REPORT OF THE REVIEW OF 2015 PMTCT DATA IN THE FCT

A Collaboration between the FCT AIDS and STI Control Programme and Health Strategy and Delivery Foundation

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Acronyms

ACACA	Area Council Agency for Control of AIDS
ANC	Antenatal Care
ARV	Antiretroviral
CTRR	Counselled Tested and Received Result
FASCP	FCT AIDS and STI Control Programme
HIV	Human Immunodeficiency Virus
HSDF	Health Strategy Delivery Foundation
MSF	Monthly Summary Form
NHMIS	National Health Management Information System
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infection

1. Background

The National Health Management Information System (NHMIS) is the nationally approved platform for reporting of health data in Nigeria. To report data onto this system, data is summarised at the health facilities in Monthly Summary Forms (MSF). These forms are submitted to the area council where the data is directly uploaded onto the NHMIS. State and National teams can download data from the platform for harmonization and validation. However, challenges exist to correctly reporting data PMTCT indicators across all HSDF supported states.

Regular analysis of PMTCT data provided by the states revealed consistent errors in data reporting for indicators across the PMTCT cascade. These errors are most pronounced in 2 indicators: **number of pregnant women counselled tested and received results (CTRR) and new, positive pregnant women who received** antiretroviral **drugs (ARVs) prophylaxis for PMTCT**. The hypothesis for these errors pointed to incorrect aggregation of data on counselling and testing for HIV in MSFs, and incorrect documentation of previously known pregnant women as newly initiated on ARVs, at the facility level. It was hypothesised that these practices in turn led to an incorrect picture of coverage rates for pregnant women accessing counselling and testing services and ARVs.

In July 2015, Health Strategy Delivery Foundation (HSDF) supported the FCT AIDS and STI Control Programme (FASCP), to conduct a review of PMTCT data across 216 facilities with a specific focus on the 2 key indicators, pregnant women CTRR and new positive pregnant women who received ARV prophylaxis. The review process eliminated the MSF as a source of error by collecting data directly from facility registers. This would also allow for identification of true coverage rates for these indicators. Collected data was cleaned, reviewed and analysed for coverage rates. Data from the review was compared to data downloaded from the NHMIS and validated by FASCP for completeness of reporting. The comparison was done per facility and by Area council.

2. Methodology

This review set out to identify actual coverage for 2 key PMTCT indicators between January and June 2015. The review also compared state validated data for PMTCT for the period January – June 2015, to the collected from facility registers for the same indicators to determine the margin of difference.

2.1 Setting and Sites

The Federal Capital Territory has 272 public and private facilities providing PMTCT services as of September 2015. It was selected for the review first, because it has one of the lowest numbers of PMTCT providing facilities compared to other HSDF supported states, making it more practical location to implement this activity with full coverage. Second, because of availability of HSDF personnel in the state to implement the review. Third, the state FASCP leadership and team showed strong interest and support for reviewing its PMTCT data.

A sample of 240 of 272 facilities in all 6 Area Councils of the FCT were selected by the FASCP team for data collection. Selection was based on a recent service availability mapping[1] conducted by FCT, which indicated that these facilities provided PMTCT services both during antenatal care (ANC) and community outreach.

[1] Service availability was conducted by HSDF in December 2014 and covered all facilities in FCT.

2.2 Data Coordination Meeting

Key stakeholders at the state and area council level were invited to a short discussion on reporting of PMTCT indicators. The aim of the meeting was to ensure a common understanding of the issues, to review current practice of aggregating at facility level and to agree on how the review will be implemented. Meeting participants included: PMTCT and M&E focal persons from FASCP, area council M&E coordinators and officers, Area Council Agency for Control of AIDS (ACACA) M&E officers and high level representatives from the Department of Public Health and Department of Disease Control, Federal Ministry of Health.

As an output of the meeting, it was agreed that the FASCP team would support the area council officials to select data collectors for the review. Data collectors would be selected based on knowledge of PMTCT indicators and experience with reviewing and reporting PMTCT data upwards from the facility level to the state. 22 data collectors were identified by FASCP.

2.3 Data Collection

Prior to the assessment 3 of the selected facilities were visited by a team of individuals from FASCP and HSDF, to review record keeping practices and to have a general idea of data availability at the facility level. Insight from the preliminary visits were used to structure the data collection tool and guide selection of data collection officers.

The tool was designed to be simple and to extract 8 key PMTCT data elements needed to investigate the 2 main indicators. This tool was designed solely for the purpose of the review and was not meant to replace any national reporting tools. Data elements collected included:

- **HCT and ANC:** Total number of 1st ANC visits, total CTRR during ANC and total CTRR during outreach
- **ARV coverage:** total number of all pregnant women testing positive during ANC, total number of all pregnant women testing positive during outreach, total number of pregnant women with previously known HIV infection, total number of pregnant women newly initiated on ARVs, total number of pregnant women previously on ART for their own health

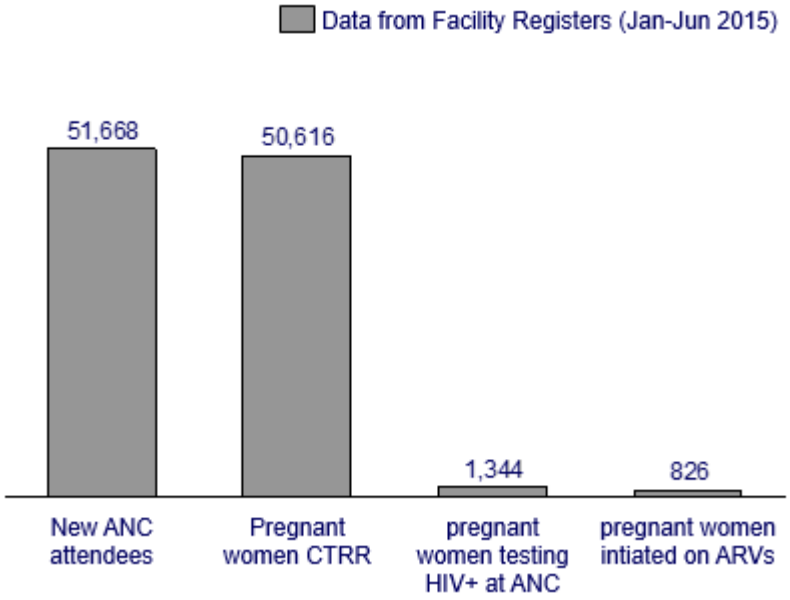
The data tool captured monthly totals for each data element from facility registers before it had been entered into the NHMIS MSF. This would ensure that errors introduced by aggregation were excluded. Once completed, the tool was sent to the FASCP M&E officer and HSDF for collation, data entry and cleaning.

2.4 Data entry and Cleaning

Data was reviewed for errors prior to entry into an excel sheet for analysis. A large proportion of errors identified were due to errors by data collectors in completing the tool. Phone calls were made to the data collectors and to facility M&E officers to correct these. Other errors identified were due to poor reporting practices at the facilities as indicated by the data collectors. Some reasons provided for poor reporting include: non-use of approved registers for reporting, poor capacity of staff to complete registers and haphazard data entry practices. To address these issues, targeted supervisory visits were planned with the state team to identified facilities. This was also an opportunity to further investigate facility records and provide correct data for the required data elements.

3. Findings of the review

Data from the review appeared to be consistent across the PMTCT indicators. However, a deeper look revealed some errors still existed in the facility registers. These errors initially attributed to the aggregation of data into MSFs could be indicative of incorrect documentation practices by facility staff.



Data from the review indicates 98% coverage for CTRR among ANC attendees and 62% coverage for positive pregnant women newly initiated on ARVs.

However, the review did not attempt to confirm the validity of these figures. Therefore, it is impossible to say that these are true coverage rates for these indicators in FCT.

Figure 1:Data from Facility registers for 4 PMTCT Indicators.

Another important discovery was the fact that data collected from the facility registers differed largely from state validated data, in almost all facilities compared. Overall, the data collected from facility registers was much higher than data reported by the state on all indicators assessed. A similar difference was also observed when state validated data was compared to data on the NHMIS platform for the same indicators. Deeper investigation showed that data from about 80 PMTCT providing facilities was not captured in the state validated data report, even though these facilities had reported on the NHMIS.

Facility registers reported 9000 more women attending ANC and over 8,500 more women receiving CTRR when compared to the state validated data. Number of new pregnant women testing positive at ANC in facility registers was also almost double the number in state validated data. This could mean that the state is grossly under-representing service delivery for PMTCT and calls to question the processes used for validation of data.

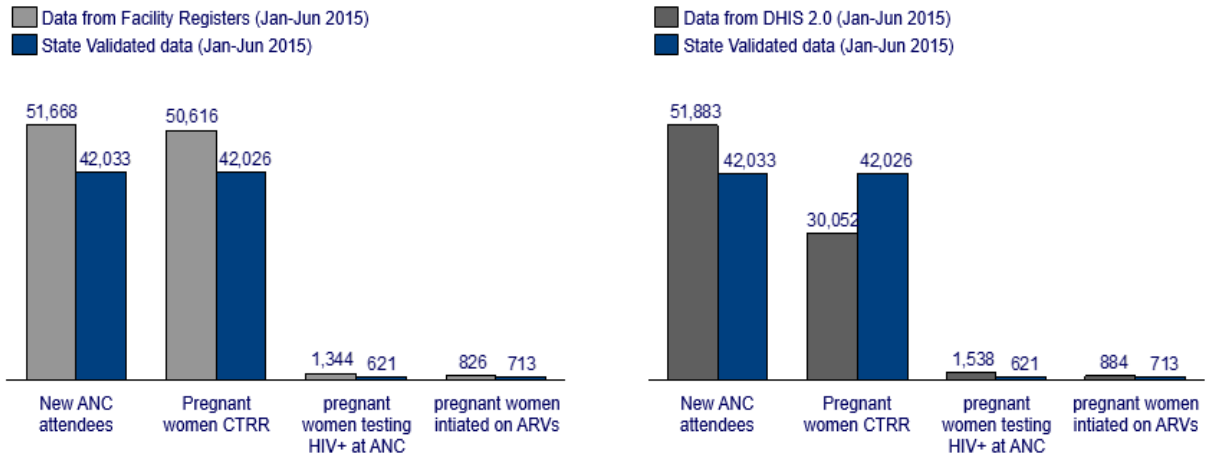


Figure 2: Comparison of FCT PMTCT data for January - June 2015, across 3 sources.
** State validated data - 222 facilities; Data from facility registers - 216 facilities; Data from DHIS – 306 Facilities.*
** DHIS data extracted 10 March 2016*

Also note that though a higher number of facilities (306 facilities) reported data on the NHMIS platform, the data collected from the review (216 facilities) is almost equal to data on the platform. This could point to a backlog of unreported data at the facility level.

4. Next Steps

The results of the review point to gaps in timeliness and consistency of PMTCT data reporting across all levels. This calls more frequent and detailed checks on data as it is reported upwards. There is also a need to outline the current steps and processes for validation of data in the state and to identify gaps in the process, to ensure the correct picture of PMTCT service delivery in the state is presented at state and national level.

Recommendations to the Department of Public Health and FASCP on strengthening PMTCT data:

- **Conduct an assessment of data reporting and validation process** of HIV/AIDS activities in the State, with a view to developing an appropriate validation methodology**.**
- **Leverage on supervisory visits to conduct structured mentoring** of facility staff in data collation and reporting at facility level
- **Use the broader monthly data review meetings to review PMTCT data at area council level.** This will ensure timely identification and correction of data errors.
- **Increase frequency of data validation meetings** from two times per year to four times per year