

The HIV landscape is undergoing a monumental and pivotal shift. As countries face declining external funding and increasing pressure to transition to domestically sustained health systems, the need for high-quality, efficient, and equitable HIV service delivery has never been more urgent. In this context, the **CQUIN Learning Network** has prioritized the development of practical, rapid tools to help countries assess, monitor, and improve the quality of HIV services—particularly as services are integrated into primary health care (PHC) platforms.

CQUIN has supported ministries of health and other stakeholders, including recipients of care, donor agencies, and implementing partners, through a dedicated Quality Management Community of Practice (QM CoP) to co-develop tools that evaluate service quality in differentiated service delivery (DSD) models. This collaborative effort has produced a streamlined, HIV program minimum package Service Quality Assessment (SQA) Tool, designed to provide country programs with standardized, actionable data on the quality of HIV services delivered across the care continuum.

Background

In October 2024, the CQUIN QM CoP conducted a comprehensive, network-wide survey across all participating countries to better understand the range and nature of HIV program SQA tools currently in use as well as the challenges related to implementation and interpretation of results. The findings revealed a highly diverse landscape: Approximately two-thirds of countries reported using CQUIN quality tools or tools combining CQUIN and SIMS indicators, while others relied on nationally developed assessment frameworks focused on specific HIV program service areas, and some continued to use various partner-driven instruments. While each of these approaches has distinct value, the variation underscored a persistent challenge for planners and policymakers—the absence of a harmonized, standardized mechanism for rapidly assessing core HIV program standards across varied service delivery settings. Inconsistent methodologies and indicator definitions have made it difficult to compare performance across regions, track progress over time, or fully integrate quality findings into national planning and decision-making processes. Recognizing this gap, CQUIN and its Ministry of Health (MOH) partners and other stakeholders prioritized the development of a unified SQA tool that could be implemented at scale, generate reliable insights into facility-level processes, and produce data that can be triangulated with national HIV monitoring and evaluation (M&E) systems and outcome indicators. This harmonized approach strengthens the ability of MOH and implementing partners to use timely, actionable data to inform planning, allocate resources strategically, and sustain the quality of HIV delivery over the long term.

Meeting the Moment: The Role of SQA in Ensuring Sustainability

Today, countries are facing critical decisions about how to transform, implement, and sustain HIV service delivery in the face of reduced donor funding and changing epidemiological trends. CQUIN is rapidly pivoting to support MOHs in countries most affected by HIV, which face urgent questions about adapting to this new reality. To address these challenges, they are engaging with peer country leaders through CQUIN to share experiences, best practices, and tools focused on priority-setting and sustainability. The WHO's 2025 Operational Guidance on Sustaining Priority Services for HIV, Viral Hepatitis, and STIs emphasizes the importance of "anchoring service delivery decisions within a broader systems approach" that protects essential services while aligning with PHC and Universal Health Coverage goals. The WHO 2025 guidance encourages planners to maintain a core focus on quality, not just access to available services, emphasizing "Expanded access without quality can lead to poor retention, missed diagnoses, treatment failure, and drug resistance." Additionally, WHO strongly recommends that quality assurance and continuous quality improvement (CQI) be integrated into all service adaptations and prioritization decisions.

In line with these recommendations, ministries of health have now initiated HIV service prioritization exercises using the International Aids Society PATHS – Planning and Action Toolbox for HIV Sustainability toolkit and CQUIN-modified Tool for Intervention, Evaluation and Ranking (TIER) tools to identify the high-impact services essential for sustaining epidemic control and safeguarding previous gains.

The CQUIN SQA Tool supports this call to action by providing a **harmonized and rapid quality assessment framework** that:

- Draws from well-established tools such as the CQUIN SQA tool for differentiated service delivery, CQUIN Advanced HIV Disease SQA Toolkit, CQUIN Recipient of Care Satisfaction Toolkit, CQUIN Key Population Friendly Service SQA toolkit, PEPFAR's SIMS, national SIMS adaptations, and other country-led evaluations;
- Triangulates prioritized HIV services identified through country outputs from the TIER tools, using these findings to inform updates and enhancements to the SQA tool, ensuring it reflects high-impact, country-specific priorities.
- Measures quality across key HIV program care continuum domains—regardless of whether HIV services remain standalone or are integrated into PHC settings.
- Offers a standardized approach to capturing data that informs minimum packages of care for HIV service delivery.

This tool is intentionally designed for ease of use and scalability, ensuring it can support both national-level monitoring and sub-national quality improvement (QI) initiatives.

The SQA tool is currently available in Microsoft Excel format, featuring:

- Automated scoring that aligns with quality standards.
- Dashboards that visualize key performance gaps and strengths across sites.
- Piloted use cases in Nigeria and Ghana, demonstrating its utility for rapid national-level assessments and DSD program reviews.

To further integrate the tool into national health systems, a DHIS2-compatible version is being finalized and will allow direct upload of facility-level data into routine government monitoring platforms, an important step toward institutionalizing quality measurement in domestic systems.

Description of the SQA tools

From the outset, the design of the SQA tool was guided by the principle of balancing comprehensiveness with feasibility and practicality for MoH and national health planners. Rather than attempting to measure the full range of HIV program processes or performance metrics, the tool focuses on a minimum package of core standards that represent the most critical determinants of quality along the HIV care continuum. This streamlined approach aims to ensure that even a rapid assessment can identify processes that are not functioning optimally, whether in HIV testing, ART initiation, retention in care, or viral load monitoring across all populations from infants to adults. By limiting the scope to essential indicators, the tool reduces the reporting burden on health facilities while enabling more regular, widespread use across a higher number of health facilities. Importantly, this approach can serve as both a routine monitoring instrument and a trigger for deeper analysis: when the assessment reveals a potential gap, it signals the need for more detailed investigation, targeted technical assistance, and focused quality improvement interventions. This model ensures that limited resources for in-depth reviews are directed toward priority areas with the highest potential to improve health outcomes and reinforce the sustainability of HIV service delivery.

This version of the SQA tool has been designed to assess the quality of HIV program services as they are delivered now, during this transitional period, irrespective of whether these services are integrated into primary health care platforms, incorporated into broader chronic care models, or maintained as stand-alone programs. The standards included in this version are closely aligned with the outcomes of the CQUIN prioritization exercise, reflecting the core set of HIV services that ministries of health have committed to sustaining in the coming years. By anchoring the tool in these priority services, it ensures that quality measurement remains relevant and actionable during ongoing health system transitions. This approach enables countries to monitor and safeguard critical HIV program functions through periods of integration and restructuring, maintaining focus on the services most essential to achieving national and global HIV targets.

1. SQA Tool (Data Collection Instrument)

The **SQA Tool** is an Excel-based questionnaire and scoring workbook used at the **facility level**. It incorporates a structured set of indicators that reflect the minimum package of HIV services, including prevention, testing, treatment initiation, continuity, and integration with PHC. This tool is designed for rapid administration during site visits or supervision and is ideal for use by district teams or facility QI teams. Key features include:

- Questionnaire organized by domain within the essential services within the care continuum (e.g., ART initiation, retention, integration, client feedback).
- Each domain has clearly defined standards and criteria, scored using a standardized rating scale (e.g., Yes/Partial/No).
- Scoring is automated using built-in Excel logic to ensure consistency and minimize user error.

THIS TOOL ENABLES PLANNERS TO QUICKLY ANSWER QUESTIONS SUCH AS:

Which regions, districts, or facility types are underperforming in HIV testing, ART initiation, and/or retention? What is the quality of the national guidelines being implemented across several sites within a district or regional context.

Are minimum package services implemented consistently across districts?

Where should supervision, coaching, or quality improvement efforts be focused on in the next quarter?

2. SQA Summary Tool (Visualization and Reporting Dashboard)

The **SQA Summary Tool** is a companion workbook that aggregates facility-level data to provide a national or sub-national snapshot of service quality across multiple domains. It is also Excel-based and requires no advanced software or connectivity. Key features include:

- Automated dashboards using facility scores across all standards, with color-coded visualizations for quick interpretation.
- Summary tables and charts help identify patterns in performance by region, facility type, or standard.
- Designed to support strategic planning, prioritization, and national reporting processes.

Adaptation Guidance: Tailoring the Tool for National Contexts

Recognizing that countries are reprioritizing HIV services and defining essential packages of care through sustainability roadmaps and PHC integration processes, the SQA Tool was developed with flexibility in mind. Ministries of health and technical partners are encouraged to adapt the domains and indicators to reflect local guidelines and minimum service delivery standards; align the tool's implementation with ongoing efforts to define Tier 1 and Tier 2 services, as recommended in the WHO 2025 guidance; and integrate community perspectives and recipient of care considerations to ensure equity-focused service evaluations. Suggestions include:

1. **Customize Standards and Indicators**: Countries can align standards with their national HIV guidelines or minimum service packages, including the integration of PHC services.
2. **Incorporate Priority-Tier Mapping**: Based on WHO's 2025 operational guidance, countries may assign Tier 1 (essential), Tier 2 (important) status to standards or indicators—guiding investments and support even under constrained budgets.
3. **Localization of Language and Standards**: Text within the questionnaire can be localized into national languages and aligned with existing QI tools to ensure terminology coherence with national quality policies.
4. **Integration with National Digital Systems**: A future version of the tools will include DHIS2 integration. In the interim, the summary outputs can be manually uploaded into national dashboards or quarterly reports to inform decision-making.
5. **Link to Quality Improvement Plans**: The tool outputs can directly inform site-level, regional, or national quality improvement plans, enabling targeted technical support, coaching, and mentorship.
6. **Facilitate Stakeholder Dialogues**: Visual outputs from the Summary Tool are well-suited for use in national QI review meetings, donor coordination discussions, or other peer learning sessions.

In conclusion, the SQA tool can support priority-setting exercises, helping countries determine which services should be maintained, scaled down, or restructured during periods of fiscal constraint. As HIV programs evolve within changing systems and shrinking budgets, **quality cannot be an afterthought**. The CQUIN Minimum Package SQA Tool offers a practical, country-driven pathway for assessing the quality of services, informing sustainability plans, as well as ensuring that DSD models remain person-centered, effective, and equitable. By embedding rapid, adaptable quality assessment within national frameworks, countries can better safeguard health outcomes, and the hard-won gains of decades of HIV response.

CQUIN guidance: Selecting a nationally representative sample of health facilities for the SQA

Definition

A national representative sample means selecting a subset of facilities for assessment in a way that accurately reflects the national healthcare system's characteristics and performance. Facilities are not homogeneous with respect to size, setting, ownership, and perhaps other characteristics; a representative sample adequately reflects the distribution and range of these characteristics, with acknowledgment that larger facilities care for a disproportionate number of clients and therefore must be represented disproportionately in the sample. Ideally, the team can identify a sample that is representative across countries, regions, or provinces, facility levels (primary, secondary, tertiary), and urban/rural settings.

This section provides considerations for sampling health facilities to help ensure that findings from an SQA can be reliably generalized to represent the national picture.

The **sampling frame** includes all health facilities providing HIV services in the country, based on the most recent Master Facility List or program data. Facilities are grouped by type, region, and ART by patient volume.

Key Components of the National Representative Sample

1. **Sampling Frame**: Sampling frame is a list of facilities from which a subset will be selected for the SQA exercise.

    - For the sample to be nationally representative, the sampling frame should consist of an **updated** comprehensive list of all facilities in the country that are providing HIV care and treatment services.

Red Flags: Indicators of a Non-Representative Sampling Frame

If the sampling frame used to select facilities has any of the following characteristics, it is unlikely to be nationally representative:

- The sampling frame includes facilities from only a few regions or subnational areas. For example, if the country has 27 regions/provinces/counties but the sampling frame covers facilities in only 4 of these, it is unlikely to be nationally representative
- The sampling frame includes facilities exclusively from either urban areas or rural areas, rather than a mix of both.
- The sampling frame includes only government-owned facilities while excluding private and faith-based facilities, or vice versa
- The sampling frame includes only easily accessible facilities while excluding those in hard-to-reach areas.

- The sampling frame includes facilities from only one or a few implementing partners, while excluding those from other partners.

2. Sampling of the facilities for SQAs

Health facilities that provide HIV services should be selected for the assessment by probability sampling, such as stratified random sampling or **probability proportional to size (PPS)** sampling. Methods such as simple or systematic random sampling are not likely to provide samples with adequate representation of large facilities or (depending on the sample size) of facilities representing the breadth of facility characteristics worth accounting for in the sample. Stratification and/or weighting for PPS sampling can ideally be done in multiple stages of selection to ensure that a sufficient range of geographic subunits, settings, and facility levels are reflected, and that larger facilities are well represented. As a rule of thumb, at least **10% of facilities from the sampling frame should be selected for the SQA**. However, if more facilities are needed to ensure sufficient representation across subnational units and facility types, a larger proportion should be included.

Example of nationally representative sampling for SQAs:

This example utilizes a multi-stage sampling approach, with the probability of selection aligned with the number of clients who are on HIV treatment or seen within a given subnational unit or facility:

- In country X, there are 50 counties. Within these counties are 4,000 facilities providing HIV Treatment services. A total of 400 facilities will be selected, accounting for **10% of facilities** providing HIV care and treatment services for adults and children.
- **Stage 1:** For this SQA, facilities from all 50 counties will be sampled; however, the **number of facilities to be sampled per county will take into consideration the PPS method** – i.e., counties with higher numbers of clients receiving HIV care and treatment services will have more facilities sampled compared to those with fewer HIV clients.
    - *For example, County A, which serves 5% of clients on ART nationally, is allocated 400 x 5%=20 health facilities to be sampled.*
- **Stage 2: Within each county, stratified random sampling (with or without PPS weighting of selection probabilities)** will be used to select the allocated number of facilities determined in Stage 1, arriving at a total of 400 facilities across all 50 counties. The stratification of sampling should be done in a way to best ensure sufficient representation of the breadth of health facility types and settings.
    - *Continuing with the example started in Stage 1: in County A, 50% of HIV care and treatment clients are seen in public secondary-level facilities; 30% are seen in public primary-level facilities; and 20% in private facilities. Therefore, 10 public secondary, 6 public primary, and 4 private facilities will be randomly selected.*
    - If the health facility level is not used for stratification, contrary to the example here, it will be especially important to weight the probability of selection by the size of the facility.

Additional Sampling Options:

A simplified, stratified approach is used to ensure national and sub-national representation. A fixed number of facilities is selected per region or stratum (e.g., 10–15 per region), ensuring a mix of high-, medium-, and low-volume sites. The sample size is based on standard public health practice, providing reasonable precision without requiring complex calculations.

Acknowledgments

The development of the CQUIN HIV Program Minimum Package Service Quality Assessment Tool was a collaborative effort made possible through the commitment, expertise, and partnership of many individuals and organizations.

We extend our sincere gratitude to the ministries of health, national HIV programs, and healthcare providers across the CQUIN Learning Network countries who generously contributed their time, insights, and experiences to shape and refine this tool. Special thanks go to members of the Quality Management Community of Practice (CoP), whose technical expertise, field perspectives, and iterative feedback were instrumental in ensuring the tool is practical, relevant, and adaptable to diverse contexts.

We are grateful to recipients of HIV care who shared their lived experiences and perspectives, ensuring that the tool reflects the realities and priorities of the communities it serves.

We also acknowledge the contributions of donor agencies, implementing partners, and technical advisors who provided guidance, resources, and strategic input throughout the development process.

Finally, we thank the CQUIN Team for their leadership, coordination, and dedication to advancing high-quality, equitable HIV service delivery through the creation of practical tools that can be implemented at scale.

Appendix 1: HIV Service Quality Assessment Standard Operating Procedures (SOP)

The **purpose** of this SOP is to provide clear instructions for implementing the HIV SQA and completing the SQA tool and questionnaire.

This SOP is **intended for persons** responsible for implementing and evaluating HIV service quality and entering data into the provided Excel-based scoring tool. Examples can include the following positions and responsibilities:

- HSQA Lead: Manages overall implementation activities
- QI/Data Focal Point: Enters assessment results into SQA tool
- Regional/National QI lead designate: Reviews auto-generated scores in the SQA tool and prepares summary tool

Implementation

The HSQA process follows a structured sequence to ensure consistent, accurate, and actionable results. It is organized into four main periods: (1) pre-assessment, (2) assessment, (3) post-assessment, and (4) follow-up - each with distinct activities that build on one another to strengthen HIV SQA and improvement.

1. **Pre-assessment**
   The pre-assessment phase lays the groundwork for a successful exercise. It focuses on clarifying the scope, selecting facilities, preparing tools, and ensuring that teams and sites are ready for implementation.
   - Define objectives and scope of the SQA
   - Select a representative sample of facilities/sites
   - Orient and train assessment teams on tool use and scoring methods
   - Schedule site visits and notify facilities
   - Prepare logistics and data collection materials
2. **Assessment**
   The assessment period involves the actual administration of the tool at facility level. Teams collect, validate, and record data on service delivery processes and quality standards.
   - Conduct facility visits/requests for data collection according to the sampling plan
   - Collect data using the SQA tool (interviews, observations, document review)
   - Score each standard using the predefined scale
   - Validate findings with facility staff
   - Record and save all data in the standardized Excel workbook
3. **Post-Assessment**
   Once data collection is complete, results are entered into the summary tool for consolidation and analysis. This stage focuses on identifying trends, highlighting performance gaps, and preparing outputs for decision-making.
   - Aggregate data into the SQA Summary Tool for analysis
   - Generate automated dashboards, tables, and performance visualizations
   - Identify service quality gaps and priority areas for improvement
   - Share preliminary results with national and subnational stakeholders
   - Share results with CQUIN staff
4. **Follow-up Assessment**

A follow-up assessment should take place within 6 months of the baseline assessment. Baseline assessments will coincide with the CQUIN annual meeting (end of year), and follow-up will align with the CQUIN mid-year meeting (spring). SQA Tool (Data Collection Instrument)

Data Collection Instrument and Entry into the SQA Tool

1. **Open the File**
   - File: **Minimum Package_SQA Tool**.xlsx
   - Enable macros and content if prompted to ensure calculations work.
2. **Review the "Information and Instructions" Tab**
   - This tab outlines the instructions for completing the SQA tool
   - Here you are also requested to enter basic information:

3. **Navigate to the "SQA Questionnaire" Tab**
   - This is the main data entry sheet.
4. **Review the Layout**
   - *Domains* – specific domains being evaluated using this tool (column B)
   - Each domain has:
     - **Standards** (Description and assessment questions) – standards for each domain are outlined to provide context. Under each standard, questions are listed; you will be asked to provide answers to each of these questions to generate a score for each domain/standard (column C)
     - **Denominator, Numerator, Multi-choice options and instructions** – where applicable, you will be asked to provide data and/or select multiple choice options in columns D, E, F, and G.
     - **Scoring** – guidance on how the scoring is calculated (column **H**)
     - **Responses and Autogenerated Scores** – where you enter responses for some domains and where scores are autogenerated for all domains (column I)
5. **Domains and Standards to Complete**
   - There are 24 domains and standards to complete

Province/Region:		District:	
Health Facility:		Type of Health Facility:	
Number of Adults currently on ART:		Date of the SQA exercise	
Number of Children on ART			
Number of Adults on TB Treatment			
List of services/units assessed during this HSQA exercise:			
_		_	
_		_	
_		_	
_		_	
_		_	

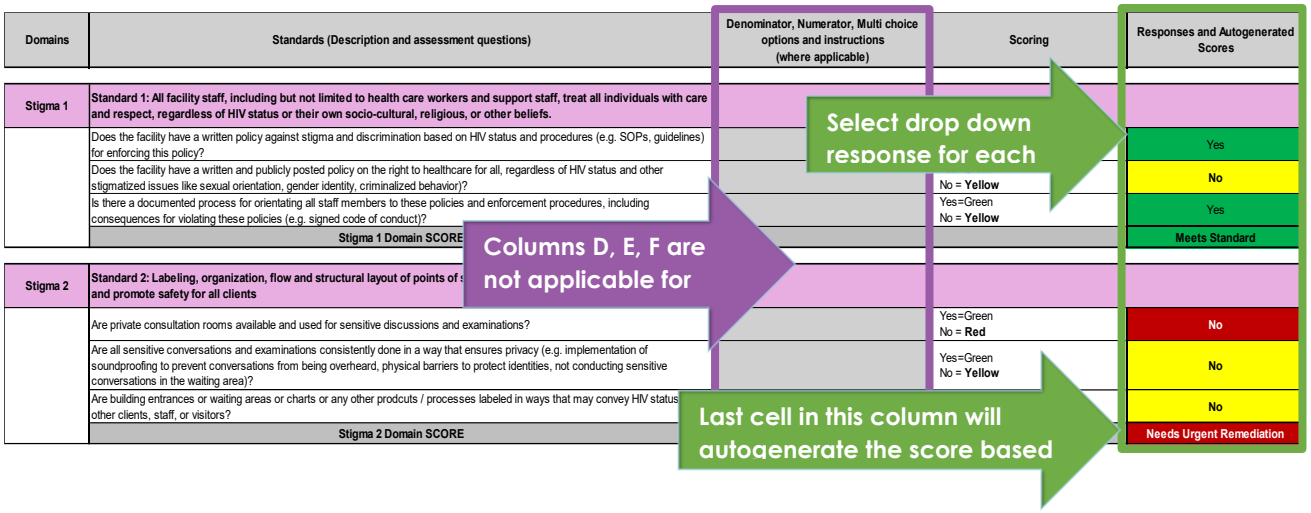
   - Domains are included in Table 1 below

Table 1: The HIV Service Quality Assessment Domains and Standards

Domains	Standards (Description and assessment questions)
Stigma 1	Standard 1: All facility staff, including but not limited to health care workers and support staff, treat all individuals with care and respect, regardless of HIV status or their own socio-cultural, religious, or other beliefs.
Stigma 2	Standard 2: Labeling, organization, flow and structural layout of points of service delivery ensure privacy, confidentiality, and promote safety for all clients
Community Engagement	Standard 3: There is a strategy and defined process for stakeholder engagement, including with Civil Society Organizations (CSOs) and beneficiaries of HIV services. The strategy includes activities to elicit and use stakeholder feedback for (1) program planning and implementation at least every 6-months and (2) review and/or evaluation of program performance data at least every 4 months.
Wait Times	Standard 4: Health facilities should provide timely access to healthcare services to minimize patient waiting times, reduce congestion, and improve overall patient satisfaction with clear protocols in place to manage waiting times efficiently.
HIV Testing Services1	Standard 5: All individuals including infants and children seeking care in outpatient, immunization clinics, chronic, and routine care settings are offered HIV testing Services (HTS) privately and confidentially in accordance with the national HIV testing Services or ART Guidelines.
HIV Testing Services 2	Standard 6: All newly diagnosed people (children, adolescents, adults) living with HIV are retested to verify their HIV diagnosis prior to, or at the time of, ART initiation using the national HIV testing algorithm.
Prevention	Standard 7: HIV uninfected individuals (adults) are offered Pre Exposure Prophylasis (PrEP) (any or all forms), according to guidelines and national policy
HIV Testing Linkage To Treatment	Standard 8: All sites that provide HTS have a standardized protocol or process for tracking successful and unsuccessful linkage of HIV-infected clients to HIV care and treatment services.
ART	Standard 9: HIV-positive individuals (all ages) are offered the option of rapid or same-day ART, according to guidelines and national policy for each age group
CTX	Standard 10: Eligible clients living with HIV (all ages) have documented prescription of cotrimoxazole (CTX), according to national guidelines for each age group
TB 1	Standard 11: All persons living with HIV (all ages) have documentation of TB screening for active tuberculosis (TB) on intake and at each clinical visit according to national guidelines
TB 2	Standard 12: All individuals with HIV who screen negative for active tuberculosis (TB) receive TB Preventive Treatment (TPT) per national guidelines for all age groups
TB 3	Standard 13: All individuals with HIV who screen positive for active tuberculosis (TB) have a specimen sent for active TB disease diagnosis
VLS 1	Standard 14: Clients on antiretroviral therapy (ART) receive routine monitoring for virologic suppression (i.e., VL ≤1000 copies/mL or criteria based on national guidelines) through assessment of viral load, per national guidelines, and the results are documented in the medical record.
VLS 2	Standard 15: Clients on antiretroviral therapy (ART) with virologic non-suppression (i.e., VL >1000 copies/mL) are tracked and receive enhanced adherence counseling (EAC) and repeat viral load monitoring per national guidelines to assess for virologic failure and the potential need to switch ART regimens.
Continuity in Treatment	Standard 16: Each ART site has a standard procedure for identifying and tracking all ART clients who have missed their last clinical review or ARV refill. The system includes procedures for client identification and tracking; standardized documentation showing evidence of more than one attempt to bring the client back into care; and the results/outcome of re-engagement efforts.
DSD 1	Standard 17: Each site offers differentiated service delivery (DSD) models for adolescent and adult clients ≥15 years old (e.g., multi-month drug dispensing, community dispensation) to meet the needs of ART clients.
DSD 2	Standard 18: All adult recipients of care should be regularly assessed for differentiated ART program service eligibility and offered the choice to opt into a less-intensive model, if eligible
AHD	Standard 19: 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
VTE EID	Standard 20: All HIV-exposed infants (HEIs) have a specimen collected for early infant diagnosis (EID). There is documented return of HIV results to caregivers within one month of sample collection.
VTE EID	Standard 21: All HIV-exposed infants (HEIs) initiate cotrimoxazole (CTX) by eight weeks of age
VTE EID	Standard 22: All HIV-exposed infants (HEIs) are tracked through the end of breastfeeding and have a documented final HIV outcome by 24 months of age
Supply 1	Standard 23: Each site has an inventory management protocol for antiretrovirals (ARVs), cotrimoxazole (CTX), isoniazid preventive therapy (IPT)/other TB preventive regimens, and HIV rapid test kits (RTKs), and submits routine and accurate orders to maintain adequate stock (between established minimum/maximum stock levels).
Supply 2	Standard 24: This health facility has a reliable supply of HIV and TB related medications and HIV testing supplies

6. **Complete Data Entry Fields**
   - For the following domains/standards (**pink color**), for each question (column C), select your responses from the drop-down in column I. The score in column I will autogenerate.
     - **Stigma 1**
     - **Stigma 2**
     - **Community Engagement**
     - **Wait Times**

Example – Stigma 1 and 2 Domains/Standards



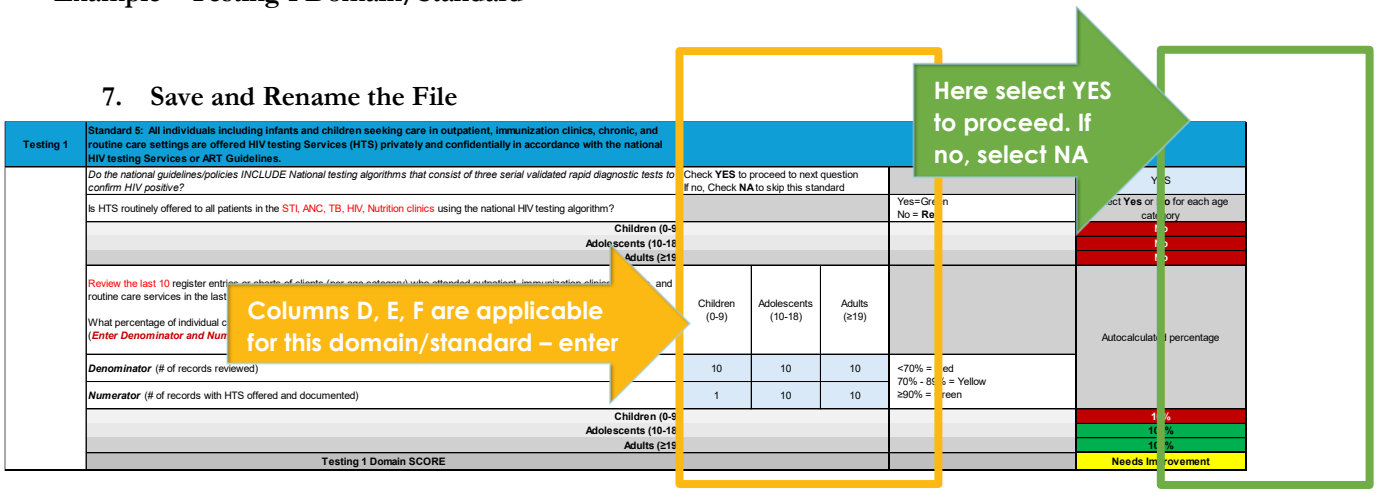
Domains	Standards (Description and assessment questions)	Denominator, Numerator, Multi choice options and instructions (where applicable)	Scoring	Responses and Autogenerated Scores
Stigma 1	**Standard 1: All facility staff, including but not limited to health care workers and support staff, treat all individuals with care and respect, regardless of HIV status or their own socio-cultural, religious, or other beliefs.**			
	Does the facility have a written policy against stigma and discrimination based on HIV status and procedures (e.g. SOPs, guidelines) for enforcing this policy?			Yes
	Does the facility have a written and publicly posted policy on the right to healthcare for all, regardless of HIV status and other stigmatized issues like sexual orientation, gender identity, criminalized behavior)?		No = **Yellow**	No
	Is there a documented process for orientating all staff members to these policies and enforcement procedures, including consequences for violating these policies (e.g. signed code of conduct)?		Yes=Green No = **Yellow**	Yes
	Stigma 1 Domain SCORE			**Meets Standard**
Stigma 2	**Standard 2: Labeling, organization, flow and structural layout of points of s and promote safety for all clients**			
	Are private consultation rooms available and used for sensitive discussions and examinations?		Yes=Green No = **Red**	No
	Are all sensitive conversations and examinations consistently done in a way that ensures privacy (e.g. implementation of soundproofing to prevent conversations from being overheard, physical barriers to protect identities, not conducting sensitive conversations in the waiting area)?		Yes=Green No = **Yellow**	No
	Are building entrances or waiting areas or charts or any other prodcuts / processes labeled in ways that may convey HIV status other clients, staff, or visitors?			No
	Stigma 2 Domain SCORE			**Needs Urgent Remediation**

2, DSD 1 and 2, VTE EID 1, 2 and 3, and Supply 1):

- An introductory question is included to check if the standard applies to the site or not
- For each question (column C), select your responses from the drop-down in column I. The score in column I will autogenerate.
- In case the standard is not applicable, select "***NA***" in ***column I*** to skip the standard. Otherwise, select "***YES***" to proceed to the next question.
- ***NB***: for the ***VLS 2 standard***, "***NA***" can only be applied for ***the last two questions*** of the standard, not for the entire standard.

Example – Testing 1 Domain/Standard

7. **Save and Rename the File**



Testing 1	**Standard 5: All individuals including infants and children seeking care in outpatient, immunization clinics, chronic, and routine care settings are offered HIV testing Services (HTS) privately and confidentially in accordance with the national HIV testing Services or ART Guidelines.**					
	Do the national guidelines/policies INCLUDE National testing algorithms that consist of three serial validated rapid diagnostic tests to confirm HIV positive?	Check **YES** to proceed to next question If no, Check **NA** to skip this standard				Y S
	Is HTS routinely offered to all patients in the STI, ANC, TB, HIV, Nutrition clinics using the national HIV testing algorithm?				Yes=Gr n No = **Re**	ct **Yes** or o for each age category
	Children (0-9					
	Adolescents (10-18					
	Adults (≥19					
	Review the last 10 register entries or charts of clients (per age category) who attended outpatient, immunization clinic and routine care services in the last What percentage of individual c (***Enter Denominator and Nu***		Children (0-9)	Adolescents (10-18)	Adults (≥19)	Autocalculat percentage
	Denominator (# of records reviewed)		10	10	10	<70% = ed 70% - 89 % = Yellow ≥90% = reen
	Numerator (# of records with HTS offered and documented)		1	10	10	
	Children (0-9					1 %
	Adolescents (10-18					1 %
	Adults (≥19					1 %
	Testing 1 Domain SCORE					**Needs Im rovement**

- Use the format:
    - **Minimum Package_SQA Tool_[FacilityName]_[DDMMYYYY].xlsx**

8. **Submit the File**
    - Each facility should submit the complete HSQA tool to the **QI focal leads** for compilation and reporting.
    - Email or upload as instructed. If any items are unclear, include notes in your submission.
9. **Troubleshooting**

Problem	Solution
Color or numeric values not updating	Press Ctrl + Alt + F9 to refresh all formulas
Unable to edit certain cells	Only edit cells in Column I (and Columns D, E, F, G where applicable); others are protected
Score not appearing	For number questions: Ensure you entered only a number (no extra spaces or units, percentage icons or typos)

SQA Summary Tool: Visualization and Reporting Dashboard

The SQA Summary Tool is a companion workbook that aggregates facility-level data to provide a national or sub-national snapshot of service quality across multiple domains. It is also Excel-based and requires no advanced software or connectivity.

Follow these instructions to complete the summary tool:

1. **Open the File**
    - File: **Minimum Package Rapid HSQA _Country HSQA Summary Tool_FINAL**.xlsx
    - Enable macros and content if prompted to ensure calculations work.
2. **Review the "Information and Instructions" Tab**
    - This tab outlines the instructions for completing the summary tool
    - Here, you are also requested to enter basic information
        - Country
        - Number of sites assessed
        - Period of the HSQA exercise
3. **Navigate to the "Sites score entry table" Tab**
    - This is the main data entry sheet.
4. **Review the Layout**
    - Sites – Each site's data will be entered into the specific row
        - Start by entering the name of the site in **row 5, starting in column B**
        - Enter the site scores within the specific rows from **Columns D-AA**
            - Scoring:
                - 1 = Red score
                - 2 = Yellow score
                - 3 = Green score
                - NA = Not applicable standard

- *Domains* – specific domains being evaluated are listed in **Column/ Row D3-AA3**

Sites Score	Corresponding Value
Green	3
Yellow	2
Red	1
Gray	NA

- *Standards* – the standards are listed and numbered in **Column/ Row D4-AA4**
- Overall Score
    - The tool will automatically generate an overall score for each site in **Column AG**
    - The tool will automatically generate the country's summarized score (for each standard) as well as the country's overall score using data across all sites – **in Row**

Sites and Country overall Score	Scoring
Green	>=75% of the maximum score achievable
Yellow	>=50% and <75% of the maximum score achievable
Red	<50% of the maximum score achievable
Gray	Not Applicable (NA)

10. "Review Results Summary" Tab

- This tab summarizes the country results and populates two figures

Figure 1. Overall score by standard illustrative example

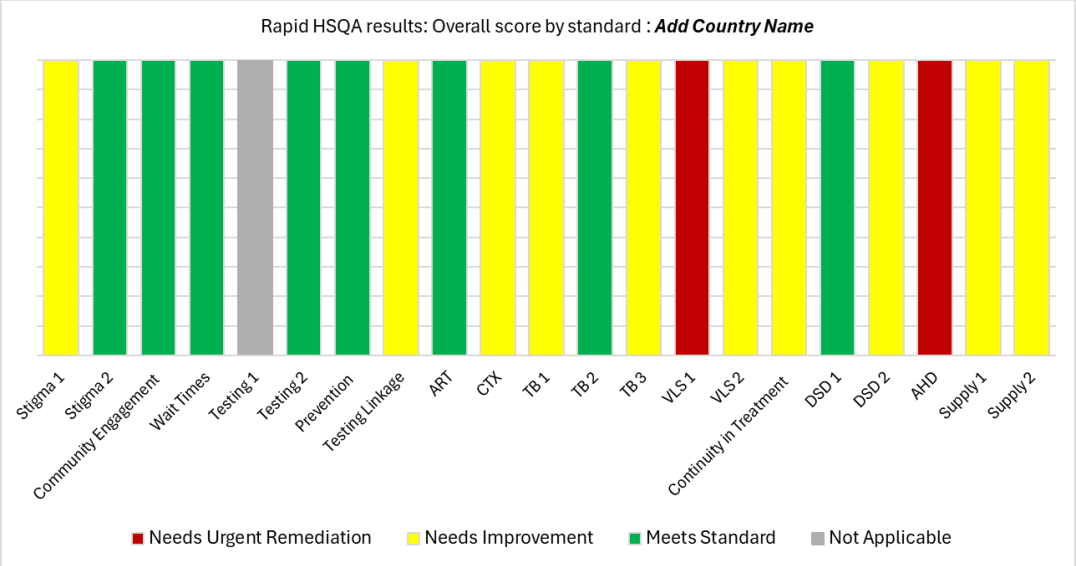
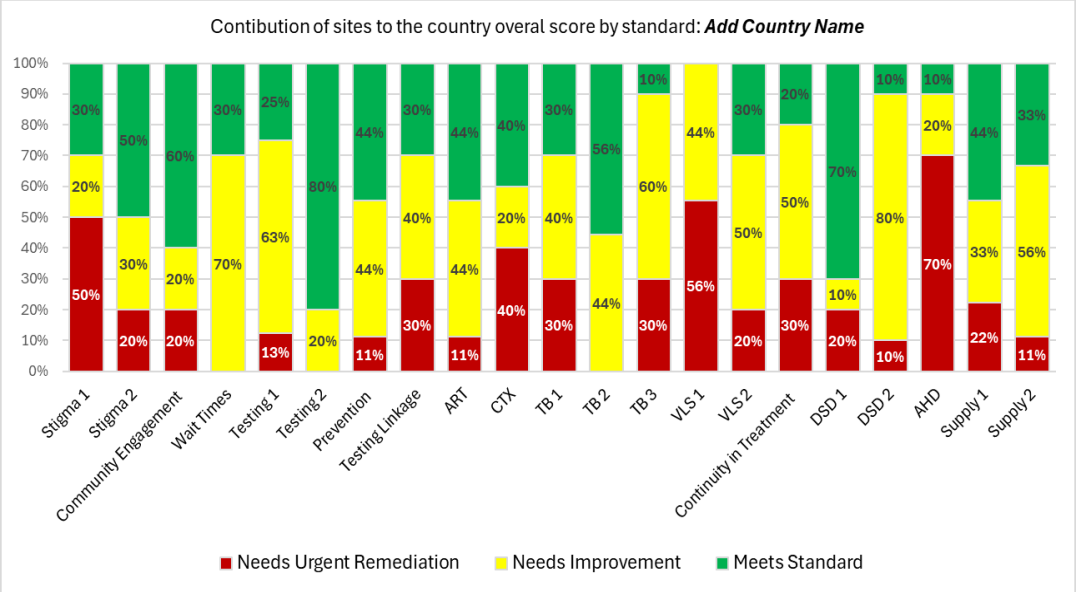


Figure 2. Contribution of sites to the country overall score by standard illustrative example



- Countries should utilize these figures to explore, through QI and collaborative initiatives, the causes and corrective actions for domains, standards, and site levels that have underperformed.
- Countries can share the overall dashboard scores and site-level contributions with CQUIN for technical assistance and support

11. Save and Rename the File

- Use the format:
    - **Minimum Package_SQA_SummaryTool_[Country]_[DDMMYYYY].xlsx**

12. Submit the File

- Each facility should submit the complete SQA summary tool to Dr. Onyekachi Ukaejiofo at ou2122@cumc.columbia.edu
- Email or upload as instructed. If any items were unclear, include notes in your submission.