USAID/Accelerating Support to Advanced Local Partners

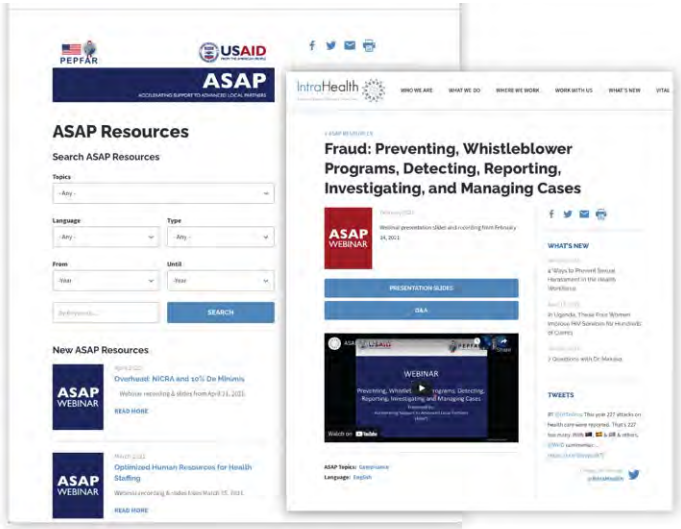
WEBINAR SERIES

USAID/PEPFAR Program and Data Quality Assurance and Improvement Tools and Processes

January 26, 2022

ASAP NOTICES

1. Welcome Local Partners – **tell us where you're from in the chat.**
2. Please use the **Q&A box to ask any questions** and the chat box for answering questions asked by the presenters.
3. We have **several polls** during the webinar today.
4. The presentation for today's webinar will be emailed to attendees and saved on ASAP's website at **www.intrahealth.org/asap-resources**



ON-DEMAND WEBINARS

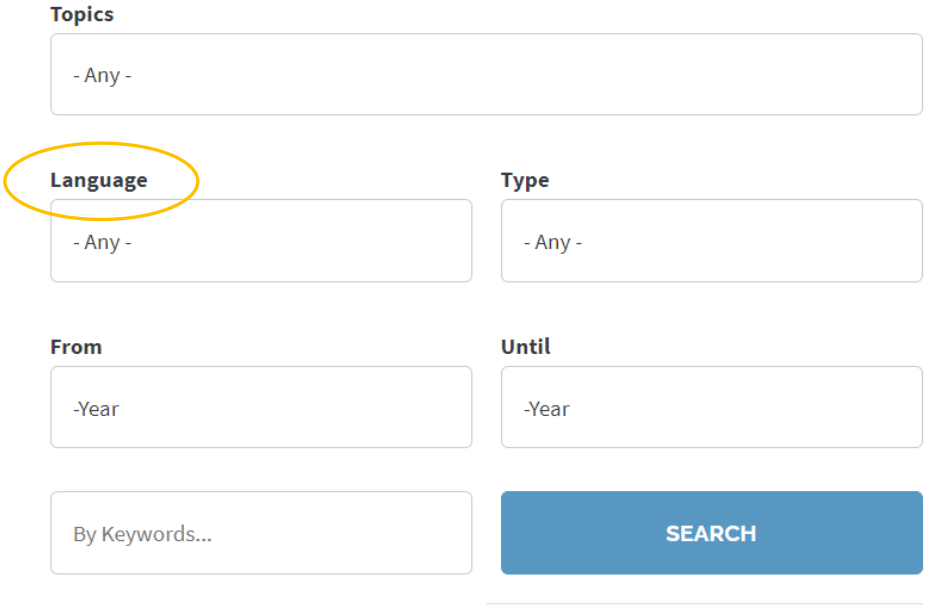
ASAP has broadcasted **65 webinars** for **more than 13,000 attendees**.

Find past webinars on ASAP's web page **www.intrahealth.org/asap-resources**

AVAILABLE IN 3 LANGUAGES

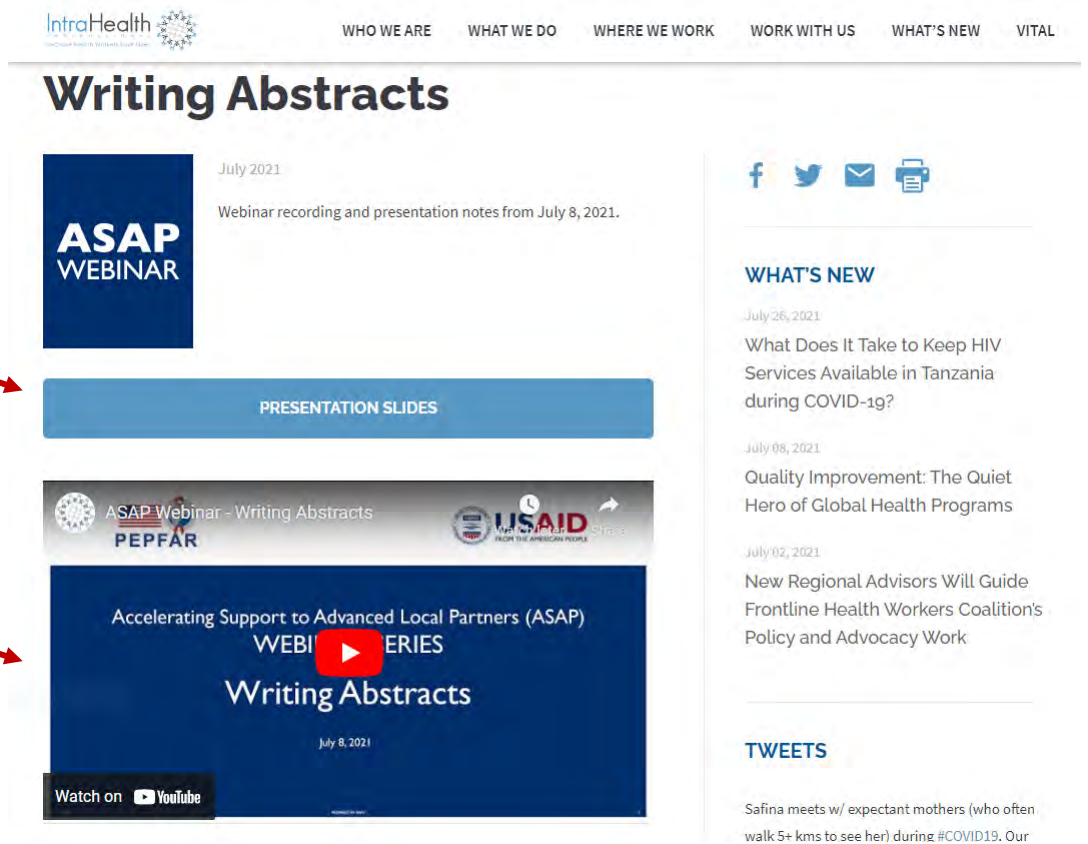
Choose your
language or topic.

Featuring webinars in
French, English, and Portuguese.



Download a pdf
of the presentation.

Watch a recording
of the webinar.



TODAY'S PRESENTERS

Webert Jose
Program and Data Quality Advisor
USAID Bureau for Global Health, Office of HIV/AIDS

Ana Scholl
Evaluation Branch Chief
USAID Bureau for Global Health, Office of HIV/AIDS

Overview of USAID/PEPFAR Program and Data Quality Assurance and Improvement Tools and Processes

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

January 26, 2022

What is QA/QI?

- **Quality Assurance (QA)** can be defined as an activity that measures performance against standards at a specific point in time

- **Quality Improvement (QI)** can be defined as an evidence-based activity designed to continually improve performance, test changes in services, measure the effect of these changes, and use data to improve clinical performance and health outcomes for clients

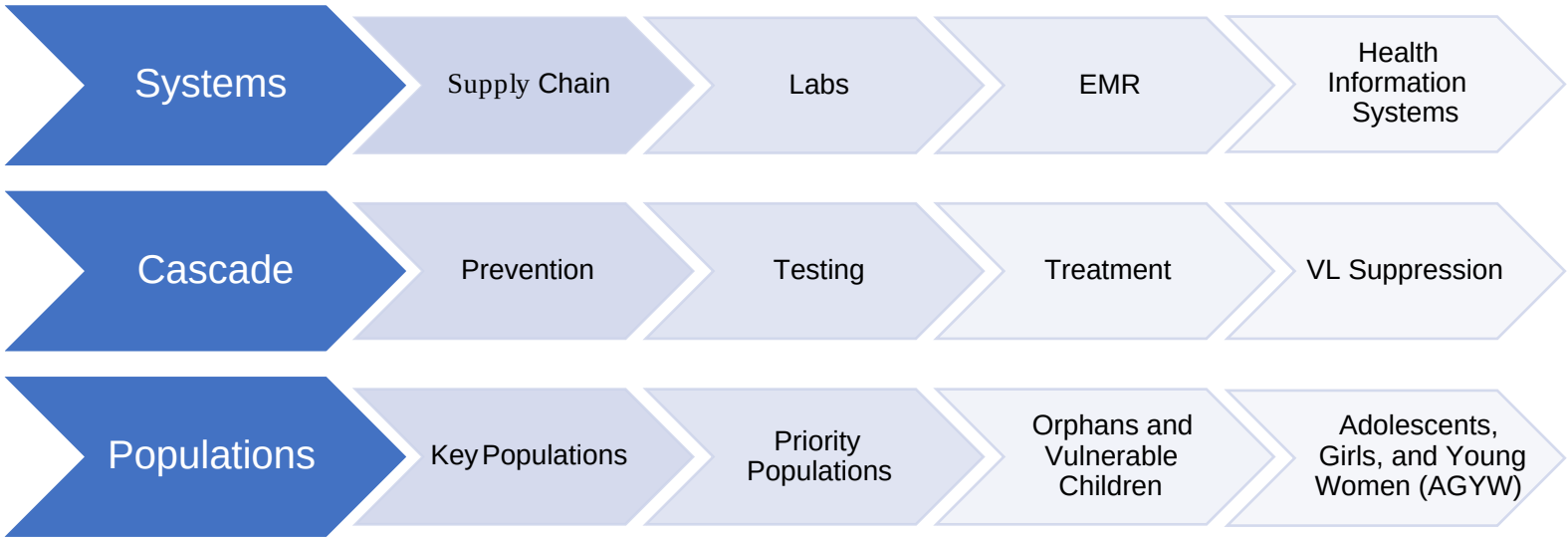
- **Quality Improvement is a specific component of "Continuous Quality Improvement (CQI)"** which is an ongoing process to engage implementing teams in identifying barriers and facilitators of providing quality services and empowering them to take actions to improve results

What do we mean by DQA?

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

- The purpose of DQAs is to ensure that high quality data are being reported to the Ministry of Health (MOH), USAID and PEPFAR by:
  - Identifying systems issues that affect quality of data being reported
  - Validating site level data aggregation and reporting processes
  - Identifying and rectifying any discrepancy between numbers recounted and numbers reported
  - Helping strengthen staff's capacity in data management and reporting
  - Identifying issues related to program quality and making plans to address them

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



DQAs can occur at any level where indicators are measured

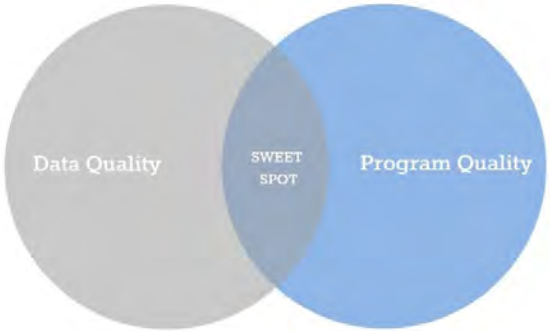
Challenges that can affect Data Quality

- **Systems Issues**
  - Lack of adequate resources for data collection and analysis
  - Data Flows that do not follow patients flow through cascade of services
  - Patient-level monitoring and reporting systems not well designed/managed to accurately generate reportable results
  - Unclear roles and responsibilities in terms of data entry, aggregation, validation and reporting
  - 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

Why specific USAID/PEPFAR Data QA/QI?

- HIV programs are results-oriented and data/evidence driven
- High 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
- Data use to assess compliance with service quality standards and technical guidelines
- PEPFAR operations dependent on high quality data for strategic decisions



Illustrative Example: How can data quality affect program quality and performance?

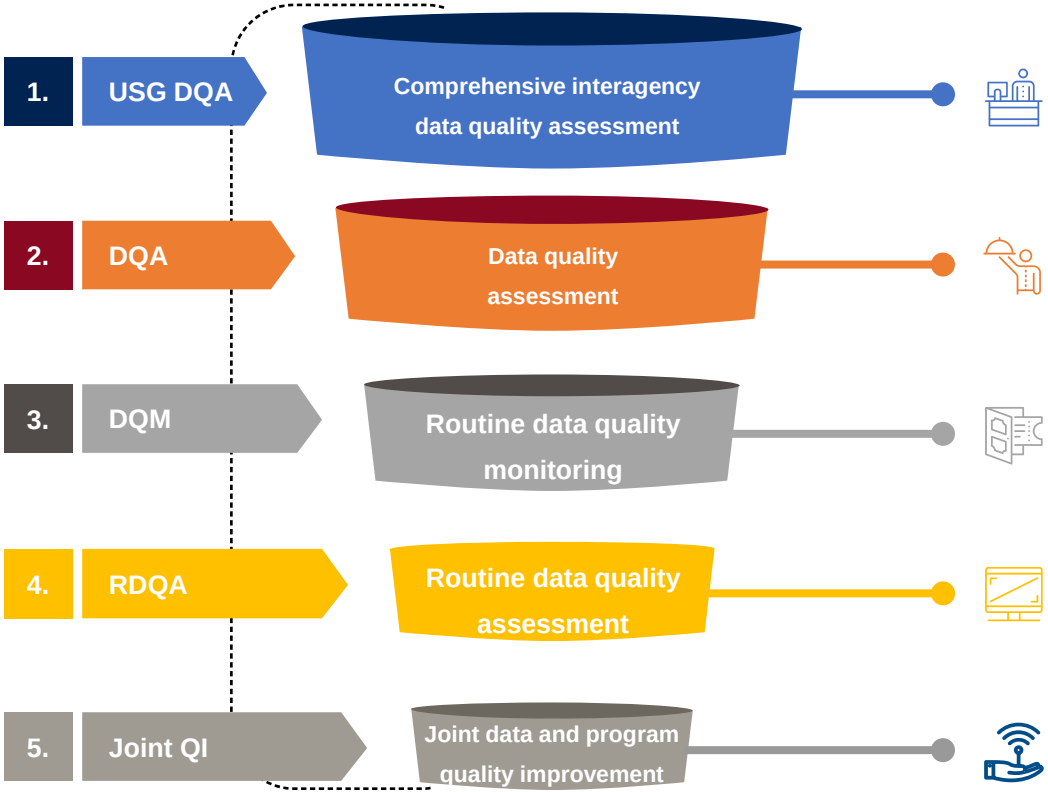
- Site inaccurately reported a high number of HTS_POS:
  - expecting increased # of patients enrolled and maintained on ART
  - more drugs than needed are sent to this site
  - more staff hired to support the site

- Site under reported number of patients
  - Partner put on Performance Improvement Plan (PIP) by USAID
  - Less commodities received in comparison with what is needed
  - Less staff hired than what is needed (impacting quality of critical services)

USAID/OHA Data Quality Assurance and Improvement Approach

Shared Responsibility for Data QA/QI

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

PEPFAR Comprehensive DQA process – Main steps

- **Systems Assessment**
  - To identify data management and reporting issues and chart the path to address the issues
- **Patient and Data Flow Mapping**
  - To understand patients flow and identify potential bottlenecks
- **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

DQA – Standard Analysis Approach

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

Verification factor (VF) greater than +/-10% points to serious data quality issues

- DQA Decision Rule defines acceptable and unacceptable discrepancy between verified and reported data
- When serious data quality issues are identified:
  - Routine Data Quality Assessment should be conducted one quarter after the Initial DQA in all the sites where issues have been identified
  - USAID or third-party may lead comprehensive patient files audit
  - Data Quality Monitoring will follow approximately one quarter after the Initial DQA in all the sites where issues have been identified in the initial DQA or during reported RDQA.
  - Capacity-Building for IP and/or staff working in all the sites supported

Verification factor (VF) between +/-5% and +/-10% indicated moderate data quality issues

- Actions to be undertaken to remediate moderate data quality issues:
  - 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

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 reports submitted 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 check proper implementation of corrective actions taken

USAID/OHA Treatment Data Quality Tools

USAID/OHA Treatment Tools

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

PEPFAR Treatment DQA

- **Context**
  - Full recount required for OGAC mandated DQA
  - Streamline DQA process to inform Program Quality
  - Challenges with Interruption in Treatment (IIT) definition (28 or 90 days)
  - Assess and address systems-related issues
- **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
- **Outcomes from USAID/OHA Treatment DQA**
  - Discrepancies between results reported and data validated
  - Issues with quality of services and compliance with standards or guidelines

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

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											
	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
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
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

Current on ART (Natic Current on ART (National Guidance 90 days)

	FEMALE												Total ND	Total TG	Total Male	Total Female	TOTAL
	<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
Defaulters (Missing)	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

New on ART

	MALE												FEMALE											
	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
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
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
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

New on ART

	FEMALE												Total ND	Total TG	Total Male	Total Female	TOTAL
	<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
February	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
Total New on ART	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											
	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
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
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

Current on ART (PEPF Current on ART (PEPFAR Guidance 28 days) Current on ART (PEPFAR Guidance 28 days)

	FEMALE												Total ND	Total TG	Total Male	Total Female	TOTAL
	<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
Defaulters (Missing)	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

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 will allow us to simultaneously identify data AND program quality issues by leveraging patient record reviews...

				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 Reporting

S/GAC DQA results reporting requirements

All OUs that conducted site-level DQAs in FY need to submit site-level DQA results in FACTSInfo by Q4 reporting deadline (mid-November) and ensure validated numbers are used for the annual reporting and COP planning

DQA Results Reporting

- All OUs that conducted site-level DQAs during FY2021 must submit site-level results
- Formal DQA, DQI, and any other patient data improvement
  - What occurred (DQA, other DQI: EMRs rollout, file room improvement, unique identifier roll out, etc.)
  - What were changes, how this revised results
  - How this would alter interpretation of reported results over time
  - Sufficient information for us to understand, otherwise we may call.
- Submission:
  - Narrative
  - Table or excel file showing DQA results
- **Submit both files into FACTS Info as a supplemental document by the Q4 reporting deadline.**

Deadline: Friday November 12th 2021.

DQA/DQI Narrative

Please submit a short summary that should answer the following questions (at a minimum):

- How many sites were visited and assessed for this DQA or DQI?
- Which indicators did you include in the DQA or DQI?
- What time period was assessed? (For example, assessed TX_CURR for Q2 vs Q1 vs. Current date of assessment)
- Did the DQA include a full file recount at all sites? If not, what proportion of files were reviewed? What records were touched with DQI?
- What type of files were reviewed?
  - Paper-based patient files
  - Electronic patient files
  - Laboratory files
  - All of the above
- Generally, what were the findings of your assessment? (For example, under-reporting at sites, over-reporting, percent of sites with data discrepancies, etc.
- What type of follow up is planned to resolve data quality issues?
- Is the MOH receptive of the site level data quality findings and working to correct national systems where necessary?
- If your DQA/DQI included an assessment of results by age/sex disaggregates, please provide those results as well.

Outline of a DQA summary report

- Number of sites assessed
- Number and list of sites with discrepancies between numbers recounted 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)

Useful Resources

USAID
FROM THE AMERICAN PEOPLE

Critical Reminder

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

Improving capacity for data quality through far-reaching, efficient virtual capacity building course

Welcome to the **USAID/PEPFAR Data Quality Assessment Tools** Online Course! This training focuses on the use of USAID/PEPFAR's Data Quality Assessment (DQA) tools and aims to provide learners with guidance and tips on the implementations and applications of DQA to improve HIV reporting. In this course, participants will be introduced to three new DQA tools that will ensure the optimization of data quality and use.

Self-paced training (can be done in 2 weeks)

- **Course Link (English):** https://rise.articulate.com/share/XpRRm67wrtb8r_Bs9xLfieMZtSBvmFzw
- **Password:** USAID
- **Course Link (French):** https://rise.articulate.com/share/TSXPH9SHK5y840WZkE-X3tI8ooPng7rl#/
- **Password:** USAID

Useful DQA tools

- Data QA/QI Tool (Measure Evaluation suite of tools) can be used for RDQA or any type of DQA
- Data QA/QI Tools (USAID/PEPFAR - Includes tally tools, data flow, and systems assessment questionnaires) can be used for initial DQA focused on the HIV treatment cascade.
- LQAS standard tool - Measure Evaluation can be used to conduct Data Quality Monitoring (DQM) focused on assessing consistency and completeness
- WHO Data quality assessment of national and partner HIV treatment and patient monitoring data and systems implementation tool
- WHO Viral Load Data Quality Assessment module WHO-UNAIDS-PEPFAR-GLOBAL FUND Joint Data Quality Module for Assessing and Strengthening Viral Load Testing Data within HIV Programs and Patient Monitoring Systems

Program Quality: SIMS- PDSA - ESD - RCA

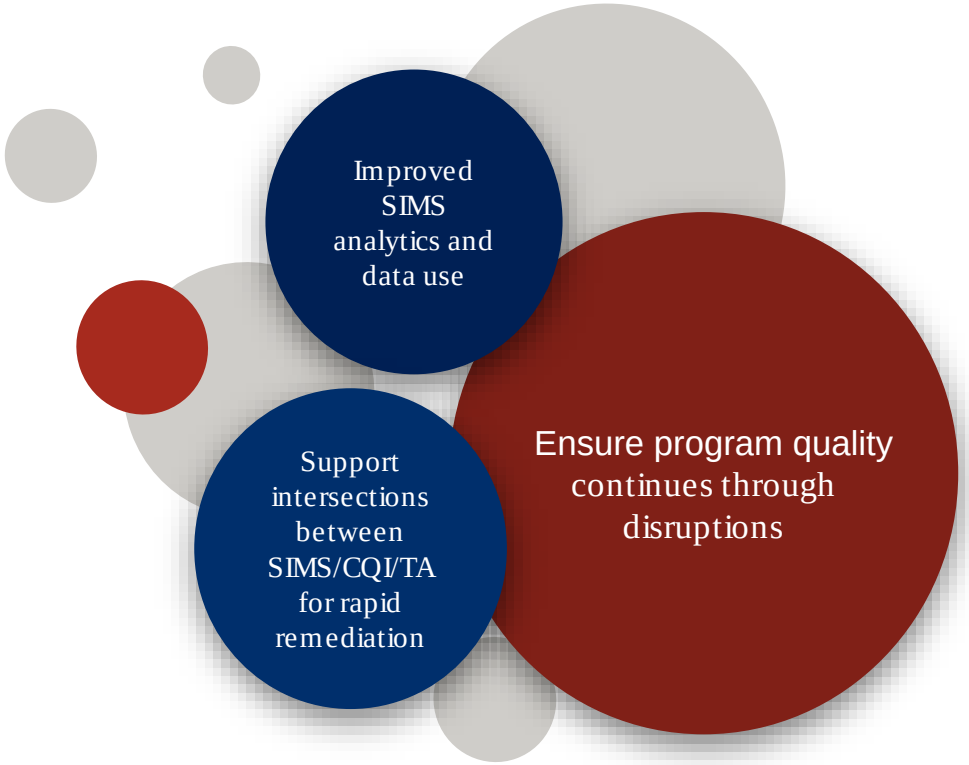
What is SIMS?

- Quality assurance method used to increase the impact of PEPFAR programs on the HIV epidemic through standardized monitoring of the quality of services at the site and above-site levels.

- **SIMS** is a standards-based survey designed to measure service quality and identify program deficiencies using simple questions and skip patterns to determine Red/Yellow/Green scores.

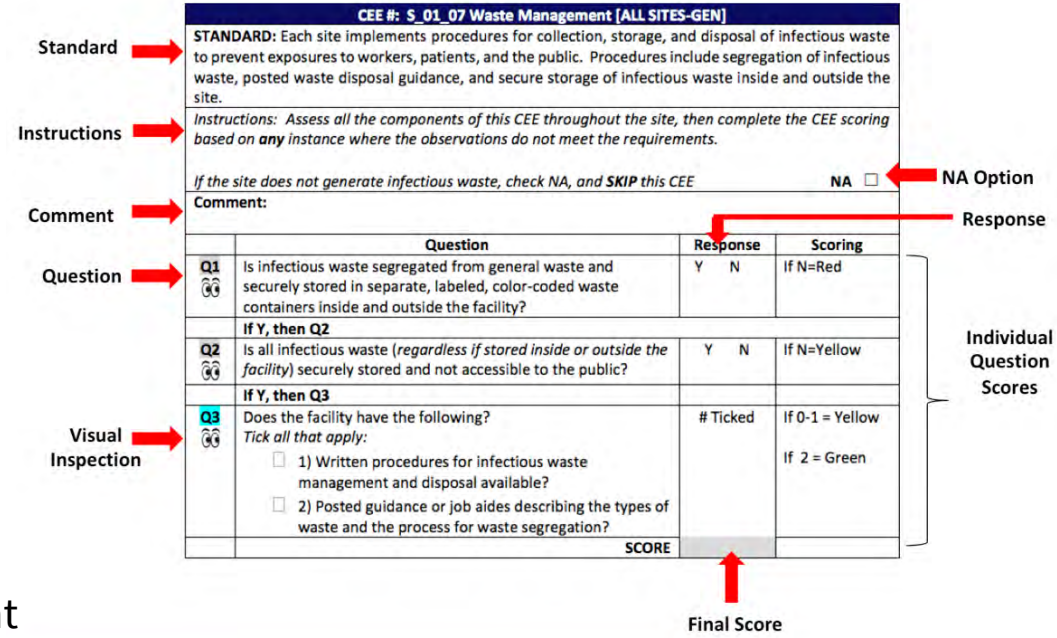
SIMS Priorities for FY22

- SIMS Revision (from SIMS 4.1 to SIMS 4.2)
  - Align SIMS CEEs to MPRs
  - Add CEEs related to pediatric DTG
  - Add CEEs related to New Infection Prevention Control – to address site safety (which includes COVID-19/TB and procedures with documented adverse events
  - Update guidance for COVID-19 adaptation
- SIMS 4.2 launch by October 1, 2022
- SIMS is encouraged to be used as a self-assessment tool



Structure of the tools and scoring process

- **SETS** are groups of CEEs arranged by program, population, or site type.
- **CEEs** or "Core Essential Elements": groups of questions built on program quality standards based upon WHO supported evidence or guidelines and/or documentation of best practices.
- **Assessment questions:** each CEE is composed of a series of questions that progressively assess against the standard



CEE #: S_01_07 Waste Management [ALL SITES-GEN]

STANDARD: Each site implements procedures for collection, storage, and disposal of infectious waste to prevent exposures to workers, patients, and the public. Procedures include segregation of infectious waste, posted waste disposal guidance, and secure storage of infectious waste inside and outside the site.

*Instructions: Assess all the components of this CEE throughout the site, then complete the CEE scoring based on **any** instance where the observations do not meet the requirements.*

*If the site does not generate infectious waste, check NA, and **SKIP** this CEE* NA ☐

Comment:

	Question	Response	Scoring
Q1	Is infectious waste segregated from general waste and securely stored in separate, labeled, color-coded waste containers inside and outside the facility?	Y N	If N=Red
	If Y, then Q2		
Q2	Is all infectious waste (*regardless if stored inside or outside the facility*) securely stored and not accessible to the public?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Does the facility have the following? *Tick all that apply:* ☐ 1) Written procedures for infectious waste management and disposal available? ☐ 2) Posted guidance or job aides describing the types of waste and the process for waste segregation?	# Ticked	If 0-1 = Yellow If 2 = Green
	SCORE		

COLOR (# score)	DESCRIPTION
G: Green (3)	Meets standard
Y: Yellow (2)	Needs improvement
R: Red (1)	Needs urgent remediation
Gray (0)	Not Applicable selected

SIMS Process

- Prioritization of SIMS Assessment site and above-site
  - OUs must provide a justification/rationale for each site/location selected
  - No preset minimum or maximum number of sites or above-site locations to be assessed in each FY

- Conducting SIMS assessments
  - Site level
  - Above-site level

- Corrective Action Plans

- Integrated data analysis to improve or sustain performance and quality

SIMS Assessment Types

- **COMPREHENSIVE ASSESSMENT:** The first assessment at a site or above-site location conducted by USG staff. Comprehensive assessments are meant to review the range of HIV services provided at the site or above-site location.

- **FOLLOW-UP ASSESSMENT:** To be completed within 6 months of the Comprehensive Assessment to re-score red/yellow CEEs and track any improvements. Follow-Up Assessments may be completed either by IPs but related data must be entered into Agency systems by USG staff to ensure that remediation and follow-up visits are happening as planned.

Description of SIMS Assessment Types and Assessment Tool Composition

Assessment Tool	Assessment Type	Conducted by	CEEs to be Assessed
Site	Comprehensive	USG	All applicable* Required and relevant** Elective CEEs
	Follow-Up	USG or IP	All CEEs that previously scored red or yellow.
Above Site	Comprehensive	USG	All applicable Required and relevant Elective CEEs

So…How Do I Define Remediation Strategies?

What *precisely* led to the Red or Yellow Score?

CEE #: S_07_01 Compliance with National Testing Algorithm [HTS]			
STANDARD: Each site performs and records rapid HIV testing in accordance with national testing algorithms.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have written or printed testing protocols or other job aides that are in full accordance with the current national testing algorithm?	Y N	If N=Red
	If Y, then Q2		
Q2	Is the site collecting the following information in either an HTS (HIV Testing Services) register, rapid testing logbook, or some other data collection tool? *Tick all that apply:* ☐ 1) Test 1 (Name of test kit and result) ☐ 2) Test 2 (Name of test kit and result) ☐ 3) Test 3, if applicable (Name of test kit and result) ☐ 4) Final test result given to beneficiary	Y N	If N to Any=Red
	If Y to All, then Q3		
Q3	*Review the 20 most recent entries within the past 12 months where the final test result was HIV positive in the HTS register/rapid testing logbook.* Does a review of these entries reveal 100% compliance with the national testing algorithm?	_____%	If <70% entries compliant=Red If 71-90% entries compliant=Yellow If >91% compliant = Green
	SCORE		

Focus on the question level to help plan **WHAT** needs to be improved and **HOW**?

Corrective Action Plans

- Develop a time-bound improvement plan to ensure that barriers and bottlenecks will be addressed within 6 months
  - Which CEEs scored yellow or red? What actions need to be taken to remediate?
- Track progress towards remediation and improvement
  - All CEEs scored red or yellow from a site assessment must be reassessed within 6 months
  - Follow-up assessments can be conducted by USG or IP staff
  - Make sure that you document your rationale for choosing either option
- Identify above-site / policy barriers that affect site level progress
- Identify support that may be needed
- For sites performing well, consider connecting with other sites that are not performing well to facilitate knowledge / best practice exchange

Using SIMS data

Using SIMS data

- Identify performance barriers and facilitate quality improvement
- Deepen analysis and guide management and improvement
- Prioritize quality improvement of core interventions where most important for epidemic control and impact
- Facilitate improvement in the quality of services and technical assistance, especially at site level
- Ensure delivery of services that meet quality standards and demonstrate accountability by showing that quality is being monitored and sustained or improved (where needed)
- Identify and take actions to address needs for coaching or design of specific tools and/or SOPs
- Help identify best practices that can be shared with underperforming sites

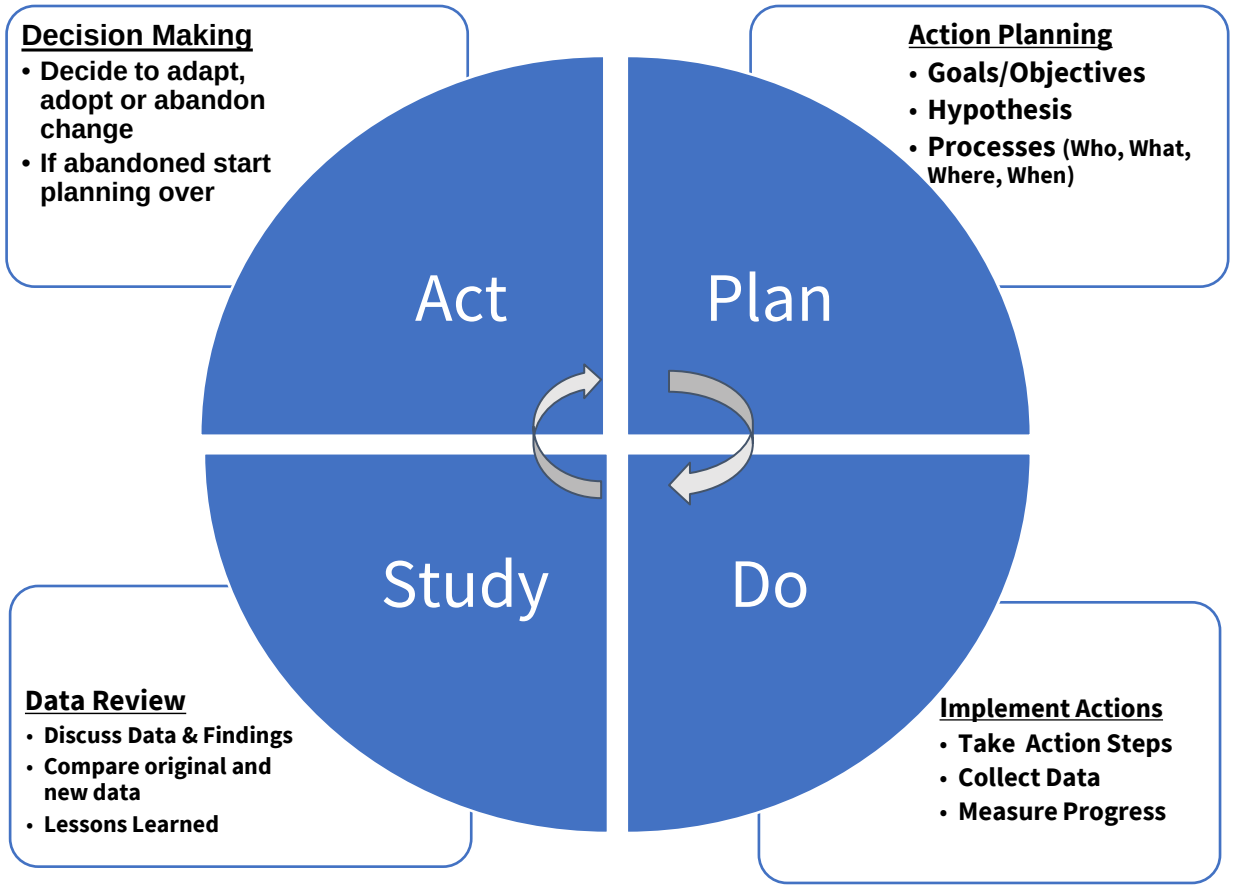
SIMS integrated analyses to improve and sustain program performance and quality

- Ensure efficient program management through cross-analysis / data review of:
  - SIMS with ER: understand how financial resources were spent? on what? for whom?
  - SIMS with MER: determine how quality of services relates to performance?
  - SIMS with above-site investments: identify policy-barrier affecting site-level progress and/or quality? Is the program on-track reaching above-site benchmarks?
  - SIMS with IP workplan: identify what support in DSD or TA that relevant IPs will need to provide?
  - SIMS with Community-led monitoring: understand what are the barriers and enablers from the patient's perspective?

Other Program Quality Tools / Processes

USAID
FROM THE AMERICAN PEOPLE

Plan - Do - Study - Act (PDSA) cycle model



Services Disruptions & no known QA/QI activities (SIMS, DQM, RDQA) conducted

HQ/OHA shares ESD tool with Mission to share with IP

IP receives ESD tool from Mission

ESD is uploaded to the IP POC mobile device

IP POC most proximal to health facility or community site visits site and report on status of services

Qualitative & Quantitative Data is received into GHSurvey or DDC

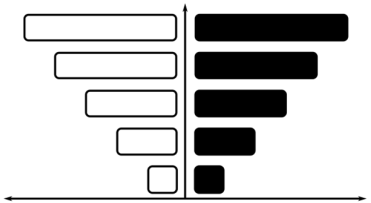
Data is analyzed and shared via a dashboard to HQ, Mission & IP

Program oversight tool during COVID-19 and other service disruptions can be expanded to cover other health areas:

[Essential Services Disruption (ESD) Tool Process Map]

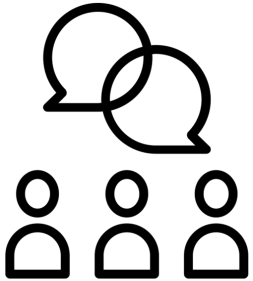
Another tool is standardized RCA package: capitalizes on existing data processes to get deeper insights into causes of IIT and guide program quality/service delivery improvements

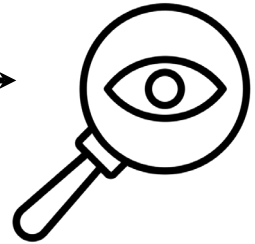
EMR, DQA, Tracing Ledgers provide a way to identify clients who missed appointments for over 7 days



Socio-demographics information allows for better tracking and identification of those at risk for IIT

Individual interviews and focus groups discussions illuminate causes of missed appointments





RCA analysis provides insights into areas needed for service improvement to increase client retention

Assessing Strategic Information Capacity & Capacity Building Efforts

PEPFAR Strategic Information Capacity Assessment (PSICA)

PSICA tool, developed by USAID, helps us **identify** local partners' **specific SI** management **needs** and **tailor capacity building programs** to support high quality PEPFAR data generation, management and use. available in English and French

Domain	Sub-Domain
Human Capacity for PEPFAR Strategic Information	Staff Availability
	Staff Competency
Organizational Processes for PEPFAR Strategic Information	Planning and Budgeting
	Process Management
	Format and Frequency
	Autonomy
Technical Infrastructure Systems for PEPFAR Strategic Information	Systems and Tools
	Autonomy
	Client Level Data
PEPFAR Data Quality and Use	Data Quality Assurance
	Data Quality Improvement
	Data Use
4	12

Thank you

USAID
FROM THE AMERICAN PEOPLE