Toolkit for Improving the Quality of Early Infant Diagnosis (EID) Services:

Tools and Lessons from EGPAF Nigeria's Experience Applying the Program Optimization Approach

December 2023

Johnson & Johnson

Elizabeth Glaser Pediatric AIDS Foundation
Fighting for an AIDS-free generation

Acknowledgments

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) expresses much appreciation to Johnson & Johnson, Inc. for funding the Early Infant Diagnosis (EID) Optimization project in both Taraba and Rivers states of Nigeria.

EGPAF also acknowledges with utmost gratitude the crucial roles of the following stakeholders: The National AIDS, Viral Hepatitis and STIs Control Programme, (NASCP) Federal Ministry of Health of Nigeria, Rivers and Taraba State AIDS and STIs Control Programme, State Ministry of Health, Taraba State AIDS Control Agency, Taraba State Primary Health Care Development Agency, Taraba State Health Service Management Board, Rivers State Hospital Management Board, and Rivers State Primary Health Care Management Board.

Special thanks to Dr. Nguavese Torbunde, Country Manager, EGPAF Nigeria, and Ivan Teri, Associate Director, Program Optimization and Health System Strengthening, EGPAF US, for their technical leadership and valuable contributions. Thanks to Nyakno-obong Okon, Umahi Godwin, and Nimasha Fernando for their contributions to the development of this document.

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Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Virus
ANC	Antenatal Care
ART	Antiretroviral Therapy
CHC	Comprehensive Health Care
DHIS2	District Health Information Software 2
DQA	Data Quality Assessment
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	Exposed Infant Diagnosis
HCWs	Health Care Workers
HEI	HIV Exposed Infants
HFs	Health Facilities
HIV	Human Immunodeficiency Virus
HMB	Hospital Management Board
HSS	Health System Strengthening
IP	Implementing Partner
J&J	Johnson & Johnson, Inc.
MOH	Ministry of Health
MPHC	Model Primary Health Care
MSV	Mentoring and Supportive Supervisory Visit
NASCP	National AIDS, Viral Hepatitis and STIs Control Programme
PCR	Polymerase Chain Reaction
PDSA	Plan Do Study Act
PHCDA	Primary Health Care Development Agency
PHCMB	Primary Health Care Management Board
PMTCT	Prevention of Mother to Child Transmission
PO	Program Optimization
POA	Program Optimization Approach
POC	Point of Care
POS	Positive
QI	Quality Improvement
QI-PM	Quality Improvement Project Monitoring
RCA	Root Cause Analysis
SAPC	State AIDS and STIs Programme Coordinator
SOP	Standard Operating Procedures
TACA	Taraba AIDS Control Agency
TB	Tuberculosis

Introduction

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) is a proven leader in the global fight to end HIV and AIDS, and an advocate for every child to live a full and healthy life into adulthood. Founded through a mother's determination, we are driven to see a world where no other mother, child or family is devastated by this disease. For more than 35 years, EGPAF has been a leader in meeting urgent needs in pediatric HIV and AIDS in the world's most affected regions.

From 2022 – 2023, EGPAF Nigeria implemented the Early Infant Diagnosis (EID) Optimization project, a Johnson & Johnson, Inc. (J&J) funded project designed to increase EID coverage amongst HIV-exposed infants (HEIs). EGPAF worked in close collaboration with health facilities teams and stakeholders including the Nigeria Federal Ministry of Health (MOH), State MOHs, and Partners.

Nigeria Context

In 2020, Nigeria had the second-highest population of children living with HIV (~130,000) globally. Despite the decreasing trend of number of pediatric HIV cases globally in recent years, new pediatric infections in Nigeria increased from 18,000 in 2016 to 21,000 in 2020, and mother-to-child transmission rates remained prohibitively high at >20%. During this same period, EID coverage increased only from 19% to 23%, and was unevenly distributed throughout the country.

To increase overall EID coverage, while also recognizing the potential to scale-up the use of POC for EID in Nigeria, the project selected to work in Taraba and Rivers states to optimize the EID cascade. Eleven comprehensive health facilities across Rivers and Taraba states of Nigeria engaged in the project; three of these comprehensive facilities served as Hub sites for spokes sites. Spoke sites are health facilities that offer patients general primary health care services (e.g., antenatal care (ANC) services, immunizations, general follow-ups and check-ups). Patients that require specialized health services may be referred from a Spoke site to a Hub site. Hub sites offer more intensive care managed by specialized health care workers (HCWs).

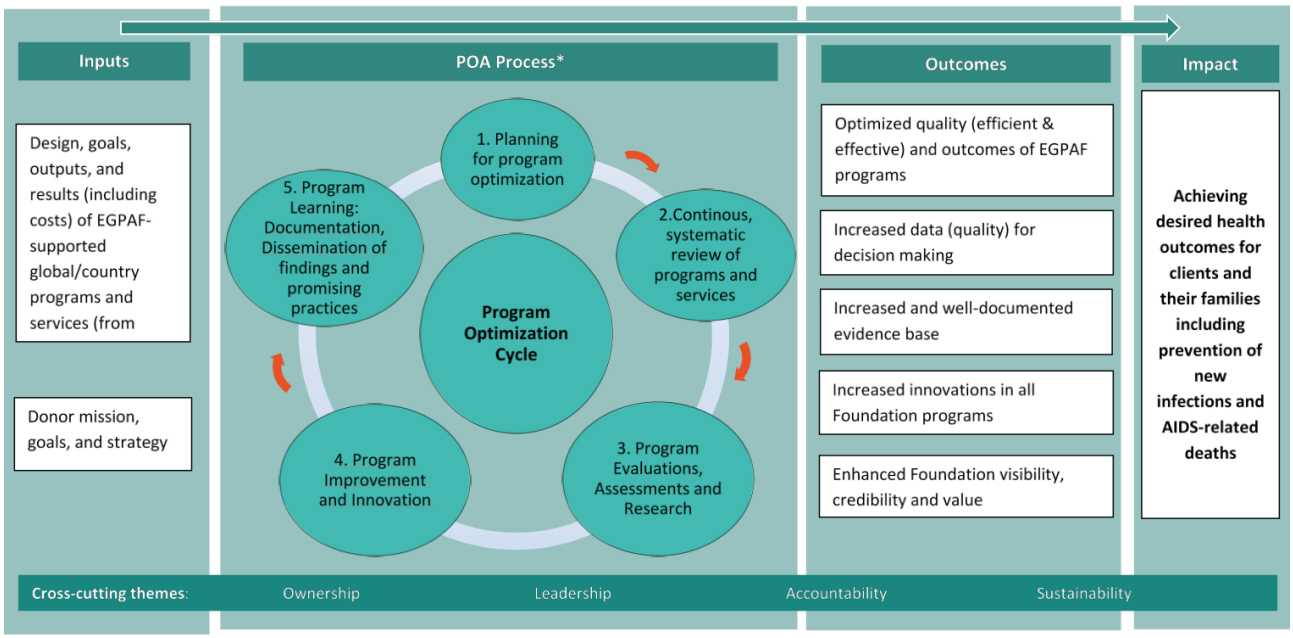
Summary of Project Activities

To implement this project, EGPAF opted to utilize a validated Program Optimization Approach (POA). EGPAF's POA is the application of standardized and continuous use of evidence and improvement science to enhance program design, implementation, quality, and impact. (Program Optimization Approach - Elizabeth Glaser Pediatric AIDS Foundation (pedaids.org)).(Fig1)

POA is a distinct approach and anot simply a continuation of "QI as usual". Specifically, the integration of program assessments / evaluations / data use are emphasized, as is the focus on broader program improvement (raising strategic questions about gaps and deficiencies, collecting and analyzing relevant data, identifying and implementing solutions, documenting impact and disseminating / scaling up lessons learned), which extends well beyond the typical QI focus on facility level health services. Therefore, although both approaches are a form of improvement science the user of this toolkit should note that POA refers to the overall, comprehensive improvement approach whereas QI refers to the more discreet actions taken by QI teams at facility level.

During the project, all health facilities were trained on quality improvement (QI) principles and methods as part of EGPAF's Program Optimization Approach (POA). Coaching was also provided to support the activation or revitalization of facility-based QI teams, and to guide teams to build their skills in how to conduct root cause analyses (RCAs) of challenges with EID services and how to identify interventions to implement and test through QI projects conducted within the facility. QI teams were provided with tools and encouraged to focus on changes and improvements within their power at the facility. By the end of the project, health facilities in both states used POA/QI to scale-up EID coverage in selected health facilities across both states. A total of 20 QI projects were undertaken, 13 in Rivers State and 7 in Taraba State.

EGPAF'S PROGRAM OPTIMIZATION APPROACH (POA) - LOGIC MODEL (FIG 1)



**The POA process cycle is similar to the Plan-Do-Study-Act (PDSA) approach which is a systematic series of steps for gaining valuable learning and knowledge for the continual improvement of a process (The Deming Institute)*

Summary of Project Accomplishments

Overall, the QI projects were successful. QI projects showed measurable positive improvements summarized below (Table 1).

Indicator	Rivers State		Taraba State	
	Baseline	Endline	Baseline	Endline
EID testing at 6 weeks	65%	84%	66%	82%
Turn-around-time for EID results	56%	92%	30%	68%
EID testing 9 months	0%	83%	6%	50%
Final outcome testing at 18 months	75%	87%	51%	69%

Table 1: Comparison of Baseline and Endline Results for Key Project Indicators

Project's Contributions to HSS

While QI at the facility-level was the main focus of EGPAF Nigeria's work, this project also contributed to overall health system strengthening (HSS), especially in two critical areas. Reporting and communication between hub and spoke sites was strengthened as both types of sites worked together on QI projects that leveraged the process of referring ANC clients from spoke sites to hub sites where they could receive more intensive care. Prioritization of EID services were the second key area of HSS as the project included advocacy to stakeholders for support with services and commodities and close coordination with the MOH. This focus on EID services and demonstrated need to dedicate attention to the quality of care offered to mothers and HEI will bolster the health system's focus on these priority populations, thus leading to them receiving more tailored services and not being overlooked by other initiatives within the health system.

Why is EGPAF Nigeria well-positioned to publish this toolkit?

Overall, EGPAF Nigeria's POA project demonstrated that changes tested at the facility-level are powerful and can contribute to strengthening the quality of EID services at the facility-level that cascade to strengthening the health system level as well. Given this success, EGPAF Nigeria believes that if these changes are tested at a larger scale, such as in more states or countries, other health facilities are likely to see similar improvements. The promising results of this project and the team's very recent first-hand experience also justify EGPAF Nigeria's strong position to share their experience and credibly suggest their methods be built upon to replicate similar success in other contexts.

Purpose of this Toolkit

The purpose of this toolkit is to provide other states in Nigeria and other programs across countries with a roadmap, set of processes, and associated practical tools that can be used to replicate implementation of Nigeria's EID POA project which resulted in stronger conventional and POC EID services in two states of Nigeria. By using this toolkit to build upon the foundational experience and lessons learned in Nigeria, other facilities will familiarize themselves with the QI approach's systematic process to make improvement and boost performance (e.g., by learning how to identify gaps in the EID cascade, generate and propose interventions on how to bridge these gaps, conduct QI projects). After adapting these methods to their local contexts and implementing these processes with dedication and fidelity, facilities can reasonably expect to see improvements in the quality of their EID services.

Development of this Toolkit

This toolkit was developed by EGPAF Nigeria, in collaboration with the MOH of Nigeria and participating health facilities based on the experiences and activities in Rivers and Taraba States through the EID POC project supported by J&J. During the project implementation phase, EGPAF QI colleagues compiled their tools and began drafting the SOPs that would form this toolkit. Draft zero of the toolkit was prepared by the end of the implementation period and then shared with health facility QI teams, MOH collaborators, technical reviewers, and other stakeholders during a two-day workshop. Workshop attendees provided inputs to ensure the toolkit's content comprehensively and accurately captured the experience of the EGPAF Nigeria program and provided their recommendations for other facilities intending to implement similar methods.

Use of this Toolkit

This toolkit is designed for other states in Nigeria and other programs across countries implementing PMTCT programs and specifically offering EID services. Any facility offering EID can use this toolkit to improve the services they offer mothers and infants. Facilities that choose to use this toolkit are encouraged to have existing QI teams or reactivate a past QI team to coordinate the processes proposed in this toolkit so that the project will benefit from interdisciplinary contributions of diverse QI team members and a stakeholder will be assigned responsibility for the projects' follow-through. However, facilities without QI teams or who are newly forming QI teams for this project can still use this toolkit to improve their EID services; if there is no active QI team a focal point should be appointed to lead this work (e.g., the PMTCT focal person). Having an active QI team will make the process more effective. Intrinsically, all facilities using this toolkit should internalize the fact that they have the power to effect change through taking small steps within the facility's control that will amalgamate into a greater force of change. With this understanding, any facility can use this toolkit to bring improvement into fruition that will ultimately enhance the quality of care for mothers, infants, and families.

This toolkit serves to accompany the HIV POC Diagnostic Toolkit (HIV Point-of-Care Diagnostics Toolkit available at Children & AIDS (childrenandaids.org). Teams using the toolkit would do well to review the HIV POC Diagnostic Toolkit in addition to this toolkit.

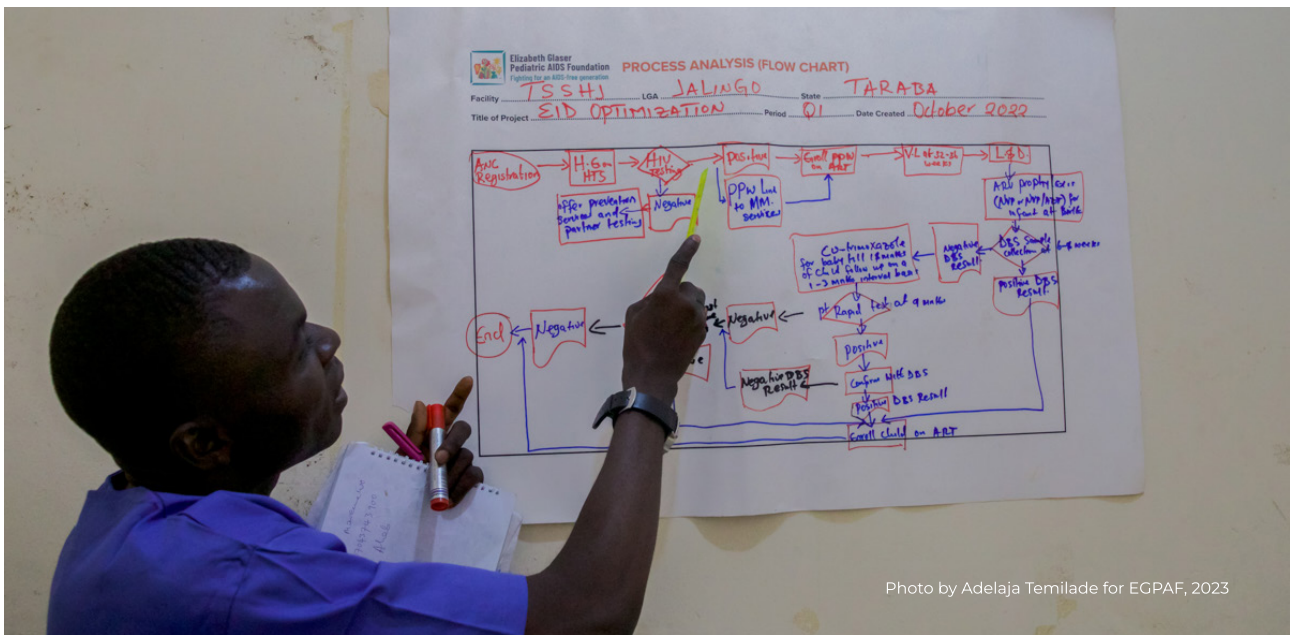


Photo by Adelaja Temilade for EGPAF, 2023

POA/QI Workshop

Rationale

Programs seeking to implement the POA for EID should first hold a workshop for training/ re-training implementers on PO concepts. HF QI teams should attend the training. For HFs without QI teams, they should be a planning to engage with facility leadership to establish QI teams before or after the training workshop, thus their expected QI teams' members should be in attendance.

Content to be covered during the training workshop should emphasize the following topics:

- Pre-Test
- POA Model & QI Principles
- Applying the Plan Do Study Act (PDSA) Cycle
- Overview and Roadmap of POA activities (e.g., Mentoring and Supportive Supervisory Visits (MSVs), QI team meetings)
- Composition of a multi-disciplinary QI Team (e.g., QI lead/state clinical mentor, ART coordinator, pediatricians/pediatric ART focal point, pharmacy focal point, Mentor Mother, PMTCT focal point, lab focal point, pediatric case managers, triage nurse, monitoring and evaluation colleague, adherence counsellor, TB focal point, HIV testing services focal point)
- Other key PO and QI concepts including process mapping, how to conduct a Root Cause Analysis (RCA) of gaps, how to identify and implement interventions through QI projects, how to effectively plan QI projects (e.g., budgeting, outlining implementation plans, how to use data to monitor the QI project)
- Criteria to inform the decision of whether a change has led to an improvement or not
- Tools and Resources to implement a QI project
- Post test

Tools

- **Workshop Agenda** – While planning the POA/QI training workshop, create an agenda outlining the content that should be covered, length of the sessions, and facilitators for each session. See a sample agenda that can be adapted in Annex 1.

- **Training Slides** – PowerPoint slides with the training content should be prepared in advance of the training, then shared with participants after the training. To request a copy of the training slides, please contact the colleagues listed in the Contact Information section.

- **Attendance Sheets** – Keep track of the attendees' names and email addresses or WhatsApp numbers for the purposes of distributing training slides after each day's session, as well as post training monitoring and follow-up for step down trainings and implementation in the respective facilities.

Procedure

1. Create or adapt the POA workshop agenda.
2. Confirm facilitators' availability.
3. Secure a venue.
4. Send training invitations to prospective participants and request confirmation of whether they will attend the training event.
5. Review and adapt the POA tools
    - Each tool that will be used to support POA implementation should be reviewed prior to the training to make sure the tools reflect the current best practices in improvement science and are suitable for the local context. Tools should be reviewed by local QI experts, such as within the MOH or IPs.
6. Prepare or review/ adapt the training slides.
7. Do a dry run / practice run through the training slides and agenda.
8. Prepare all of the training materials and print necessary hard copies (e.g. workshop training agendas for all participants and post and pre-test)
9. Facilitate the training
10. Consider offering a post-training evaluation questionnaire at the end of the training
11. After the training, support attendees to conduct a step-down training on QI with other HCWs at their facility.
    - Step-down trainings should be held as soon as possible after the workshop at a time convenient for the majority of staff at the facility (e.g., afternoon hours when the majority of clients have left the facility). If any attendees are transferred out or leave their HF, these trainings ensure QI knowledge is retained at the HF.
12. During MSVs, ensure QI teams are actively implementing projects according to the training provided (behavior) and, where possible, attaining desired results.

When to Complete

The POA/QI workshop should be preferably held before teams are set to begin implementing POA so that they will have all of the skills and tools necessary for successful implementation. Start planning the training at least three weeks in advance so there is sufficient time to prepare materials and coordinate with speakers.

Other Recommendations & Considerations

- When planning the resources and budget for the workshop, consider how to ensure timely payment of workshop attendees (e.g., for per diems and transport allowances).
- Include members of the MOH in the workshop as speakers and attendees. Involvement of MOH in planning and facilitating the POA/QI workshop is key for their buy in and ongoing support of the POA projects.
- Facility QI lead should inform the EID project Lead at least two weeks before the meeting/ trainings to facilitate approval and technical support.

SOP on Conducting a Baseline Assessment

Rationale

The baseline assessment provides sites with an understanding of their starting point and current state before implementing POA. This baseline data is valuable because they are the points against which progress will be measured. Without baseline data, projects will not have a firm, quantifiable understanding of their existing strengths and gaps, and will also not be able to fully appreciate the improvements they will be making and that will be evident from comparison of baseline to endpoint results.

Tools

- **Baseline Assessment Data Collection Tool** – The purpose of this tool is to collect all necessary data points from sites in order to assess their baseline performance on EID services. This baseline data will serve as reference points to assess change and the key performance indicators the POA project will aim to address. The tool should specify the areas of assessment and how the data should be collected, including the source of each data point and reporting periods to increase fidelity and consistency of reporting across sites. When feasible, the data collection tool should be digitized (e.g., Excel-based or on a digital application such as DHIS2 or KoboCollect). To request a copy of the baseline assessment data collection tool, please contact the colleagues listed in the Contact Information section.
- **Baseline Assessment Analysis Plan** – Even before baseline data is collected, an analysis plan should be created. Creating this plan will allow the project to have the foresight to dedicate sufficient time and resources towards that analysis of the baseline data needed to extract as much meaning as possible from the results. When possible, the analysis process should also be digitized or automated (e.g., data visualizations that automatically update when data is entered). Keep in mind that baseline assessment and endpoint assessment results will need to be compared, thus analysis tools can be designed with this future comparison in mind.

Procedure

1. Understand the areas or units that require assessment
2. Create or adapt the baseline assessment data collection tool including indicators
3. Pilot the data collection tool to determine if it collects the required information and is user-friendly.
4. Revise the data collection tool based on feedback from the pilot exercise.
5. Train data collectors on using the data collection tool.
6. Support sites to conduct the baseline assessment and monitor data quality.
7. Conduct the data analysis according to the analysis plan.
8. Share the results back with sites in a timely manner.
9. Get feedback from other sites on the shared results.

When to Complete

The baseline assessment should be one of the first activities of the POA project and preferably be completed before sites have started implementing POA for better evaluation of outcomes. The assessment can be completed before the POA/QI workshop to enable sharing of the baseline assessment results during the training. Sharing data during the training will foster a better understanding of the gaps to inform the RCA being conducted.

Other Recommendations & Considerations

- Consider results of the baseline assessment alongside results of the initial DQA. If the DQA reveals challenges with accurate documentation and reporting of data, the results of the baseline assessment may reflect these same challenges. In the case of data collection or data quality challenges, annotate and caveat the baseline assessment results with these concerns.

SOP on How to Conduct a Collaborative, Rapid Root Cause Analysis of EID Utilization

Rationale Tools

- **Fishbone Diagram:** When completing the fishbone diagram, team members are asked to discuss the different types of factors that may be contributing to a particular problem or outcome. Teams are encouraged to use the 5 Whys approach, meaning they ask Why five times to unmask a problem, dig below the surface of the issue, and uncover the underlying root cause.

- **Process Maps:** Process maps visually depict the flow of work and the steps and people involved in a healthcare process. These maps are also commonly referred to as flowcharts or workflow diagrams. Organizations or teams use this tool to gain a better understanding of a process and to improve its efficiency

Procedure

1. Form a multi-disciplinary team of different cadres and persons with experience with the process or outcome of interest.
2. Draw the current process map illustrating the steps of the current process that are contributing to the outcome or problem. See a process map template in the EID Tools
    a. Define the process to be diagrammed. Write its title at the top of the template.
    b. Discuss and decide on the boundaries of your process: Where or when does the process start? Where or when does it end? Discuss and decide on the level of detail to be included in the diagram.
    c. Brainstorm the activities or steps that take place. Write each on a piece of paper. Focus on the steps of the current process, not how the process is supposed to happen.
    d. Arrange the activities or steps in proper sequence according to how they actually happen, not how they should happen.
    e. When all activities/steps are included and everyone agrees that the sequence correctly reflects how the process currently happens, draw arrows to show the flow of the process.
    f. Review the flowchart with others involved in the process (workers, supervisors, community, clients) to see if they agree that the process is drawn accurately and reflects reality.
3. Draw the desired process map illustrating the ideal steps of the process that are contributing to the outcome or problem. Repeat steps 2a – 2f above.
4. Compare the desired and current process map, focusing on the steps that are different.
5. Draw the fishbone diagram. See a fishbone diagram template in the EID Tools
    a. Agree on a problem statement (effect). Write it at the center right of the template which represents the head of the fish.
    b. Brainstorm on the major categories of causes of the problem. If this is difficult or too time consuming, use these generic headings:
        i. Methods
        ii. Machines (equipment)
        iii. People (man/woman power)
        iv. Materials
        v. Environment

vi. System (Management)

vii. Process

viii. Write the categories of causes as branches from the main arrow.

c. Post the completed process maps and fishbone diagram on the health facility walls as visual reminders of the ongoing improvement priorities.

When to Complete

Teams should complete their root cause analysis during planning and brainstorming, before project implementation as the results from this exercise will inform which factors and which parts of the process their improvement efforts should focus on.

Other Recommendations & Considerations

- When conducting an RCA, teams should avoid assumptions about why a process works or does not work and avoid assumptions about which factors are the root causes of a problem. Teams should also avoid blaming an individual for a challenge or bottleneck; all individuals are part of the system and the system is what has produced the results, not the individual.
- Teams should be encouraged to take a systems-thinking perspective to the RCA process. All systems are perfectly designed to produce the results they yield; thus, the issues in the system or process must be identified.
- Facilitators of the RCA process should encourage teams to dig deep and think beyond the surface-level factors that are easily visible and easy to blame for the problem.

SOP on How to Conduct a DQA

Rationale

After a series of QI project implementation and data collection, there is a need for a DQA. During the DQA, the team will visit the facilities to assess the quality of the data collected. This includes checking data for completeness, accuracy, consistency, validity, timeliness and alignment with the prescribed data collection and reporting process. Accurate data is important because this data will be used to identify gaps that teams will work to improve and track their progress on improvement over time; low-quality data may lead teams to miss gaps that need attention or lead them to incorrect conclusions about which projects contributed to an improvement or not.

Tools

- DQA tool: Colleagues evaluating data quality at sites should bring a DQA tool (in form of checklist) and extract of the facility reported data for concurrence that will evaluate data quality and lead to a determination about how strong EID data is at that site. The tool

should assess the quality of data from all the data points needed to calculate the EID key performance indicators that projects will aim to improve. The data points include HEI registration, EID test done, EID result received EID POS linkage to ART, rapid testing at 9 months and Final outcome at 18 months.

Procedure

1. Select which project indicators will undergo a DQA based on the gap identified.
2. Inform sites and other relevant stakeholders of the dates when the DQA will be performed and which indicators will be included
3. Desk Review: Conduct a review of all relevant and available documents related to the QI project indicators before going to the field to verify data.
    - For QI project indicators that have previously undergone a DQA, the focus should be on documents and data that have been created and collected since the previous DQA was conducted.
4. Prepare the DQA tool or adapt an existing tool.
5. Train colleagues on how to use the DQA tool
6. Field Review: Conduct the DQA by visiting the health facilities where the EID program is being implemented to observe and review data collection tools like registers, forms and quality improvement journals (photos, survey or polling data, curricula for trainings, minutes of meetings and attendance). Complete the DQA tool during the site visit.
7. Compile results of the completed DQA tools
8. Identify errors or weaknesses in data quality that need to be corrected and improved
9. Create action plans that sites can use to improve their data quality
10. Communicate and share findings to relevant stakeholders in the state
11. Continue to monitor data quality overtime to ensure continuously improving quality

When to Complete

DQAs should be completed at minimum once during the EID POA project and preferably quarterly to monitor data quality over time.

Other Recommendations & Considerations

- The state (MOH) should be actively involved in all DQAs activities for the purpose of ownership and sustainability.
- A copy of the DQA checklist should be retained in the facility.

SOP on How to Document & Monitor QI Projects

Rationale

Since QI is a framework for a systematic improvement of quality of care, it is important to ensure that all steps, processes, approach and tested changes are documented for the purpose of effective monitoring of the tested changes using a set(s) of indicators. A QI Documentation Journal is a hardcopy tool for use by facility-based QI teams to document QI projects in their facilities. Upon completion and review of the QI Documentation Journal by the facilities, there is also a need to have an electronic version of the documentation, which was being done using the QI-PM.

Tools

- QI Documentation Journal – See a QI Documentation Journal template in the EID Tools. A sample of QI project documentation is shown in Box 1.
- QI-PM – EGPAF's digital application for documenting and monitoring health facility-based QI projects.

Procedure

1. Build sites' capacity on QI documentation using QI Documentation Journals and/or QI-PM or another digital tool.
2. Sites complete their documentation and update it at least monthly.
3. QI Technical Officers reviews documentation and monitors it at least monthly.
4. Provide feedback to sites about the quality of their documentation and reporting so that it continuously improves.

When to Complete

- QI Documentation Journals or digital documentation of QI projects, such as using EGPAF's QI-PM tool, should be updated at least weekly. Once the project is complete, the documentation should be finalized so the project's methods and data can be preserved.
- A QI Officer should monitor all QI projects at least monthly. If QI projects are being documented in paper-based QI Documentation Journals, the QI Officer can request that sites share copies of their journals by taking pictures of the pages and sharing them through WhatsApp, SMS, or email. If QI projects are being documented electronically in the QI-PM app, the QI Officer can review this documentation on the QI-PM application's in-built Dashboard and the PowerBI Dashboard which aggregates and visualizes data from all projects documented in QI-PM. QI Documentation Journals should also be reviewed in-person during MSV trips.

Other Recommendations & Considerations

- If documentation in QI Documentation Journals or in QI-PM is insufficient or if sites express challenges completing timely and accurate documentation, consider holding a Link & Learn Session. During this session, sites can engage in documentation-focused capacity building sessions, work directly in their QI Documentation Journals, and aim to leave the session with a stronger Journal and documentation.

Box 1: Sample QI Project

QI Project Title: Improving dried blood spot (DBS) sample acceptance for Federal Medical Center Jalingo at the PCR lab by training HCWs on proper DBS Sample collection

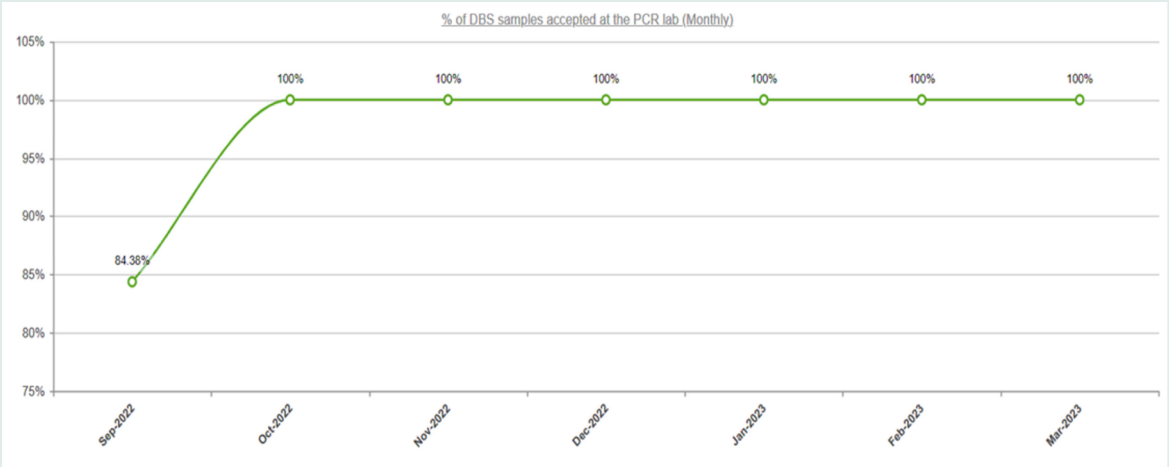
Problem Statement: Because DBS samples were improperly collected by the HCWs at Federal Medical Center Jalingo within the period of October 2021 to September 2022, out of the 96 samples collected within the said period, 15 samples were rejected. This rejection of samples affected HEIs in the sense that their status cannot be determined on time thus affecting the goal of EID for the affected HEIs. In view of this, the facility sought to train HCWs on proper EID sample collection with the aim of seeing meaningful improvement in samples acceptance rate at the PCR lab.

Period	*Denominator	*Numerator	*Percentage	Annotation
Sep-2022	96	81	84.38%	Baseline Data (Oct 21 - Sep 22)
Oct-2022	19	19	100%	
Nov-2022	22	22	100%	
Dec-2022	8	8	100%	
Jan-2023	10	10	100%	
Feb-2023	17	17	100%	
Mar-2023	14	14	100%	

***Denominator** = Number of DBS samples sent to the PCR lab for EID testing

***Numerator** = Number of DBS samples accepted at the PCR lab for EID testing

***Percentage** = Percentage of DBS samples accepted at the PCR lab for EID testing among those sent to the lab



SOP on How to Conduct an MSV

Rationale

As part of efforts to ensure adoption of QI initiatives by the facility teams, an MSV is important in order to assess facilities' progress, provide additional hands-on coaching, and continue establishing strong lines of communication with stakeholders. During the MSV the team can ensure the formation and strengthening of the QI team and iterate the need to adopt the QI/POA approach for improving healthcare services in the facility while also ensuring that the QI team steps down the QI concepts learnt during trainings and workshops. Also, during the MSV, the team can assess the quality of data, strengthen collaboration with stakeholders, offer onsite mentorship to facility HCWs, and review progress made on the project.

Tools

- MSV Scope of Work, Agenda, and Objectives: See a sample MSV Scope of Work, Agenda, and Objectives in Annex 2.A.
- MSV Budget: The budget for the MSV should include, at minimum, the following items: transport costs, lodging if an overnight stay is required, per diems for all participating staff if an overnight stay is required, and printing costs to bring paper-based materials to sites.
- MSV Report Outline: See a sample MSV Report Outline in Annex 2.B.

Procedure

1. Prepare the scope of work and share with the relevant stakeholders for adoption. This includes the objectives of the MSV, dates for the activities, responsible persons, and facility visit schedules.
2. Draw up a budget for the MSV and submit for approval and release of funds.
3. Embark on the MSV, starting with an in-brief and ending with a debrief with the relevant stakeholders.
4. Submit report for the MSV upon completion outlining the success, challenges, gaps, action items and next steps.
5. Follow up on the next steps from the MSV.

When to Complete

- MSVs should be done quarterly; however, as the needs arise, they can be done bi-monthly or monthly.

Other Recommendations & Considerations

- MSVs should invite representatives from various stakeholders, such as the State MOH or local government. These representatives may be able to resolve challenges or root causes of an issue during the MSV itself, such as by delivering commodities or contacting other colleagues for clarification on a process.

- Communication with sites must be sustained between MSVs, especially to follow-up on next steps and action items agreed upon during the visit.
- There should be cross learning of best practices between the facility staff during the MSVs visit. For example, one HCW from a particular health facility can participate in the MSV to another health facility.

SOP on How to Conduct a Link & Learn Session

Rationale

As the facility QI teams are activated, and QI meetings are held monthly, the QI teams are able to identify areas where improvements are needed for optimization of the EID activities in the facilities. As such QI projects are initiated by the respective facilities' QI teams with the aim of bridging existing gaps and scaling up performance for optimal EID utilization in the facilities. In view of this, there will be need for the respective QI teams to link and cross learn from each other by sharing experiences on the various innovative strategies adopted and used by health facilities implementing QI projects. Linking and cross-learning will improve knowledge of QI and its application as a PO approach.

Types of Link and Learn

- Mentees across different facilities coming together to link and learn
- One mentee facility coming to the best performing facility to link and learn

Procedure

- Physical visit to the facility that performed the QI project for mentoring
- Feedback from the mentee facility

Tools

- Link & Learn Session Agenda and Objectives: See Annex 3 for a sample of a Link & Learn Session agenda and objectives.
- Link & Learn Session Slide Set: Slides should walk attendees through content for the session in an engaging and interactive manner. To request a copy of the Link & Learn Session slide set, please contact the colleagues listed in the Contact Information section.

Procedure

1. Choose the type of Link & Learn session that will be held.
    - Session Type A: Mentees from different facilities come together during one session.
    - Session Type B: The QI team from one facility visits a high performing facility to learn from their approaches.

2. Prepare the concept note and share with the project lead for approval. This includes the rationale, objectives, participants, budget amount, proposed venue and dates for the activities.
3. Draw up a concise budget for the activity and submit for approval and release of funds.
4. Plan all logistics arrangement.
5. Prepare slides and share for adoption.
6. Carry out the activity.
7. Submit report for the link and learn session upon completion outlining the success, challenges, gaps, action items and next steps.
8. Follow up on next steps from the link and learn session

When to Adopt Link and Learn

Consider offering a Link & Learn session when there is a topic all facilities would like to learn more about or an area many facilities need to strengthen, such as improving documentation of QI projects in QI Documentation Journals. Also, consider offering a session when new QI projects or equipment are introduced. Sites should have some degree of QI implementation experience in order for the session to be fruitful.

Other Recommendations & Considerations

- Sessions should be very practical. By the end of the session, sites should leave with reinforced skills or knowledge that gives them the confidence to know they can improve a specific area.
- Sessions should also be productive, and sites should leave with tangible evidence of their improved skills or knowledge. For example, if the topic of the session is improving documentation in QI Documentation Journals, sites should leave the session with stronger documentation in their own QI Documentation Journals.
- Consider offering an evaluation at the end of the session to receive feedback from sites on whether they have effectively gleaned new knowledge from interacting with other sites.
- Although sessions focus on making an improvement in a certain area, sites should also leave sessions with an understanding of what they are doing well so that they do not become discouraged and feel their good work is appreciated.
- QI team members from other sites who are performing well in a certain area can serve as Link & Learn Session co-facilitators or coaches for other sites so they can share their hands-on experience to strengthen the collaborating sites.

SOP on How to Conduct the Endline Assessment

Rationale

The endline assessment provides sites with an understanding of how far they have progressed since their starting point and beginning POA implementation. Without endline data, projects will not have a firm, quantifiable understanding of their changes over time, and will also not be able to fully appreciate the improvements they have made since the baseline.

Tools

- **End line Assessment Data Collection Tool** – The purpose of this tool is to collect all necessary data points from sites in order to assess their end line performance on EID and evaluate the project using the key performance indicators the POA project aimed to address. Consider duplicating the baseline assessment tool so the same data will be collected and can support baseline – endpoint comparisons. The tool should specify how the data should be collected and the source of each data point to be collected to increase fidelity and consistency of reporting across sites. When feasible, the data collection tool should be digitized (e.g., Excel-based or on a digital application such as DHIS2 or KoboCollect). To request a copy of the endline assessment tool, please contact the colleagues listed in the Contact Information section.

- **End Line Assessment Analysis Plan** – Even before endline data is collected, an analysis plan should be created. Creating this plan will allow the project to have the foresight to dedicate sufficient time and resources towards that analysis of the endline data needed to extract as much meaning as possible from the results. When possible, the analysis process should also be digitalized or automated (e.g., data visualizations that automatically update when data is entered).

Procedure

1. Begin preparing for the endline assessment by creating or adapting the end line assessment data collection tool.
2. Provide each site with a copy of the tool and support them to complete the assessment.
3. Conduct the data analysis according to the analysis plan.
4. Share results back with sites in a timely manner.
5. Share the challenges encountered and solutions preferred with other sites.
6. Request feedback from other sites on the results shared to support interpretation of the results and to inform next steps.

When to Complete

The endline assessment should be one of the last activities of the POA project and preferably be completed soon after sites have finished their POA projects. The assessment should be scheduled with enough time for data collection and analysis before final reports are due and before dissemination meetings are held.

Other Recommendations & Considerations

- Consider the results of the endline assessment alongside results of the last DQA. If the DQA reveals challenges with accurate documentation and reporting of data, the results of the endline assessment may reflect these same challenges. In the case of data collection or data quality challenges, annotate and caveat the endline assessment results with these concerns.

Photo by Adelaja Temilade for EGPAF, 2023

Other Guidance & Considerations

A) Considerations for QI Coaching

A.1) We are preparing our team of QI coaches. What tips do EGPAF Nigeria QI coaches have for other QI coaches?

- The primary aim of coaching HFs implementing QI is to equip the HF team with skills to improve performance in any area they choose.
- Coaches working with teams new to QI should start by coaching teams on how to draw process maps of the area they seek to improve and how to complete the fishbone diagram as part of root cause analysis.
- Coaches should teach the team how to document QI accurately as well as review the documentation made.
- Coaches should encourage and ensure the QI team meets regularly at the facility.
- Coaches should do frequent follow-ups on the team through the QI project period to ensure the various steps are understood by the team and they are able to replicate it on another project.

A.2) Our team of QI coaches is preparing to start coaching. What do the EGPAF Nigeria QI coaches wish they knew before beginning to coach QI teams?

- Get a team of very interested / committed HCWs in place who are passionate about making change
- Gather your resources, including your tools (e.g., fishbone diagrams, process maps, QI documentation journals, and other tools for implementing QI) so that you will be well prepared to coach teams from the start of the QI implementation process.
- Integrate QI into the daily activities of HCWs so that as they are implementing, they are doing QI as part of their daily activities, not just focused on the QI projects
- Ensure the QI team meets regularly at the facility
- Ensure the QI team has wider knowledge of tools and methodology for QI
- Encourage teams to develop ideas and strategies using the QI tools
- Encourage teams to regularly update their QI Documentation Journals so that progress made can be documented
- During QI team meetings held at least monthly but preferably weekly, offer reminders about documentation
- If the QI project will take ~1 month, then offer reminders weekly to update the QI documentation journals

- *Review QI activities that have been carried out, including the tested changes, data, etc.
- Review of QI activities should be done 75% through the implementation process for projects ~1 month in duration. For projects that will take more than 1 month, review can be done at half-way through implementation and at 75% through the implementation process.

A.3) Our health facility-based QI teams are new to QI documentation. What suggestions does the EGPAF Nigeria team have for coaching health facility-based QI teams to have strong documentation of QI projects?

- Training on QI project documentation must be held first so that attendees understand what "documentation" entails.
- Provide facility teams with documentation tools (I.e., QI documentation journals) and remind teams to document their QI activities regularly. Documentation should not just be updated, but it should be reviewed regularly (e.g., indicators, progress) to know where the project is and where it ought to be. It is one thing to have documentation and another thing to make use of the documentation while the project is still in progress.
- Ensure the QI project data is properly stored and that there is always a source documented noted and data is from the correct source document. This is why DQA is very important to validate the data the facilities have collected, check the source document against the journal. The journal includes space to record the source document. Triangulate the source document with the journal. Data validation is also important during documentation to ensure data are reliable and accurate. Before finalizing documentation in the journal, data must be validated.

A.4) Our facilities have already started documentation, but there is room for improvement. How do we coach facility-based QI teams to improve their existing QI documentation?

- Improving documentation to encourage QI teams that have already started documentation:
- Schedule a periodic meeting solely focused on documentation (e.g. General Hospital Bali, held a virtual meeting (could have been in-person) to review the QI documentation journal. During this review areas for improvement were spotted.)
- Work with the team to identify areas that are not being documented properly. Then provide coaching on proper documentation and allow the team to re-document and revise their documentation before reassessing their documentation.
- Identifying poor documentation that could be improved: Show examples from fellow facilities previously completed documentation journals to illustrate proper documentation and documentation that can be improved. Examples of completed documentation journals from other facilities or countries should be available for reference.
- Ensure QI coach themselves are trained and very conversant with documentation so they can spot good documentation when they see it.

A.5) I am a QI coach. How do I spot good QI documentation in comparison to documentation that could be improved?

Good documentation must have the following:

1. Strong project title should be concise and meaningful, not just restating the project (e.g., Poor EID Coverage)
2. Strong problem statement answering why you are implementing the project.
3. Improvement Aim is an area where many facilities have trouble. This should always seek to cover the gap between performance and the desired targets. It should also specify the scope and goals that are SMART, (specific, measurable (e.g., numeric targets that are percents or counts),, achievable, realistic and time-bound (e.g., 1-month)). Example: Improve 9m EID testing from 46% to 95% within 1-month through SMS reminders and home-based tracking --> Includes a numeric goal and guidance on how it will be realistically achieved.
4. Indicators – good documentation must have properly written outcome indicators which seeks to know how the improvement aim has been achieved at the end. Numerator and denominator descriptions should be included.
    - Denominator at the start of the project should remain the same throughout the duration of project implementation.
    - Numerator will change month-to-month. Specify if the numerator is cumulative or a snap-shot. Track the percentage progress over time.
    - For example, if the numerator is 4 in month 1, then by month 2 there are 5 new clients tested, then the numerator for month 2 is (4+5) = 9.
5. Run Charts – Good documentation must have clear data and a clear visual representation of that data.
6. Graphs should have a title. Data should be collected over a period of time (e.g., 1-month), there should be a proper plot.
    - The target is working towards the denominator and numerator being the same and decreasing or eliminating the gap. Result of 20/20 = 100% which will be very clear on the graph.
    - Change over time should be clear.
    - Confirm if the facility team is comfortable plotting points on the graph.
7. Check that the improvement plan section is properly filled for many facilities

A.6) Our facilities have been trained on QI documentation and now have ongoing QI projects but have not yet started documenting their work. What should we do as QI coaches to encourage documentation of ongoing work?

- For facilities that have not started documentation, there is a need for more training on QI documentation. Physical training is preferred for maximum attention, instead of a virtual session where attendees' attention may be divided.

- Onsite mentoring and supervision should be carried out by the QI coaches.
- QI documentation journals should be made available in the facility.

B) Considerations for Health Facilities Implementing QI

B.1) Our health facilities have many competing interests and many activities other than QI. How do I encourage facilities to undertake QI activities as a priority?

- QI team should be comprised of the QI lead or coordinator and other heads of different thematic areas in the facility who have shown high interest in QI activities.
- Have a clear objective of the QI activity that you want to implement and a clear goal of what you want to achieve. This will help keep teams focused and clearly identify improvement based on the findings. With this clear objective, the team can identify gaps, lessons, improvements, and details after planning and implementation.
- During QI meetings, EID should be discussed as a priority. Each QI meeting should have a clearly defined agenda for what you want to discuss concerning EID and its components (e.g., today's meeting is about EID) -- the agenda should clearly identify EID as a topic for discussion.

B.2) A health facility or health facility staff member says they are too busy for QI. How can I respond to encourage them to prioritize QI?

- If a facility says they are too busy to implement QI:
    - The QI team consists of a few focused members and is comprised of focal persons for key units in the facility. This small team can meet to discuss QI on behalf of their broader teams. Where the QI team is very small (e.g., 5 – 10 staff members).
    - Best way is to integrate QI into their daily activities at the facility. For example, facilities have a to-do list and list of their normal activities. Each activity, no matter how small, requires the facility to meet to discuss general matters and normal activities. QI can be integrated by seeking how to improve these general activities and the routine services provided at the facility (e.g., EID). EID is something the facilities are already doing. During day-to-day activities, facility teams can implement QI tools and practices (e.g., drawing RCA and process maps) then as each person carries out their work they are thinking about improving performance.
    - Unit heads should be encouraged to delegate QI tasks to team members in order to improve optimal reporting and completion of tasks.
    - The QI team should have a functional WhatsApp platform where minutes and other deliverables can be shared.
    - If I am a doctor, I know one challenge with orientation of clients, I can sensitize the client on ANC, VL testing, prophylaxis, and other things that are involved in properly following the EID cascade for quality services for clients.
    - If I am in the lab, the lab can make requests for regular stock level before stock-outs occur or stock redistribution from nearby centers so that no process is interrupted by lack of supplies.

- During facility meetings, discuss areas where improvement is still needed and follow the QI cycle to make improvements in different departments. Check the data, follow the process and cycle to continue implementation. Review results again at the next meeting.
- Each person should take note of gaps and challenges, such gaps and challenges can be discussed during facility general meetings where solutions can also be generated. After meetings, colleagues can work to implement the solutions in their respective departments. For example, in a facility there are a few pregnant women who when they register for ANC they do not go for HIV testing. The facility adopts a process whereby when a client registers for ANC, the client is referred for HIV testing and the client is given a note to take to the lab, the lab reports the HIV status on the note, then the client returns the note to the ANC clinic to continue with services. Performance was improved through this modification and improvement in the clinic process.
- Seeing the gap, generating a solution, and implementing the solution will become part of the general mindset at the facility.

B.3) We are working with health facilities new to QI. What recommendations do you have for health facilities undertaking their first QI project?

- Learn from the work of other facilities who have strong QI teams and active QI projects.
  - If a health facility wants to identify a facility to learn from, they should communicate with their QI advisor whose role includes sharing lessons and promising practices across facilities and stakeholders.
- Identify your QI advisor and stay in close coordination.

- Each QI facility should be assigned a QI advisor who is an expert in QI (e.g., a QI expert at another health facility, the supporting IP, or within the MOH). This QI advisor should be available to answer any questions the facility has about QI tools and best practices.

- Close coordination between the QI advisor and facility can be facilitated by creating clear communication channels (e.g., deciding on whether WhatsApp, email, or phone calls) are preferred methods of communication and scheduling standing check-in meetings.

- The QI advisor and the health facility QI team lead maintain a shared responsibility for remaining accessible and communicating in a way that is strong for both parties.

C) Considerations for Documenting and Reporting on QI

C.1) We need to report about our QI activities to a donor. What recommendations do you have for reporting on QI to a donor?

Also consider how familiar your donor is with QI and tailor your reporting to their level of QI experience. For example, if your donor audience is not very familiar with QI, your report or presentation could begin with a brief refresher on the key QI principles and tools implemented

so that the audience will have this strong understanding then be able to well understand the result and accomplishments you will present.

When reporting QI activities to a donor, reports should include;

1. Provide overview/background of the QI project
2. State QI project topic
3. State the problem
4. Aim statement
5. Root cause analysis
6. Target achievable
7. Timeline
8. Documentation of project outcome
9. Summary/conclusion

C.2) QI Documentation Journals are not being completed. How can we encourage strong documentation?

Sites can support each other to produce strong documentation and hold each other accountable for documentation. To motivate sites to complete or strengthen documentation, reiterate the importance of documentation in preserving a site's knowledge as part of their internal memory and for capturing this experience so their lessons can be shared with other sites. Emphasize that strong documentation during the QI project is easier than leaving all documentation for the end of the project which could be overwhelming.

1. Emphasize on the need to document QI project in real time
2. Provide training on the process of documentation
3. Provide necessary tools for documentation or reporting
4. Do a peer-to-peer learning review of facility reporting i.e., draw example from other facility documentation
5. Provision of reporting format for QI journal
6. List the names of responsible persons involved in the QI project.

Other Cross Cutting Considerations

- This toolkit will remain valuable even after the QI planning process. During the QI implementation process, refer back to this toolkit to reflect on the considerations above. These considerations will take on stronger meaning as teams become immersed in QI implementation and the practical examples included will be of greater value as teams find themselves in the same situations with similar questions.

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Annex 1:
POA Workshop Materials

Annex 1.A: Sample POA Workshop Agenda

Program Optimization Approach (POA) Workshop
To analyze gaps and identify solutions to EID cascade

Workshop Objectives:

1. Learn and utilize program optimization skills by completing I) process mapping exercise and II) root cause analysis on the EID cascade, informed by data and evidence
2. Create a list of key gaps and barriers in the EID cascade to inform the group's agreement on the state of EID, focusing on the state of the existing conventional systems.
3. Brainstorm evidence-based solutions and agree upon promising solutions to be piloted in the state and selected health facilities.

DAY 1

Start	End	Activity / Topic	Presenter/ Facilitator
08:00	08:05	**Welcome**	
08:05	08:20	**Introductions**	
08:20	08:35	**Opening Remarks, Goodwill Messages and Overview of Workshop** • Opening Remarks: • Goodwill Messages: • Overview of the workshop's purpose, objectives, and agenda	
08:35	08:45	**Icebreaker** • Participants complete an activity to get acquainted with other participants	
08:45	09:00	**Setting Expectations and Pre-test** • Each participant writes expectations for the workshop on post-it notes and the group synthesizes 3-4 common expectations. • Pre-test for all participants	
09:00	10:15	**Overview of the EID Cascade and Current Processes** • Overview of PMTCT/EID National Guideline (including PMTCT pillars, EID testing protocol, HEI ARV Prophylaxis) • Presentation on National PMTCT/EID Cascade Data (comparing achievements vs targets) • Presentation on State PMTCT/EID Cascade Data (comparing achievements vs targets)	
10:15	10:45	**Morning Tea Break**	
10:45	11:00	**Data Review** • Review of the EID Baseline Assessment data	
11:00	11:45	**Introduction to Quality, Quality Improvement, PDSA, and Program Optimization Approach (POA)** • Overview of quality, quality improvement, and Plan Do Study Act Cycle • Introduction to POA concept, key steps, and relevant tools • Explanation of how the POA approach will drive the EID activity and the workshop's activities	

Start	End	Activity / Topic	Presenter/ Facilitator
11:45	12:45	**Introduction to Process Mapping** **Process Mapping Group Work** • Groups form to conduct process mapping exercise using a flow chart tool	
12:45	13:45	**Lunch**	
13:45	15:00	**Introduction to Root Cause Analysis** **Root Cause Analysis Group Work** • Groups form to conduct root cause analysis using 5-Whys and Fishbone Diagram	
15:00	16:00	**Large Group Debrief** • Each group presents their process map (flowchart) and root cause analysis (fishbone diagram) • Large group agrees on their position regarding the state of EID, focusing on the state of existing conventional EID systems	
16:00	16:30	**Closing** • Review the workshop objectives and how they were met/will be met tomorrow • Review of key lessons	

DAY 2

Start	End	Activity / Topic	Presenter/ Facilitator
08:00	08:15	**Welcome** • Recap of Day 1 • Overview of the objectives and agenda for day 2	
08:15	09:00	**Solution Brainstorming and Prioritization** • Learn how the process mapping exercise and root cause analysis should inform solutions	
09:00	10:00	Leading Improvement	
10:00	10:15	Morning Tea Break	
10:15	12:00	**Solution Brainstorming and Prioritization Group Work** • Groups reconvene to brainstorm interventions and strategies in response to the root causes identified • Groups also brainstorm on indicators/measures, identify which key collaborators will be engaged in the design and implementation of their solutions	
12:00	**13:00**	**Lunch**	
13:00	14:00	**Continue Solution Brainstorming and Prioritization Group Work (if needed)**	
14:00	15:30	**Group Presentations & Large Group Debrief** • Each group presents their proposed solutions to the large group for discussion • Large group identifies which solutions should be recommended for wide-scale implementation	
15:30	16:00	**Post-test for all participants**	
16:00	16:30	**Closing** • Revisit workshop objectives and Key Lessons • Next Steps • Exit evaluation	

Annex 2:
MSV Materials

Annex 2.A: Sample MSV Scope of Work, Agenda, and Objectives

MENTORING AND SUPERVISORY VISIT IN RIVERS STATE

SCOPE OF WORK

Activity Date:

Venue:

Rationale for the Visit

The previous MSV which was held last year was very successful in strengthening the health facilities on Quality Improvement (QI) initiatives. Since then, the facilities have been implementing quality improvement projects on the EID POC optimization projects and are also reporting on the Viiv BT projects. With the progress made in the EID optimization project as evident from the data sent from the facilities, it has become imperative to visit the health facilities once again to assess the quality of the data for all data sent from August 2022 till date to ensure data accuracy and reliability. Also, the QI initiatives were adopted mainly on the EID POC optimization project, however, there is need to meet with the relevant facility teams to advocate for the adoption of QI in improving HIV indicators other than the EID indicators. Additionally, to engage two facilities (ZH Bori and ZH Ahoada) with the aim of improving the collaboration and the relationship between EGPAF and the facility

Hence, this MSV is designed to strengthen facilities' reporting and data as part of ways to ensure data quality across projects as well as strengthening facilities QI teams to adopt QI across projects while also improving good collaboration between EGPAF and GON.

Objectives of the Visit

- To assess the quality and verify data across all program indicators in the facilities
- To provide on-site mentoring to PCMs and HCWs on reporting and QI documentation in the facility
- To assess the level of adoption of Quality Improvement (QI) in the ViiV Breakthrough Partnership project with the aim of improving case finding, retention and viral suppression of children an d adolescents in the facilities
- To strengthen the facilities' QI teams and offer on-site mentorship and guidance where necessary.
- To strengthen the collaboration between EGPAF and GON in the facilities.

Visit Schedule

Day/Date	Facility	Responsible staff
Monday, 3rd July	Brief meeting at SASCP's office and ZH Ahoada	SASCP, EGPAF, IHVN, RSHMB
Tuesday, 4th July	Zonal Hospital Bori	SASCP, EGPAF, IHVN, RSHMB
Wednesday, 5th July	Zonal Hospital Isiokpo	SASCP, IHVN, EGPAF, RSHMB
Thursday, 6th July	Zonal Hospital Okrika	SASCP, IHVN, EGPAF, RSHMB
Friday, 7th July	MPHC Churchill. CHC Oyigbo, and Debrief at SASCP's office	SASCP, IHVN, EGPAF, RSPHCMB.

Annex 2.B: MSV Report Outline

i. Title

ii. Introduction

   a. MSV dates

   b. Location

   c. Report date

iii. Background

   a. Overview of preparation, goals, and stakeholders for the MSV.

iv. Objectives

v. Visit Agenda

vi. Summary of MSV Activities by Facility Visited

vii. Summary of Progress on Activities by Facility Visited

viii. Summary of Action Items by Facility and Expectations by the Next Site Visit

ix. Summary of Findings and Lessons Learned

x. List of MSV Participants

Annex 3:
Link & Learn Session Agenda and Objectives

Start	End	Activity / Topic	Facilitator
10:00	10:05	Welcome	
10:05	10:20	Introductions	
10:20	10:35	**Opening Remarks, Goodwill Messages, and Overview of Workshop** • Opening Remarks: • Goodwill Messages: Representative from Facility • Overview of the workshop's purpose, objectives, and agenda	
10:35	10:45	**Icebreaker** • Participants complete an activity to get acquainted with other participants	
10:45	10:55	Setting Expectations	
10:55	11:15	Overview of EGPAF's activities in Nigeria	
11:15	**11:45**	**Morning Tea Break**	
11:45	12:00	**Overview of Quality Improvement and Program Optimization Approach (POA)** • Overview of Program Optimization Approach (POA) and Quality Improvement highlighting Plan Do Study Act Cycle	
12:00	14:00	**Facility Presentations on completed QI Projects (Problem Statement, Improvement Aim, Root Cause Analysis, Improvement Plan, and Tested Changes)** • Discussion, Questions & Answers	
14:00	**15:00**	**Lunch**	
15:00	16:00	Cross-cutting strategies, Lessons learned, and Challenges	
16:00	16:30	**Closing** • Review the workshop objectives and how they were met/will be met tomorrow • Review of Key Lessons	

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For further information or to request copies of materials mentioned in this brief, please contact:
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