ASAP WEBINAR

ON

PEPFAR DATA QUALITY ASSESSMENT

AUGUST 5, 2020

Questions and Answers

ACCELERATING SUPPORT TO ADVANCED LOCAL PARTNERS (ASAP)

Contract No. AID-OAA-I-14-00031

PEPFAR Data Quality Assessment

1. Under the CQI slide, SC QI at site level seems to be missing. Was this an oversight?

In the PEPFAR program, SC (Supply Chain) is considered as above-site. The specific main supply activities are not considered as site-level

2. Are there sample DQA tools that have been used that will be shared with us for learning purposes and improvement?

Various tools can be found through the links below:
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

3. Any confidence interval for VF that might be set by an M&E expert?

Generally, we consider as acceptable any Verification Factor between 95% and 105%. A good verification factor must equal 100 +/- 5 (discrepancy between -5% and +5%).

4. Why is more than 100% called under reporting and vice versa? Please explain.

When a site reports less patients received services than what was confirmed when recounting, that means there was under reporting. In other words, when the number reported is less than the number that has been confirmed, we talk about under reporting.

As an example, a facility reported 30 patients were served during the reporting period. After we reviewed records and recounted patients who received services during that reporting, we found there were 40 patients who received services. The number reported is 30 and the number recounted is 40. We know that 30 < 40. Therefore, number reported < number recounted. This facility has been reporting less patients (under-reporting).

The verification factor will be:

Verification Factor = (Number recounted (validated) / Number reported) * 100
Verification Factor = (40/30) *100
Verification Factor = 133%
Verification > 100% => under-reporting

In short, reported less = under reporting

5. Are there recommended DQA methodologies/tools apart from MEASURE's tools?

MEASURE EVALUATION produced most known tools especially for routine DQAs (RDQ) that organizations can conduct regularly. Tools used by PEPFAR for assessing quality of treatment data that were presented during the webinar can be used as well if that is preferred. Finally, the link below to resources developed by WHO specifically focused on HIV/AIDS:
https://www.who.int/hiv/pub/toolkits/hiv-data-quality-assessment/en/

6. Anything to share pertaining to the DQA chart board?
   Unclear on the intent of this question.

7. What is the full meaning of CQI?
   Continuous Quality Improvement which is an ongoing process to engage implementing teams in identifying barriers and facilitators of providing quality services and empowering them to take actions to improve results.

8. What is the difference between a data quality assessment and a data quality audit?
   Data Quality Assessment is a process by which quality of data that is reported is evaluated across quality domains. When the assessment is conducted by an independent party that is external and independent from the organization that generated and reported data, this DQA is considered an audit.

9. Can you repeat the difference between DQA and DQM?
   DQA: Data Quality Assessment (in-depth exercise focused on assessing the main data quality criteria). In terms of main steps, a DQA should include: patients/data flow mapping, data management and reporting system assessment, data verification (full recount / recreation of numbers reported, cross validation of data between the primary data source and a secondary data source), action plan development. A comprehensive DQA implies full recount of the patients files for the selected reporting period.

   DQM: Data Quality Monitoring. Routine exercise generally combined with supportive supervision visits and aimed at continuous data quality improvement. The focus is mainly on assessing completeness and consistency of the data, considering one or two data sources. Only a sample of patients files are typically selected and reviewed. Often these monitoring visits complement DQAs and monitor implementation of data quality improvement recommendations.

10. What is the difference among the terms data quality assurance, data quality improvement and data quality audit?
    Data Quality Assurance can be defined as the process of data profiling to identify inconsistencies and other anomalies in the data, determine root causes of systematic anomalies and perform basic data cleansing activities (e.g removing outliers, missing data interpolation)

    Data Quality Improvement can be defined as the continuous and systematic effort to achieve stable and predictable quality of data, suitable to serve organizational purposes. This refers also to the application of quality management methods and tools to close the gap between existing and expected levels of quality

    Data Quality Audit is an external, independent assessment of data quality. Various data quality assessment methods and tools can be used to evaluate the quality of data.

11. How do you assess DQA guidelines? What are the standards?
    In the OHA Treatment DQA Tally sheet, there is a tab "Current Sample cross-check" designed to perform cross-validation between the main data source (used for reporting) and a secondary data source.

    For each DQA exercise, specific standards are defined in the DQA protocol. DQA Team Lead needs to ensure compliance with the standards. The DQA report should also be written according to those standards.

12. What does USAID/PEPFAR use as their baseline to set project targets? This seems to be a problem in most of the project/programs. Please share more.
    Targets are set annually based on a combination Epi data, budget, and PEPFAR priorities decided with the host country government

13. Can't the ratio be the other way around; i.e, reported/recounted and then change the meaning of the resulting quotient?
    That's correct. Some organizations used to define the Verification Factor as "Reported" / "Recounted". Then, the meaning of the resulting quotient will be the reverse

    We are not prescribing any specific approach to our IPs. We would like to make sure that actions are being taken routinely to ensure that high quality data can be reported. The formula used for the Verification Factor must be provided when referring to over or reporting so that any reader can understand what is being said. Ultimately, we need to know whether an organization reported accurately how many people they served or if they over- or under-reported.

14. Can we use an example of 20 recounted and 30 reported on the over and under verification factor issue?
    Verification Factor = (Number recounted / Number reported) * 100
    Verification Factor = (20/30) *100
    Verification Factor = 67%
    Verification < 100% => over-reporting
    The number reported is 30 and the number recounted is 20. We know that 30 > 20. Therefore, number reported > number recounted
    (when the number reported is higher, we talk about over reporting. In short, reported more = over reporting)

15. If we say we recount 20 patients, but the facility reported that 30 patients started on ART, using the formula we get 66%, which is less than 100. Does it mean this was over reporting? It's not clear, as I thought it would be under reporting. Please clarify.
    This result means that you over-reported to PEPFAR. You can only confirm 20 patients received services but your reported over this number (that 30 patients received services). Result of 66% means that only 66% of what was reported is verified during DQA. In other words, we cannot verify 100% of what was reported to PEPFAR. Therefore, you over-reported to PEPFAR.

The facility reported more patients than what was confirmed when recounting.
When the number reported is higher, we talk about over reporting. In short, reported more = over reporting

16. How often would you recommend a DQA is conducted at different levels?
    Generally, we encourage/recommend:
    1) Data Quality Monitoring to be conducted at least on a quarterly basis. Generally combined with supportive supervision and project monitoring visits and focused mainly on assessing completeness and consistency of the data, considering one of two data sources. Only a sample of sites and a sample of patient files are typically captured during DQM.
    2) Routine Data Quality Assessment (at least on a quarterly basis). The focus can be only on a few sites and/or one specific indicator. All the patients files for the selected reporting period will be assessed when conducting a Routine Data Quality Assessment in a specific site.
    3) Comprehensive DQA focused on in-depth assessment of the overall program every year or two (80-100% of the program beneficiaries and the most relevant indicators)

17. Under USAID, do we have standard mitigating steps to follow? If so, would you mind sharing for our use?
    We generally don't prescribe specific approaches or tools to our Implementing Partners. Our suggestion is to make sure that:
    1) Staff are trained on the PEPFAR data systems (get proper understanding of the indicators)
    2) Understanding the issues with Data Quality and mainly their impact on the overall program performance
    3) Data Quality Monitoring can be performed during every single supportive supervision visit
    4) Routine Data Quality Assessment can be performed, as much as possible, on a quarterly basis

18. If we access the same data for two persons who will do DQA, could they get the same or different result?
    If the same protocol, tools and processes have been used in the same site for the same indicators and the reporting period, the results should be the same. There shouldn't be any difference. Data quality assessors should be trained and supported to ensure consistency in and quality of DQA implementation (ensuring that the protocol is followed with fidelity, tools are used appropriately, etc.).

19. Which kind of project positions are responsible to lead the DQA in an organization?
    In an organization, all staff have a critical role to play in ensuring quality of the data being reported. However, staff working as Strategic Information Specialist or Monitoring and Evaluation Specialist used to play a more predominant role because they are the ones in charge of managing and compiling data for reporting.

20. May you kindly clarify on the DQA decision rule for the verification factors? Which one is the best practice: +/-5% or +/-10%. Also, I have seen some sources having three categories:
    a) No data quality issues b) Minor data quality issues c). Major data quality issues depending on the magnitude of the verification factor. Is this applicable to USAID/PEPFAR programs?

    USAID/PEPFAR considers any discrepancy over +/-10% between what was reported and what can be verified during DQA indicative of major data quality issues. +/-5% discrepancy does not indicate serious issues with data quality. All the VF findings should be considered in tandem with the results of the qualitative assessments that point to the root causes of data quality issues. Typically our focus on the 3 categories below which align well with the categorization above:
    category 1: +/-5%
    category 2: between +/-5% and +/10%,
    category 3: > +/- 10%

    We are not prescribing any specific approach to our IPs. We would like to make sure that actions are being taken routinely to ensure that high quality data can be reported. The decision rule needs to be explained properly in the DQA report considering all collected information.

21. Where at what level and how is a senior manager involved or make sure our reports maintain the required quality (quality assurance)? They cannot be involved at every stage and don't have the required skills.

    In an organization, the staff submitting a report is considered accountable in case there are any issues or concerns with the content. To be able to provide strong justification for critical programmatic decisions to be taken, Senior Managers, USAID and PEPFAR need high quality data. Therefore, employees at all levels and mainly the ones responsible for Strategic Information or Monitoring and Evaluation need to be equipped and empowered to ensure and maintain high quality data is being generated and reported. In addition, Senior Manager will need to ensure that appropriate resources are dedicated to data management, monitoring and evaluation, including DQA and supportive supervision. Some organizations may have dedicated QA/QI staff.

22. At what time interval is advisable for DQA?

    Please see response to question number 16. We encourage initiative to conduct DQA routinely. Implementation of quality improvement recommendations should be monitored and in cases of persisting data quality issues, a more in-depth data quality follow-up assessment may be needed.

23. In the RDQA tool we have sections that we look at Systems and Human Resource/Capacity, how often are we supposed to conduct this part of the assessment during DQA's? Secondly, as much as it seems thorough to conduct periodic DQAs, in situations where funding and human resources are limited, what is the recommended frequency to conduct these DQAs?

    We are recommending routine, at least quarterly checks of data quality. We, however, do not prescribe tools for our partners to use. This is something you can adapt to your situation. Ultimately, reporting accurate data is in everyone's best interest and all our partners should be confident that they are reporting quality data and addressing any challenges affecting data

quality. Not reporting accurate data may lead to data fraud accusations, undermine partner's successes in terms of service delivery, and negatively affect partner's standing within PEPFAR.

24. Please orient us on data analysis software's including Excel, SPSS, NVIVO and other software.
    Orientation/training of partner staff is beyond the scope of OHA/HQ. IPs have MEL in their workplans, and budgets and these questions should be raised with them

25. There is a possibility that the current COVID-19 pandemic will affect our data targets, which may in one way or the other affect overall quality. Are there measures in place to mitigate this? For example, revising targets to suit the context.
    This is a big concern for all the stakeholders. Appropriate decisions / follow-up actions will be taken by each USAID Mission jointly with OGAC on a case by case basis.

26. It's good to hear overlapping of data and service quality improvement. Isn't it good to align data & service quality improvement on trainings/supports/implementation of USAID funded projects?
    The Data Quality Monitoring approach proposed by the Office of HIV/AIDS is focused on combining Data Quality validation with Sites Improvement Monitoring System (SIMS) which is an activity assessing quality of services being provided. Our vision is to combine Program and Data Quality as much as possible. Also, the tools presented during the webinar aim to facilitate not just specific data quality but also program quality improvement actions.

27. Any serious challenges observed by USAID regarding the impact of COVID-19 to the DQ and DQA process? Any mitigation strategy?
    Because of COVID-19, in-person activities can't be conducted. Some implementing partners have been adopting innovative approaches like virtual data validation site visits after hours or over weekends.

    The Agency is working on related official guidance. In some countries like Thailand, USAID staff request a copy or remote access to the project database and have phone or video calls with the project team in order to check the quality of their data.

    Our recommendation to Implementation Organizations would be to envision approaches without any concern for staff safety and getting patient privacy data compromised.