Program Quality Overview

PROGRAMMATIC M&E LFA TRAINING

OCTOBER 2019 – JANUARY 2020
GENEVA, SWITZERLAND

TheGlobalFund
1. Program Quality and the Role of the LFA

Presentation outline:

1. Program Quality & Importance to the Global Fund
2. Approaches to Program quality assessment
3. Planning and Implementation of Programmatic Spot Checks & Targeted HFA
4. Expected outputs
5. Spot light- New Spot Check: AGYW
6. Spot light- HFA : Quality of Care Assessment
7. Case study – Review & Discussion
What is Program Quality?

The degree to which health programs increase the likelihood of desired outcomes

- Poor quality health programs are an impediment to achieving Global Fund’s objectives & waste resources
- To support the objective to maximize impact, program quality requires measurement
1. Program Quality and Importance to the Global Fund

- **Mainstreaming program quality is a key component of the Global Fund strategy**

- The Global Fund is committed to improving program quality to \textit{maximize} impact at the country level

  - Identifying and addressing \textit{critical bottlenecks} at different levels of country systems
  
  - Identifying and replicating \textit{best practices} leading to better health outcomes
  
  - Assurance, monitoring and continuous quality improvement to drive impact
1. Data Use For Action and Improvement (DUFAI) Framework

**Country processes**

1. Investments in country data systems and analytical capacities

2. Program monitoring

3. Systematic data analysis & synthesis

4. Evaluations

5. Data use through ongoing dialogue, action and improvement

**Global Fund entry points**

- Improve data availability & quality ($6m)
  - Support partners in development of normative tools and guidance, and dissemination harmonized tools and process to countries.
  - Invest in HMIS / DHIS through regional and global software development and TA network: $6m

- Analytics and data use ($6m)
  - Build in-country analytical capacity, Strengthen data analysis and program reviews: $3m
  - Technical assistance pool: $3m

- Comprehensively evaluate for learning and accountability ($5.5m)
  - GF-led evaluations in focused countries: $5m
  - Thematic reviews: $1.5m

**Coordination with partners**

- $6m

**The Global Fund**

- Le Fonds mondial
- El Fondo Mundial
- Глобальный фонд
- 全球基金

الصندوق العالمي
Concept on program quality

- Program quality has many dimensions and is complex to measure

- During the grant cycle, program quality assessments are conducted to obtain insight into the quality of GF-supported programs

- A combination of assessment methods as appropriate to the country context are used to monitor program quality and identify issues, define activities for program improvement and follow up on implementation of ongoing quality improvement measures
The Global Fund supports program monitoring to:

1. To track program performance
2. To assist in effective management
3. To inform and support timely decision-making through systematic collection of data alongside program implementation
4. Assess adherence to established standards and procedures for program quality
5. Plan for future risk mitigation and assurance activities
1. Program Monitoring

How does the Global Fund support countries in program monitoring?

- By participation in global efforts to harmonize monitoring frameworks and indicators for unified data collection and reducing reporting burden on countries.
- By the development and application of M&E frameworks for KPs, AGYW, measuring human rights-related barriers to access services and for COEs
- By Strengthening and using existing country reporting platforms to access real time data
- By using a set of tracer indicators to assess program quality.

Each indicator is given a score using a scale of 0 to 4 based on the results, and a composite score is generated resulting in a program quality tracer rating: very high/high/moderate/low program quality.
# Program Quality: HIV

<table>
<thead>
<tr>
<th>Components</th>
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</thead>
<tbody>
<tr>
<td>PLHA know their status: % of estimated people living with HIV knew their positive status</td>
</tr>
<tr>
<td>ART coverage: % estimated people living with HIV currently on ART (adults and children)</td>
</tr>
<tr>
<td>12 month ART retention: % of people who ever initiated ART are still on ART at 12 months after ART initiation (adult and children)</td>
</tr>
<tr>
<td>Viral suppression: % of people who retained in ART for at least 6 months with viral load below 1,000 copies/ml</td>
</tr>
</tbody>
</table>

The sources of the data for these components are either:
(1) Data quality reviews; (2) country evaluations; (3) data quality spot checks; (4) national or disease specific program review; (5) routine programmatic analysis; (6) partner reviews; (7) review of data systems (community/facility); (8) thematic reviews; systematic data quality checks; (9) prospective country evaluations; (10) National program reports (UNAIDS Global AIDS Monitoring, WHO ART Report, Global Cascade Workshop); and (11) national representative; surveys (PEPFAR Population-based HIV Impact Assessment, DHS, AIS); results from PU/DR
## Program Quality: Malaria

Malaria program quality is assessed as a composite of three indicators which are rated according to their performance.

<table>
<thead>
<tr>
<th>Component</th>
<th>Main Data Source / means of implementation</th>
<th>Frequency of Implementation in High Impact and Core countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>ITN Use: Proportion of population that slept under an insecticide-treated net the previous night</td>
<td>MIS or MICS or DHS</td>
<td>on average every 2 years</td>
</tr>
<tr>
<td>Diagnostic coverage: proportion of suspected malaria cases that receive a parasitological test</td>
<td>HFA, QoC</td>
<td>1-3 years</td>
</tr>
<tr>
<td>IPTp Coverage: % of women who received at least 3 doses of IPTp for malaria during ANC visits during their last pregnancy**</td>
<td>HFA, QoC</td>
<td>1-3 years</td>
</tr>
</tbody>
</table>
# Program Quality: TB

<table>
<thead>
<tr>
<th>Components</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment coverage: % of notified cases of all forms of TB - bacteriologically confirmed plus clinically diagnosed, new and relapses among all estimated cases (all forms)</td>
<td></td>
</tr>
<tr>
<td>Treatment success rate: % of TB cases, all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated (cured plus treatment completed) among all notified TB cases (drug susceptible)</td>
<td></td>
</tr>
<tr>
<td>Treatment success rate - RR/MDR-TB: % of bacteriologically-confirmed RR and/or MDR-TB cases successfully treated (cured plus completed treatment) among those enrolled on second-line anti TB treatment</td>
<td></td>
</tr>
<tr>
<td>ART for TB/HIV: % of HIV-positive registered TB patients (new and relapse) given anti-retroviral therapy during TB treatment</td>
<td></td>
</tr>
</tbody>
</table>

The sources of the data for these components are either:

1. Data quality reviews;
2. Country evaluations;
3. Data quality spot checks;
4. National or disease specific program review;
5. Routine programmatic analysis;
6. Partner reviews;
7. Review of data systems (community/facility);
8. Thematic reviews; systematic data quality checks;
9. Prospective country evaluations;
10. Nationally program reports (WHO Global TB report); and
11. Results from PU/DR.
### 2. Approaches to Program Quality Assessment: Options

<table>
<thead>
<tr>
<th>Assurance</th>
<th>Main service provider</th>
<th>Assurance</th>
<th>Service provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of data systems (community/ facility)</td>
<td>Country led (TA as needed); Quality assurance by identified QA service provider/LFA</td>
<td>Partners review</td>
<td>Partners</td>
</tr>
<tr>
<td>Program quality/ data quality spot checks</td>
<td>LFA</td>
<td>Country evaluations</td>
<td>GF-led with service provider in focused countries</td>
</tr>
<tr>
<td>Health facility assessment (national/targeted)</td>
<td>Country led (TA as needed) Targeted HFA by LFA/ identified service provider</td>
<td>Thematic reviews</td>
<td>Secretariat-led with service providers</td>
</tr>
<tr>
<td>Data quality reviews (national/targeted)</td>
<td>Country led (TA as needed); Quality assurance of national DQR by identified QA service provider; Targeted DQR by LFA/ identified service provider</td>
<td>Prospective Country Evaluations</td>
<td>Secretariat (TERG-led) with service providers</td>
</tr>
<tr>
<td>Review of Laboratory systems</td>
<td>Country led (TA as needed); Quality assurance by identified QA service provider/LFA</td>
<td>Population-based surveys (Examples: IBBS, PSE for KP, TBPS, MIS)</td>
<td>Country led (TA as needed) or partner contracted service provider</td>
</tr>
<tr>
<td>Routine programmatic analysis (Examples: Service Cascade-HIV)</td>
<td>Country led (TA as needed) or identified service provider in some scenarios</td>
<td>Community based monitoring</td>
<td>Country led (TA as needed)</td>
</tr>
<tr>
<td>Program reviews</td>
<td>Country led (TA as needed) with support of identified service provider in some scenarios</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Approaches to Program Quality Assessment

Harmonized Health Facility Assessment Approach

- Joint stakeholder process to harmonize existing health facility assessment implementation, led by WHO and supported by the Global Fund, the World Bank, USAID, GAVI, UNICEF and several other agencies.

- Harmonized indicators, definitions, standard questions (question bank)

- Coordinated implementation at country level and with partners to avoid duplication of efforts and to improve results.

- Improved comparability of results across time, geographical location

**WHO HFA(SARA)** Modular approach enables customization of the survey to the specific country context
2. What is a Health Facility Assessment?

- WHO recommends countries conduct the assessment as a routine aspect of a country’s strategic planning cycle.
- Generates evidence to support the planning and managing of a health system.
- Assessment tool designed to assess and monitor the service availability and readiness of the health sector, quality of care, data quality, management.
- Address the following key questions (among others) on health services:
  - What is the availability of different health services in a country?
  - To what extent are facilities prepared to provide specific health services?
  - To what extent does the service delivery process follow generally accepted standards of care?

HFAs are used by countries for their own strategic planning, but also provide assurances to donors.
While health facility assessments are developed for larger scale implementation, these tools can be used for a more focused assessment with a smaller and targeted sample.

Country teams can decide to use specific modules (e.g. HIV, TB or Malaria) or some specific domains of a module (service availability, service readiness, management and finance or quality of care) depending on the country context.
2. WHO SARA

- **Introduction to Service Availability and Readiness Assessment**
  
  [https://www.who.int/healthinfo/systems/sara_introduction/en/](https://www.who.int/healthinfo/systems/sara_introduction/en/)
  
  Description: The current WHO Service Availability and Readiness HFA survey “plus” additional selected quality of care indicators/questions

- **SARA Reference Manual contains the instrument & indicators:**
  

## 2. Comparison of a nationally representative HFA and the Targeted HFA

<table>
<thead>
<tr>
<th></th>
<th>Nationally representative HFA</th>
<th>Targeted HFA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tool</strong></td>
<td>Harmonized Health Facility Assessment tool or other HFA tool that includes core indicators and quality of care (e.g. SARA plus, SPA, SDI)</td>
<td>Harmonized Health Facility Assessment tool or other HFA tool that includes core indicators and quality of care (e.g. WHO SARAplus)</td>
</tr>
</tbody>
</table>
| **Components**         | Entire Health Facility Assessment survey tool  
-Comprehensive assessment includes general and specific services (e.g. RMNCH, HIV, TB, malaria, non-communicable diseases, etc.)  
-Include all facility management, supervision, HR, finance, lab, pharmacy, etc. sections | Only the HIV, TB and/or malaria components of the Health Facility Assessment survey tool |
| **Sample Size**        | Nationally representative (census or representative sampling)                                | Will vary, but generally 20 - 40 sites                                     |
| **Inference of results** | Nationally representative                                                                     | Will vary based on sampling used if inference is possible beyond the sites visited and to what extent |
### 3. Comparison of Planning a National and Targeted HFA

<table>
<thead>
<tr>
<th></th>
<th>Nationally HFA</th>
<th>Targeted HFA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Funding</strong></td>
<td>Global Fund with or without Partners; Partners</td>
<td>Global Fund Country Team</td>
</tr>
<tr>
<td><strong>Planning</strong></td>
<td>Coordinating group of country stakeholders</td>
<td>LFA M&amp;E team in collaboration with the PR, MoH and in-country stakeholders, i.e, WHO</td>
</tr>
<tr>
<td><strong>Implementer</strong></td>
<td>Country-led with TA as needed</td>
<td>LFA M&amp;E team</td>
</tr>
<tr>
<td><strong>Methodology</strong></td>
<td>Census or representative sampling, requires Master Facility List</td>
<td>Will vary, but generally 20 - 40 sites</td>
</tr>
<tr>
<td><strong>Tools</strong></td>
<td>✓ Select modules based on objectives;</td>
<td>✓ Focus on HIV, TB &amp; Malaria services &amp; Quality of Care;</td>
</tr>
<tr>
<td></td>
<td>• Guidance</td>
<td>• Guidance</td>
</tr>
<tr>
<td></td>
<td>• May Adapt questionnaires based on objectives</td>
<td>• May adapt Questionnaires based on objectives</td>
</tr>
<tr>
<td></td>
<td>• Data Entry CSPRO or similar</td>
<td>• Data Entry -Excel sheet</td>
</tr>
<tr>
<td></td>
<td>• Data Analysis Excel Workbook</td>
<td>• Data Analysis -Excel sheet</td>
</tr>
<tr>
<td></td>
<td>• Develop a data analysis plan</td>
<td>• Develop a data analysis plan</td>
</tr>
<tr>
<td><strong>Data Collection</strong></td>
<td>✓ Training</td>
<td>✓ Conduct Actual Survey</td>
</tr>
<tr>
<td></td>
<td>✓ Pilot &amp; Modification as needed</td>
<td>✓ Data management</td>
</tr>
<tr>
<td></td>
<td>✓ Conduct Actual Survey</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ Data Management</td>
<td></td>
</tr>
<tr>
<td><strong>Quality Control</strong></td>
<td>Yes</td>
<td>Will vary, but generally 20 - 40 sites</td>
</tr>
<tr>
<td><strong>Inference of results</strong></td>
<td>Nationally representative</td>
<td>Will vary based on sampling used if inference is possible beyond the sites visited and to what extent</td>
</tr>
</tbody>
</table>
4. Outputs - Priority SARA Indicators: TB

**TB: Service Availability Indicators**

- TB diagnostic testing
- Provision of drugs to TB patients
- Management and treatment follow-up for TB patients

**TB: Service Readiness Indicators**

- Guidelines for diagnosis and treatment of TB
- Guidelines related to MDR-TB treatment (or identification of need for referral)
- Staff trained in TB diagnosis and treatment
- Staff trained in client MDR-TB treatment or identification of need for referral (in countries where applicable)
- Guidelines for TB infection control
- Staff trained in TB Infection Control
- Guidelines for management of HIV & TB co-infection (in countries where applicable)
- Staff trained in management of HIV & TB co-infection (in countries where applicable)
- TB microscopy
- HIV diagnostic capacity (in countries where applicable)
- System for diagnosis of HIV among TB clients (in countries where applicable)
- First-line TB medications in stock
<table>
<thead>
<tr>
<th><strong>Malaria: Service Availability Indicators</strong></th>
<th><strong>Malaria: Service Readiness Indicators</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria Services</td>
<td>Guidelines for diagnosis and treatment of malaria</td>
</tr>
<tr>
<td>Malaria diagnosis</td>
<td>Guidelines for IPT</td>
</tr>
<tr>
<td>Malaria Diagnostic testing</td>
<td>Staff trained in malaria diagnosis and treatment</td>
</tr>
<tr>
<td>Malaria diagnosis by clinical symptoms</td>
<td>Staff trained in IPT</td>
</tr>
<tr>
<td>Malaria Diagnosis by RDT</td>
<td>Malaria Diagnostic capacity</td>
</tr>
<tr>
<td>Malaria Treatment</td>
<td>First line antimalarial in stock</td>
</tr>
<tr>
<td>IPT drug</td>
<td>ITN</td>
</tr>
<tr>
<td></td>
<td>IPT drug</td>
</tr>
</tbody>
</table>

4. Outputs- Priority SARA Indicators: Malaria
4. Outputs- Priority SARA Indicators: HIV

**HIV: Service Availability Indicators**
- HIV Counselling & Testing
- HIV/AIDS care and support services
- Treatment of opportunistic infections
- Intravenous treatment of fungal infections
- Care for Paediatric HIV/AIDS patients
- ARV prescription or ARV treatment follow-up services
- Treatment follow-up services for persons on ART

**HIV: Service Readiness Indicators (1)**
- Guidelines on HIV Counseling & Testing
- Guidelines for clinical management of HIV
- Staff trained in HIV Counselling and testing
- Staff trained in clinical management of HIV
- HIV Diagnostic capacity
- System for diagnosis of TB among HIV+ clients
- IV treatment fungal infections
- Guidelines for Antiretroviral therapy,

**HIV: Service Readiness Indicators (2)**
- Staff trained in ART prescription and management
- CD4 or Viral load
- Three first-line Anti-Retrovirals
- Dried blood spot (DBS) filter paper for diagnosing HIV in newborns
- Nevirapine (NVP) syrup
- System for diagnosis of TB among HIV+ clients
- Maternal ARV prophylaxis
- Zidovudine (AZT) syrup
## Existing LFA Programmatic Spot Checks

<table>
<thead>
<tr>
<th>HIV</th>
<th>TB</th>
<th>Malaria</th>
<th>AGYW</th>
<th>PWID</th>
<th>DHIS</th>
<th>M&amp;E Plan &amp; Implementation</th>
<th>Supervision</th>
<th>Training</th>
<th>HPM related</th>
</tr>
</thead>
</table>
Planning Programmatic Spot Checks

1. Country Team request LFA to implement Spot checks based on risk, country context and assurance needs.

2. Based on knowledge of the local context, LFA can also recommend a need for a Spot Check.

3. Standard Terms of Reference for Spot Checks developed; may be customized based on objectives and context.

4. LFA & Country team to agree on the Scope of Work, Sampling approach, Experts and LoEs before Spot check starts.
Implementing a Spot Check

Step 1: Complete the planning template, based on the ToRs

Step 2: Review relevant background materials and grant information to contextualize Spot Check

Step 3: Identify & Coordinate with in-country stakeholders in advance

Step 4: Respond concisely to each question in the ToR based on review of documents and responses to interviews during field work

Step 5: Summarize results and submit raw data across all entities assessed as annex to the final report.

Step 6: Interpretation, limitations, recommendations and Report including an executive summary

Note!! Verification includes checking the reliability of supporting/underlying documents for any evidence of fraud. If found, alert GF and provide evidence.
LFA is expected to analyze data across all facilities and across all key informants interviewed. This applies to both qualitative and quantitative data.

- **For qualitative data:**
  (i) conduct a thematic analysis and present synthesized findings across the individuals interviewed or facilities assessed
  
  (ii) focus on examining data and recording emerging patterns or themes within the data to explain key issues and to serve as basis for recommendations.

- **For quantitative data:**
  (i) for categoric responses[ yes/no/partially]: Use frequency tables & charts
  
  (ii) where results are presented in %, provide the counts (n) : # of sites/ people interviewed
Step 6: Classify findings into Major and Minor issues and list them in order priority

<table>
<thead>
<tr>
<th>Major issue</th>
<th>Minor Issues:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant gaps that pose <strong>major risks</strong> to the successful implementation of the assessed activity</td>
<td>The identified gaps pose <strong>minor risks</strong> that can be managed and/or strengthening measures can be implemented within a short timeframe</td>
</tr>
</tbody>
</table>

The LFA’s recommendations should be **specific, relevant** and **realistically achievable** in the implementation context. The LFA should provide an **appropriate timeframe** for the implementation of each recommendation.
### 3. Linking SMART recommendations to Data Use for Programme Improvements

**Specific, Measurable, Achievable, Result-oriented, Time-bound**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>1. PCU has no supervision plan</strong></td>
<td>PCU to develop a supervision plan to enhance the supervision of Disease Programmes and Implementation Partners.</td>
<td>By 30 March, 2020</td>
<td>PCU</td>
</tr>
<tr>
<td><strong>2. LFA found HIV tests’ data discrepancy between Laboratory register and Monthly Integrated Activity Report</strong></td>
<td>LFA recommends that health facility in-charge should make sure the correct figures are transferred from Lab register to Monthly Report</td>
<td>By June, 2020</td>
<td>Health Facility in-charge and BPHS/EPHS implementers</td>
</tr>
<tr>
<td><strong>3. Developing comprehensive supervision policies and plans to guide the support supervision activities for Community TB interventions, covering both the community sputum collection points and Community mobilization and demand. The documents should articulate the different types of SS visits and objectives of each visit i.e. programmatic, M&amp;E, financial etc.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. The integrity of data at the ABCD site is questionable, with 100% of the documents reviewed having at least one data inconsistency/ error. There should be remedial training and close monitoring by the PR of CPAI PEs on adherence to good data recording practices</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Programmatic Spot Checks Spotlight:

1) Adolescent Girls & Young Women
2) Human Rights
The following tools are now available:
- Generic TOR
- Guidance note
- Planning tool
- Reporting template

AGYW/HR are relatively new areas. Key areas for consideration when planning and conducting a spot check:

Selection of sites:
- Volume – having a good mix of high and low volume sites
- Service diversity – focus on those offering a diversity of services, especially with a defined package of service
- If there are issues for follow up based on previous assessment
- Newly identified districts for scale up

Approach:
- Key informant interviews – service staff (community workers/outreach/peer educators), beneficiaries
- Desk review of relevant documents
  - International & national guidelines on programming for adolescents e.g. UNAIDS/HIV prevention, WHO’s/adolescents health, NSPs,
  - Youth/AGYW strategy, HR guidelines etc.
  - Program documents – progress report, documented implementation strategies etc.
1. Mapping of available service providers targeting AGYW/Youth
   - Accessibility & services provided
   - Coordination and how that is supporting referrals/linkage.

2. Targeting and enrollment of AGYW into the program – vulnerability assessment where applicable, risk assessment etc
   - Is there a structured process of continually identifying needs of AGYW, and whether the program is addressing those needs in a timely manner.

3. Defined package of service provided and linkage to national guidance where this exists.
   - Link to reporting YP 2 indicator – how is this computed? When is a beneficiary counted as “reached” and reported in YP 2 indicator?
   - What is the definition of “reached”?

4. Are services tailored to specific age groups based on country led guidance?
   - Community strengthening - are there activities/services provided to families, households & communities.

5. Compliance/adherence to interventions – availability and use of SOPs/guideline for delivering interventions

6. Relevance and appropriateness of service/s provided and if aligned to expectations and needs.
   - Individual beneficiaries
   - Households, families and communities

Key areas for consideration at implementation
Key areas for consideration at implementation level

Adequacy of M&E system with regards to the following:

- Availability of tools that support identification & enrollment of vulnerable AGYW into the program, track services provided & reporting, changes occurring to the beneficiaries, clarity & understanding of tools by providers

- When individuals are counted as being “reached” depending on the intervention provided
- Reporting of unique individuals who receive a defined package of service, is there a system to address potential double reporting within the program?

- Design of data collection and reporting tools among different service providers and alignment to a particular system to avoid double counting; support the counting of AGYW and youth having received multiple services

- Monitoring of referrals and linkages made to services not offered by the PR/SR
- Mechanisms that ensure data quality at all levels

- Data use – is there evidence that data is analyzed and use beyond reporting to the next level?
<table>
<thead>
<tr>
<th>1. Availability of systems and structures that support implementation of HR programs; dedicated staff, capacity building for the staff etc.</th>
<th>6. Implementation modality – is this effective in reaching, identifying and addressing HR issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Specific interventions/services delivered</td>
<td>7. Availability and use of tools to track services/activities</td>
</tr>
<tr>
<td>3. Which populations/individuals are targeted?</td>
<td>8. Clarity for use by providers</td>
</tr>
<tr>
<td>4. How are beneficiaries identified?</td>
<td>9. Effectiveness in tracking progress</td>
</tr>
<tr>
<td>5. Identify areas for improvement</td>
<td></td>
</tr>
</tbody>
</table>
Recommendations

• Quality Recommendations are a fundamental part of program monitoring process

• Taking sufficient time in developing them is essential for many reasons:
  
  i) Without recommendations, a report has reduced chance of being used
  
  ii) Recommendations are the result of the LFA Spot Check & analysis
  
  iii) They define and prioritize actions for program improvements
  
  iv) Recommendations should make a constructive contribution to the correcting the identified issue
  
  v) Recommendations should form the basis for follow-up
SMART RECOMMENDATIONS

Specific: Address one specific issue and one or more specific related actions

Measurable: For the future, to assess the extent to which a recommendation has been implemented. Add baseline information and an indicator in the report for future comparison

Achievable: Highlight what must be done within reason; should possible in practical terms

Results-oriented: Actions suggested should be designed to lead to a concrete result

Time-bound: Important for prioritization, create pressure for action, enhances accountability
Answer these questions

- Based on your experience, what do you think about the quality of the Spot Check?
- How well does the report address the objectives?
- Are the recommendations linked to the Findings?
- Are the recommendations SMART?

Groups

- Group 1: Community TB
- Group 2: Female Sex Workers (FSW)
- Group 3 Adolescent Girls and Young Women (AGYW)

Step 1

- Quick review of objectives, ToR, Background, Methodology, Findings & recommendations of your respective area
<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>SAMPLE ² (all @ 5 records/observations per facility)</th>
<th>TOOLS USED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>ANC</td>
</tr>
<tr>
<td>ZAMBIA</td>
<td>8 facilities (60-70)</td>
<td>✓</td>
</tr>
<tr>
<td>Liberia</td>
<td>(44+ facilities) (250-400 patients per topic)</td>
<td></td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>138 facilities/690 patients</td>
<td>✓ Added newborn and delivery care</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>@80 FACILITIES 300 PATIENTS</td>
<td>✓</td>
</tr>
<tr>
<td>Nigeria</td>
<td>3300 facilities 1-4 records</td>
<td>✓</td>
</tr>
</tbody>
</table>
Record review of documented care process for individual patient
  • HIV/ART/HTS;
  • Malaria/IPT;
  • TB;
  • MNH (PMTCT for ANC);
  • PMTCT for HIV positive women and exposed infants
  • partograph review for delivery care,
  • Outpatient care for sick child (focus pneumonia/diarrhea/malaria);
  • VMMC;
  • Outpatient care for chronic conditions (hypertension, diabetes)[not yet tested]
RECORDED EVIDENCE THE PATIENT CARE PROCESS IS IN ADHERENCE TO STANDARDS

- What examinations, tests, diagnosis, treatment, and counseling are recorded for individual patients
  - Measured by reviewing recorded information for individual patients

**Strengths**

- Can select sample based on the types of cases desired
- Promotes importance of recording patient information—critical for continuity of care, sharing information between providers
- Can assess care over time for chronic/long-term treatment conditions (e.g., TB, HIV)

**Limitations**

- Depends on availability of records and completeness of recording
- Must assume what is recorded actually occurred
- Need database/register for drawing sample
**EXAMPLES OF FINDINGS (1)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn ARV within 3 days</td>
<td>87%</td>
</tr>
<tr>
<td>Newborn ARV after birth</td>
<td>41%</td>
</tr>
<tr>
<td>ART during delivery</td>
<td>53%</td>
</tr>
<tr>
<td>Partner test</td>
<td>5%</td>
</tr>
<tr>
<td>Cotrim</td>
<td>80%</td>
</tr>
<tr>
<td>Life-long final result</td>
<td>56%</td>
</tr>
<tr>
<td>Life long after delivery</td>
<td>17%</td>
</tr>
<tr>
<td>3 drug ART during pregnancy</td>
<td>15%</td>
</tr>
<tr>
<td>Life-long during pregnancy</td>
<td>39%</td>
</tr>
</tbody>
</table>

**Liberia 2017**  PMTCT positive women (n=176)
**Table A7.b1  Number of observed patients where the indicated suspect malaria eligibility criteria was met**

<table>
<thead>
<tr>
<th></th>
<th>Total observed sick children</th>
<th>Patients meeting criteria for suspect malaria</th>
<th>Among suspect malaria patients</th>
<th>Among patients with malaria test prescribed, test result received prior to departure</th>
<th>Among patients with blood test results</th>
<th>All treated correctly</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(a)</td>
<td>(b)</td>
<td>(c)</td>
<td>(d)</td>
<td>(e)</td>
<td>(f)</td>
</tr>
<tr>
<td>Zambia</td>
<td>N</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td></td>
<td>62</td>
<td>7F 50 O</td>
<td>94%</td>
<td>55%</td>
<td>73%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>na</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>45%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>3132 O</td>
<td>1146 F 3027 O</td>
<td>88%</td>
<td>63%</td>
<td>63%</td>
<td>51%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>52%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>49%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>43%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>46%</td>
</tr>
</tbody>
</table>
### Table A5.1 Antiretroviral therapy

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of records reviewed</th>
<th>Number of facilities</th>
<th>Months patients have been on ART</th>
<th>Among all patients</th>
<th>Viral load at least once</th>
<th>Most recent VL non-detectable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>0-6</td>
<td>7-12</td>
<td>&gt;12m</td>
<td>Confirmatory test</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(a)</td>
<td>(b)</td>
<td>(c)</td>
<td>(d)</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>INFORMATION NOT COLLECTED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zambia</td>
<td>70</td>
<td>7</td>
<td>0</td>
<td>100%</td>
<td>0</td>
<td>79%</td>
</tr>
<tr>
<td>Liberia</td>
<td>187</td>
<td>44</td>
<td>79%</td>
<td>18%</td>
<td>4%</td>
<td>96%</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>178</td>
<td>62</td>
<td>1%</td>
<td>7%</td>
<td>92%</td>
<td>98%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>INFORMATION NOT COLLECTED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ISSUES FOR RECORD REVIEW: DRAWING SAMPLE

- ANC, delivery, PMTCT, HIV, TB all have registers where eligible cases are easy to identify
  - Problem if ANC records are not maintained at facility—then must take opportunistic sample of patients present day of survey
- Difficulties for outpatient curative care (malaria and sick child)
  - Some facilities do not maintain patient records at facility
  - Where records are maintained:
    - Information in register varies—some have presenting symptoms, some final diagnosis, some neither
    - Patients (particularly sick children) may have multiple diagnoses (see following slide)—this must be taken into account during analysis
## Table 1.2 Comparison of records selected from outpatient register, that met the criteria for the indicated diagnosis and the diagnoses noted in the patient record

<table>
<thead>
<tr>
<th>Patient record selected for assessing indicated illness</th>
<th>Total patient records selected</th>
<th>Diagnoses noted in the reviewed patient record</th>
<th>No diagnosis noted in patient record</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a</td>
<td>b</td>
<td>c</td>
</tr>
<tr>
<td>Suspect malaria</td>
<td>58</td>
<td>33 (56.9%)</td>
<td>7 (12.1%)</td>
</tr>
<tr>
<td>Respiratory illness</td>
<td>59</td>
<td>4 (6.8%)</td>
<td>13 (22%)</td>
</tr>
<tr>
<td>Diarrheal illness</td>
<td>59</td>
<td>0 (0%)</td>
<td>3 (5.2%)</td>
</tr>
<tr>
<td>Total</td>
<td>175</td>
<td>37 (21.1%)</td>
<td>23 (13.1%)</td>
</tr>
</tbody>
</table>

1 More than one diagnosis might have been recorded
PMTCT, HIV, and TB

To capture process of care for TB, HIV, HIV + women and exposed infants: the patient must have been under treatment for a specific amount of time (or be a number of weeks postpartum)

Eligibility information must be captured for each record. Do not assume sample records all met the official eligibility criteria

If management of positive cases (ANC + for HIV or + for malaria) are desired, the sample should specify positive cases otherwise sample may be too small to provide a good picture of care

If different management of children and adults is a concern, the sample should specify children or adults, otherwise sample may be too small to provide a good picture of care
 ISSUES WITH COLLECTING INFORMATION

- Reading charts—abbreviations and illegible handwriting
  - Facility nurses are very helpful in reading charts—they know individual doctor’s writing and abbreviations

- Time required for finding sample records: varies by organization of facility.
  - In general this was not a problem
  - Data collectors must identify replacements when records are not found
ISSUES WITH ANALYZING INFORMATION

- Want to use facility as unit of measure (average percentage/measure for the facility and then calculate the average across district/regional/national facilities)

**Rational:**
- Eliminates bias if sample sizes vary—equal representation of patient care in large volume and small volume facilities
- Eliminates bias if distribution of positive and negative test results (malaria and HIV) are skewed by facility—picture of care of positives may primarily be from a few facilities.
- Except for outpatient curative care—facility practices are similar across patients and providers
Found many problems with presenting results using different denominators (subsets of subsets)

Either need clear tables that show how the denominator changed or the same denominator for items in graph

One country had a graph showing high percentages of HIV exposed infants being tested and results available; e.g., (illustrative)

- 20 HIV + women records reviewed
- 10 infants came to PMTCT clinic postpartum
- Blood for PCR test drawn on 5 infants
- Results returned for 4
- Presented result: 40% of exposed infants had blood drawn and results returned: actual is 20%
- No explanation for the 10 infants never brought to clinic
USING THE QOC TOOLS AND INFORMATION

- Encourage local supervision to use the tools as a guide to assess care
  - Reinforces to providers and supervisors what the standards are
- Education to managers/supervisors how to use information
  - Comparing QOC results with readiness results to help identify source of problem with QOC – lack of guidelines? Lack of tests or drugs? Non-trained staff?
  - Develop job aids to reinforce the standards being assessed—poster where patient and provider can see key points;
Back up slides