MINISTRY OF HEALTH

On-site Data Verification (OSDV) Report

National Leprosy & Tuberculosis Control Program (NLTCP)

Reporting Period: Jan-June 2024

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1.0 Background/Introduction

Onsite-data verification (OSDV) is one of the major activities implemented under direct supervision of the Monitoring and Evaluation (M&E) unit of the national Leprosy & Tuberculosis Control Program (NLTCP) with support from the Global Fund. Sem-annually this exercise is conducted to verify service delivery data reported from all service delivery points (clinics, health centers & hospitals) to reconcile service delivery data of all reportable indicators before submission of final report to the Global Fund and stakeholders.

This report describes and summarizes the OSDV conducted by the program for the period January to June 2024. It covers clinical, laboratory and data recording and reporting with emphasis on the seven high burden TB counties.

2.0 Executive Summary

The OSDV was conducted by three teams of technicians from the NLTCP comprising case managers, Laboratory, program and M&E staff. All fifteen (15) counties were visited and a total of seventy two (72) TB treatment facilities, representing about 72% of all TB treatment facilities in the country were targeted and assessed for data and service quality. During the first quarter of 2024, **River Cess, Grand Bassa, Bong, and Nimba** counties were observed to have significant data discrepancies primarily due to issues like incorrect or late report submissions, lack of logistics, and limited knowledge among TB clinicians. Specific facilities such as Neeziun Clinic, St. Francis Hospital, River Cess District Hospital, LAC Hospital, C.B. Dunbar, Phebe Hospital and Jackson F. Doe Hospital were notably affected. These challenges were attributed to factors like staff attrition, data entry issues, and inadequate Knowledge and skills on TB report preparation. There was significant data disparity observed in **Bomi, Margibi, Cape Mount and Lofa counties** while **Gbarpolu** County showed accurate reporting in the TB Case notification in the HMIS versus Facility data for both quarters one and two. No data entry was done in the HMIS for both quarters one and two in Lofa and Margibi Counties. Over Reporting was detected in the data entered in the HMIS for both quarter one and two in Cape Mount and Bomi Counties. There was significant achievement in **Montserrado** on five key indicators with 4,883TB cases counted against 4,356 notified and reported in DHIS. For gene X-pert testing results, the team counted 1,596 against 1,373 reported. There was disparity between number reportedly tested for HIV with known status and notified cases. The recount also revealed 4,882 against 4,354 reported. Finally, the county reported 58.4% treatment success rate but the actual calculation

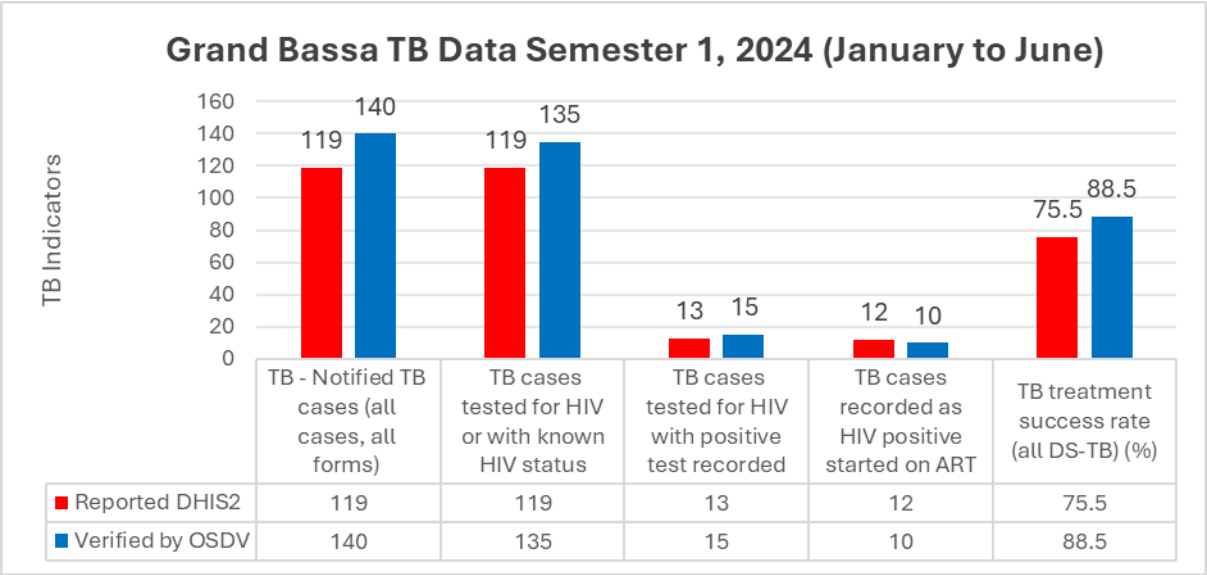
revealed 74.4% In **Grand Gedeh, River Gee, Maryland, Grand Kru and Sinoe**, there has been no training for service providers for up to five years. As a result, there is up to about 90% Knowledge gap in TB case Management and other service delivery points.. All TB focal persons in these counties except Maryland, are new because of staff attrition that has occurred during the past five years. In **Sinoe county**, only FJ Grant Hospital provides active and full TB services amongst the three facilities visited. The remaining two (Grigsby Farm and Gbason Town Clinics) are screening for TB and referring patients/simples according to staff but with no evidence seen. Maryland and Grand Kru counties reported Laboratory data in the DHIS2. Manor recording errors were identified in TB recording ledgers at all facilities visited. TB case detection rates in all five counties visited were low with as low as one or two TB cases notified for the period under review at most of the facilities visited or no case at all. Grigsby Farm, Gbason Town, Jarkaken and Duogee Clinics, as well as Gbarzon and Edith H. Wallace Health Centers are facilities that notably reported very low TB case detection**.** HIV testing was not done for all notified TB cases especially in the central lab. TB/HIV Focal person are not visiting facilities regularly in all counties visited due to knowledge gab and logistic problems. In Montserrado the county made significant improvement on all key indicators.

3.0 Findings from High Burden Counties

3.1 Grand Bassa County

In Grand Bassa County, the major data discrepancy issue was observed in quarter one 2024. The errors observed were due to late report submission from LAC Hospital which is one of the biggest referral hospitals in the county. Some of the factors for the errors were narrated by the service providers as the lack of logistic for TB/HIV collect report, TB clinicians had limited knowledge of recording in the ledgers. The data also indicates 67% of co-infected patients were place on ART. A significant need for improve counselling strategies and one stop shop to increase ART initiation for TB/HIV co-infected patients at LGH.

Laboratory data indicate sputum transport is being done but needs improvement to increase GeneXpert testing coverage. Training laboratory staff on monthly lab data collection is important to cross check rider sputum transport data. There is urgent need for sensitization of clinicians about sputum collection, contacting of riders for sputum transport and regular monitoring of sputum transport system to improve GeneXpert testing coverage.

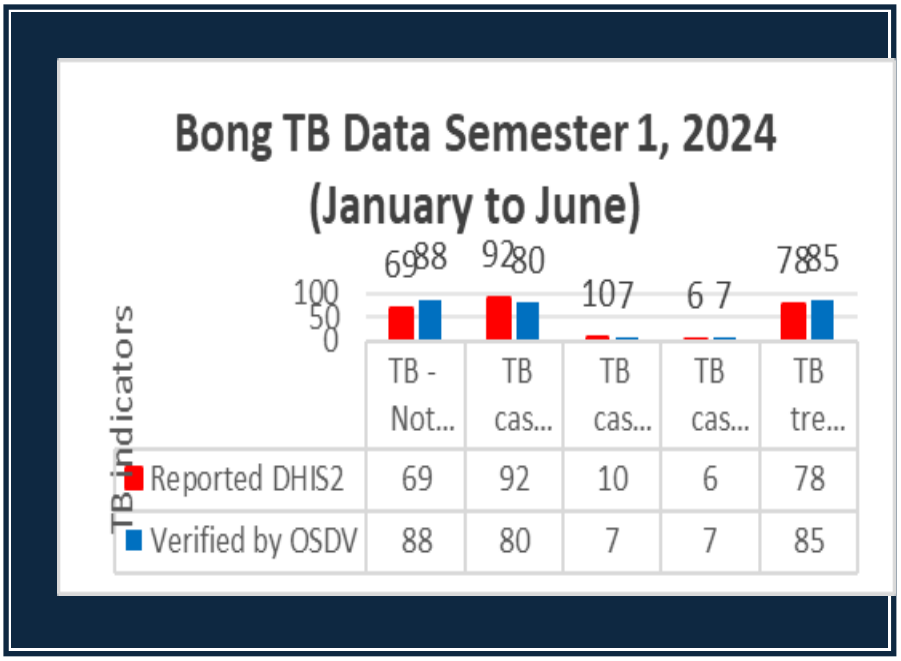


Data source: Team #3 field data

The graph above shows significant differences between data reported and actual data verified through physical count in the ledgers. The county under reported on four of the five key indicators during the reporting period.

3.2 Bong County.

Bong County's major data discrepancy issue was observed in quarter one 2024 and the two main referral hospitals (Phebe and CB Dunbar) were the source of the errors during the reporting period. Data entry error by the data officers and limited knowledge of TB clinicians were observed to be the main reasons for the data discrepancy. However, despite the above challenges there was some level of improvement in quarter 2, 2024.



The Table above shows the level of discrepancy observed in Bong County. The county's data shows that data reported in DHIS and spot check from primary data source were mismatched significantly.

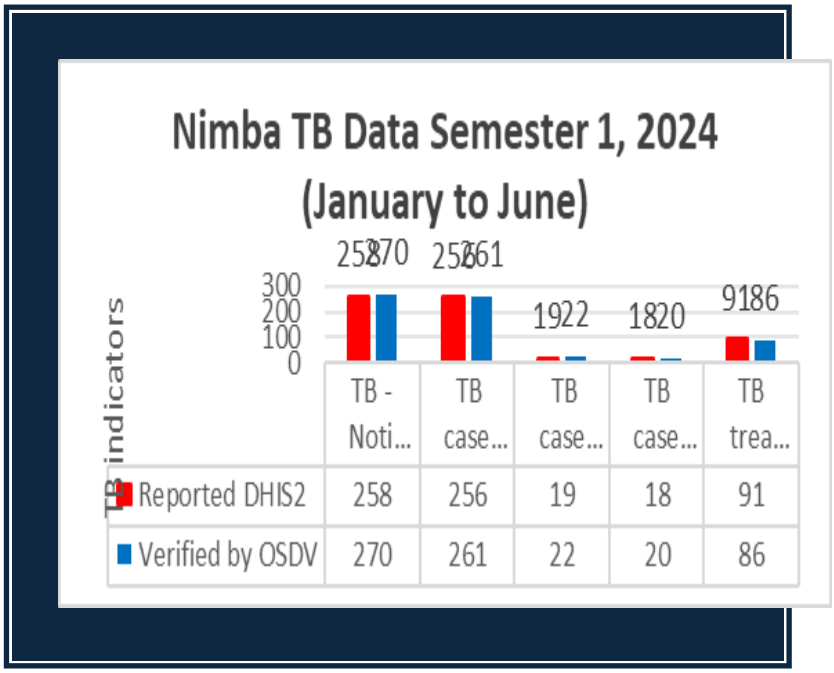
Laboratory data in Bong County also indicate huge discrepancy with less number of sputum samples being transported to gene X-pert sites.

There is need for sensitization of clinicians about sputum collection, contacting of riders for sputum transport and regular monitoring of sputum transport system to improve GeneXpert testing coverage.

3.3 Nimba County

Nimba County's major data discrepancy issue was observed in quarter one 2024. The discrepancy was as a result of reporting errors from Jackson F. Doe Hospital and was due to various reasons, including limited knowledge of TB clinicians in data recording and reporting, lack of logistics for TB/HIV to Collect report etc.

The graph on the right indicates that the county's DHIS report differs from the actual ledger count conducted by the verification team on all key indicators including TB case notification and treatment success rate during the period in review.

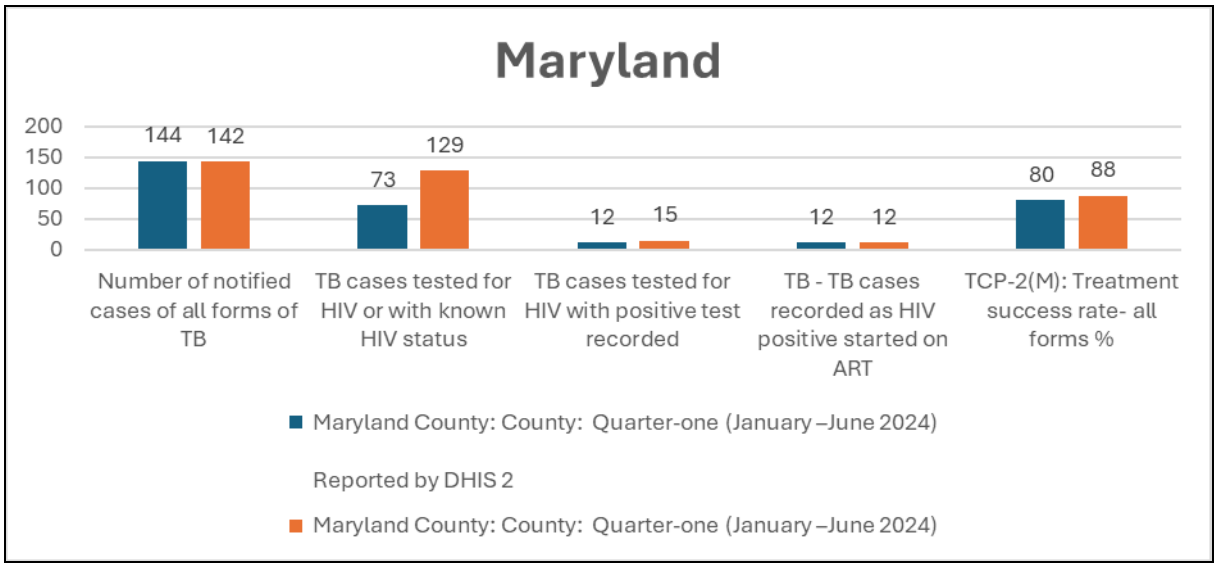


Additionally, Laboratory data indicate significant discrepancy with no sputum transport reported which needs improvement to increase GeneXpert testing coverage from other microscopic sites. However, despite the lab data errors, Nimba County is the only county that demonstrated interest in monthly lab data collection and entry.

There is need for sensitization of clinicians about sputum collection in collaboration with **Riders** for Sputum transport and regular monitoring of sputum transport system to improve GeneXpert testing coverage.

3.4. Maryland County

The team observered significant data discrepancy in Maryland during both quarters. According to information gathered by the team the primary reason is limited knowledge gap in data recording and reporting and this is so because staff have not been trained or refreshed for the past five or more years. As indicated in the graph below, there was significant difference between data reported in DHIS and actual ledger count conducted by the team. Example, notified cases reported in quarter one was 64 and the ledger count revealed 69 (difference of 5). In quarter two 80 TB cases were reported notified and 73 cases were notified by the team. There was marked differences in data reported and data counted on all key indicators.



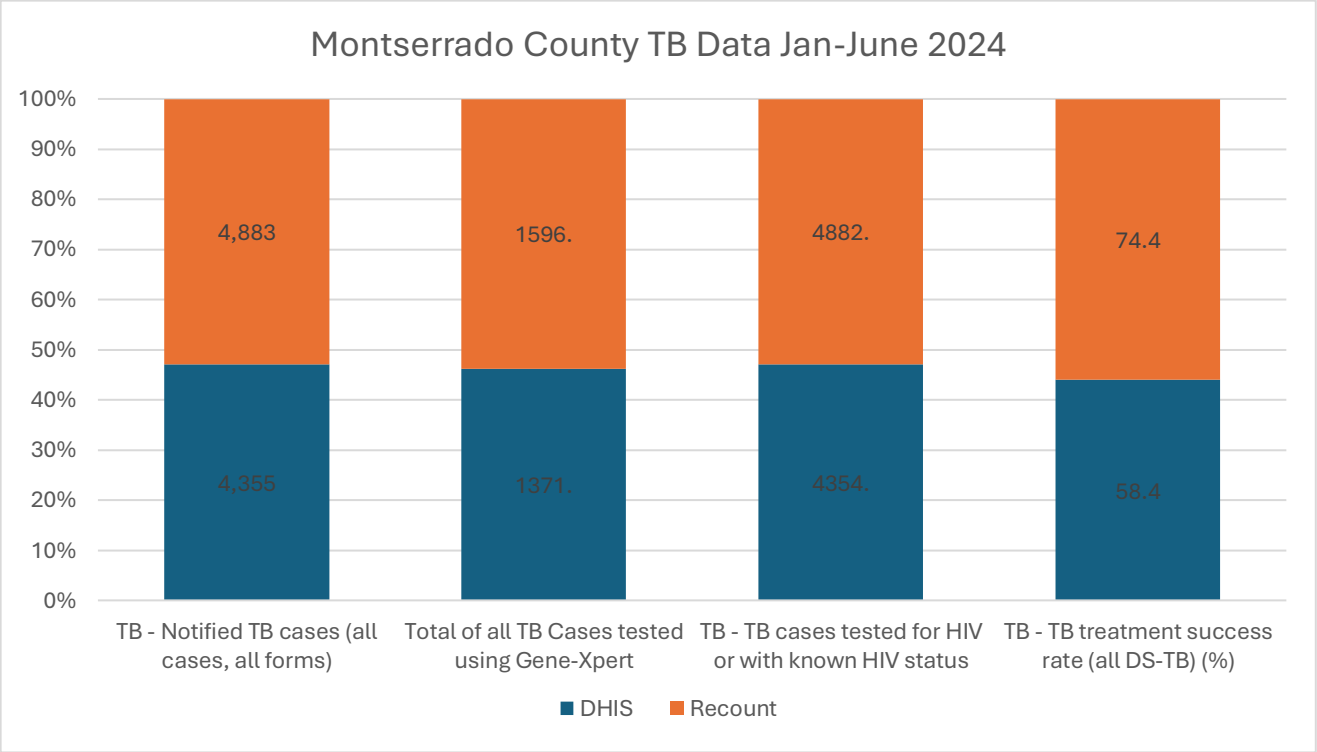
Data source: Team 2 field data

The graph above shows a cumulative achievement in Maryland County on five key indicators with 144 TB cases reported notified against 142 cases counted on the spot. Strangely enough is the significant and unrealistic difference between the notified cases that were tested for HIV with known status. The only data reported correctly by Maryland during the period in review was TB cases that were placed on ARV.

The support to Maryland County by Partners In-Health (PIH) is seen in the high number of cases notified but the challenge in the county is the limited knowledge of service providers in TB data recording and reporting. Both PIH and the NLTCP need more collaboration to strengthen support to the county for high quality TB services and reporting.

3.5. Montserrado County

The OSDV conducted in Montserrado covered 23 of the 46 (53%) TB treatment facilities. The selection of these facilities was informed by the presence of data in the DHIS for comparison. Generally, the county made significant gains on key indicators during the period in review.

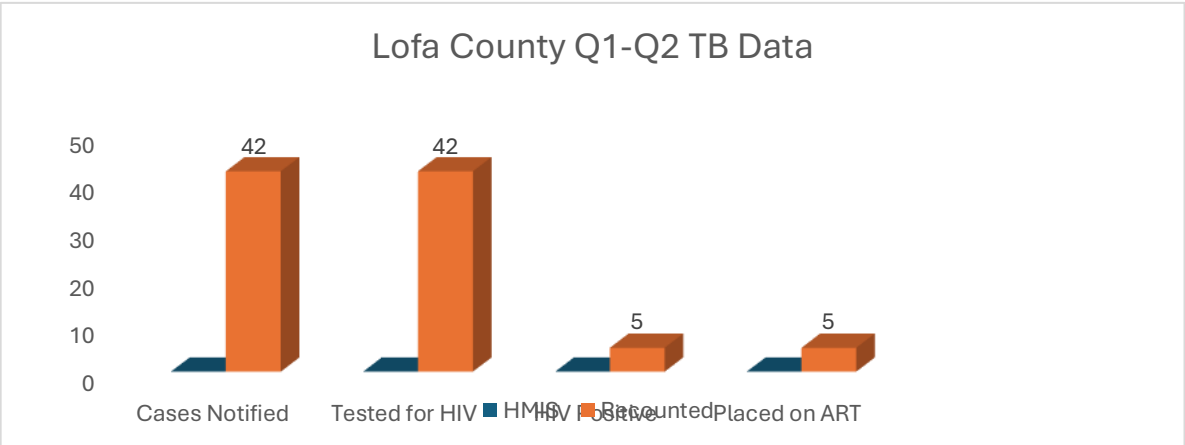


Data source: Field data

The graph above shows a significant achievement in Montserrado on five key indicators with 4,883TB cases counted against 4,356 notified and reported in DHIS. For gene X-pert testing results, the team counted 1,596 against 1,373 reported. There was disparity between number reportedly tested for HIV with known status and notified cases. The recount also revealed 4,882 against 4,354 reported. Finally, the county reported 58.4% case notification, but the actual calculation revealed 74.4%

3.6. Lofa County

There was a gross data gap observed in Lofa County during the period in review. The team observed that no data was entered in the DHIS for the two quarters.



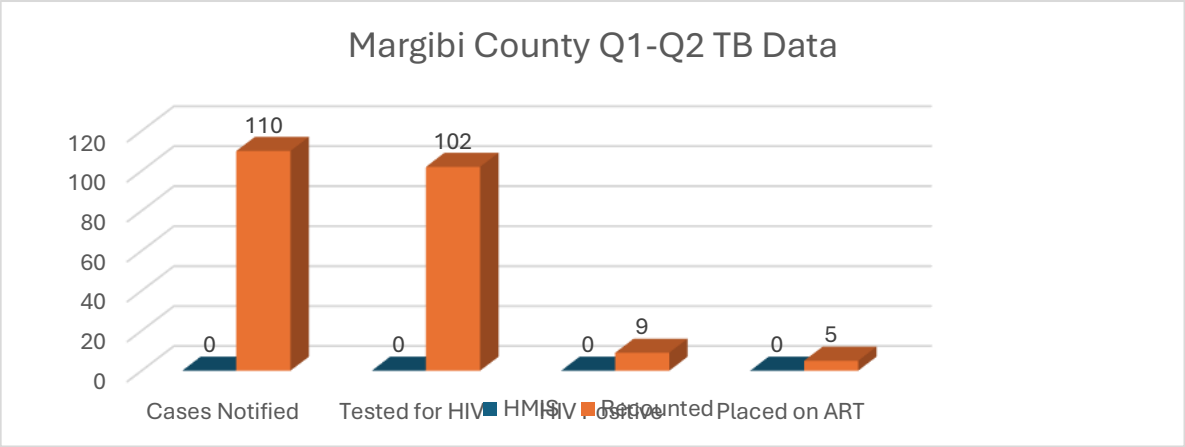
Data source: Team #1 Field data

The graph above shows that Lofa did not collect/enter TB data during the reporting period. However, the team was able to conduct ledger count which revealed 42 notified cases, 42 TB cases were tested

for HIV and know their status while five TB cases were tested positive and placed on ART. This discovery and analysis shows the county's failure to pay the deserved attention to TB services despite the recent training and engagement with the CHT in Gbarnga during M&E training and the grant start up meeting in Monrovia followed by official launch of the GC-7 grant by the Government.

3.7 Margibi County

There was a gross data gap observed in Margibi County during the period in review. The team observed that no data was entered in the DHIS for the two quarters.



Data source: Team #1 Field data

The graph above shows that Margibi County did not collect/enter TB data during the reporting period. However, the team was able to conduct ledger count which revealed 110 notified cases, 102 TB cases were tested for HIV and know their status while 9 TB cases were tested positive and 5 of them placed on ART. This discovery and analysis show the county's failure to pay the deserved attention to TB services despite the recent training and engagement with the CHT in Gbarnga during M&E training and the grant start up meeting in Monrovia followed by official launch of the GC-7 grant by the Government.

4.0 Findings from Non-High Burden TB Counties

4.1 River Cess

The team observed major data discrepancy issue in quarter one 2024. The discrepancy is said to have occurred due to wrong report submission from three health facilities in the county (Neeziun clinic, St. Francis Hospital and River Cess district Hospital). Other factors that attributed to the discrepancy include lack of logistic for TB/HIV Collect report, staff attrition, TB clinician limited knowledge on TB report preparation including the reporting period.

However, despite the above challenges the county made some improvement in quarter 2, 2024 data.

This River Cess performance shows high level of discrepancy between data reported in DHIS2 and data verified on all five key indicators. A total of 24 TB cases were reported notified in DHIS2 but the actual ledger count was 17 and this was consistent with notified cases tested for HIV. Treatment success rate was reported at

60% but the actual ledger count was 80%. This analysis verifies significant data discrepancy in the county during the reporting period. There is a need for the program to conduct training/refresher training and maintain mentoring and supervision of TB services in the county before the next reporting period.

Additionally, Laboratory data in River Cess reveals low GeneXpert testing at the same time follow up tests were not done for patients on treatment. GeneXpert testing is crucial in diagnosing TB effectively and identifying Rif resistance at diagnosis. Sensitization of clinicians about sputum collection, contacting of riders for Sputum transport and regular monitoring of sputum transport system will improve GeneXpert testing coverage.

4.2 Gbarpolu County

Gbarpolu County was the only non-TB burden county that reported good quality TB data during the period in review with equal number of TB cases notified and reported in DHIS and matches actual with ledger count (15/15). The same number of notified cases matches with those tested for HIV and received results. All other data for key indicators were consistent (0-0) except TB treatment success rate which was reported in DHIS to be 45% but verified to be 55%.
The performance of Gbarpolu County is laudable and needs to be encouraged and sustained for the next reporting period.

NO	Indicator- Gbarpolu County	DHIS	Recount
1	Notified TB cases of all forms of TB	15	15
2	TB cases tested for HIV or with known HIV status	15	15
3	TB cases tested for HIV with positive test recorded	0	0
4	TB cases tested HIV positive and placed on ARV	0	0
5	TB Treatment success rate- all forms:	45	55%

4.3 Bomi County

Bomi County's combined data quality for quarters one and two were fairly good with equal number of TB cases notified (38)/reported and counted. However, there was inconsistency between the number of cases tested for HIV with know HIV status (40) reported while the actual count was 38. Bomi also reported treatment success rate of 48% while the verified count was 52%. Additionally, Bomi did not do entry for laboratory data for the period in review.

4.4 Cape Mount County

Cape Mount county's data quality was also fairly good. According to the verification team the county reported 29 notified TB cases in DHIS while the actual ledger count revealed 27 cases. Cape Mount also reported 29 cases of TB that were tested for

HIV but only 26 cases were physically counted. For TB cases tested positive for HIV, the reported cases match with the physical count (6) as well as those who accepted to be placed on ARV (3). Additionally, Cape Mount did not do entry for laboratory data for the period in review.

4.5 Sinoe County

Sinoe County reported a fairly good quality data as were verified by the verification team. The county a combined quarters one and two notified TB cases of 28 in DHIS which match with the ledger count. The disparity in the data was seen in the number of cases tested for HIV during the same period which was reported in DHIS to be 24 while the ledger count was 12 cases. However, a consistency was observed in the number of active TB cases who were tested positive for HIV and recorded to be two in DHIS against ledger count of 2. It was also observed that none of the co-infected cases were placed on ARV according to ledger count and DHIS report. Treatment success rate was recorded at 53.8% which the actual calculation was 52%. Additionally, no data entry was conducted for laboratory data in Sinoe County.

4.6 Grand Gedeh County

There was a fairly good quality data reported and verified in Grand Gedeh County during the period in review. Notified cases of TB reported in DHIS was 60 and ties with the actual ledger count. The same was consistent with the number of them that were tested for HIV with known status. However, the number of TB cases tested positive for HIV (6) varied between reported and ledger count (5). The county reported zero for those TB positive cases that were placed on ARV while the ledger counted discovered five (5) during ledger count. Lastly, the TB treatment success rate reported was 74% while the verified count was 68%.

NO	Indicator-Grand Gedeh	DHIS	Recount
1	Notified TB cases of all forms of TB	60	60
2	TB cases tested for HIV or with known HIV status	60	60
3	TB cases tested for HIV with positive test recorded	6	5
4	TB cases tested HIV positive and placed on ARV	0	5
5	TB Treatment success rate- all forms:	74%	68%

Data source: Team #2 field data

4.7 River Gee County

In River Gee County there was significant data disparity during the period in review. There was a total of eighteen (18) TB cases notified and reported in DHIS but the ledger count revealed neighteen (19). It was even more inconsistent to report that among the eighteen (18) notified cases reported, twenty (20) were counted to have been tested for HIV and know their status. The only consistent data reported by the county and verified to be true was that there

were no TB cases tested for HIV and non was placed on ARV. TB treatment success rate was reported to be 93% but the actual result was 85%.

NO	Indicator- River Gee	DHIS	Recount
1	Notified TB cases of all forms of TB	18	19
2	TB cases tested for HIV or with known HIV status	18	20
3	TB cases tested for HIV with positive test recorded	0	0
4	TB cases tested HIV positive and placed on ARV	0	0
5	TB Treatment success rate- all forms:	93%	85%

Data source: Team #2 field data

4.8 Grand Kru County

In Grand Kru County, there was a gross data discrepancy between reported and verified data. During the quarter in review the county reported fourteen (14) TB cases notified and recorded in DHIS but the ledger count revealed nineteen (19). The county also reported that fourteen (14) notified cases were tested for HIV with known status, but the ledger count revealed twenty (20). The county also reported two (2) cases of TB were tested positive (co-infected) but the ledger count revealed on case only. Furthermore, it was confirmed through ledger count that the co-infected case was placed on ARV. Finally, Grand Kru County reported 50% TB treatment success rate, but the team calculated a success rate of 41% during the period in review.

NO	Indicator- Grand Kru	DHIS	Recount
1	Notified TB cases of all forms of TB	14	19
2	TB cases tested for HIV or with known HIV status	14	20
3	TB cases tested for HIV with positive test recorded	2	1
4	TB cases tested HIV positive and placed on ARV	1	1
5	TB Treatment success rate- all forms:	50%	41%

Challenges

1. Service and data quality were enormous during the semester OSDV. The team from the south-east of the country made emphasis on the huge knowledge gap and rapid staff attrition observed.
2. Data recording and reporting is the main reason for poor data quality in all the counties.
3. Data entry for laboratory data was not done in all counties except Nimba
4. Quarter two data recording and reporting was a bit improved compared to quarter one.

5. The allocated number of days for the OSDV exercise was not adequate for the number of facilities spread over long distances.

Recommendations

1. The NLTCP should conduct training/refresher training for all TB clinicians, county focal persons and county data managers in all the counties.
2. Laboratory unit should ensure that laboratory data are collected and entered into DHIS
3. NLTCP through the Case Management Unit should mentor and orientate service providers and CHTs to ensure new and difunctional TB facilities are re-opened

Conclusion

This OSDV is the first one to be implemented under the GC-7 grant. The experience and lessons learned will make the second semester OSDV a little better. The mitigation measures that are expected to address the challenges would help to improve data and service quality.

Shortly after the completion of this OSDV the editing and re-entry of the validated data encountered problem when the DHIS server experienced a breakdown. This is a major challenge that seems to have contributed to poor data quality.