PUDR - Programmatic performance Section

LFA Training 2019/2020
Geneva, Switzerland

The Global Fund

Outline

1. **Expectations from the LFA in PUDR review – What**
   A. Data verification and validation
   B. Adequate analysis of reported results
   C. Trend and cross analysis
   D. Disaggregation results
   E. Data and quality of services issues (risks and root causes)
   F. Previous recommendations implementation

2. **Expectations from the LFA in PUDR review – How**
   a) Engage with CT when planning and doing the review
   b) Engage with stakeholders in country
   c) Collaborate with fellow LFA experts during PUDR review

3. **Case studies**
   a) PU/PUDR indicators review
   b) Programmatic and M&E risks and related Mitigating Actions

1. **PU template overview**

A PU is a tool that supports in the following:

1 | **Review of progress** — • Reviewing implementation progress of grants (programmatic, financial, and management progress) and assigning an overall grant rating.

2 | **Identifying issues** — • Identifying implementation issues and potential future risks

3 | **Recommendations for grant improvement** — • Guidance on performance improvement and corresponding to risk mitigation measures.

Focus Portfolios:
- Review of Programmatic component (verification of programmatic performance is not requited)
- If review planned and budgeted by the CT, then the review follows the same steps as required.

A. Data verification and validation (1)

General principles *(PUDR guidelines, pages 22-26)***:**

a) No changes in any values in the PR results, only in columns for " LFA verified results".
b) For each results specify how it was verified, if a different approach used should be explained.
c) Indicate if there are discrepancies between the target accumulation in PF and the PR results to ensure that results are aligned to the appropriate reporting period.
d) If results are consistent with the agreed measurement methods and data sources. If different, this should be explained.
e) If results are reported consistently with the way targets were set in the PF.
f) If results have not been verified, to select "not verified" and provide an explanation.
g) Results related to estimates should be verified against the source (i.e. technical partners reports)

A. Data verification and validation (2)

Verification methods:
a) Desk review only, unless different method is specified by CT or PF for a particular indicator or WPTM

Verification approach:
a) Verify compliance of results with indicator definition as per GF indicator guidance sheets and/or PF.
b) Verify whether results actually correspond to the respective reporting period
c) Verify national results against national and/or PR aggregated databases
d) Identify other potential data sources available or co-exist with data source used by PR
e) Report on data quality: comment on the timeliness and completeness of reported results as per data source (database)

B. Adequate analysis of reported results

a) Confirm results reported by the PR, or correct and clarify the discrepancies.
b) Comment on the indicator performance and provide reasons of over/under achievement.
c) Comment on targets achievement in terms of coverage and quality of care;
d) Use for analysis results from other sources if available (ex: WHO, UNAIDS, etc.)
e) Analysis of performance disaggregated by SR or administrative regions (national vs sub-national) if not provided by PR.
f) For sub-national results, indicate the national results and the grant's contribution to national results where available.

C. Trend and cross analysis

a) Analysis of different periods results - comparison with previous trends (including at least one previous reporting period) and explanation of over/under-achievements.
b) Provide yield analysis for diseases indicators where possible (testing coverage vs positivity rate)
c) Provide analysis of indicators that are related (prevention and testing; testing and treatment; positive vs enrolled, etc) to conclude about the coverage trends
d) Triangulation of all available data to conclude on the epidemic trends based on the impact and outcome results.
e) Flag opportunities for efficiencies and value for money in terms of finding the missing cases and targeting the key hotspots/areas.
f) Synthesis in analysis and clear recommendations (concise, specific, realistic and time-bound).

D. Disaggregation results analysis

Reporting requirements :
- High Impact and Core should report on **KPI 6-e** indicators (HIV-O1; TCS-1; TCP-1; MDR-3; CM-1a and CM-2a)
- High Impact and Core – Other indicators as required by the CT.
- Focused countries – Not Required.

LFA Verifications:
a) Check if all required disaggregated results are available. If not, clarify with the PR if and when they can be reported.
b) Check that disaggregation categories numbers add up to the total result. If not, explain why.
c) Ensure that all disaggregated results are correctly reported as per the indicator guidance sheet (as number or percentage). If not, correct and clarify.
d) Ensure that % results reported have correct denominators as per the guidance and respective disaggregation category. For example: % of PLHIV on ART, for female category denominator is # of estimated female PLHIV .
e) Use disaggregation results in your analysis of overall indicator results

E. LFA Review of Progress on Mitigating Actions

(Section-Grant management 4- Section B)

a) Mitigating actions in the PU/PUDR are prepopulated from the GF Integrated Risk Tool and prioritized by the CT.

b) LFA should review and comment on the status of key mitigations actions implementation.

c) Also, review any other recommendation/MAs from programmatic spot-checks, OIG, AMAs if requested by the CT.

d) If required by the CT, LFA should organize sites visits to verify recommendations.

F. LFA findings and recommendations

a) New section structure (drop down table with risk categories and risks) is aligned with the categorization used in the GF Integrated Risk Tool

b) List only "important" programmatic or M&E issues that impacts or likely to impact program implementation and results.

c) Findings and recommendations should be related to general data systems or program quality. Do not repeat issues related to the actual indicator performance.

d) LFA is expected to identify additional programmatic risks and then the CT decides whether it needs to be included on IRM or not.

e) Provide clarification on the key root causes for each risk.

f) Propose practical, feasible and time bound recommendations

2. Expectations from the LFA in PUDR review – How

1. **Engage with the CT when planning and performing the review and agree on:**
   - The scope of the review to be undertaken, prior to conducting the review
   - Deadline for submission of reviewed PUDR
   - Specific requests (expanded scope) by the CT including data sources, exceptional methods for verifications, disaggregation categories, etc.

2. **Engage with stakeholders in-country**
   - Planning for submission of PUDR documents with PR
   - Work with implementing partners (PR, SR), MOH/disease programs, relevant technical partners on data verification and validation
   - Discuss and clarify reasons for discrepancies

3. **Collaborate with fellow LFA experts during PUDR review**
   - Work across their technical expertise to provide holistic analysis of the progress
   - Compare indicator performance vs budget absorption and drugs availability/procurement, etc. providing actionable recommendations.

Case Studies

Case study 1- LFA review of PU/PUDR
What is missing in the LFA comments?

Indicator	LFA comments
TB/HIV-6(M): Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	1) The PR reported a result of 62 percent (3,063/4,944) 2) The PR provides sufficient supporting documents. 3) Targets are not fully achieved.

Case study 1- LFA review of PU/PUDR (2)

Indicator	LFA comments
TB/HIV-6(M): Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	**1) The PR reported a result of 62 percent (3,063/4,944).** Results N/D are reported as per the indicator definition. However, they are not consistent with the supporting documents provide by the PR and 3 implementing SR. The LFA corrected the achievement and final verified result is 3,052/4944 or 61.7%. The reason for this inconsistency is that 11 patients have been double recorded in on of the regional registers. 2**) The PR provides sufficient supporting documents** in the form of Sub-Recipient reports to the PR and the National Tuberculosis Program (NTP) routine reports. **3) Targets are not fully achieved,** however, results show an increase from 85% (Jan-Jun 2018), 91% (Jul-Dec 2018), and to 93% in the current period. 4) Underachievement was due to common issues such as (i) late diagnosis and deaths; (ii) medication side-effects; (iii) limited human resources; and (iv) incompliance with national TB/HIV guidelines 5) In terms of subnational analysis, three (A,B and C region) out of the 20 regions have achievement between 50%-60% which contributed to underachievement of this result. 6) It should be noted that out of total new TB patients only 80% were screed for HIV, and considering the 15% TB/HIV coinfection it would mean that there are ~185 additional TB/HIV patients that does not know their status and were not enrolled on ART treatment. Recommendations: 1) The PR to perform consistency checks between the aggregated data registers before reporting the final result. 2) The PR together with the NTP/NAP to ensure increase in TB/HIV collaborative activities, consistent reporting between NAP and NTP, advocate providers to initiate ART during the anti-tuberculosis treatment and ensure that all TB patients are tested for HIV.

Case study 2- LFA review of PU/PUDR
What is missing in the LFA comments?

Indicator	LFA comments
Malaria I-10(M): Annual parasite incidence: Confirmed malaria cases (microscopy or RDT): rate per 1000 persons per year (Elimination settings)	1) The PR reported an annual parasite incidence of 4.69/1,000 population 2) The PR provided sufficient supporting documents 3) The reported 72,427 confirmed malaria cases, or a 3.6 percent decrease.

Case study 2- LFA review of PU/PUDR (2)
What is missing in the LFA comments ?

Indicator	LFA comments
Malaria I-10(M): Annual parasite incidence: Confirmed malaria cases (microscopy or RDT): rate per 1000 persons per year (Elimination settings)	**1) The PR reported an annual parasite incidence of 4.69/1,000 population** (72,427/ 15,417,194), which is lower than the target of 4.90. The result is slightly lower than 2017 (4.74/1,000 after LFA modification), but much higher than 2015 (3.27/1,000) and 2016 (2.46/1,000 after LFA modification. **2) The PR provided sufficient supporting documents i**n the form of data generated from the HMIS for public health facilities, MIS for VMWs and both HMIS and MIS for private providers. The supporting documents confirm both the numerator and the denominator. The denominator (15,417,194) is reported based on MoH data for estimated mid-year population, which is consistent with the description included in the PF. It should be noted that the denominators reported for 2015, 2016 and 2017 were based on population projections of the National Institute of Statistics. **3) The reported 72,427 confirmed malaria cases, or a 3.6 percent decrease.** The number of confirmed malaria cases for public health facilities, VMWs and private providers are as follows: (a) Public health facilities (national data, i.e. all 25 provinces): 46,087, against 35,648 in 2017; (b) VMWs: 20,126, against 9,873 in 2017; and (c) Private providers: 6,201, against 29,640 in 2017. 4) The possible reasons for the achievement as provided by the PR appear to be plausible. 5) The annual parasite incidences for 2016 (2.56) and 2017 (4.94) as included in the trend analysis provided by the PR appears to be based on the data reported before LFA review and hence, do not take into consideration LFA modifications. 6) The PR commented that malaria cases increased in 7 provinces, especially Pv species. The LFA notes that at the time of previous PU. commented that the number of confirmed malaria cases increased in six provinces in 2017. The provinces with the increased malaria cases in 2018 are the same provinces with the increased malaria cases in 2017.

Case study 3- LFA review of PU/PUDR

What is missing in the LFA comments ?

Indicator	LFA comments
VC-1(M): Number of long-lasting insecticidal nets distributed to at-risk populations through mass campaigns	1) The LFA verified a result of 10,685,831 2) The PR provides sufficient supporting documents. 3) Good performance but Targets are not fully achieved.

Case study 3 - LFA review of PU/PUDR (2)

Indicator	LFA comments
VC-1(M): Number of long-lasting insecticidal nets distributed to at-risk populations through mass campaigns	**1) The LFA verified a result of 10,685,831.** Type of verification: PR-level verifications (interviews, and data review). We verified that 10,685,831 LLINs were distributed during the mass campaign. This is analyzed by region as follows : Region: Southern - 5, 506,015; Northern - 1,384,199; Central - 3,795,617. Total-10,685,831 **2) The PR provides sufficient supporting documents.** Data source: LLINs Mass Campaign 2018 Draft Report dated 15 June 2019 and shared with CT on 25 June 2019. **3) Good performance but Targets are not fully achieved.** Achievement for this indicator was 98% (10,685,831/10,958,223) as not all of LLINs received in the country were distributed. The 2018 LLIN mass distribution campaign distributed nets in 4,932 distribution sites. LLINs were received and distributed as follows according to the draft report. Region LLLINs received LLINs distributed Achievement Southern 5,240,401 5,506,015 105% Northern 1,459,423 1,384,199 95% Central 4,257.234 3,795,617 89% Total 10 957,148 10,685,831 98% It is our understanding that final reconciliation and analysis of variances noted is underway. Recommendations: The PR to provide the final results of the final reconciliation and analysis of variances in the next reporting period.

Case study 4 - LFA review of Programmatic and M&E risks and related Mitigating actions

Instructions: Please look at the MA required and read the PR response. Consider the verification report provided by the LFA and respond to the following questions:

1. Are those comments supporting or not the PR response? Is the LFA clearly confirming or not the PR response?
2. Have the LFA provided sufficient information (clarification) to understand why the CT should use LFA recommended status for each MA?
3. Which documents and questions should the LFA have requested to the PR to verify the reported progress?
4. What is missing in the LFA comments, and what would you change?

Case study 4 - LFA review of Programmatic and M&E risks and related Mitigating actions (2)

Step 1. Grant Management_4. B. PR & LFA Review of Progress on Mitigating Actions.

Risk details	timeline	Mitigating action	PR status	PR comments	LFA Status	LF comments
"Programmatic and M&E." Inadequate design and operational capacity of M&E systems. The data verification mechanism used by the PR to ensure the quality of the reported data is not effectively and appropriately fed back to SRs and SSRs.	15-Jun-19	PR to develop and submit a supervision plan (QA officers)	Met	Supervision plan was developed on a monthly basis since the beginning of this year instead of on a quarterly basis as it used to be for the QA officers, because of the socio-political instability these monthly plans had to be adapted every time. Reports are available for the GF or LFA revision.	In Progress	Documentation was provided by the PR to the LFA regarding 134 sites covered by supervision or quality assurance visits conducted by the QA Officers for the period from January to April 2019. However, as of September 3 2019, the PR did not provide neither the reports for the month of May and June 2019 nor the planning for the months of July, August and September 2019.
"Programmatic and M&E". Inadequate program quality and efficiency. There are limited processes in place for regular capacity building, supply management, supervision and feedback to and from the point of care to higher level of service organization.	31-Dec-19	PR to report on progress achieving milestones of the M&E mitigation actions plan explaining processes and activities to strengthen PR M&E capacity with a focus on systematic analysis, data and program quality assessments, feedback to SRs and SSRs and follow up on implementation of corrective measures.	In Progress	An M&E plan that includes the priorities and milestones was developed by the PR and approved by the GF in order to better follow up the progress strengthening the PR and SR M&E capacity. Systematic analysis of malaria data became more complicated early this year because the MOH no longer authorizes the M&E departmental officer to feed data into the DHIS2 system that was developed by the PR for and with the PNCM to allow for specific dashboards. The PR is currently discussing with the MOH in order to decide the way to move forward. GF had proposed to support the development of dashboards for the national programs but again the MOH/UEP had decided to work internally with the programs in order to decide the best strategy in the future. Many leadership changes at the MOH and in the PNCM have hampered the development of the initiative.	In Progress	PR provided feedback to the SRs during this period under review through management letters. The PR also developed Excel worksheets that allow the follow up on the implementation of the corrective measures.

Case study 5- LFA review of Programmatic and M&E risks and related Mitigating actions

Instructions: Please look at the LFA recommendations and answer the following questions:

1. Is the root cause comment provided by the LFA in alignment to the standard root cause and risk selected in both cases?
2. Are the root causes important as to propose a Mitigation Action?
3. Are the mitigating actions proposed practical, feasible and timebound?
4. Did the LFA included sufficient explanations to explain the verified status of the proposed Mitigation Action?
5. What is missing in the LFA comments, and what would you change?

Case study 5- Reviewing how the LFA reports their findings and recommendations of Programmatic and M&E risks and proposes related Mitigating actions (2)
Step 2. LFA_Findings&Recommendations_6.

Risk Category	Risk	Root Cause	Root Cause Comment	Mitigating Action	Actor	Actor Type	Timeline DD/MM/YYYY]	Status	LFA Comments
Programmatic and M&E	Limited data availability and inadequate data quality	Disaggregated data is not collected or reported enabling the program to target populations, sub-groups and geographic areas.	The current data collection tools do not allow to report disaggregated data by age for the following four [4] indicators: I-3.1(M); CM-1a(M); CM-1b(M); CM-1c(M)	Follow up should be made to adapt/update the collection tools in order to reports disaggregated data	Management	PR	11/30/2019	Not Started	This issue was previously raised with the PR and the Global Fund CT
Programmatic and M&E	Limited use of data	Analysis of available data (i.e., triangulation) to assess coverage, quality and impact does not happen and is not used for strategic investments and improvements to program quality.	Data related to malaria diagnosis and treatment activities present discrepencies between DHIS2 SISNU [from UEP] and DHIS2 Tracker [DELR] [Please see lines 59 to 73 in the Grant Rating Tool Excel document; the tab named "Working Notes"].	Activities [such as routine meetings] to ensure triagulation/comparison of identical data collected and/or aggregated through different data management systems should be defined and held on a regular basis.	Management	PR	10/31/2019	In Progress	