Orientation on USAID/PEPFAR DQA/QI

Webert Jose & Ana Scholl
USAID, Office of HIV/AIDS
SIEI Division / Evaluation Branch

August 5, 2020

What do we mean by DQA?

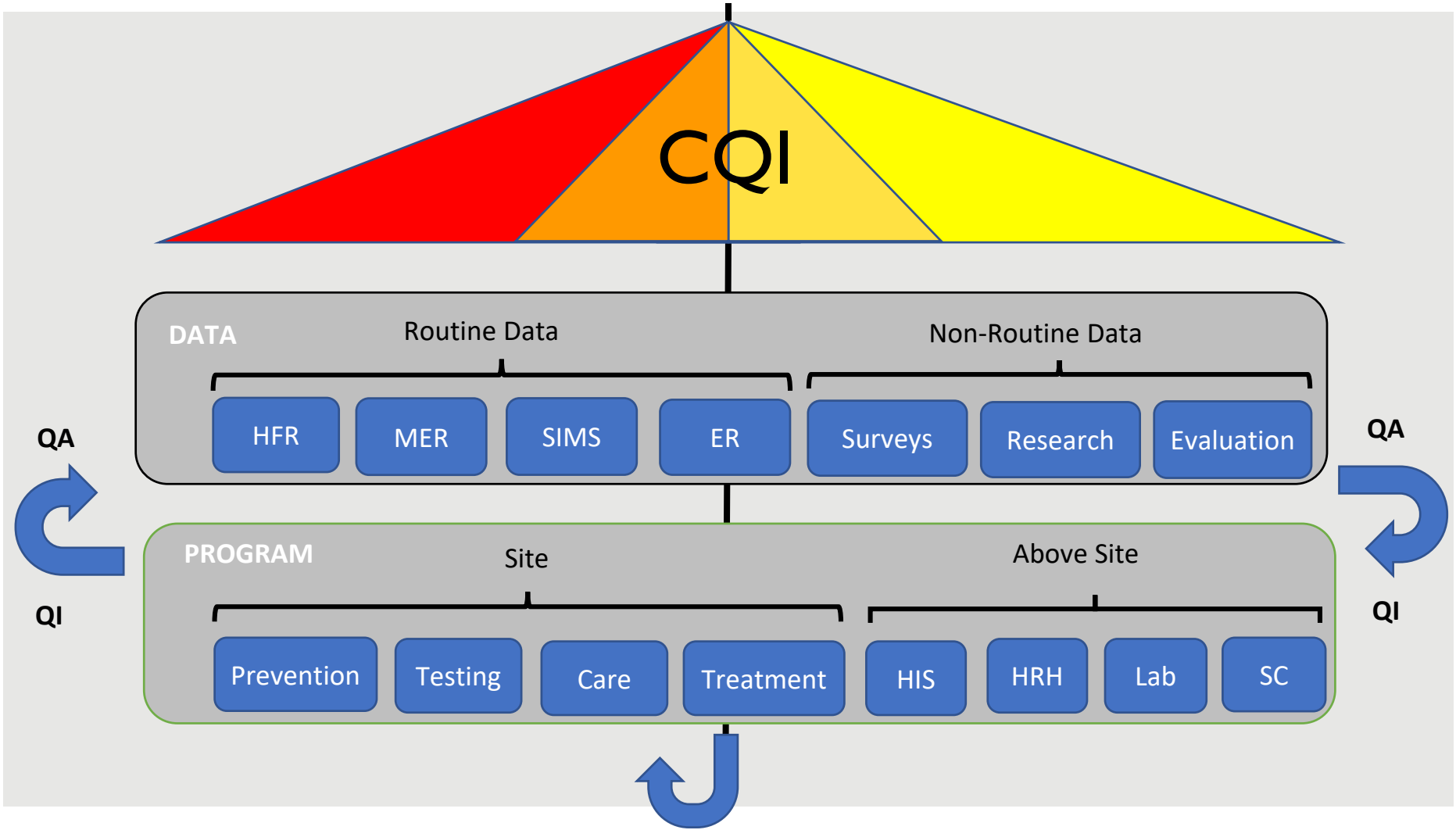
- A Data Quality Assessment (DQA) is quality assurance activity assessing one or more dimensions of data quality (validity, accuracy/precision, completeness, confidentiality, integrity, reliability and timeliness)

- The purpose of this activity is to:
  - Ensure that high quality data are being reported to the Ministry of Health (MOH), USAID and PEPFAR
  - Identify and rectify any discrepancy between numbers recounted and numbers reported
  - Identify systems issues that can affect quality of data being reported
  - Validate site level data aggregation and reporting process
  - Help strengthen staff's skills in data management and reporting
  - Identify issues related to program quality and make plan to address them

Why is Data Quality Important for HIV programs?

- HIV programs are results-oriented and data driven

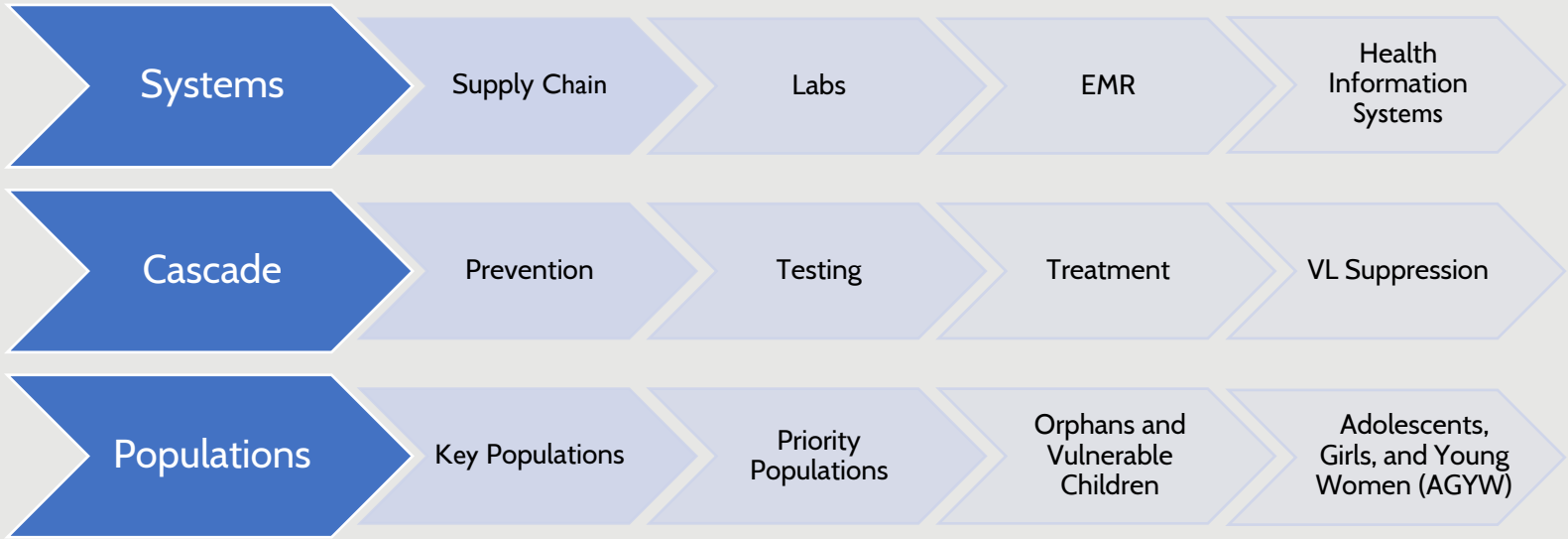
- Quality data essential for:
  - monitoring & evaluation of progress towards the 95-95-95
  - accurate assessment of partner performance
  - accountability and good governance
  - planning and decision-making
  - minimum quality standards assessment across prevention, care and treatment services


CQI
DATA
Routine Data
Non-Routine Data
HFR
MER
SIMS
ER
Surveys
Research
Evaluation
QA
QI
QA
QI
PROGRAM
Site
Above Site
Prevention
Testing
Care
Treatment
HIS
HRH
Lab
SC

Why USAID PEPFAR specific Data Quality requirements?

- Alignment with PEPFAR terms of data generation and use
- Efficient and accurate tracking of 95-95-95 progress
- Mitigation of poor data quality risks to service/program quality and partner organization data fraud accusation
- Increased use of available data for secondary data analyses

What could be the focus of a DQA? A few examples…



DQAs can occur at any level where indicators are measured

Challenges that can affect Data Quality

- **System Issues**
  - Lack of adequate resources for data collection and analysis
  - Data Flow / management and reporting systems not designed to properly generate the results to be reported
  - Unclear roles and responsibilities
  - Dependency on other entities (MoH) for data reporting
- **Other Factors**
  - Misunderstanding of indicators definition, how to compile data, use tally sheets, and prepare reports
  - Lack of interest or motivation when performing data entry and quality checks
  - Lack of training in data QA/QI
  - Math errors during data consolidation from data sources

How can data quality affect programming?

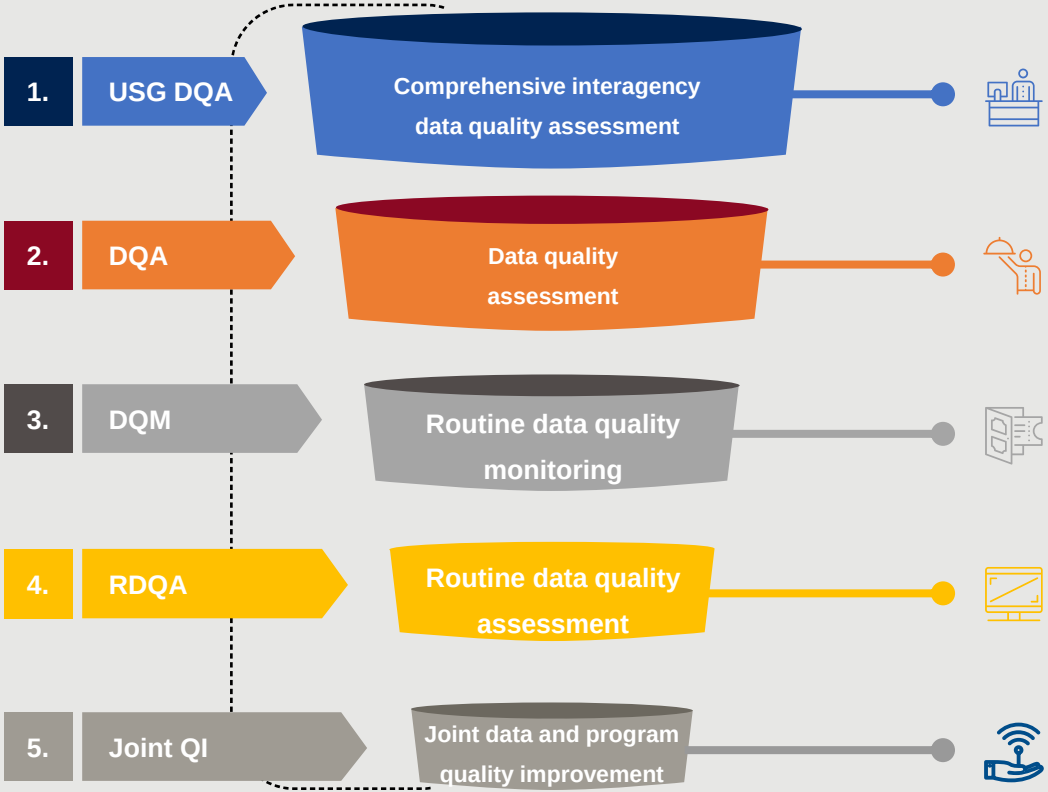
- Site inaccurately reported a high number of HTS_POS:
  - increased # of patients to be enrolled and maintained on ART
  - more drugs than needed are sent to this site
  - more staff hired to support the site

- Site under reported number of patients =>, low performance on all the clinical indicators
  - Partner put on Performance Improvement Plan (PIP) by USAID
  - Less commodities received in comparison with what is needed
  - Less staff than needed are affected quality of critical services

USAID/OHA Data QA/QI Approach

USAID
FROM THE AMERICAN PEOPLE

Multilayered Approach



OGAC mandated, comprehensive, national data quality assessments focused on treatment

USAID-operation specific, comprehensive data quality assessment focused on priority areas

USAID or third-party routine data quality checks, monitoring visits

Routine data quality assurance and improvement practices by partners

Addressing identified data and program quality issues across all levels

DQA Process – Main steps

- System Assessment
  - To identify root causes of the problem and chart the path to address the issues
- Data Verification
  - To identify whether there is issue with data quality and the seriousness of the problem
  - To assess validity and consistency of the results reported
  - Site level Cross validation (cross-check primary with alternative data sources)
- Action Plan development
  - Actions to address issues identified, based on findings from system assessment and data verification
- Post DQA Follow-up Actions
  - Outline specific needs or support

DQA – Standard Analysis Approach

- Verification factor (VF): measures the percentage of a reported indicator that could be verified by manual recreation of the indicator.

  VF=(Recounted/Reported)*100

  For example, if 80 people were reported for TX CURR and the DQA only find evidence that 78 people should have been reported for TX CURR, then the VF is (78/80)*100 or 97.5%

  - If VF > 100%, we talk about "under-reporting"
  - If VF < 100%, we talk about "over-reporting"

- Concordance: measures the alignment of selected data elements between the reporting tools and the patient charts.

  Concordance= (# of Files Matching /# of Files Reviewed)*100

DQA Decision Rule - Verification factor (VF) > +/-10%

- HQ or third-party should lead comprehensive patient files audit.
- Routine Data Quality Assessment should be conducted one quarter after the Initial DQA in all the sites where issues have been identified during the initial DQA.
- Data Quality Monitoring should be conducted one quarter after the Initial DQA in all the sites where issues have been identified in the initial DQA.
- Capacity-Building for IP and/or staff working in all the sites supported

DQA Decision Rule - Verification factor (VF) between +/-5% and +/-10%

- IP should conduct a comprehensive patient files audit in a representative sample of high-volume sites reached during the Initial DQA.
- The quarter after the patient files audit, Data Quality Monitoring should be conducted in 10% of the sites assessed in the initial DQA
- Routine Data Quality Assessment should be conducted in a proportion of high-volume sites INCLUDING 25% of those where issues have been identified.
- Capacity-Building for staff working in the sites where data issues have been identified

Questions

USAID
FROM THE AMERICAN PEOPLE

Extract of the USAID/OHA Treatment Data Quality Tools

DQA - Patient and Data Flow mapping

DATA FLOW MAPPING TOOL

Data Mapping Introductory Script

Date

Partner

Facility name

Assessor

Time started

Time stopped

INSTRUCTIONS TO ASSESSOR:

This exercise should immediately follow the in-brief with the facility. Ideally, it should be completed with head of the ART unit, but if he/she is too busy or unavailable it should be completed with the person who is primarily responsible for updating documentation in the register. If it is still not feasible, it is ok to postpone this activity until the head of the ART unit is available.

Note:

- Do not read the questions word for word but rather ask the nurse to pretend that you are a newly identified positive patient. Have them walk you through the steps of initiating ART, noting when the ART number is given and whether it is documented if a patient initially refuses treatment
- Probe the nurse as to how they complete monthly report, how the indicators are calculated including counting those that are considered lost to follow-up. Try not to make any assumptions about the facility's processes.
- Ask what data source(s) they use for monthly reporting each for NCASC, MOHP.
- Report back the results of the data flow to the team and use this information to help the team prepare for the recount

---

Script:

To begin, we would like you to walk us through the treatment cascade at your facility. Please describe the process that a patient goes through from the time of ART initiation, through drug pickup and on-going treatment and care. We are also interested in understanding how this process may differ for different

DATA FLOW MAPPING TOOL

ANTIRETROVIRAL THERAPY – *FOR COMPLETION WITH ART NURSE*

Guiding Questions	Sketch Data Flow. Note differences for new or returning patients.
When a patient is confirmed HIV positive, describe what happens between HIV+ confirmation and ART initiation. How are the services recorded and what tools/registers are used. **Consider the following-probes:** Tell me how patients are started on ART in this facility. • *In what month and year did the facility begin providing antiretroviral therapy (ART)?* • *How is ART initiation documented?* • *At what point in the patient flow is an ART code assigned? Where is this recorded?* • *Does this process differ between inpatient and outpatient clinics? For pregnant women? Pediatrics? TB patients?* • *Who do patients see prior to the doctor or health care provider (triage nurse, medical assistant etc.)?* • *Describe the process for filing out the patient files* ○ *When are the patient files pulled?*	

DQA - System Assessment

Checklist for assessing site-level client monitoring systems

- *FOR COMPLETION WITH DATA CLERK/RECORDS ASSISTANT* -

Instructions for the review team (parts A and B)
This is one of the first tools the team should use once arriving at the site after the team has done introductions and are settling in. Most questions are appropriate for the site data clerk, but if the questions would be better answered by the facility management this is indicated.

Part A: ART-specific questions

1. **Reporting** (for the management of the facility)
   1.1. How does the facility submit monthly reports on ART to the NCASC/Ministry of Health and Population?
   ☐Electronic report (HMIS)
   ☐ Paper form/report (Hard copy)

   1.2. What is the source(s) of data for the monthly reports on ART submitted to the NCASC/Ministry of Health and Population?
   1.2.1. What source is used for clients at the ART site?
   _____
   1.2.2. What source is used for ARV dispensation?
   _____
   1.2.3. What source is used for _____?
   _____
   1.2.4. Explain why you are using these sources.
   _____

   1.3. How often do you report on ART to the NCASC/Ministry of Health and Population?
   ☐ Daily
   ☐Weekly
   ☐Monthly
   ☐ Other: _____

   1.4. How does the ART site submit reports for donors/implementing partners (i.e. PEPFAR, GF, AHF etc.)? (*Skip to question 1.5 if the facility is not supported by an implementing partner*)?
   ☐Electronic report

   1.6. How often do you report to the donors/implementing partner(s)?
   ☐Daily
   ☐ Weekly
   ☐Monthly
   ☐Other: _____

2. **Personnel** (for the management of the facility)
   2.1. Who is responsible for calculating ART indicators and completing monthly reports for the NCASC/Ministry of Health and Population and/or implementing partner? (please mark all that apply)

   ART:
   ☐ A dedicated ART site-based monitoring and evaluation staff hired by the Ministry of Health and Population or implementing partner
   ☐ Medical recorder
   ☐ART In-charge
   ☐Nurse or other clinical/medical staff member
   ☐ART counsellor
   ☐Other: _____

   2.2. Are processes in place to ensure that ART data are compiled and reported if the designated personnel are not available?
   ☐Yes
   ☐ No

   2.3. Have personnel been trained on how to use and complete paper-based registers and reporting forms?
   ☐Yes
   ☐ No

   2.4. Have personnel been trained on how to use and update DHIS2 tracker capture for individual patient tracking system?
   ☐ Yes
   ☐ No
   ☐ N/A

3. **Data Quality** (for the management of the facility)
   3.1. Does the facility follow quality control procedures for data entry into an electronic register, DHIS2

USAID/OHA Treatment DQA Tally sheet

1. We do not prescribe which tool our treatment partners could/should use as they conduct their data quality checks/RDQAs
2. The tool we are presenting is a USAID tool that was based of and thus aligned with a PEPFAR/CDC DQA tool used to interagency DQAs
3. The tool we developed extends beyond just assessing/validating treatment numbers to support program quality improvement more directly;
4. Caveat of using the tool is absolute attention to and protection of PII and confidentiality (no names, addresses, phone numbers, etc.)

USAID/OHA Treatment DQA Tally sheet

Context

- Full recount required for OGAC mandated DQA
- OHA FO requirements to check Program Quality
- Challenges with LTFU definition (28 or 90 days)

Structure of OHA/DQA tally sheet:

- Excel format with 19 data points / variables
- 4 first data points/variables can be filled out at any time prior to site visit
- 15 data points / variables to be filled on site

P.S.: There are various other tools that can be used to conduct DQA

DQA - Tally Sheet (Data Entry Tab)

January 1, 2019 - March 31, 2019															
OU	Township / Province / District	Site Name	Site Code	Patient unique ID	Sex (M / F / TG / ND)	Date of birth (DD/MM/YYYY) *ENTER "ND" IF DOB	Date of HIV diagnosis (DD/MM/YYYY)	Date of ART initiation (DD/MM/YYYY)	Transfer-in or Transfer-out	Date of last visit/drug pickup (DD/MM/YYYY)	Date of next visit (DD/MM/YYYY)	# Daily doses picked up/dispensed *ONLY NUMBERS	ART Regimen (what regimen and how many pills per daily	Date of Latest VL test (DD/MM/YYYY) *ENTER DATE	Last VL Test Results *ONLY NUMBERS SHOULD BE ENTERED. DO NOT

DQA - Summary

Current on ART (National Guidance 90 days)

	MALE												FEMALE												Total ND	Total TG	Total Male	Total Female	TOTAL
	ND	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-49	50+	ND	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-49	50+	ND					
Active	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Defaulters (Missing)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Current on ART	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

New on ART

	MALE												FEMALE												Total ND	Total TG	Total Male	Total Female	TOTAL
	ND	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-49	50+	ND	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-49	50+	ND					
January	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
February	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
March	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total New on ART	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Current on ART (PEPFAR Guidance 28 days)

	MALE												FEMALE												Total ND	Total TG	Total Male	Total Female	TOTAL
	ND	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-49	50+	ND	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-49	50+	ND					
Active	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Defaulters (Missing)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Current on ART	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

DQA Results Summary

DATE
PRIME PARTNER
DISTRICT
SELECT FACILITY
ASSESSMENT PERIOD

THIS TAB CONSOLIDATES THE RESULTS OF ALL THE ACTIVITIES AND ALLOWS FOR COMPARISON OF REPORTED AGAINST RECREATED, GIVING A PERCENT CONCORDANCE.

FOR RESULT INTERPRETATION:
IF PERCENT CONCORDANCE IS >100%, THIS SHOULD BE INTERPRETED AS OVER-REPORTING
IF PERCENT CONCORDANCE IS <100% THIS SHOULD BE INTERPRETED AS UNDER-REPORTING
WITHIN 5% OF 100% IS EXCELLENT CONCORDANCE

		TX_CURR			TX_NEW		
SEX	AGE	PEPFAR REPORTED	RECOUNTED	% CONCORDANCE-PEPFAR (VF= # recounted / # reported)*100%	PEPFAR REPORTED	RECOUNTED	% CONCORDANCE-PEPFAR (VF= # recounted / # reported)*100%
MALE	<1		0	-		0	-
	1 TO 4		0	-		0	-
	5 TO 9		0	-		0	-
	10 TO 14		0	-		0	-
	15 TO 19		0	-		0	-
	20 TO 24		0	-		0	-
	25 TO 29		0	-		0	-
	30 TO 34		0	-		0	-
	35 TO 39		0	-		0	-
	40 TO 49		0	-		0	-
	50+		0	-		0	-
	UNKNOWN		0	-		0	-
	MALE TOTAL	0	0	-	0	0	-
FEMALE	<1		0	-		0	-
	1 TO 4		0	-		0	-
	5 TO 9		0	-		0	-
	10 TO 14		0	-		0	-
	15 TO 19		0	-		0	-
	20 TO 24		0	-		0	-
	25 TO 29		0	-		0	-
	30 TO 34		0	-		0	-
	35 TO 39		0	-		0	-
	40 TO 49		0	-		0	-
	50+		0	-		0	-
	UNKNOWN		0	-		0	-
	FEMALE TOTAL	0	0	-	0	0	-
	ND TOTAL		0	-		0	-
	TG TOTAL		0	-		0	-
TOTAL	TOTAL	0	0	-	0	0	-

OTHER INDICATORS WITH DISAGGREGATES OF INTEREST				
INDICATOR	DISAGGREGATE	RECREATED	PEPFAR REPORTED	% CONCORDANCE-PEPFAR (VF= # recreated / # reported)*100%
MMD	MMD eligible	0		-
	1 month dispens	0		-
	MMD - 2 month	0		-
	MMD- 3 months	0		-
	MMD - 4 months	0		-
	MMD - 5 months	0		-
	MMD - 6 months	0		
	MMD - 7+	0		-
	No MMD	0	0	
	MMD 3-5	0	0	
	MMD 6 and +	0	0	
	TOTAL MMD - 3-	0	0	-
Viral Load	Test done	0		-
	Suppression	0		-

CHART CROSSCHECK RESULTS	
Number of Patients Currently on ART (PEPFAR DEFINITION)	0
Number of CURRENT Patients on ART Sampled from Register	0
SOURCE DOCUMENT COMPARISON AGAINST REGISTER	**Date ART Initiation**
Number of patients with ART different initiation date	0
Number of sampled patients with same ART initiation date: high precision	0
% Concordance for ART initiation date	-

DQA - Tally Sheet (Filled out with data)

01-07-19 to 30-09-19

OU	Township / Province / District	Site Name	Site Code	Patient unique ID	KP Group	Sex (M / F / TG / ND)	Date of birth (DD/MM/YYYY) *ENTER "ND" IF DOB	Date of HIV diagnosis (DD/MM/YYYY)	Date of ART initiation (DD/MM/YYYY)	Transfer in or Transfer out	Date of last visit/drug pickup (DD/MM/YYYY)	Date of next visit (DD/MM/YYYY)	# Daily doses picked up/dispensed	ART Regimen (what regimen and how many pills per daily	Date of Latest VL test (DD/MM/YYYY)	Last VL Test Results *ONLY NUMBERS	Cut-off date
				011-8552	ND	F	16/05/1990	19/05/2015	22/05/2015		22/09/2019	20/10/2020	60	TDF/3TC/EFV	02-10-19	27451	30-09-19
				010-6663	ND	F	31/05/1974	24/04/2015	06/10/2019		28/08/2019	09/03/2020	150	AZT/3TC/NVP	08-05-19	20	30-09-19
				062-9998	MSM	M	19/03/1988	21/03/2019	21/03/2019		03/07/2019	29/10/2019	60	TDF/3TC/EFV			30-09-19
				039-7882	FSW	F	01/11/1990	22/06/2017	22/06/2017		04/09/2019	29/01/2020	60	TDF/3TC/NVP			30-09-19
				014-7865	MSM	M	15/02/1972	06/10/2015	04/04/2016		24/09/2019	27/11/2019	60	TDF/3TC/EFV			30-09-19
				0613-6735	FSW	F	05/11/1983	17/01/2019	19/02/2019		16/07/2019	19/02/2020	120	TDF/3TC/NVP	10-04-19	20	30-09-19
				0569-6745	FSW	F	12/11/2018	08/08/2018	08/08/2018		27/08/2019	25/03/2020	120	AZT/3TC/NVP	24-03-18	155	30-09-19
				0663-8975	FSW	F	04/05/1983	13/05/2019	13/05/2019		27/08/2019	22/10/2019	60	TDF/3TC/EFV	12-06-19	804	30-09-19
				0070-9876	ND	F	04/04/1998	23/07/2019	16/02/2019		10/06/2019	10/07/2019	90	TDF/3TC/EFV	17-06-09	20	30-09-19
				023-4653	FSW	F	10/08/1984	26/07/2018	26/12/2019		17/07/2019	17/06/2019	150	TDF/3TC/EFV			30-09-19
				035-6772	FSW	F	01/01/1980	07/04/2017	07/04/2017		03/08/2019	30/10/2020	60	TDF/3TC/EFV			30-09-19
				0422	FSW	F	08/07/1983	15/08/2018	15/08/2018		11/09/2018	13/10/2018	30	TDF/3TC/EFV			30-09-19
				0577	MSM	M	15/06/2006	23/07/2005	24/08/2015		13/07/2019	12/05/2019	120	TDF/3TC/EFV	30-01-19	10385	30-09-19
				0450	FSW	F	09/05/1993	09/11/2017	09/11/2020		19/06/2019	19/07/2019	30	TDF/3TC/EFV	15-07-81	46	30-09-19
				0428	FSW	F	14/08/1994		08/09/2017			29/10/2019	90	TDF/3TC/EFV	03-04-19	794	30-09-19
				0675	MSM	M	10/03/1991	18/04/2019	18/04/2019		18/08/2019	16/10/2019	90	TDF/3TC/EFV	08-08-18	32	30-09-19
				0676	FSW	F	21/03/1992	18/04/2019	05/06/2019				90	AZT/3TC/NVP	09-05-18	63	30-09-19
				0023	ND	F	14/04/1974	15/05/2014	28/07/2014		05/06/2019	07/08/2019	90	TDF/3TC/EFV	27-02-19	143	30-09-19
				0161	FSW	F	06/12/1988	11/12/2015	10/12/2015		23/07/2019	25/09/2019	180	TDF/3TC/EFV			30-09-19
				0665	FSW	F	10/12/1986	20/05/2019	20/05/2019		05/08/2019	06/11/2019	90	TDF/3TC/EFV	22-07-19	170654	30-09-19
				0504	FSW	F	25/05/1989	17/11/2017	22/11/2017		18/08/2019	10/11/2019	120	TDF/3TC/EFV			30-09-19
				184	FSW	F	10/12/1971	10/02/2016	10/02/2015		08/05/2019	02/08/2019	90	TDF/3TC/EFV	24-04-19	20	30-09-19
				0673	FSW	F	29/09/1987	20/01/2017	03/06/2019		21/08/2019	21/11/2019	90	TDF/3TC/EFV	12-12-18	78	30-09-19
				0041	FSW	F	01/01/1987	02/10/2014	06/10/2014		07/08/2019	26/12/2019	90	TDF/3TC/LPV	07-08-19	36	30-09-19

DQA Results Summary (with Data)

DATE
PRIME PARTNER
DISTRICT
SELECT FACILITY
ASSESSMENT PERIOD

THIS TAB CONSOLIDATES THE RESULTS OF ALL THE ACTIVITIES AND ALLOWS FOR COMPARISON OF REPORTED AGAINST RECREATED, GIVING A PERCENT CONCORDA

FOR RESULT INTERPRETATION:
IF PERCENT CONCORDANCE IS >100%, THIS SHOULD BE INTERPRETED AS OVER-REPORTING
IF PERCENT CONCORDANCE IS <100% THIS SHOULD BE INTERPRETED AS UNDER REPORTING

		TX_CURR (90 days)			TX_NEW		
SEX	AGE	PEPFAR REPORTED	RECOUNTED	% CONCORDANCE-PEPFAR (VF= # recounted / # reported)*100%	PEPFAR REPORTED	RECOUNTED	% CONCORDA PEPFAR (VF recounted reported)*1
MALE	<1	0	0	-	0	0	-
	1 TO 4	0	0	-	0	0	-
	5 TO 9	0	0	-	0	0	-
	10 TO 14	1	2	200.00%	1	1	100%
	15 TO 19	145	52	35.86%	18	14	78%
	20 TO 24	883	662	74.97%	90	84	93%
	25 TO 29	826	866	104.84%	81	86	106%
	30 TO 34	577	654	113.34%	53	50	94%
	35 TO 39	356	411	115.45%	28	24	86%
	40 TO 49	405	554	136.79%	32	28	88%
	50+	148	230	155.41%	12	10	83%
	UNKNOWN	0	19	-	0	0	-
	MALE TOTAL	3341	3450	103.26%	315	297	94%
FEMALE	<1	0	0	-	0	0	-
	1 TO 4	0	0	-	0	0	-
	5 TO 9	0	0	-	0	0	-
	10 TO 14	1	0	0.00%	0	0	-
	15 TO 19	24	12	50.00%	3	3	100%
	20 TO 24	134	94	70.15%	15	17	113%
	25 TO 29	205	175	85.37%	21	20	95%
	30 TO 34	228	213	93.42%	8	9	113%
	35 TO 39	209	225	107.66%	10	10	100%
	40 TO 49	252	316	125.40%	16	14	88%
	50+	88	158	179.55%	7	6	86%
	UNKNOWN	0	4	-	0	0	-
	FEMALE TOTAL	1141	1197	104.91%	80	79	99%
	ND TOTAL		1	-		0	-
	TG TOTAL		0	-		0	-
TOTAL	TOTAL	4482	4648	104%	395	376	95%

OTHER INDICATORS WITH DISAGGREGATES OF INTEREST				
INDICATOR	DISAGGREGATE	RECREATED	PEPFAR REPORTED	% CONCORDANCE-PEPFAR (VF= # recreated / # reported)*100%
MMD	MMD eligible	0		-
	1 month dispen	357		-
	MMD - 2 month	416		-
	MMD- 3 month	1657		-
	MMD - 4 month	1533		-
	MMD - 5 month	313		-
	MMD - 6+	419		-
	TOTAL MMD - 3+	3922	0	-
Viral Load	Test done	0		-
	Suppression	0		-

CHART CROSSCHECK RESULTS	
Number of Patients Currently on ART (PEPFAR DEFINITION)	4,648
Number of CURRENT Patients on ART Sampled from Register	232.4
SOURCE DOCUMENT COMPARISON AGAINST REGISTER	**Date ART Initiation**
Number of patients with ART different initiation date	25
Number of sampled patients with same ART initiation date: high precision	25
% Concordance for ART initiation date	11%

Tally Sheet and Data Quality Issues

Scenario 1

- In this scenario, there is a new data capturer on your team capturing aggregated data based on case files
- The monthly tool for aggregated data asks to TX CURR totals for pediatric and adult cases
- The new team member doesn't know the correct definitions (pediatric = under 15 years old, adults = 15 and older)
- The new team member captures anyone under 18 as a pediatric case, and anyone 18 and above as an adult for 6 months in a row
- The project manager is very concerned about the spike in pediatric cases

1) Which data quality criteria does this scenario violate?
2) What steps would you take to identify this problem when it started?
3) How should managers and/or the M&E respond to this problem?

Scenario 2

- In this scenario, what is the issue each of the patient data, if any?
- What actions should be taken by managers and/or the M&E team to address such issues?
- What steps could you take to prevent such type of data quality issue?

Date of birth (DD/MM/YYYY) *ENTER "ND" IF DOB CANNOT BE FOUND	Date of HIV diagnosis (DD/MM/YYYY)	Date of ART initiation (DD/MM/YYYY)	Transfer-in or Transfer-out	Date of last visit/drug pickup (DD/MM/YYYY)	Date of next visit (DD/MM/YYYY)	# Daily doses picked up/dispensed *ONLY NUMBERS SHOULD BE ENTERED. DO NOT ENTER TEXT.
04/04/1998	23/07/2019	16/02/2019		10/06/2019	10/07/2019	90
10/08/1984	26/07/2018	26/12/2019		17/07/2019	17/06/2019	150
01/01/1980	07/04/2017	07/04/2017		03/08/2019	30/10/2020	60
08/07/1983	15/08/2018	15/08/2018		11/09/2018	13/10/2018	30
15/06/2006	23/07/2005	24/08/2015		13/07/2019	12/05/2019	120
09/05/1993	09/11/2017	09/11/2020		19/06/2019	19/07/2019	30
14/08/1994		08/09/2017			29/10/2019	90
10/03/1991	18/04/2019	18/04/2019		18/08/2019	16/10/2019	90
21/03/1992	18/04/2019	05/06/2019				90
14/04/1974	15/05/2014	28/07/2014		05/06/2019	07/08/2019	90
06/12/1988	11/12/2015	10/12/2015		23/07/2019	25/09/2019	180

Scenario 3

- In this scenario, there are many values missing for the individuals.
- What are the consequences of missing/incomplete data?
- What steps can you take to prevent this risk to data quality?

	ART Regimen (what regimen and how many pills per daily doses)	Date of Latest VL test (DD/MM/YYYY) *ENTER DATE WHEN SPECIMEN COLLECTED	Last VL Test Results *ONLY NUMBERS SHOULD BE ENTERED. DO NOT ENTER TEXT.	C
0	EFV 400	17/11/2018	2000	
0		26/11/2018		
0	EFV 400			
0	EFV 400			
0		18/11/2018		
0	EFV 400	06/02/2019	450	
0	EFV 400	01/09/2019	30000	
0		05/03/2019	1000000	
0	EFV 400	09/03/2019		
0				

Post-DQA Follow-up Actions

Post-DQA Follow-up actions

- Quality improvement action plans developed to address systems, data quality and/or program quality issues
- Cross-analysis of DQA results with performance data reported
- Update results reported to reflect results of DQA validation
- DQA reports shared with relevant stakeholders
- Capacity-building or Technical Assistance to relevant staff
- Increased supportive supervisions combined with routine data quality monitoring
- Follow-up DQA to be conducted as follow-up on corrective actions taken

DQA report outline – Key components

Outline of a DQA summary report

- Number of sites assessed
- Number and list of sites with discrepancies between numbers reported and results reported greater than 10%
- Number of beneficiaries' records reviewed
- Data and program quality issues identified / addressed
- Health system issues identified and addressed
- Actions plan to address issues identified, including timeline, staff/ entity responsible (health system, data and program quality issues)

Critical Reminder

1. There are **various other tools** that can be used to conduct DQA
2. Using this **OHA Treatment DQA tally sheet is NOT MANDATORY**
3. **Personally Identifiable Information** (patient address, phone numbers, names) **should never be collected during the DQA**
4. If using this tally sheet, you should never collect any information that could reveal identity of any patients

Knowledge Check

Q1. Who is responsible to ensure Data Quality?

Q2. Raw data used to report in Quarter 1 have been checked last week and the same results were found. This statement refers to which data quality criteria?

Q3: Not all facilities are reporting, and/or facilities are reporting after deadline. This statement refers to which data quality criteria?

Q4: True or False: DQA can be conducted only on the care and treatment indicators?

Q5: True or False: DQA can be conducted only by USAID staff?

Q6: True or False: USAID/OHA or OGAC may decide to conduct in-depth DQA or audit on data reported?

Q7: True or False: DQA is expected to be routinely conducted during supportive supervision visits?

Q8. Identify if this situation refers to “over-reporting” or “under-reporting”

TX_CURR reported: 120 ; TX_CURR recounted: 110

Q9. Identify if this situation refers to “over-reporting” or “under-reporting”

TX_NEW recounted: 150; TX_NEW reported: 130

Q10. Identify if this situation refers to “over-reporting” or “under-reporting”

Verification Factor = 120%

Q11. Identify if this situation refers to “over-reporting” or “under-reporting”

Verification Factor = 85%

Useful DQA tools

- Data QA/QI Tool (Measure Evaluation focused on TX_CURR only) for RDQA and even for Initial DQA not focused on the overall clinical cascade

- Data QA/QI Tools (USAID/PEPFAR - Includes tally tools, data flow, and systems assessment questionnaires) for initial DQA focused on the overall clinical cascade.

- Measure Evaluation standard tool for Data Quality Monitoring (DQM) focused on assessing consistency and completeness

Resources on Program and Data Quality

- https://www.globalhealthlearning.org/course/data-quality
- https://www.who.int/hiv/pub/toolkits/hiv-data-quality-assessment/en/
- https://www.measureevaluation.org/resources/publications/tl-19-26

Points of Contact at OHA for DQA support

- Ana Scholl (e-mail: adjapovicscholl@usaid.gov)
- Webert Jose (e-mail: wjose@usaid.gov)
- Josephine Mungurere-Baker (jmungurerebaker@usaid.gov)

Thank you

USAID
FROM THE AMERICAN PEOPLE