Program Quality Overview

PROGRAMMATIC M&E LFA TRAINING

OCTOBER 2019 – JANUARY 2020

GENEVA, SWITZERLAND

The Global Fund

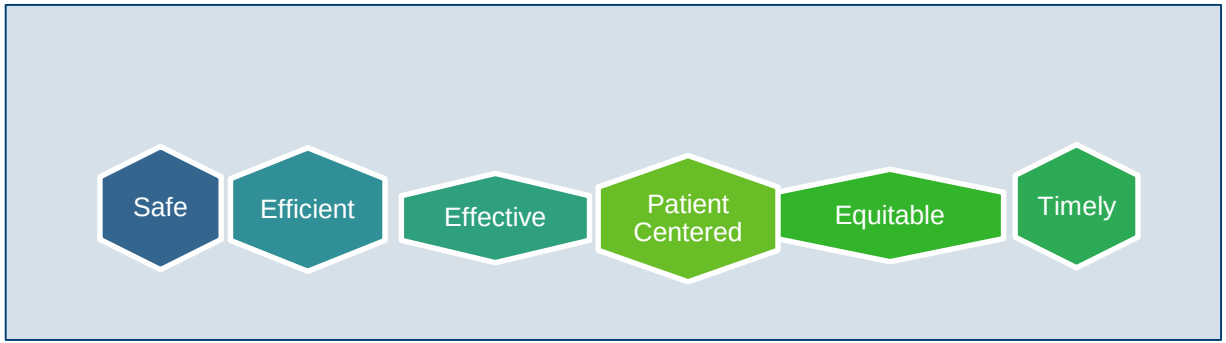
1. Program Quality and the Role of the LFA

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***

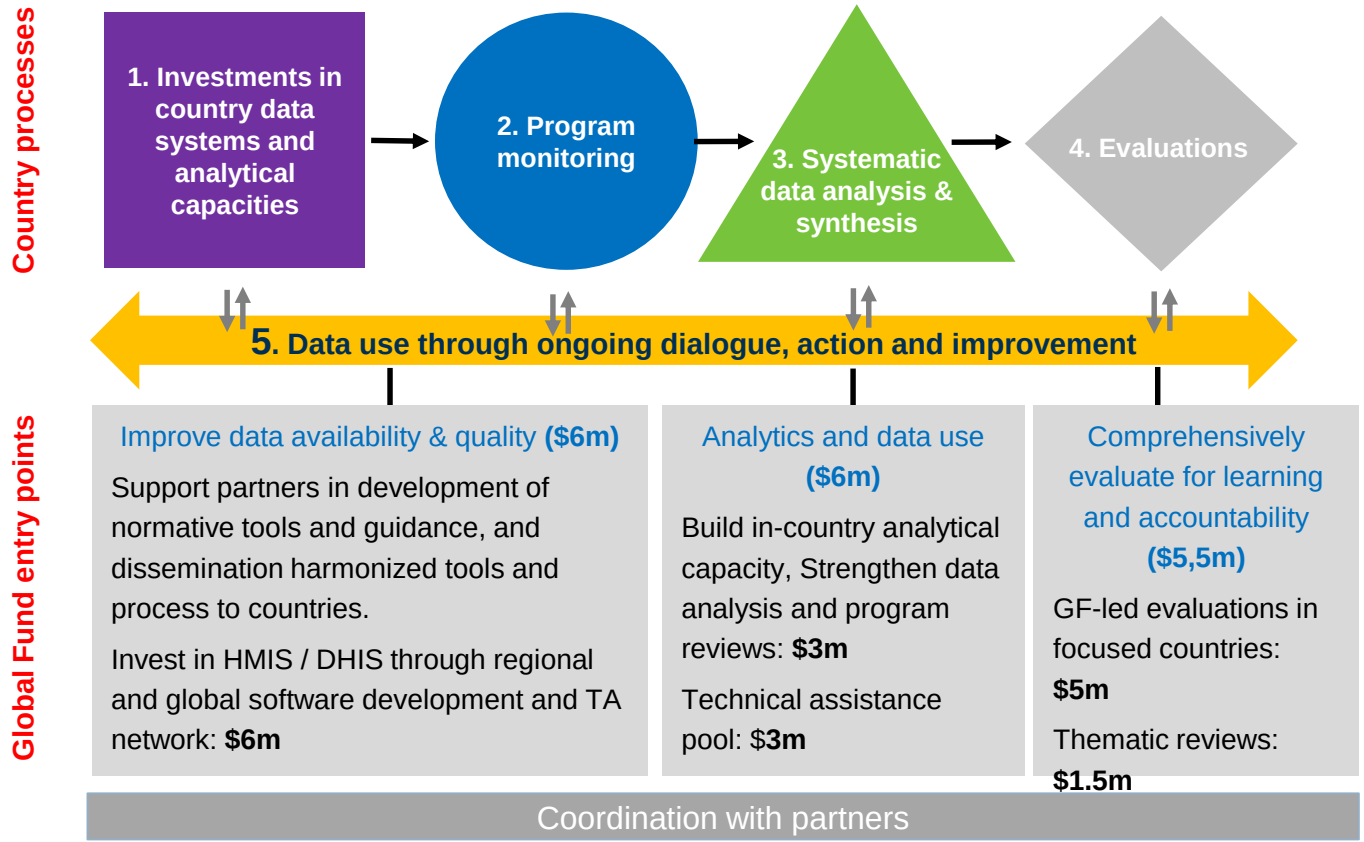
- The Global Fund is committed to improving program quality to **maximize** impact at the country level

Identifying and addressing **critical bottlenecks** at different levels of country systems

Identifying and replicating **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



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. 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

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

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.

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

Program Quality: TB

Components
Treatment coverage: % of notified cases of all forms of TB - bacteriologically confirmed plus clinically diagnosed, new and relapses among all estimated cases (all forms)
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)
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
ART for TB/HIV: % of HIV-positive registered TB patients (new and relapse) given anti-retroviral therapy during TB treatment

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

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

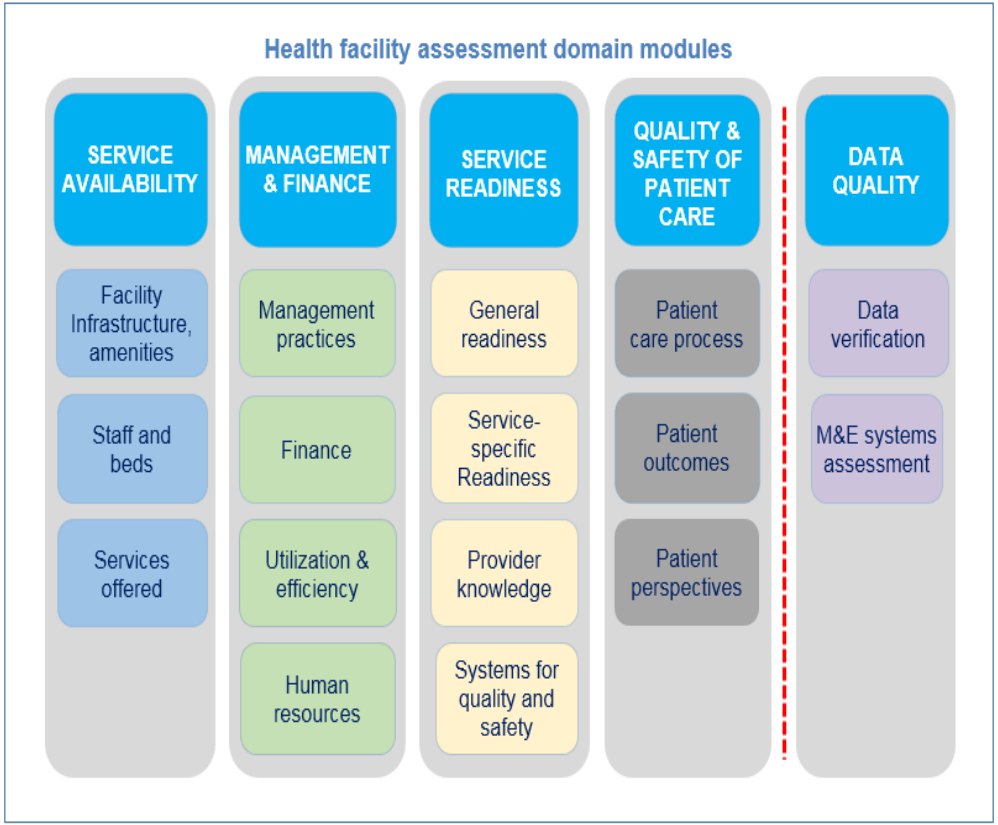
Harmonized Health Facility Assessment Approach

- 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?***

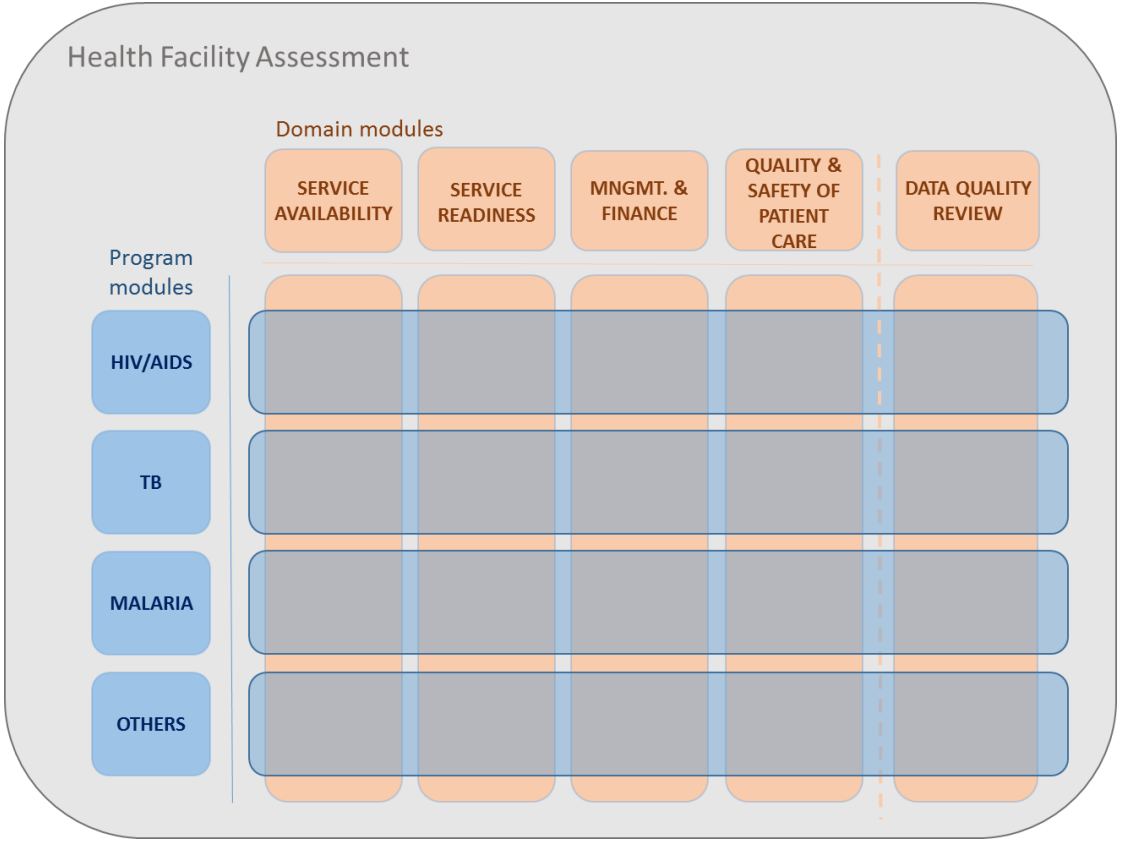


HFAs are used by countries for their own strategic planning, but also provide assurances to donors

2. What is a Targeted Health Facility Assessment ?

- 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/
  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:**

http://www.who.int/healthinfo/systems/sara_reference_manual/en/

- **SARA Implementation Guide** contains guidance on the planning, methodology, sampling, questionnaire adaptation, electronic tools, data collection, supervision, data processing, analysis and reporting: http://www.who.int/healthinfo/systems/sara_implementation_guide/en/

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

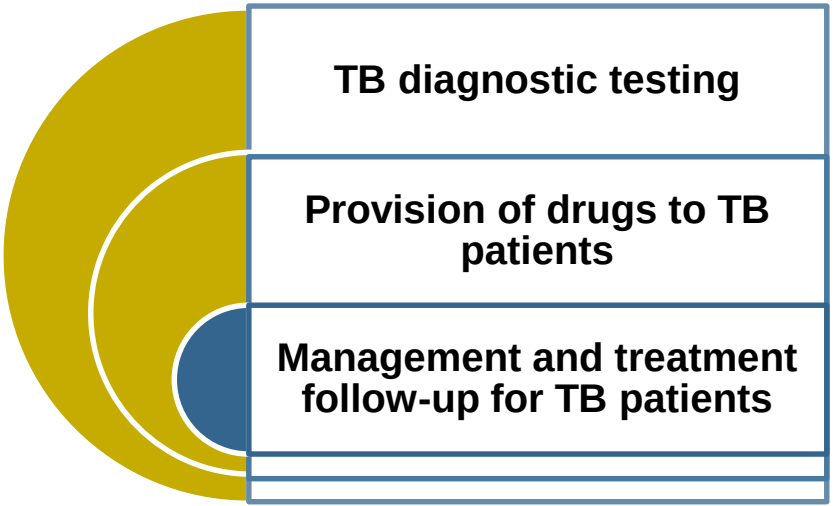
	Nationally representative HFA	Targeted HFA
Tool	Harmonized Health Facility Assessment tool -or other HFA tool that includes core indicators and quality of care (e.g. SARA plus, SPA, SDI)	Harmonized Health Facility Assessment tool -or other HFA tool that includes core indicators and quality of care (e.g. WHO SARAplus)
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

	Nationally HFA	Targeted HFA
Funding	Global Fund with or without Partners; Partners	Global Fund Country Team
Planning	Coordinating group of country stakeholders	LFA M&E team in collaboration with the ,PR, MoH and in-country stakeholders, i.e, WHO
Implementer	Country-led with TA as needed	LFA M&E team
Methodology	Census or representative sampling, requires Master Facility List	Will vary, but generally 20 - 40 sites
Tools	✓ Select modules based on objectives; • Guidance • May Adapt questionnaires based on objectives • Data Entry CSPRO or similar • Data Analysis Excel Workbook • Develop a data analysis plan	✓ Focus on HIV, TB & Malaria services & Quality of Care ; ✓ Guidance ✓ May adapt Questionnaires based on objectives ✓ Data Entry -Excel sheet ✓ Data Analysis-Excel sheet ✓ Develop a data analysis plan
Data Collection	✓ Training ✓ Pilot & Modification as needed ✓ Conduct Actual Survey ✓ Data Management	✓ Conduct Actual Survey ✓ Data management
Quality Control	Yes	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

4. Outputs -Priority SARA Indicators: TB

TB: Service Availability Indicators

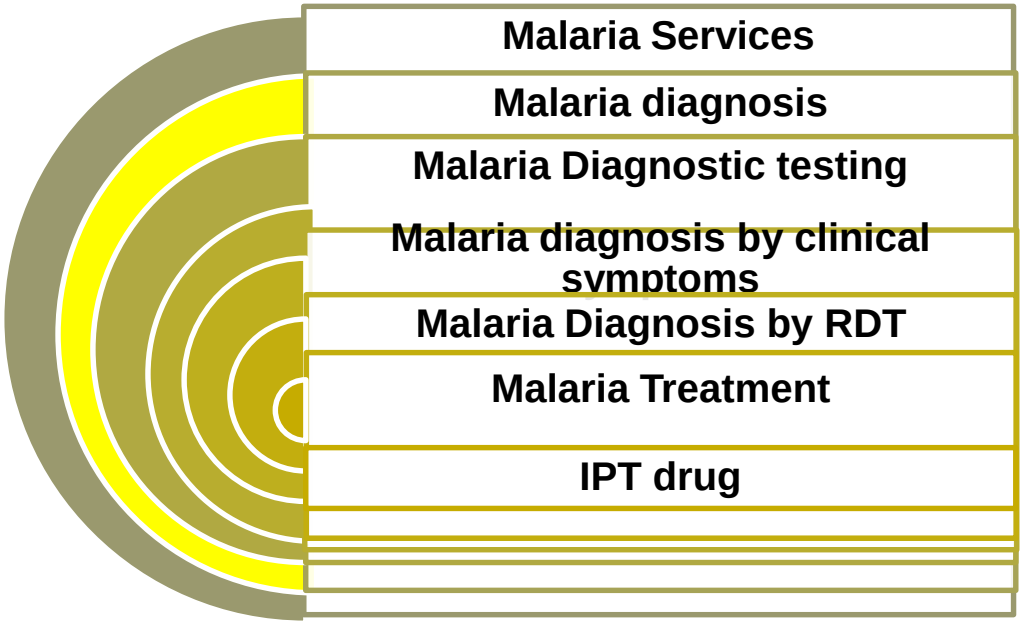


TB: Service Readiness Indicators

- 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

4. Outputs- Priority SARA Indicators: Malaria

Malaria: Service Availability Indicators

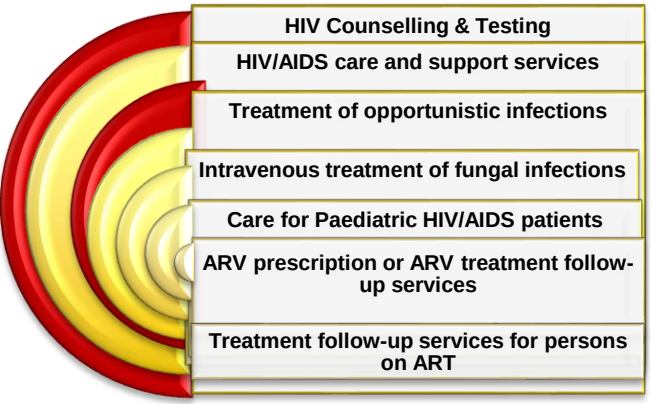


Malaria: Service Readiness Indicators

- Guidelines for diagnosis and treatment of malaria
- Guidelines for IPT
- Staff trained in malaria diagnosis and treatment
- Staff trained in IPT
- Malaria Diagnostic capacity
- First line antimalarial in stock
- ITN
- IPT drug

4. Outputs- Priority SARA Indicators: HIV

HIV: Service Availability Indicators



HIV:Service Readiness Indicators *(1)*

for discussion with Disease Advisors

- 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)*

For discussion with disease advisors

- 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

HIV	TB	Malaria	AGYW	PWID	DHIS	M&E Plan & Implementation	Supervision	Training	HPM related
1. Community based HIV testing among key populations	**2**. Community based TB activities (including MDR-TB where appropriate)	**3**.Implementation of malaria vector control interventions (LLINS distribution and IRS)	**4**. Adolescent Girls and Young Women programs	**5**.Assessment of implementation of Opioid Substitution Therapy program	**6**. DHIS implementation and hospital data recording/ coding system	**7.** Assessment of M&E plan and implémentations	**8**. Assessment of supervision effectiveness in a given health program	**9.**Training activities and related expenses	**10**. HPM Supply Management Review
11. Prevention services among key populations	**12.** HPM Procurement Review	**13**. Community based malaria case management activities	**14.** M&E Assessment	**15**. Assessment of training activities and related expenses	**16**. HPM Quality Monitoring for Pharmaceuticals HPM Quality Monitoring for Pharmaceuticals	**17**. HPM LMIS Implementation Review		**18**. HPM ACT co-payment mechanisms First Line Buyers	

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

3.Spot Check Analysis

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

Major issue	Minor Issues:
Significant gaps that pose major risks to the successful implementation of the assessed activity	The identified gaps pose minor risks that can be managed and/or strengthening measures can be implemented within a short timeframe

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

1. PCU has no supervision plan	PCU to develop a supervision plan to enhance the supervision of Disease Programmes and Implementation Partners.	By 30 March, 2020	PCU
2. LFA found HIV tests' data discrepancy between Laboratory register and Monthly Integrated Activity Report	LFA recommends that health facility in-charge should make sure the correct figures are transferred from Lab register to Monthly Report	By June, 2020	Health Facility in-charge and BPHS/EPHS implementers
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&E, financial etc.			
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			

Programmatic Spot Checks *Spotlight:*

1) Adolescent Girls & Young Women
2) Human Rights

Key recommendations: Planning and Implementation

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, WHOs/adolescents health, NSPs,
- Youth/AGYW strategy, HR guidelines etc.
- Program documents – progress report, documented implementation strategies etc.

Key areas for consideration at implementation

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 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?

Human Rights(HR) areas for consideration at implementation level

1. Availability of systems and structures that support implementation of HR programs; dedicated staff, capacity building for the staff etc.	6. Implementation modality – is this effective in reaching, identifying and addressing HR issues
2. Specific interventions/services delivered	7. Availability and use of tools to track services/activities
3. Which populations/individuals are targeted?	8. Clarity for use by providers
4. How are beneficiaries identified?	9. Effectiveness in tracking progress
5. Identify areas for improvement	

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

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Group Work: Critique of Programmatic Spot Check Report

Step 1

- Quick review of objectives, ToR, Background, Methodology, Findings & recommendations of your respective area

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)**

World Health Organization

ASSESSING QUALITY OF CARE USING RECORD REVIEWS (RR) DURING HEALTH FACILITY ASSESSMENT

October 2019

Experience with assessing QOC using RR during HFA

COUNTRY	SAMPLE [2] (all @ 5 records/observations per facility)	TOOLS USED							
		ANC	PMTCT w ANC	PMTCT PP	Malaria	TB	HTS	ART	Child observation
ZAMBIA	8 facilities (60-70)	✓	✓	✓	✓	✓	✓	✓	✓
Liberia	(44+ facilities) (250-400 patients per topic)			✓	✓ child	Partial [1]		✓	
Sierra Leone	138 facilities/690 patients	✓ Added newborn and delivery care			✓	✓	✓		
Burkina Faso	@80 FACILITIES 300 PATIENTS		✓		✓	✓		✓	
Nigeria	3300 facilities 1-4 records	✓	✓		✓	✓		✓	✓

TOOLS FOR RR QOC

- ***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]*

QOC INDICATORS AND METHODS FOR HFA (1)

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

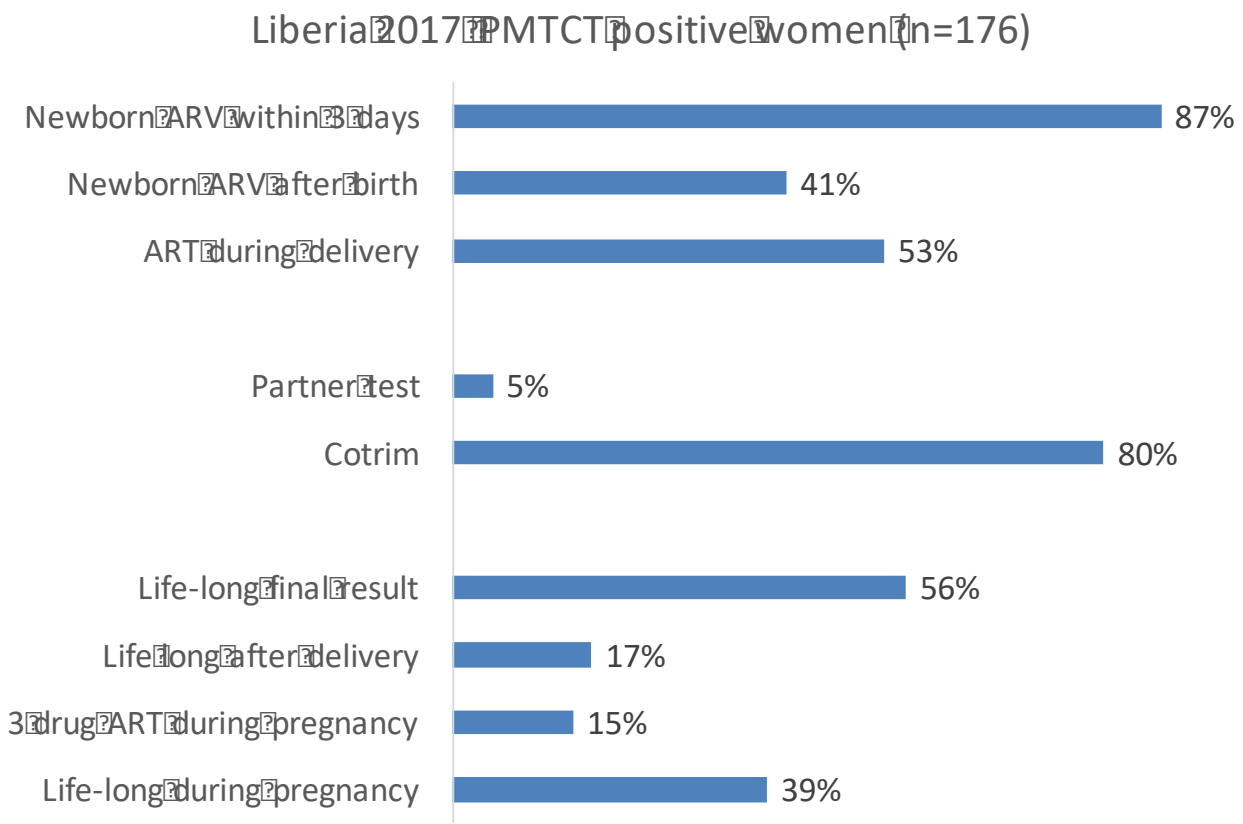
Strengths

- 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)



EXAMPLES OF FINDINGS (2)

Table A7.b1 Number of observed patients where the indicated suspect malaria eligibility criteria was met

	Total observed sick children	Patients meeting criteria for suspect malaria[1]	Among suspect malaria patients		Among patients with malaria test prescribed, test result received prior to departure	Among patients with blood test results				All treated correctly
			Observation identifies patient had fever	Any malaria test prescribed		Positive test recorded	Among positive test results, those treated correctly	Negative test result	Among negatives, those treated correctly	
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
	N	N (%)		N (%)	N (%)	N (%)	N (%)			
Zambia	62	7F 50 O	94%	55%	73%	0%	na	100%	100%	45%
Nigeria	3132 O	1146 F 3027 O	88%	63%	63%	51%	52%	49%	43%	46%

EXAMPLES OF FINDINGS (3)

Table A5.1 Antiretroviral therapy

Country	Number of records reviewed	Number of facilities	Months patients have been on ART			Among all patients				
			0-6	7-12	>12m	Confirmatory test	CD4 at least once/within 1st 2 months	CD4 within past 6 months	Viral load at least once	Most recent VL non-detectable
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Sierra Leone					INFORMATION NOT COLLECTED					
Zambia	70	7	0	100%	0	79%	79%	44%	7%	4%
Liberia	187	44	79%	18%	4%	96%	11%	71%	10%	2%
Burkina Faso	178	62	1%	7%	92%	98%	73%	27%[1]	7% VL6m: 6% VL12m: 6%	6%
Nigeria					INFORMATION NOT COLLECTED					

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

ELIGIBILITY DIAGNOSIS AND ADDITIONAL DIAGNOSES FOR CHILDREN

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

Patient record selected for assessing indicated illness	Total patient records selected	Diagnoses noted in the reviewed patient record						No diagnosis noted in patient record
		Malaria	Pneumonia	Other respiratory	Watery diarrhea	Dysentery	Other diagnosis	
	a	b	c	d	e	f	g	H
Suspect malaria	58	33 (56.9%)	7 (12.1%)	13 (22.4%)	6 (10.3%)	1 (1.7%)	22 (37.9%)	4 (6.7%)
Respiratory illness	59	4 (6.8%)	13 (22%)	38 (64.4%)	2 (3.4%)	1 (1.7%)	7 (11.9%)	5 (8.5%)
Diarrheal illness	59	0 (0%)	3 (5.2%)	10 (17.2%)	50 (86.2%)	3 (5.2%)	5 (8.6%)	4 (6.9%)
Total	175	37 (21.1%)	23 (13.1%)	61 (34.9%)	58 (33.1%)	5 (2.9%)	34 (19.4%)	13 (7.4%)

[1] More than one diagnosis might have been recorded

ISSUES: ELIGIBILITY CRITERIA

- 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

ISSUES WITH ANALYZING INFORMATION (2)

- 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