The Global Fund for AIDS, TB and Malaria

Draft Report for the Data Quality Audit for HIV/AIDS in Malawi **(MLW-102-G01-H, MLW-506-G03-H, MLW-708-G07-H)**

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Final Audit Report

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drug
CDC	US Centers for Disease Control and Prevention
CSPC	Community Social Protection Committee
DC	District Commissioner
DQA	Data Quality Audit
HH	Household
HIV	Human Immunodeficiency Virus
I-TECH	International Training & Education Center on HIV
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
MoGCCD	Ministry of Gender, Children and Community Development
MoH	Ministry of Health
NAC	National AIDS Commission
OVC	Orphans and Vulnerable Children
PLWA	Persons Living with HIV/AIDS
PR	Principal Recipient
PU/DR	Performance Update/Disbursement Request
SCTP	Social Cash Transfer Program
SCTS	Social Cash Transfer Scheme
SDP	Service Delivery Point
SR	Secondary Recipient
TA	Traditional Authority
TB	Tuberculosis
TO	Transfer Out
UNICEF	The United Nations Children's Fund
VDC	Village Development Committee

I. Executive Summary

The audit team was comprised of three consultants from JSI and two consultants from a JSI partner organization, Khulisa, located in Johannesburg, South Africa.

The Global Fund originally recommended three indicators for the Malawi audit, one each from rounds one, five and seven. However, after a desk review of the data systems for these indicators it was determined that it would not be possible to review three indicators in a two-week audit period. Therefore, JSI selected indicators from rounds 1 and 7, 'PLWAs currently on ART' and 'young people who accessed youth friendly services' respectively. While in country the National AIDS Commission (Principal Recipient [PR] for HIV Round 1, HIV Round 5 and HIV Round 7) informed the audit team that the SR responsible for the indicator 'young people who accessed youth friendly service' was not available. The third indicator, "OVC whose households receive social cash transfers (Round 5: Indicator 3.4)" was therefore selected as a replacement.

The period selected for review was Oct 1, 2009 – March 31, 2010, corresponding to Period 17 of the Round 1 grant and Period 6 of the Round 5 grant. Data was not available in the most recent Grant Performance Reports. Instead, the Global Fund provided the relevant PU/DR to the auditors.

For indicator 2.1, a two-stage cluster sampling methodology was used to sample three districts, and nine service delivery points. Districts were sampled with probability of selection proportionate to volume of service. The three districts selected were: Lilongwe, Blantyre, and Nsanje. Three health facilities per district were selected randomly, one each from large, medium and small volume strata. For Indicator 3.4, service delivery is at the district level. Only Mchinji, Phalombe, and Chitipa districts had made cash transfers to beneficiaries during the reporting period under review. Since there were only three districts reporting results for the indicator no sampling was required and the three reporting districts were selected. Due to logistical constraints only Mchinji and Phalombe districts could be audited.

All sites and aggregation levels were visited between August 30 and September 10, 2010. At each site a questionnaire was administered to (1) qualitatively evaluate data management capacity (Protocol 1 – System Assessment), and 2) quantitatively assess the accuracy, timelines, completeness and availability of source documents and reporting forms (Protocol 2 – Data Verifications). For the quantitative evaluation, source documents were identified and indicator values recalculated for the reporting period. Recalculated values were compared to the reported values and a verification factor calculated for each site and aggregation level and a composite national score.

Results: Data accuracy for the ART indicator ranged from 90% to 101% at the SDPs and was 99.2% at the M&E Unit, suggesting the program had over-reported by only

0.8%. Several reasons contributed to the over-report including minor arithmetic errors, copying errors, failure to have indicator data recorded and the use of proxies such as the total number of clients registered and clients recorded as on 1st line treatment. Both availability and timeliness of reports was 100%; completeness was 96.4%. The M&E Unit for the ART Program is well staffed and well organized with significant level of external technical assistance. The M&E unit collects data from the health facilities as part of supervisory visits and data is cleaned on-site and the supervisors' copy is taken to the M&E unit for further aggregation. The only weaknesses noted during the audit included minor incompleteness of source documents and the supervisors' copies of the quarterly facility reports. In addition, there are no written standards for addressing incomplete or missing cards. Minor breaches of confidentiality were noted in the use of patient names in commonly used registers, and the names are sometimes visible to other patients while they are being attended to.

For the OVC Indicator (social cash transfer scheme) at the M&E Unit, data accuracy was 61%; availability was 2.4%; timeliness was 0%; and completeness 100%. Both the PR and SR appeared disorganized and lacking in knowledge of the status of the cash transfer program and the data flow for the indicator on the number of children whose households receive cash transfer. Conclusive explanations of how the PU/DR was prepared for the specified reporting period were not provided to the audit team. At site level, the payment form (Form 5) that has proof of payment does not have details on the children living in the beneficiary households. A monthly report template is provided but M&E officers at district level do not use them due to reported difficulties in completing the templates.

Recommendations: The ART reporting system in Malawi is highly organized and produces good quality data. Its effective use of comprehensive supervision to ensure good quality reporting should serve as a model to other HIV/AIDS treatment programs. However, no system is perfect and the audit team recommends the following to further improve upon this impressive system. The M&E Unit for the ART Indicator should develop an error log to document how the gaps in recorded data were addressed. Patient identifiable information should be limited to patient master cards and manually linked to registers through unique patient IDs.

For the OVC indicator, the PR and SR should prepare reports that are supported by an audit trail. Current and archived data should be readily accessible to relevant data management staff to improve institutional memory. The OVC indicator need to be operationally defined and the data flow documented. Data management roles and responsibilities should be clearly documented. To avoid future situations where districts implement cash transfers and fail to report, procedures to address incomplete, inaccurate, missing data/reports and or late reports should be documented and implemented. Clear instructions and trainings ought to be provided regarding the preparation of reports. Ideally, implementation of the relational electronic database should be accelerated and scaled up in all the districts. The payment form (Form 5) should be redesigned to include OVC details to facilitate manual linkage of the number OVC whose households receive cash transfer.

II. Introduction and Background

Purpose of the DQA

Globally, there is increasing interest in the measurement of indicators to capture key information about disease treatment, care, and prevention programs. This reliance on indicators necessitates quality assurance mechanisms that promote reliable data collection, management and storage. As national programs and donors invest in diseases like Acquired Immunodeficiency Syndrome (AIDS), Tuberculosis (TB) and Malaria, assessing program effectiveness and management demands the development and maintenance of strong monitoring and evaluation (M&E) systems.

In the spirit of the M&E component of the "Three Ones" and the "Stop TB Strategy" numerous multilateral and bilateral organizations, including the Global Fund, have collaborated to develop tools to help programs improve data management and reporting aspects of their M&E systems and to improve overall data quality. In order to ensure the quality of reporting for its performance based funding mechanism, The Global Fund has issued an IQC for data quality audits. John Snow, Inc. (JSI) was selected as the implementing agency for the DQA of the Rounds 1, 5, 7 HIV/AIDS grants in Malawi.

Background on the program/project

Malawi is among the countries in Southern Africa at the epicenters of the HIV and AIDS pandemic, with HIV infection predominantly transmitted through heterosexual intercourse and about 15% of new infections are MTCT. The program supported by the round one grant aims to bring a balanced approach between prevention, care, support and treatment of HIV and AIDS in Malawi and to reduce the burden of HIV and AIDS-related illnesses and deaths so that they no longer pose a threat to economic growth and political stability. The program consists of assistance to expand voluntary counseling and testing centers, to provide services to HIV-infected mothers to prevention transmission of the disease to their infants; and commencement of antiretroviral therapy to eligible patients. The program is also strengthening home-based care and treatment of opportunistic infections[1].

Although the HIV and AIDS prevalence rate seems to have stabilized in Malawi, the number of orphans and vulnerable children had been projected to increase[2]. The program supported by the Round Five Grant aims to strengthen and develop an enabling policy and legal framework to protect the rights of orphans and other children who have been made vulnerable by HIV and AIDS and poverty; strengthen institutions and technical capacity at all levels to ensure a rapid scale up of the national response to the orphan

[1] Grant Performance Report; Malawi Round 1 (MLW-102-G01-H-00); 23 April 2010

[2] 2010 epidemiological projections actually show that the total number of orphans has started to decrease in 2009. This is due to the high ART coverage.

crisis, giving particular attention o district and community capacity and systems; and increase access of orphans and vulnerable children to primary and secondary education and other services with support from the safety nets providing school bursaries and cash transfers to households caring for orphans and vulnerable children[3].

As for the Round Seven grant, the overall goal of the program is to reduce the transmission of HIV among young people aged 10 to 24 and all adults in Malawi. To achieve its goal, the program will expand effective HIV and AIDS behavior change communications for the general population; promote safer sex practices among young people in high risk groups and settings; scale up interventions designed to fight
HIV transmission among young people; reduce the vulnerability of young people to HIV infection, especially among girls and young women; and expand advocacy and social mobilization for HIV prevention at the district and community levels[4].

The National AIDS Commission is the Principal Recipient (PR) for HIV Round 1, HIV Round 5 and HIV Round 7. The Ministry of Health is a sub-recipient for Round 1. The actual SRs and recipients of funds for the cash transfers are the implementing seven districts. However, MoGCCD is an SR for other OVC indicators and MoGCCD houses the SCTP secretariat and has committed to include the cash transfer indicator as part of their reporting on all OVC indicators.

Indicators and Reporting Period – Rationale for selection

The indicators selected for the DQA in Malawi were:

- **Round 1:** Indicator 2.1: Number of PLWA who are alive and on treatment;

- **Round 5:** Indicator 3.4: OVC whose households receive social cash transfers;

The Global Fund originally recommended three indicators for the Malawi audit, one each from rounds one, five and seven. However, after a desk review of the data systems used to report on the selected indicators it was determined that it would not be possible to review three indicators in a two-week audit period. Each indicator is reported through a separate system to a specific government ministry using a different reporting system. Thus, an independent sample would have had to be drawn for each indicator. With three clusters to select for each indicator, and three service delivery sites per cluster, a total of nine clusters and 27 service delivery sites would have been required. This would not have been possible in two weeks with a team of four auditors. Therefore, after review of the available data in the Performance Updates sent by the Secretariat for the specified reporting period, JSI selected indicators from rounds 1 and 7, 'PLWAs currently on ART' and 'young people accessing youth friendly services' respectively. Initially, the round five indicator, 'OVC whose households receive social cash transfers' which had

[3] Grant Performance Report; Malawi Round 5 (MLW-506-G03-H); 23 March 2010
[4] Grant Performance Report; Malawi Round 7 (MLW-708-G07-H); 02 February 2010

only 3/7 districts reporting in the Performance Update and was deemed problematic for review, was excluded[5].

On arrival in Malawi and during the introductory meeting with the PR it was learned that the M&E personnel at the Secondary Recipient (SR) responsible for management and reporting for the indicator 'young people accessing youth friendly services' were 'out of the country' during the time of the audit and the indicator would therefore be impossible to verify during the audit period. The audit team therefore made the decision to audit the Round 5 indicator 'OVC whose households receive social cash transfers'.

The period selected for review was October 1st, 2009 to March 31st, 2010 which corresponds to Period 17 of the Round 1 grant and Period 6 of the Round 5 grant. Data were not available in the most recent Grant Performance Reports available on the Global Fund website. Instead, the Global Fund forwarded the Performance Update / Disbursement Requests (PU/DR) for the relevant period to JSI. This document is the quarterly reporting form from the PR to the Global Fund and represents the most recent data available from the Global Fund. The period was selected by the Global Fund Secretariat.

Service Delivery Sites – Rationale for selection

Indicator 3.1 – Round 5: Number of OVC whose households receive social cash transfers

For the OVC indicator, the level of service delivery is the district. All data management is handled by the district team which travel to Traditional Authorities (TA), Village Clusters (VC) within TAs, and Zones within VC, to make cash transfers to previously identified beneficiaries on a monthly basis. Reporting for the indicator to the national level is quarterly. For the reporting period selected for the audit, only three districts had reported making cash transfers to beneficiaries. The three districts are:

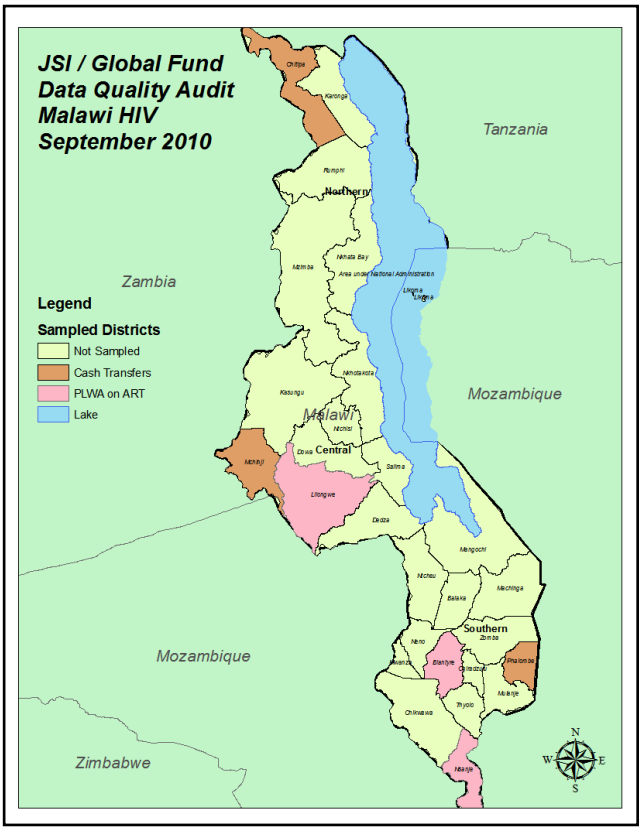

Figure 1: Districts Selected for Malawi DQA Sept 2010

[5] During the audit it was established that cash transfers had taken place in the 3 districts but there no formal reports that were reviewed by the audit team save for a belated report from one of the district that was received in July after the PU was prepared.

1. Mchinji
2. Phalombe
3. Chitipa

Thus, for the OVC indicator, no sampling was required and all districts with service delivery in the reporting period were selected for the audit. In the end, audit data was collected only in Mchinji and Phalombe districts as it was not feasible to travel to the third district, Chitipa, within the two week period.

Indicator 2.1 – Round 1: Persons Living with HIV/AIDS on Anti-retroviral Treatment (ART)

For indicator 2.1, the audit team used a two-stage cluster sampling methodology to sample three districts, and nine service delivery points. Districts were sampled with probability of selection proportionate to volume of service, while service delivery points were selected randomly from three volume strata (large, medium and small). The reported values for the indicator were traced and verified from service delivery point through the national level and compared with the values received by The Global Fund (PU/DR). For this indicator, data are sent from service delivery points directly to the national level. In this case, the cluster sampling algorithm was used to limit the travel required by the audit team. Reviewing nine sites selected entirely at random would have resulted in an unmanageable amount of travel for the allotted audit period.

Three districts were selected with probability of selection proportionate to the volume of service in the district (see Annex 1 for details on sampling for the indicator). The volume of service was calculated as the total ever enrolled in ART in the district, minus those who have died, stopped treatment, transferred out, or defaulted (lost to follow-up). The three districts selected were:

- Lilongwe
- Blantyre
- Nsanje

Service delivery sites were then ranked and stratified on volume of service into three strata; small, medium and large. One site was chosen at random from each of the three strata. Thus, three sites per district were selected for a total of nine service delivery sites.

	PLWA on ART
1. Lilongwe District	
a. Area 18 Health Centre	764
b. Dr David Livingstone Memorial Clinic	89
c. Lilongwe Health Clinic	23
2. Blantyre District	
a. Ndirande Health Centre	1760
b. Chitawira Private Hospital	278
c. Blantyre Water Board Clinic	63
3. Nsanje District	

a. Kalemba Community Hospital 862
b. Ndamera Health Centre 390
c. Sorgin Health Centre 89

Description of the Data Collection and Reporting System

PLWA Currently on ART

For the ART indicator the SR is the Ministry of Health (MOH). Service delivery for PLWA on ART is recorded on the Patient Master Card and in the ART Register. When a patient comes for a follow up visit, the regimen and patient status (i.e. alive and on treatment, or transferred out) is recorded on the Patient Master Card. Other adverse outcomes (stopped, defaulted or died) get updated during quarterly cohort analysis and/or after active follow up. In the event that the patient status has changed, the ART Register is also updated.

There were 276[6] treatment sites reporting for the reporting period. Each site reports directly to the district on a monthly basis. Data that is reported to the district is not used internally and it is not transmitted onwards to the national level. For national level reporting facilities prepare quarterly reports for collection by the HIV Unit of the Ministry of Health (MoH). A standardized quarterly report, "ARV clinic supervision form version 6", is compiled at the end of each quarter. Each quarter a team comprised of district and national M&E staff visits each facility to validate the indicator and provide mentoring and capacity building for reporting on the indicator as necessary. After the validation exercise the MoH/HIV Unit enters the data from the facilities into the ART Supervision database in Lilongwe. The HIV Unit then generates a quarterly report which is submitted to the PR.

The team that visits health facilities provides the health facilities with blank reporting forms and a schedule for the next visit. Since the facilities are visited each quarter and the value for the indicator is derived during the visit, and since these visits take place prior to the deadline of reporting, timeliness and completeness of reporting are practically never at issue.

OVC whose households benefit from social cash transfers

For the OVC indicator, the data is generated and managed at the district. Each of the seven districts in the pilot program has previously identified beneficiary households through a systematic and participatory process of community meetings. At the

[6] The HIV unit visited the 277th facility in the database to check if drugs were in stock and if they were ready to start. The facility had not started and the supervisors did not fill a supervision form. However, in order to document the visit, a 'null-report' was entered in the database.

community level, Community Social Protection Committees (CSPCs) are formed under the Village Development Committee (VDC) and consist of volunteers.

Typically, villages are grouped into Village Clusters (VC) with about 1000 households. For each VC a VDC is formed comprised of elected members. Before a VC can be integrated into the cash transfer scheme, the VDC has to organize the election of a Community Social Protection Committee (CSPC)[7]. A CSPC is composed of 9-12 volunteers and is created to identify and screen potential household beneficiaries which are then selected during community meetings.

Level	Component	Roles and Responsibilities
National Level	National AIDS Commission	The Principal Recipient of fund from Global Fund.
	Social Cash Transfer Secretariat (MoGCCD)	Overall managerial responsibility, TA, Monitoring & Oversight - Provide technical assistance to the district level secretariats - Receive information from the districts - Aggregate data from district and Prepare PU/DR - Provide feedback to districts
District Level	Social Cash Transfer Secretariat (Desk Officer, Social Welfare Assistants & Trainers)	Daily management, implementation & monitoring of the Social Cash Transfer Scheme - Plan, implement, record, monitor and report all activities required to establish community level committees - Train and assist these committees to perform their tasks in the targeting process - Monitor the approval and delivery process - Compile and submit monthly monitoring reports to MoGCCD
Community Level	Community Social Protection Committee (within VDC)	Targeting and follow-up of beneficiary household - Identified beneficiaries and draws a list of beneficiaries - Submit list to district - Oversee payments to HH - Monitor and submit HH changes to the district

Table 1: Illustration of Malawi Social Cash Transfer Program Structures

Each VC is divided into about three zones (groups of villages). About 10%[8] of the estimated 1000 at-risk households per Village Cluster are selected to receive the cash transfers. Each month the district schedules visits to designated pay points to pay the

[7] From Malawi SCTP Manual of Operations
[8] It is estimated that approximately 10% of all households in Malawi are ultra poor and labour constrained

selected household beneficiaries. The amount of monthly cash transfers vary according to household size and take into account if the household has children enrolled in primary and/or in secondary school. The heads of beneficiary households will sign or finger-print a pre-printed form (Form 5) when receiving their payment. This record of payment is then archived in folders at the district level as the source document for the indicator. Apart from targeting beneficiary households, CSPCs, follow up the implementation of cash transfers and submit changes in household status to the districts.

For the indicator under review, the districts (which are SRs for the Global Fund Program) report monthly to the Ministry of Gender Children and Community Development (MoGCCD). The M&E Officer at the district level is required to compile monthly reports using Monthly Monitoring Report Template. The compiled monthly reports are supposed to be forwarded to the District Commissioner (DC) by 10th day of the following month and submitted by the DC to the national Secretariat (Ministry of Gender, Children and Community Development) by the 20th day of the same month in both electronic and hard copies. The Ministry of Gender is required to submit quarterly and half yearly synthesized reports for the seven districts to the PR. The deadline for reporting is the 21st of the month following the end of the quarter or six months for the PU/DR.

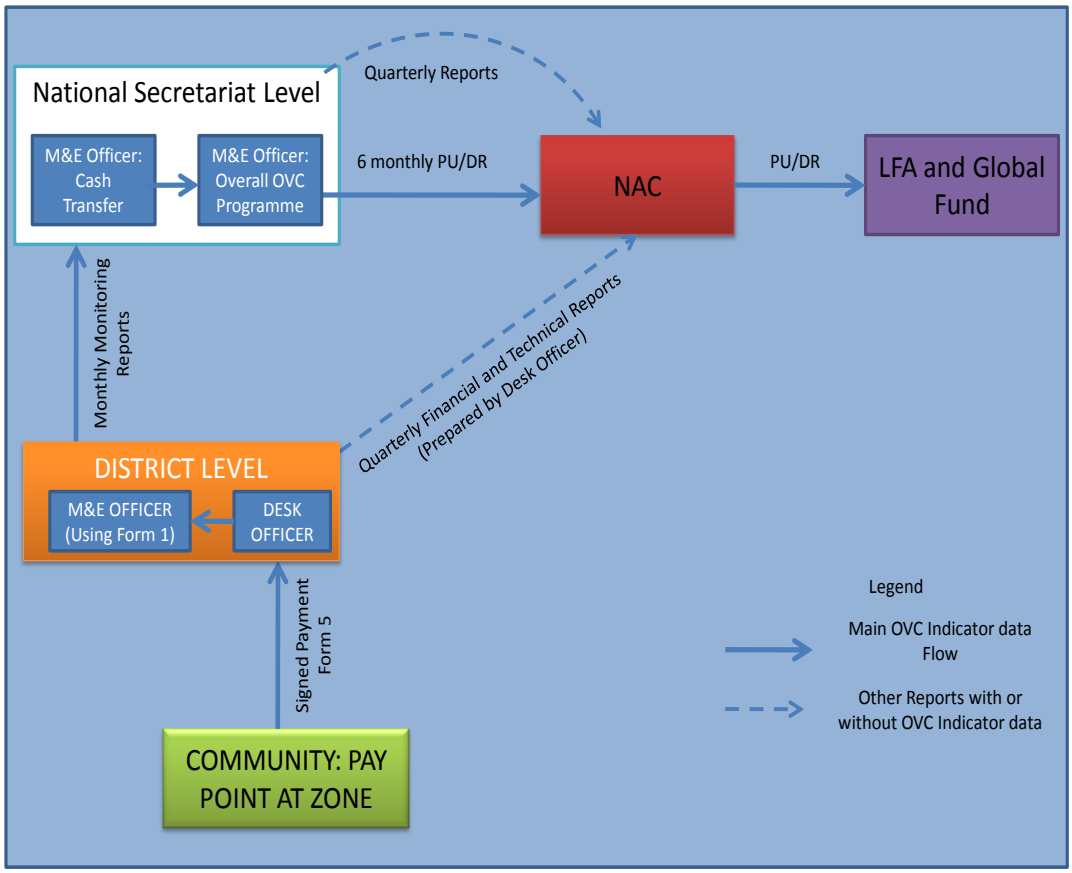

Figure 2: Illustration of Data Flow for the OVC Indicator

The Desk Officers at the Social Cash Transfer Secretariat at the district level also compile quarterly financial and technical reports which are submitted directly to the PR as required by the districts status as a SR. These financial and technical reports however, do not contain the value of the indicator 'number OVC whose households received social cash transfers'.

III. Assessment of the Data Management and Reporting System

PLWA Currently on ART

Description of the performed system assessment steps

For the system assessment, the audit team used Protocol 1: System Assessment of the Data Management and Reporting System standardized tool from the Global Fund. Interviews were conducted with relevant program staff (typically data managers) and responses recorded in the MS Excel template. Where required, documents were requested to validate responses pertaining to written documentation.

The Data Management System assessment of the ART program in Malawi registered an average score of 2.79 (range 2.45 – 2.99). The functional area 'indicator definitions and reporting guidelines' scored highest with an average score of 2.99 while the functional area 'data management processes' scored lowest with 2.45. With no intermediate levels for the program, overall, the SDP's (facilities) performance, though slightly better, was reflective of the M&E unit's performance. Still the M&E unit performed slightly better (2.77) than the SDPs with regards to the functional area 'data management processes'.

a) M&E Structure and Functional Capabilities
   - Staff positions necessary for the reporting needs of the program/system have been filled.
   - The links among the different stakeholders providing technical assistance and support are strong.
   - Program Staff at all levels have received training on the data management processes and tools.
   - The review and aggregation of data and reports are done in teams at all levels.
   - Supervisory visits that are done as part of data collection and reporting help to improve the quality of the program's reported data.

However,
   - The program did not have an organisational chart. Because the team is small, they did not see the need for an organisation chart.
   - The problem of staff shortage was reported by some program personnel at facility level.

- The program has no documented/formal training plan in place that includes training needs for all levels of the data management system.

b) Indicator Definitions and Reporting Guidelines
- There exists a comprehensive ART Management Guideline document used at every level of the program.
- Instructions and manuals/pamphlets on how data management forms should be completed have been developed by the program. These are included in the ART guideline document, the reverse side of the ART master cards and the Version 3 User Instruction Pamphlet.
- Supervisory visits to facility ensure that data is reported through the levels of the data management system and also provides a routine opportunity for technical assistance and orientation/training.

However,
- The audit team noted that there was no written policy that described how, where and how long source documents and data had to be kept/stored or organised.

c) Data Collection and Reporting Forms and Tools
- There exist clear instructions and guidelines on how to complete forms and tools at every data management level. These guidelines and instructions are found in the ART Guideline booklet and the Version 3 user instruction pamphlets given to all facilities by the M&E unit/MoH.
- Standard source documents, national data collection and reporting tools are routinely and consistently used by all service points and are always available in sufficient supplies at service points

However,
- Program supervisors transcribe data from facilities' completed reporting tools to their own tools; this process poses a potential risk to data quality through transcription errors.

d) Data Management Processes
- The provision of feedback in the program is routine, consistent and includes national program summaries.
- Data management tools and processes allow for the monitoring of clients who drop out, deaths, defaulters and clients who are transferred out of an SDP.

However,
- There are no documented procedures to address data gaps due to incomplete, inaccurate, missing data/reports and or late reports.
- There is no document that serves as a guide to the administration of database, neither is there one that has back-up procedures.

e) Links with National Reporting Systems
- National tools and forms are routinely used by all facilities.
- The reporting channel used is the national reporting channel.

However,

- Usage of ID numbers by facilities was not consistent and at times these ID numbers were not known.

Dashboard summary statistics

SUMMARY TABLE Assessment of Data Management and Reporting Systems		I M&E Structure, Functions and Capabilities	II Indicator Definitions and Reporting Guidelines	III Data-collection and Reporting Forms / Tools	IV Data Management Processes	V Links with National Reporting System	Average (per site)
M&E Unit							
-	Ministry of Health (MoH)	**2.33**	**2.86**	**2.83**	**2.77**	**2.67**	**2.69**
Service Delivery Points/Organizations							
1	Area 18 Health Centre	**3.00**	**3.00**	**3.00**	**2.25**	**2.75**	**2.80**
2	Dr David Livingstone Memorial Clinic	**3.00**	**3.00**	**3.00**	**2.50**	**3.00**	**2.90**
3	Lilongwe Health Clinic	**2.67**	**3.00**	**2.67**	**2.50**	**2.50**	**2.67**
4	Ndirande Health Centre	**3.00**	**3.00**	**3.00**	**2.25**	**2.75**	**2.80**
5	Chitawira Private Hospital	**2.33**	**3.00**	**3.00**	**2.00**	**2.75**	**2.62**
6	Blantyre Water Board Clinic	**3.00**	**3.00**	**3.00**	**2.50**	**2.75**	**2.85**
7	Kalemba Community Hospital	**3.00**	**3.00**	**3.00**	**2.75**	**2.75**	**2.90**
8	Ndamera Health Centre	**3.00**	**3.00**	**3.00**	**2.50**	**2.75**	**2.85**
9	Sorgin Health Centre	**3.00**	**3.00**	**2.67**	**2.50**	**3.00**	**2.83**
Average (per functional area)		**2.83**	**2.99**	**2.92**	**2.45**	**2.77**	**2.79**

Table 2: Summary Table - Systems Assessment – ART

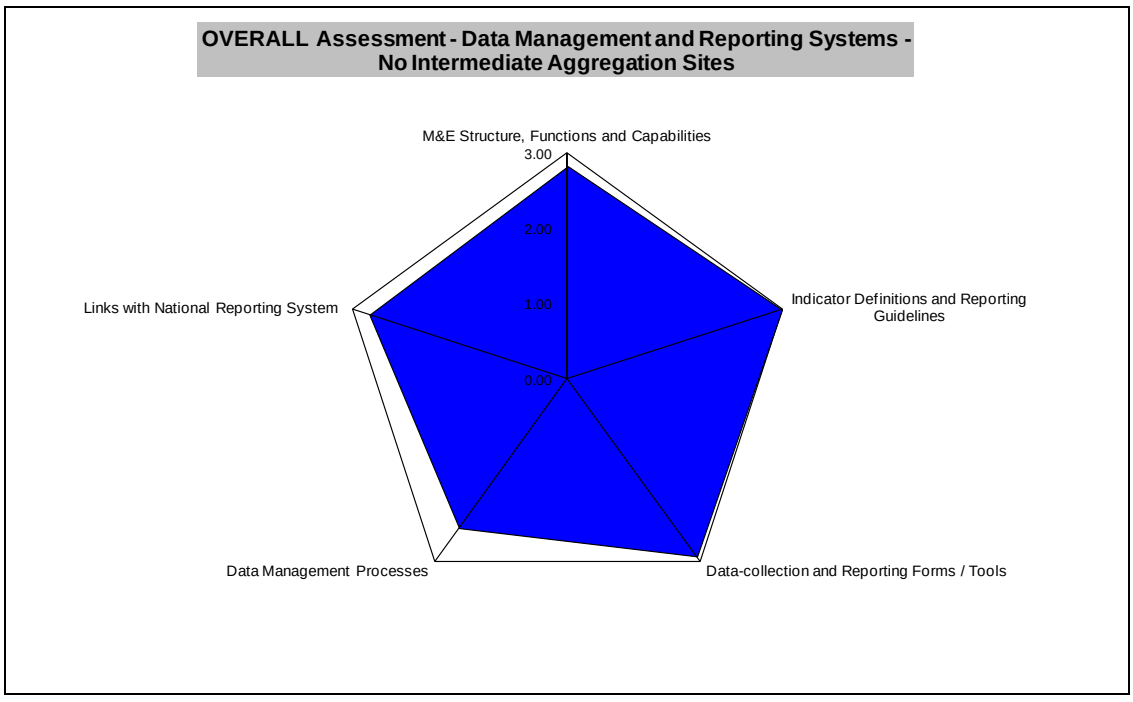

Figure 3: Spider Graph-System Assessment-ART

Key findings at the three levels:

⇨ *Service Delivery Sites:*

- Staff at SDPs have received training on the data management processes and tools. This training is provided by the respective district with support from the MoH. Trainings are usually followed up with refresher trainings, especially when changes or revisions are made to tools or processes. However, at two facilities the audit team noticed that some staff had not been refreshed since the introduction of revised data collection and reporting tools.
- Reviewing and aggregating quarterly reports are done by a team at facilities. Even though a few facilities reported having problems due to staff shortages, almost all facilities designate a team made up of a medical assistant or clinical officer, a nurse and a clerk to aggregate data and draft reports. This promotes a culture of knowledge transfer and effectiveness and ensures that data is more credible.
- The audit found that facilities are using the ART guidelines provided by the HIV Unit/MoH. Facility staff are aware of the demands of the indicator and program and are providing services in line with what the program demands. However, a few facilities are still using old ART guidelines and definitions. This in most part did not affect the quality of the reported data but had the potential to do so.
- Facilities have clear instructions provided by the HIV unit/MoH on how to complete the national data collection and reporting forms/tools. These guidelines and instructions are found in the ART Guideline booklet and the Version 3 user instruction pamphlets given to all facilities by the M&E unit/MoH. One facility was found to be using the old versions of the national tools together with old instructions and guidelines.
- At all facilities, at least two types of source documents (Patient Master Cards, Patient Registers) were available for the audit. Therefore, there was always a document available to do a trace and verification and others to do at least one cross-check when time permitted.
- The system at facilities allows for the tracking or monitoring of adverse outcomes including; defaulters, drop outs, deaths, those who stop treatment and loss to follow up clients. It also allows for the tracking of new cases and patients who transfers in from another facility. This capability ensures that accurate numbers of those alive and on treatment can be calculated at any point in time. However, at all facilities but one, it was noticed that there were no back-up systems to the manual and or hard copy of the source documents.
- Even though much has been done at facility level to ensure client privacy and confidentiality, facilities do not require that confidentiality agreements are signed by their staff, especially data clerks and cleaners. This would provide a legal basis for the provision of privacy and security to client personal information.

- It was also noticed that systems at facilities do not eliminate the possibility of double counting, especially the possibility for it to happen across facilities. For example, if an individual can wilfully enrol in more than one facility for ARVs.
- Facilities do not use their unique ID numbers for reporting and in some cases, these ID numbers for the facility are not known (even though they do exist).

⇨ *Intermediate Aggregation Levels:*

Not applicable for Malawi ART Program since reporting is direct from service delivery point to the national level.

⇨ *M&E Unit:*

- Staff positions especially M&E related positions necessary for the reporting needs of the program/system were filled. However, the program did not have an organisational chart. The program explained that it did not find an organisation necessary chart as the program team is small. The audit team advised the program to document such a chart that was inclusive of the entire system from SDP to the M&E unit including the supervisors.
- There was no documented/formal training plan in place. Training provided to the facilities was said to be a collective effort of a number of entities including the MoH, Districts, NAC and other agencies. The M&E unit or MoH's links to the districts that provide direct technical assistance to the local facilities were seen to be strong. Supervisory visits that are used as a method of providing technical assistance and training, and carried out as part of data collection and reporting, help to improve the quality of the program's data.
- There are no written policies that state or describe how, where and how long source documents and data have to be stored and or organised.
- The HIV unit/MoH or M&E unit has identified standard source documents (Master Cards and ART registers) and reporting tools used at all levels of the data management system (At facilities and the HIV unit of the MoH).
- Despite the drafting and distribution of instructions on how to complete the standard forms and tools, the fact that supervisors transcribe data from facilities' completed reporting tools to their own tools on the day they visit opens up a potential risk to data quality due to transcription errors.
- Even though the M&E unit routinely provides feedback (done in three ways (1) as a hard copy of the overall program report, (2) as an on-site review of data, and (3) as certificates of excellence to facilities where data was verified to be of good quality) to the SDP it was noticed that there was no written procedures to address data gaps (incomplete, inaccurate, missing data or reports and late reports).
- There was no document that guided the administration of the database at M&E unit. Also no back up procedure manual existed even though data was said to sit on a server where backed up is supposed to be automatic.

Overall Strengths and Weaknesses of the Data-Management System

	13 Questions	Answer	Comments
1	**Are key M&E and data-management staff identified with clearly assigned responsibilities?**	Yes - completely	At M&E unit, all M&E and data management positions are filled. Of the nine sites we visited, only one facility reported that a nurse had left. There, interim nurses had been brought in to fill the gap (Lilongwe health center). The staff could always use more resources. Every site/facility had nurses, clerks, and at least one clinician involved in the ART clinic. When there were problems in staff organization, it was often because staff had several different duties to address including ART clinical work. Supervisors were available and worked between facility and M&E unit, as the liaison.
2	**Have the majority of key M&E and data-management staff received the required training?**	Yes - completely	All staff receive ART certification training (Module 10). This training includes guidelines for correctly filling out master cards, reporting forms, and registers. Ongoing support is given in the form of quarterly supervisory visits by supervisors sent by the M&E unit/HIV unit/MoH. The programme was advised to draft a training plan which should address a routine training plan for new staff between quarterly visits
3	**Has the Program/Project clearly documented (in writing) what is reported to who, and how and when reporting is required?**	Yes - completely	These are all written in the ART guidelines, and upcoming supervisory visits are outlined in advance and provided to the facilities during preceding supervisor's visits
4	**Are there operational indicator definitions meeting relevant standards that are systematically followed by all service points?**	Partly	Some facilities were still using older operational definitions (e.g. definition of default, older vs. newer definition as in the older versions of the ART guideline booklet)
5	**Are there standard data collection and reporting forms that are systematically used?**	Yes - completely	Tools used are national tools/forms. All collection and reporting forms are used consistently and are regularly restocked at facilities by MoH Supervisors (public health centers) and the Malawian Business Coalition for Private Health Centers.
6	**Are data recorded with sufficient precision/detail to measure relevant indicators?**	Yes - completely	Tools are designed to capture enough details to report on the indicator. All facilities report number of people alive and on ART specifically
7	**Are data maintained in accordance with international or national confidentiality guidelines?**	Partly	Facilities make an effort to secure source documents which are always available at the facility. There are no 'confidentiality agreements' with staff in any facilities. As it functions at the facility, there are no issues with confidentiality, but the potential for abuse does exist
8	**Are source documents kept and made available in accordance with a written policy?**	Partly	Nearly all source documents were available and well organized. Auditors did not see any written guideline specific to ART records for storage and organization and if there are guidelines, they are not necessarily being followed. Some facilities are storing master cards by quarter, some in groups of 50, 100. Disorganization in few facilities is a problem, as the trace and verification using master cards was delayed, some cards could not be found (e.g. Kalemba).
9	**Does clear documentation of collection, aggregation and manipulation steps exist?**	Yes - completely	Information on these is captured in the ART guidelines, and in reporting forms. These are also covered during ART management trainings.
10	**Are data quality challenges identified and are mechanisms in**	Partly	Challenges are identified during the facility visit, and there is no written standard on how to address incomplete or missing cards. When errors or inconsistencies/discrepancies

	13 Questions	Answer	Comments
	place for addressing them?		are noticed, changes are made immediately with no documentation. Recommendation: create an error log, rather than making changes with no documentation
11	**Are there clearly defined and followed procedures to identify and reconcile discrepancies in reports?**	Yes - completely	Discrepancies in recorded patient data exist and the challenges are addressed immediately. Timeliness is not an issue, as reports are completed before or during a supervisory visit. The fact that reports generated by facilities are routinely check/reviewed by supervisors from the MoH makes for routine reconciliation of captured discrepancies.
12	**Are there clearly defined and followed procedures to periodically verify source data?**	Yes - completely	Supervisors are required to make quarterly visits to the site to establish what is happening, review source documents, revise drafted reports and collect such reports for the M&E unit. So data is routinely verified during quarterly visits by these supervisors.
13	**Does the data collection and reporting system of the Program/project link to the National Reporting System?**	Yes - completely	All guidelines provided at the national reporting system are disseminated and followed at the facility level. Tools used and procedures are all dictated by the national/ M&E level. Reporting is through a single channel of the national ART reporting system.

The M&E Unit for the ART Program is well staffed and well organized. They have a significant level of external technical assistance providers on staff (from the International Training & Education Center on HIV, I-TECH supported by funds from the US Centers for Disease Control and Prevention, CDC). They have a proprietary database in which they record and regularly update data on service delivery and which produces standardized automated reports on results. They regularly provide feedback in the form of national and site level results to all reporting facilities and a network of national and external stakeholders. They organize and lead data validation exercises at facility level every quarter using a majority of existing district level staff. They claim to be able to do this with a budget for M&E less than what is internationally recommended (7-10 percent of overall budget.) The estimated man-power requirements are about three person-hours per facility per quarter. The staff acknowledges, however, that the current level of quarterly supervisory visits to service delivery points will be difficult to maintain if services are scaled up in the future.

OVC whose households receive social cash transfers

Description of the performed system assessment steps

For the System Assessment, the audit team used Protocol 1: System Assessment of the Data Management and Reporting System standardized tool from the Global Fund. Interviews were conducted with relevant program staff (typically data managers) and

responses recorded in the MS Excel template. Where required, documents were requested to validate responses pertaining to written documentation.

The Malawi cash transfer program had an average score of 1.78 (range 1.47 – 2.0) for the system assessment. The functional area "Links with the national reporting system" (average 2.0) scored highest. The area of "Data collection and Reporting Tools/Forms" scored the lowest (1.4). The sites performed better than the national office with Phalombe scoring (1.93) and Mchinji (1.82) compared to the national score (1.60).

a) M&E Structure, Functions and Capabilities

- There is an institutional framework that outlines staff responsibilities for the cash transfer program.
- Staff that are involved in data management are in place. There are at least two people each level who can manage and report on the indicator data. At the national office there is an M&E Officer for the cash transfer program and an M&E Officer for the overall OVC program. At the district level there is a desk officer.
- The M&E person for the SCTP is required to check the quality of data received from districts. The Director Child Development Affairs is supposed to check and then send the reports to NAC.
- CSPC members are trained in the scheme according to the written guidelines, and some staff members at the Phalombe district level received training or inter-district knowledge sharing in Machinga district.

However:

- There are no clear outlines of specific data-management responsibilities at the M&E unit.
- There are significant gaps in staffing and high staff turnover, which leads to difficulties in cumulative and periodic reporting, building staff capacity, and ensuring that the internal monitoring guidelines are met.
- The SCTP has no training plan. There are no routine training programs for staff, which is problematic due to high staff turnover. Not all staff have been trained, and for those who have, they still have difficulty using the reporting tools. As a result, the reporting tool had not been used during the reporting period. For the entire reporting period of October 2009 to March 2010, only one report (from Likoma district) for the month of March 2010 was received (in July 2010).
- Lack of institutional memory on data management was evident due to staff turnover

b) Indicator Definitions and Reporting Guidelines

- Description of services is comprehensively documented in "Manual of Operations for the Malawi Pilot Social Cash Transfer Scheme" dated August 2007

- Guidelines for Internal Monitoring and reporting have been written and are periodically revised, most recently in January 2010 "Malawi Social Cash Transfer Program: Guidelines for Internal Monitoring" Revised Version, January 2010".

However:

- The indicator "Number of Orphans and Vulnerable Children whose households receive social cash transfers" has not been operationally defined, documented and shared with reporting levels.
- Data on number of children and on number of orphans residing in households that receive SCTP funds is collected, but it was unclear if the final reported number represents orphans only or includes all the children. All children living in the SCTP-targeted ultra poor and labor constrained households could be considered vulnerable.
- There was also lack of clarity regarding the appropriate age of eligible children for the indicator with some district going with the cut-off age of:
    i. Under 18 (Mchinji),
    ii. Under 19 (Phalombe)
    iii. "Technical children" meaning children over 18 but still in school.
- It was unclear during the audit if the indicator is reported cumulatively or just the number of beneficiaries within the reporting period.
- There is no specific program policy written for document storage and archiving

c) Data-collection and Reporting Forms / Tools

- Data Collection Forms: A number of forms have been identified including
    i. Form 1: Application / Approval Form to Register a Household for the Social Cash Transfer Scheme;
    ii. Form 2: CSPC Level List of Applications / Beneficiaries and
    iii. Form 5: Payment Form that is signed or finger-printed by Beneficiaries.
- Form 1 information on number of children per household and those that are school going.
- The Community Social Protection Committee members have been oriented on how to complete the Form 1 and Form 2
- Monthly Monitoring Reports have been provided to the district

However:

- The payment form (Form 5) does not have details on the children living in the households that receive cash transfer, which makes manual linking the beneficiary household data to the OVC data collected on Form 1 complicated.
- Form 1 does not have proof that the household received cash transfers or an undated and untitled Excel database that is reportedly updated with changing household head status.
- Templates for monthly monitoring reports are provided but M&E officers at district level do not use them due to the difficulty in completing them.

Specifically, accessing financial information from accounts office was reported as problematic.

- At the M&E unit level only one late report was received from the 7 that were expected from the districts. While beneficiaries are required to use Beneficiary Cards with ID numbers to receive every disbursement, the numbers and the date of payment are not recorded on the cards.

d) Data Management Processes

- Feedback is provided, though limited by cash availability. The audit team reviewed "Quarterly M&E Visits: Phalombe Program Assessment: Tying Loose Ends" dated August 2010.
- The revised monitoring guidelines stipulate that quarterly monitoring visits that include verification of the information from the district MMRs as an inspection/auditing exercise be conducted by the national secretariat.
- Supervisory visits are made when funds are available: The audit team reviewed a report titled "Brief Quarterly Report Jan-Mar 2010"
- There is an MS Access database that is being rolled out- Mchinji and Machinga have started the populating it

However:

- The procedures for aggregation and manipulation, including the linkage of Form 5 with Form 1, at the district or national level, have not been documented.
- The mechanisms to establish data discrepancies are weak due to poor communication and sharing among the various role players.
- There are many challenges that are not being identified and/or adequately addressed. OVC details were not directly linked to recorded disbursements.

e) Links with National Reporting System

- The Internal Monitoring Guidelines define a reporting system that is linked from the district to the national level. National data collection tools have been designed for the indicator data; these tools are the ones used by the SCTP
- The indicator data are reported through a single channel of reporting.

However:

- The revised reporting tool is yet to be used universally by all sites- instead each site has improvised MS Excel statistic reporting tables that does not contain all the recommended fields
- ID numbers using a national coding system are not used for the service delivery sites

Dashboard summary statistics

SUMMARY TABLE Assessment of Data Management and Reporting Systems		I M&E Structure, Functions and Capabilities	II Indicator Definitions and Reporting Guidelines	III Data-collection and Reporting Forms / Tools	IV Data Management Processes	V Links with National Reporting System	Average (per site)
M&E Unit							
-	Ministry of Gender, Children and Community Development	**1.33**	**1.86**	**1.40**	**1.43**	**2.00**	**1.60**
Service Delivery Points/Organizations							
1	Mchinji District Site	**1.67**	**1.75**	**1.67**	**2.00**	**2.00**	**1.82**
2	Phalombe District Site	**2.33**	**2.00**	**1.33**	**2.00**	**2.00**	**1.93**
Average (per functional area)		**1.78**	**1.87**	**1.47**	**1.81**	**2.00**	**1.78**

Table 3: Summary Table - Systems Assessment – OVC

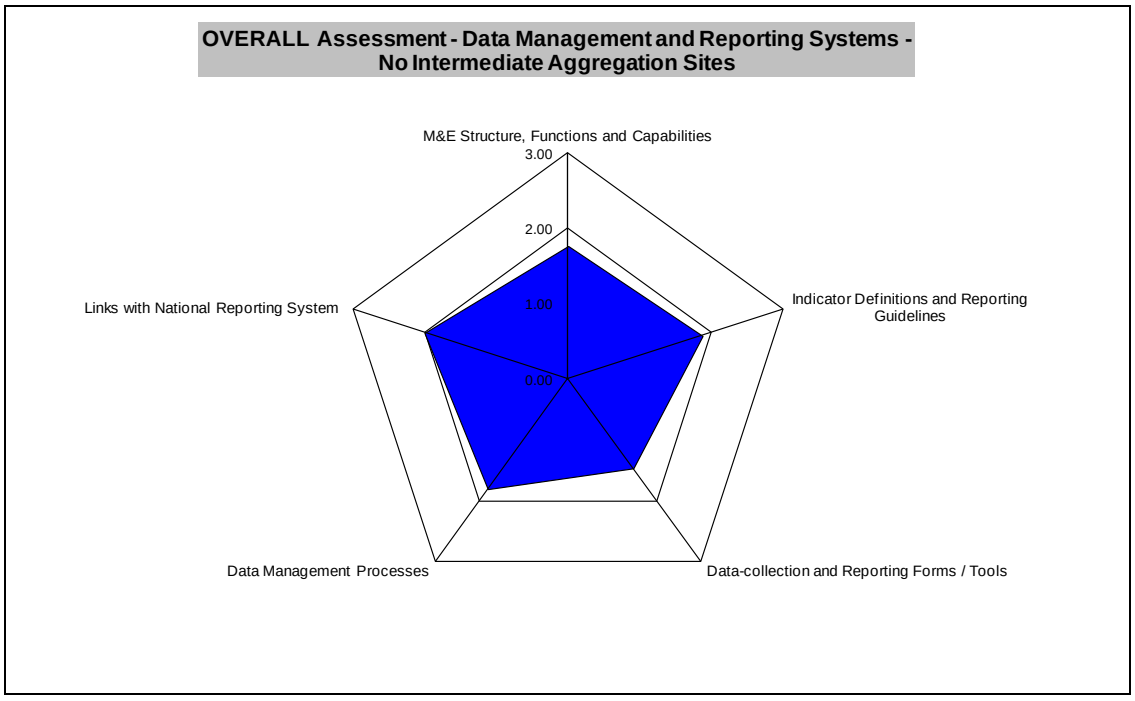

Figure 4: Spider Graph-System Assessment-OVC

Key findings at the three levels:

⇨ *Service Delivery Sites:*

- The approval process involves community members who are supposed to know each other well. There are also verification activities by extension workers from the district and the district team. To effect payments, the Desk Officer prepares a payment order. Each zone has its own payment order and the community representative must sign once the payments are made. Beneficiaries are required to use Beneficiary Cards with ID numbers, but it was found at sites that these numbers and the date of payment are not routinely recorded.
- In 2010 there were no IDs in place and only the ones shown to the audit team were for the previous year. Provision of new cards is being considered, and there is an unresolved issue of whether to laminate the cards and prevent them from getting torn/worn out but lose the ability to make records on them and at the same time
- The audit team established that majority of the districts had not reported during the period under review. Four of the seven districts did not receive funds from the PR for the cash transfers so these were not paid to beneficiaries.
- District and community level staff inconsistently reports the dates of availability of, and actual disbursements, of funds in their monitoring reports.
- The M&E Officer at the district level is required to compile a monthly monitoring report using Monthly Monitoring Report Template. The compiled monthly report is supposed to be forwarded to the District Commissioner (DC) by the 10th day of the following month and submitted by the DC to the national Secretariat (Ministry of Gender, Children and Community Development) by the 20th day of the same month in both electronic and hard copies.
- The changes in the household reported by the CSPC members do not contain changes in children status e.g. newborns, deaths, change of child to adult status or children starting or dropping out of school.
- The Excel database reviewed by the audit team had no dates or title and it was difficult to tell its currency and whether it was cumulative or just for the reporting period under review
- Double payment could occur, as the pay point managers do not always tick as they are supposed after a household head collects and signs the payment form. Other completeness issues include: the dates of when individual beneficiaries receive the cash transfers is not recorded (some payment forms are printed without this date column); the beneficiary ID column is not completed; not all forms are signed by a community member of social protection committee.
- The national reporting guidelines stipulate that the M&E officers should also get a copy of the signed payment forms from the Desk Officer. In both district visited the payment form 5 was always in the custody of the accounts staff.

- The number of orphans per household is recorded on the enrollment forms and entered into the Excel spreadsheet which is only updated periodically, and not comprehensively. There is no way of knowing accurately, for a given reporting period, how many orphans there are per household.

⇨ *Intermediate Aggregation Levels:*

Not applicable for Cash Transfer indicator since reporting is direct from district to the national level and the district is the service delivery point.

⇨ *M&E Unit:*

- There are no written procedures to address late or missing reports at the M&E unit despite the high number of missing reports at the national level.
- Availability of records was a wide-spread problem, but data was still reported in the PU/DR based on a process that was not explained by the MOGCCD
- Despite the many missing reports reasons for the lack of submitting reports had not been established and/or attended to.
- Despite the limited field visits that are made, source data is not verified. For the period of Jan to March 2010 some districts, like Phalombe, were implementing cash transfers and yet there were no reports that were actively collected during such visits.
- The level of communication and sharing of cash transfer activities and related data issues at the M&E unit level is also inadequate; staff had limited knowledge or recall of relevant information. Auditors were told that one staff member, who was on study leave, was the only custodian of reports from the districts. Neither of the two M&E officers at the department: one for cash transfer program and another for the overall OVC program had knowledge of or access to reports. The M&E officer for the overall OVC program is the one who prepares the PU/DR which is then submitted to NAC.

Overall strengths and weaknesses of the Data-Management System

	13 Questions	Answer	Comments
1	**Are key M&E and data-management staff identified with clearly assigned responsibilities?**	Partly	There is a general institutional framework that outlines staff responsibilities. However, at the M&E unit, there is no clear outline of specific data-management responsibilities. There are significant gaps in staff and high staff turnover, which leads to difficulties in cumulative and periodic reporting, building staff capacity, and ensuring that the internal monitoring guidelines are met.
2	**Have the majority of key M&E and data-management staff received the required training?**	Partly	Community Social Protection committee members are trained in the scheme according to the written guidelines, and some staff members at the Phalombe district level received training or inter-district knowledge sharing in Machinga district, but no routine training programs exist for all staff, which is problematic due to high staff turnover. Not all staff have been trained; those that have been trained in the use of tools, especially the reporting tool, found them difficult. As a result, very few reports are prepared at the district level. For the entire reporting period of October 2009 to

	13 Questions	Answer	Comments
			March 2010 only one report of 42 (from Likoma district) was reviewed by the audit team.
3	**Has the Program/Project clearly documented (in writing) what is reported to who, and how and when reporting is required?**	Yes - completely	Guidelines for Internal Monitoring have been written and are periodically revised, most recently in January 2010 "Malawi Social Cash Transfer Program: Guidelines for Internal Monitoring. Revised Version, January 2010". The M&E Officer at the district level is required to compile a monthly monitoring report using Monthly Monitoring Report Template. The compiled monthly report is supposed to be forwarded to the District Commissioner (DC) by 10th day of the following month and submitted by the DC to the national Secretariat (Ministry of Gender, Children and Community Development) by the 20th day of the same month in both electronic and hard copies.
4	**Are there operational indicator definitions meeting relevant standards that are systematically followed by all service points?**	No - not at all	The indicator "Number of OVC whose households receive social cash transfers" has not been operationally defined, documented and shared with reporting levels. For example, data on number of children and on number of orphans residing in households that receive SCTP funds are collected, but it was unclear if the final reported number represents orphans only or all vulnerable children living in the ultra poor and labor constrained households targeted through the SCTP. There was also lack of a clear definition regarding the age of those reported as children with some districts using those under 18 (Mchinji), others under 19 (Phalombe), while others also had "technical children" meaning children over 18/19 but still in school. It was also unclear during the audit if the indicator is reported cumulatively or not.
5	**Are there standard data collection and reporting forms that are systematically used?**	Partly	**Data Collection Forms:** A number of forms have been identified including Form 1: Application / Approval Form to Register a Household for the Social Cash Transfer Scheme, Form 2: CSPC Level List of Applications / Beneficiaries, and Form 5: Payment Form to be signed by Beneficiaries. However, Form 5 documents proof of payment does not contain details of children in households that receive cash transfer. In order to determine the number of OVC whose households received cash transfers one must link Form 5 with either Form 1 (containing old information) or an undated and untitled Excel database that is reportedly updated with changes in household demographic data. **Reporting Forms:** The forms have been created in the Internal Monitoring Guidelines and distributed nationally, but district staff is not using them. The reason for this is not definitively known, but district M&E staff has created their own reporting templates for their data based on their programmatic knowledge and capability. The reporting forms often aggregate data and make accessing specific data figures difficult.
6	**Are data recorded with sufficient precision/detail to measure relevant indicators?**	No - not at all	There were no observed systems for counting the specific indicator (number of OVCs within households receiving cash transfers). The records of OVC were kept on a standardized Form 1, but this form was not used for payment distribution. Form 5 details final beneficiaries, and is used at the district level to record grant disbursements. Form 1 was often outdated with OVC data and was not linked to Form 5 for reporting. The changes in the household reported by the CSPC members only refers to changes with regard to head of households and does not contain changes in children status for example, the newborns, the once who have started school, the ones who have left school, the ones who have graduated to 18/19 years. Changes in child status are only updated during the retargeting of beneficiaries, done once every two years.
7	**Are data maintained in accordance with international or national confidentiality**	N/A	The system is set-up to be a transparent process at the community level to ensure that implementation and decision-making is honest, so confidentiality issues are not applicable. It is in the best interest that the payments are public knowledge at the community level.

	13 Questions	Answer	Comments
	guidelines?		The community social protection committee members keep a file of the photocopied Form 1s and beneficiary households are known and approved by the community.
8	**Are source documents kept and made available in accordance with a written policy?**	Partly	The documents at the district level are kept in accordance with national archiving policy, but no program specific guidelines exist for the storage of document records. National archiving policy is not necessarily known at every district and pay point level
9	**Does clear documentation of collection, aggregation and manipulation steps exist?**	Partly	While there are documented procedures for data collection, the procedures for aggregation and manipulation at the district or national level have not been documented. The audit team could not establish if the national level reports contain the number of children or the number of orphans for the indicator being reviewed. The linkage of Form 5 and Form 1 to establish the number of the children is also properly documented and districts are using Excel spreadsheet to update household status and establish the number of children from benefiting households.
10	**Are data quality challenges identified and are mechanisms in place for addressing them?**	No - not at all	There are many challenges that are not being identified and/or adequately addressed. The mechanisms to establish data discrepancies are weak due to poor communication and sharing among the various role players. OVC details were not directly linked to recorded disbursements. District and community level staffs are inconsistently reporting dates of availability of funds and dates of disbursements of funds for their monitoring reports. Availability of records was a wide-spread problem, but data was still reported in the PU/DR based on a process that was not explained by MOGCCD. The auditors could not identify an explanation for these shortfalls and discrepancies.
11	**Are there clearly defined and followed procedures to identify and reconcile discrepancies in reports?**	Partly	The M&E officer for cash transfer had visited district levels to identify and reconcile problems of non-reporting by districts. The audit team reviewed a report "Brief Quarterly Report Jan-Mar 2010. However, despite this there were many reports missing; the reasons causes for the lack of submitted reports had not been established or attended to.
12	**Are there clearly defined and followed procedures to periodically verify source data?**	No - not at all	The revised monitoring guidelines stipulate that quarterly monitoring visits that include verification of the information from the district MMRs as an inspection/auditing exercise be conducted by the national secretariat. The audit team reviewed a report "Brief Quarterly Report Jan-Mar 2010." However, there was no reported data at the national level to verify. An audit team visit to participating districts and pay points established that cash transfers were being implemented in 3 of the 7 districts. This proves that source data is not being verified at all within implementing districts or that the verification process is poor.
13	**Does the data collection and reporting system of the Program/project link to the National Reporting System?**	Yes - completely	The Internal Monitoring Guidelines define a reporting system that is linked from the district to the national level. National data collection tools have been designed for the indicator data and these tools are the ones used by the SCTP. The indicator data are reported through a single channel of reporting. The data from the district is sent to the national secretariat in the Ministry of Women and Child Development.

IV. Verification of Reported Data

PLWA Currently on ART

Description of the performed data-verifications steps

For the Data Verification Steps the audit team used Protocol 2: Data Quality Assessment Protocol 2 HIV_ART Treatment standardized tool from the Global Fund. At the M&E unit, aggregated and reported numbers for 276 facilities by the HIV Unit of MoH were cross checked against actual reports from these facilities. These reports were checked for accuracy, availability, completeness and timeliness. At service delivery points/facilities, numbers submitted to the M&E unit were cross checked as the assessment team did a complete recount of number of PLWA alive and on treatment by the 31st of March 2010. All findings were recorded in the MS Excel DQA P2 tool.

Verification and cross-checks were done using client master cards, ART registers, facility drug registers and other verifiable documents maintained by these facilities.

At facility level verification of data was done using the Patient Master Cards and recounting from the first record to the last one as of March 31st 2010. The audit team used the registers to fill gaps in the patient cards regarding main treatment outcomes, the dates the outcomes occurred, and when these outcomes were actually put on record. Report forms at the facility have two sets of data- one completed by the facility itself and another by the supervisors when they come for the quarterly visits. The audit team used the checked data (except where no checked numbers existed).

At the national level the source documents for recounting were the forms completed by supervisors at the facility level and then taken to the national office. Thus the availability, timeliness and completeness of reports at the national level are not entirely dependent on the facility reporting abilities.

Data Accuracy – Verification Factor

The verification factors (VF) ranged from 90% to 101%. The average VF for the SDPs was 98% the same for the adjusted VF for the HIV Unit of the MoH. Seven of the 9 facilities visited had a VF ranging from 98% to 101%. Main reasons for the discrepancies include:

- Main treatment outcomes change over time and the outcomes captured by the facility at the time of facility report preparation may be different to the outcomes during audit. For example for one facility, the total number of patients ever registered recounted (536) during the audit closely matched the number derived

from the reported (537). However, the main treatment outcomes varied due to misclassification of when the outcome occurred and when these were entered in the patient master cards and the registers.

- Manual summation and transcription errors also contributed to the discrepancies.
- At one facility, many master cards had been taken out of the files and had not been re-filed for a long time. Locating every card was difficult. Many were not located, and patient status was determined through patient register cross-checks.

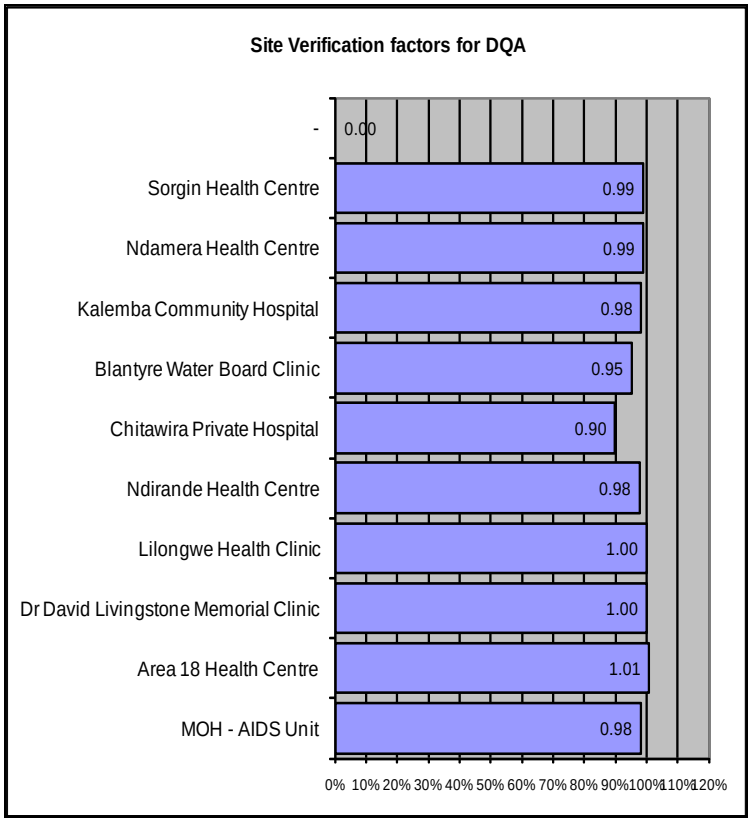

Figure 5: Verification Factors for Facilities-ART

Total number of individuals reported by the M&E unit to The Global Fund was 206,805 individuals, but when reports from the SDPs were aggregated, the audit team found the total number of PLWA alive and on treatment as reported by facilities (available reports) was 205,158 individuals resulting in 1,647 patients less than the number reported. This resulted in a verification factor of 99.2%.

Table 4: Differences in Reported and Recounted Numbers at National Level

Facility No.	Facility	Reported	Recounted	Audit Team's Comments
3017	Kanyezi HC	21	22	Possible minor arithmetic error.
3092	Kapelula HC	5	0	Nothing recorded for the indicator. 5 clients captured as total registered.
3091	Mpepa HC	6	0	Nothing captured for the indicator. 6 clients captured as total registered.
2960	Mwansambo HC	59	49	Possible copying error.
3087	Life Line Kasese HC	32	0	Nothing recorded on the indicator. 32 clients recorded as 1st line (Start) ARV.
3074	Chankhungu HC	157	0	Nothing recorded on the indicator. 157 clients recorded as 1st line (Start) ARV.
3083	Mtengowanthenga Dream Project	1,438	0	The verified data had been erased while 1,438 was captured as clinic own data. Clinic own data was not used for recounting as only verified data is used for reporting purposes.
Total Over-Report (Reported-Recounted)		1,647		

As mentioned above, the verification factor at the M&E unit was 99.2% while that for the SDPs was estimated at 99%. Thus the overall program verification factor after controlling with verification factors obtained at SDPs is 99.1%. Meaning the ART program in Malawi over reported total number of PLWA alive and on treatment by 0.9%.

Cross-Checks

At facility level (SDP) cross-checks were routinely done by cross-checking patient cards against ART registers. Where time permitted additional cross -checks were done using the ART registers and checking against the drug registers, OPD registers or Pharmacy records. Except for Kalemba Community Hospital, at least one cross-check was done at all facilities. Four facilities had a second cross-check completed. Facilities that had only one cross-check done include Sorgin Health Center (HC), Area 18 HC, Ndirande HC and Chitawira Private Hospital. All cross-checks resulted in a perfect score of 100%.

Precision and confidentiality of reported data

Tools are designed to capture enough details to report on the indicator. The details captured include the Patient/Guardian details (these include names, ART number, birth date and sex), Date if Transfer In, Status at ART Initiation, First HIV positive test, ART Regimens and start dates, Adverse Outcomes and Outcome date.

With regard to confidentiality, facilities make an effort to secure source documents which are always kept at the facility. However, patient names are used in all the source documents. In addition, there are no confidentiality agreements in all facilities with staff.

Availability, completeness, and timeliness of reports

- From the data verification exercise performed during the audit, the program had an availability factor of 100%. Of the 276 reports expected by the M&E unit, 276 were received and these were verified by the audit team.
- The program had 100% on time reports as all available reports (276) were observed to have reached the M&E unit on time as stipulated by the program's reporting timelines.
- The M&E unit had a completeness factor of 96.4% as 266 of the available reports were judged to be complete. A report was judged to be complete if in addition to the report being available, the indicator variable and field 'Number PLWA who are alive and on treatment' was filled with the verified number of the supervisor. Other criteria considered in addition to the above two was that the reports had facility details/information and contained a figure or explanation why no figure could be given.

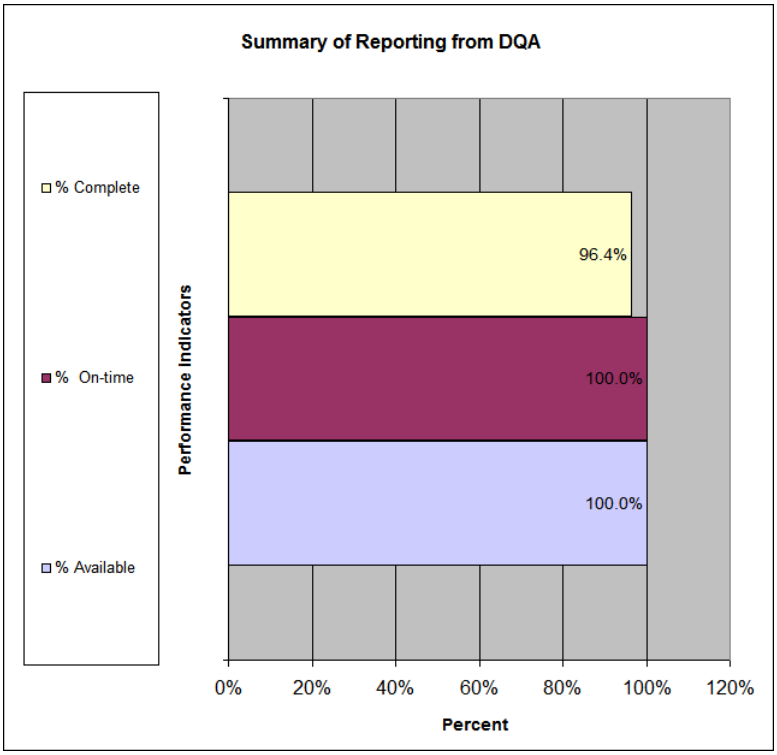

Figure 6: Availability, Completeness and Timeliness - ART

Key findings at the three levels:

⇨ *Service Delivery Sites*

		Verified Counts at Audited Sites	Reported Count at Audited Sites	Site and Unadjusted District VFs)
	Service Point Summary	**4251.00**	**4335.00**	**0.98**
1	Area 18 Health Centre	771.00	764.00	1.01

		Verified Counts at Audited Sites	Reported Count at Audited Sites	Site and Unadjusted District VFs)
	Service Point Summary	**4251.00**	**4335.00**	**0.98**
2	Dr David Livingstone Memorial Clinic	89.00	89.00	1.00
3	Lilongwe Health Clinic	23.00	23.00	1.00
4	Ndirande Health Centre	1720.00	1760.00	0.98
5	Chitawira Private Hospital	250.00	278.00	0.90
6	Blantyre Water Board Clinic	60.00	63.00	0.95
7	Kalemba Community Hospital	864.00	879.00	0.98
8	Ndamera Health Centre	386.00	390.00	0.99
9	Sorgin Health Centre	88.00	89.00	0.99

Table 5: Facility Level VFs for the ART Indicator

Verification factors at this level ranged from 101% (1% under reporting) to 95% (5% over reporting). All verification factors were within the acceptable range of ±10%.

⇨ *Intermediate Aggregation Levels:*

Not applicable for Malawi ART Program since reporting is direct from service delivery point to the national level.

⇨ *M&E Unit:*

			III	IV	V
Verified Counts at Audited Sites	**Reported Count at Audited Sites**	**Unadjusted Verification Factors)**	**% Available Reports**	**% On-time Reports**	**% Complete Reports**
205140	**206805**	**99.2%**	**100.0%**	**100.0%**	**96.4%**

Table 6: National Level VF, Availability, Completeness and Timeliness - ART

At the M&E unit, data verification yielded the unadjusted figures above. These show that the quality of the reported data by the M&E is good enough to be used to inform on the program's performance on data quality.

The main reason for the discrepancy was that the available report forms were not complete and did not have the values for the number and alive and on treatment. In such circumstances, the national office possibly used values from the clinic (if available) and not the checked one from the supervisor; or used the values derived from secondary outcomes for patients alive and on treatment e.g. number on 1st line treatment. The audit team recorded as 0 if there were no values in the field "Total Alive and on Treatment".

Overall assessment of Data Quality

Overall, the program's data was judged to be of very good quality as adjusted data verification factor was estimated at 99.1% meaning the program could have over reported by a very small margin of 0.9%. The program is extremely well organized and managed and should serve as a model for ART programs in other countries. It proves that intensive supervision, a key factor for maintaining high quality data, can be conducted with a reasonable commitment of program resources.

OVC whose households benefit from social cash transfers

Description of the performed data-verifications steps

At the national level the audit team was not able to conduct a satisfactory trace and verification. It took the audit team two visits to the Ministry of Gender, Children and Community Development (MoGCCD) to access a copy of the prepared PU/DR for the reporting period. However, the reports received from sub-reporting levels, particularly the three districts cited in the PU/DR could not be retrieved as ostensibly the former Cash Transfer Program coordinator had gone on study leave without handing over the reports from the districts. The M&E officer who prepared the PU/DR was unable to explain why he had not kept copies of the reports he had used to compile the PU/DR. In addition, while at the sites, the audit team could not confirm that such reports were submitted to the MoGCCD. The only formal report found at the MoGCCD with indicator data had been received late in July 2010 from Likoma district for the month of March 2010. The indicator was 0 as the district had not received funds from the PR to implement cash transfers.

At the site level, the first step in data verification was to establish the appropriate source documents to be used in recounting the OVC indicator value that had been reported (the value found in the PU/DR). A signed or fingerprinted Form 5 is the only document with evidence of cash transfers to households. However, Form 5 does not record the number of child beneficiaries. Form 1 (the enrollment form) has OVC details per household. Therefore, to establish the number of OVC beneficiaries one would have first to ascertain a particular household received cash transfer (from form 5) in the reporting period and then link with Form 1 to determine the number of child beneficiaries. As the households that were reported were in the thousands (about 8,000 in Mchinji and 3,000 in Phalombe) the audit team determined that it would have been a laborious and protracted exercise to manually link the beneficiary households with the number of OVC and verified that this is not done routinely for monthly reporting. Thus the audit team was only able to recount the number of household benefitting from social cash transfers based on signed payment forms.

Indicator values for households that received cash transfer were recalculated for the period October 1st 2009– March 31st, 2010 (Period 6 of Round 5 grant) using the Form 5 payment signature form. The recounted values were then compared with the copy of the

LFA verified PU/DR for the period under review. The LFA verified PU/DR was used for comparison due to the unavailability of indicator values in the Grant Performance Report at the Global Fund website.

Data Accuracy – Verification Factor

Phalombe District Site: The number of households receiving social cash transfers verified by the LFA was 3,140, a highly unlikely figure, as the Phalombe district MS Excel database had 2,398 approved household beneficiaries. Among these 2,398 households a total of 337 households in Nazombe Traditional Area did not receive cash transfers during the reporting period. Thus, the households that received cash transfers were about 2,061, a figure close to the one the audit team recounted (1,949).

The audit team recount was 1,949 households with a VF of 62% (1949/3140). The cash transfers in Phalombe were made in the months of January, February and March 2010 during the reporting period. Some households received cash for more than one month. The audit team used signed and dated forms and where there was a duplicate record per household, the form with the most households per pay point was used for recounting.

This discrepancy between the LFA verified results and audit team recount cannot be explained. The district site was emphatic it did not have 3,140 as beneficiary households.

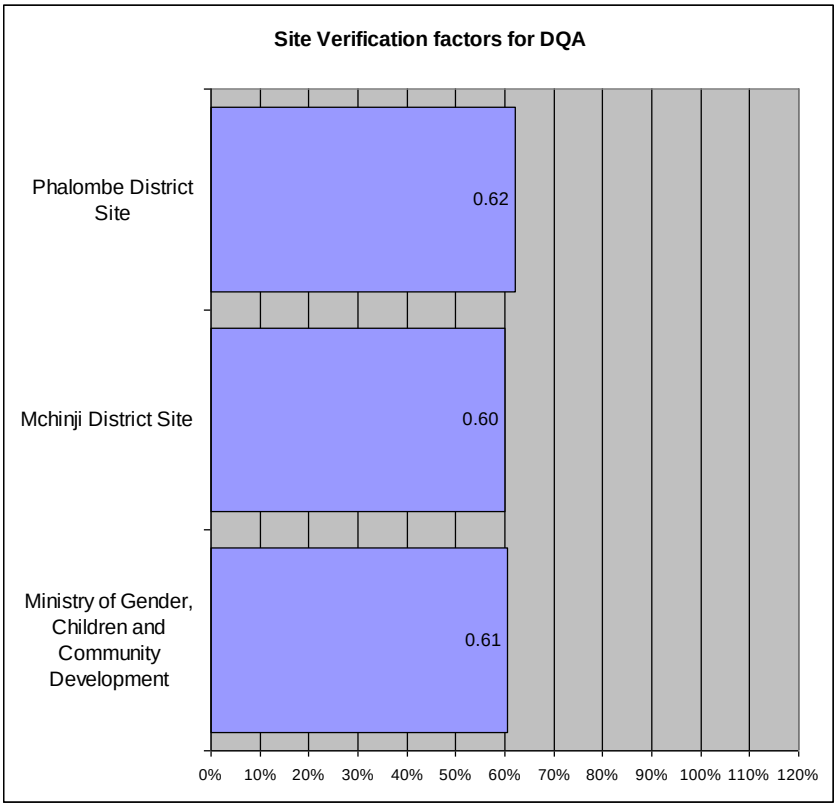

Figure 7: Verification Factors for OVC Indicator

Mchinji District Site: The LFA verified figure was 8,324 household recipients. This number of households receiving social cash transfers recounted from the available signed payment forms provided to the audit team was 4,993. The cash transfers for three months October to December 2009 were made in one day in December and the household heads signed three separate forms (containing similar information) for each month. The audit team used forms for one month to recount. The district did not receive funds from the PR to make the payments for the 1st quarter of 2010.

At Mchinji the database had 8,831 beneficiaries. The discrepancy between the reported figure and the recounted figure by the audit team is due in part to the fact that the audit team was not provided with all the payment forms for the reporting period. Data for two Traditional Authorities (TAs) was completely missing. Data from a third TA was partially missing. From an existing Excel database the audit team determined that the missing reports represented nearly 3091 households- 777 households in Mloyeni, 1400 households from Mavwere TA and 914 from Simphasi TA.

National Level: The aggregate of beneficiary households in Chitipa, Mchinji and Phalombe district was 14,440. However, the audit team recounted number was 0. Therefore VF could therefore not be calculated. From the chart of Site verification factors above the VF for the national level is 61 due to the adjustment of the VF.

Cross-Checks

As there was no secondary data source no cross-checks could be performed. However, the audit team performed spot checks (verification of service delivery) in two zones within Mchinji and Phalombe districts respectively. CSPC members helped auditors identify household beneficiaries. Each beneficiary confirmed that he/she had received a disbursement, though several beneficiaries could only estimate the period and frequency that they had received payment.

Phalombe Spot-check

	Name	Dates of Receipt (estimated)
1	Falesi Mulanje	Jan-Mar 2010
2	Duncan Magombo	For 3-4 months
3	Teresa Kaliati	For 3 months
4	Estere Bakuwa	For 3 months
5	Mapira Sakwata	For 4 months

Mchinji Spot-check

	Name	Dates of Receipt	ID card available?
1	Esintha Selevasi	Oct-Dec 2009	Yes
2	Benita Selevasi	Oct-Dec 2009	Yes
3	Evelesi Papiasi	Oct-Dec 2009	Yes, but not on the correct zonal distribution list
4	Mag Kuwani	Oct-Dec 2009	Not yet received
5	Tikambenji Densi	Oct-Dec 2009	No, worn out
6	Alinesi Amadi	Received, but couldn't remember dates	Yes

Precision and confidentiality of reported data

The records of OVC were kept on a standardized Form 1, but this form was not used for cash transfers. The Form 5 has details of the household beneficiaries but manual linking of this form to Form 1is a tedious process. Form 1 was often outdated with OVC data as the changes in the household status reported by the CSPC members only refers to changes with regard to heads of households. Changes in children status for example, the newborns, the once who have started school, the ones who have left school, the ones who have graduated to 18/19 years are not routinely reported. Changes in child status are only required to be updated during the re-targeting of beneficiaries that is done once every two years.

With regard to confidentiality the system has been developed to be a transparent process at the community level to ensure that identification of beneficiaries, implementation and decision-making is honest, so confidentiality issues are not applicable. It is in the best interest that the payments are public knowledge at the community level. The community social protection committee members keep a file of the photocopied Form 1s and beneficiary households are known and approved by the community.

Availability, completeness, and timeliness of reports

There are currently seven districts implementing the Social Cash Transfer Scheme as reported in the PU/DR, and each district was required to submit a monthly report of activities to the M&E unit. During the auditing period of October 2009-March 2010, each district should have submitted six reports, totaling 42 reports nationally. Only one report was submitted during the audit period, equaling 1/42 or 2.4% availability overall. The submitted report was complete, so the completeness factor was 100%. The submission was for the period of March 2010, but was not received until July 2010, resulting in a timeliness factor was 0%.

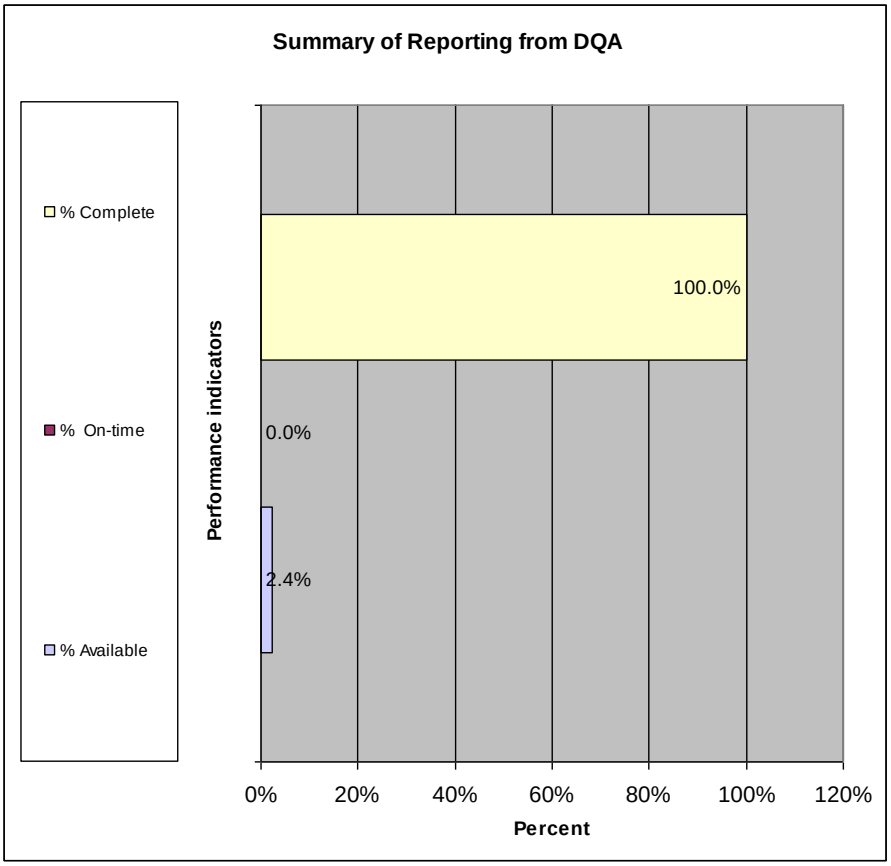

Figure 8: Availability, Completeness and Timeliness – OVC Indicator

Key findings at the three levels:

⇨ *Service Delivery Sites:*

- For the cash transfer indicator the service delivery point is the district. At the district office it was acknowledged that the data management requirements for the indicator are substantial. A system of standardized forms has been developed to help identify potential beneficiaries based on income and social status. From these, beneficiaries are selected by community consensus through a series of meetings.
- Data are entered into a database in two of the seven districts. The database is left over from a similar program sponsored by UNICEF that ran for several years in Mchinji District. The database in Mchinji is not yet current and therefore cannot be used at the present time to report accurately on results for cash transfers. (Incidently, it seems likely that the LFA is using this database for reporting 'verified' counts in the PU/DR.)
- The source document is the record of payments made to beneficiaries based on households. OVC within households are recorded on intake forms during screening for potential beneficiaries. An MS Excel spreadsheet had been created to maintain a count of OVC within TAs, VC, and zones. There are roughly 100

household beneficiaries per VC. There is no record of the current number of OVC within specific households, so any reporting on number of OVC benefitting from the social cash transfer scheme is necessarily an estimate. The database, once it is up to date may alleviate this problem.

- Households can be counted based on the record of payment. However, there was no indication of tallying of households for quarterly reporting (e.g. a tabular report showing number of households by zone, VC and TA). Rather, they seem to be taking the data from the computer which, as noted above, is not up to date. Since the database is based on the starting number of households in the program and households drop off as beneficiaries relocate or die, the number compiled in this way tends to overestimate the real number of beneficiaries served. Neither the data from the Excel file, or the UNICEF database matched the value of the indicator for households reported on the PU/DR.

⇨ *Intermediate Aggregation Levels:*

Not applicable for Cash Transfer indicator since reporting is direct from district to the national level and the district is the service delivery point.

⇨ *M&E Unit:*

- The PR was unable to send the necessary data to the Audit Team prior to the field visit. They were contacted about a month prior to the arrival of the audit team in country.
- Upon arrival in Malawi the PR still did not have the national level data for the specified reporting period for this indicator. The Audit Team was sent to the offices of the SR[9], the MoGCCD which were also initially unable to produce national level or district level results for the required districts. They claimed that the program coordinator for the cash transfer program had left the country to pursue a graduate degree abroad and they couldn't locate the relevant records in his files or computer. He was reported to have left two weeks prior to the audit team's arrival in Malawi. Since the PR was notified of the audit and data for the indicator was requested a month prior to the arrival of the audit team in Malawi there should have been sufficient time to access the records from the staff member before his departure.
- However, neither the PR nor the SR could produce these data until we had met with them several times. At that point they were able to produce reports for two districts plus a printout of an MS PowerPoint presentation with results for a third district. The two reports and presentation were quarterly report from the districts detailing activities planned and undertaken, challenges and recommendations but the reports did not have data on the indicator under review.

[9] MoGCCD is an SR for other OVC indicators and not the one on number of OVC whose households received social cash transfers. The actual SRs and recipients of funds for the cash transfers are the implementing seven districts. However, MoGCCD houses the SCTP secretariat and has committed to include the cash transfer indicator as part of their reporting on all OVC indicators.

- It is only the monthly monitoring report from the districts that contains data for the indicator. During the audit the M&E Officer Cash transfer at MoGCCD and the districts themselves reported that no monthly reports were made during the reporting period under review. The reporting using the previous monthly template was found difficult due to the demands it made for the M&E Officer at district level to seek financial data from the finance office. As a result, the district, in a participatory process led by the national secretariat, revised both the internal monitoring guidelines and the tool which was released to the districts with the hope that the three districts that had received funds from the PR would use the revised tool to report on the cash transfers. At the district level it was found that the tools had not yet been put in use, except in Likoma District. How the indicator data for OVC was sourced for the PU/DR still remains a mystery, though as noted above, the audit team suspects they use the database, at least in Mchinji.
- Both the PR and SR appeared disorganized and lacking in knowledge of the status of the cash transfer program. The SR have dedicated staff for the management of data for the indicator but these staff are either new or have other responsibilities to other aspects of the OVC programming. No one at national level was up to speed on the status of the program.

Overall assessment of Data Quality

Failure to include the OVC beneficiaries in the payment Form 5 puts the reporting of the number of OVC whose households benefit from social cash transfers at risk. A complicated reporting tool and inaccessible finance data could also be affecting the preparation and submission of reports at the district level. Poor data quality is due to preparation of reports that have not been supported by auditable reports from sub-reporting levels. Though the districts audited appeared motivated, reasonably equipped and trained, the disorganization at national level is alarming. Particularly with advance notice of the arrival of the audit team, the level of disorganization and lack of knowledge of the status of reporting at both the PR and the Ministry of Gender is surprising.

After mid-term review by the Global Fund, the cash transfer scheme was only renewed for 10 months, rather than the three years normally accorded after a successful review. The Global Fund Social Case Transfer Program is a pilot project and the Government of Malawi is supposed to take over making the payments to beneficiaries in the future. Though the initial program managed by UNICEF and the Global Fund financed follow-on Program are highly popular with beneficiaries and seem to be alleviating poverty to some degree, it is unlikely the Government of Malawi will have financing to continue the program.

V. Recommendation Notes and Suggested Improvements

Malawi: Data Quality Audit Recommendations Notes	
Name and Address of Program/project (and Organization): National Response to HIV/AIDS in Malawi Malawi National AIDS Commission Lilongwe	
Contact Person: Washington Kaimvi, Director of Finance	
Auditor: John Snow Inc. (JSI) and Khulisa Management Services	**Audit Date:** August and September 2010
Major Findings:	
1. Preparation of Reports without Adequate Audit Trail	
Level: M&E Unit	Relevant Indicator(s): OVC
Classification: Major[10]	M&E Functional Area: Indicator Definitions and Reporting Guidelines

[10] Classification of the data quality issues was made in the context of how the issues affected the data quality for the programs under review.

Explanation of Data Quality Finding:

For the reporting period selected for the audit, only three districts had reported making cash transfers to beneficiaries. During the audit two reports and presentation were made available. However these are quarterly reports from the districts detailing planned and actual activities and challenges faced but these reports do not have data on the indicator under review. It is only the monthly monitoring report from the districts that contains data for the indicator and none had been received at MoGCCD by the time the PU/DR was prepared.

There were claims that a former program coordinator held the data but the M&E officer for the overall OVC program at the MoGCCD who prepares the PU/DR was unable to explain why the data used to prepare the PU/DR, which may have been within reach of the M&E officer at one time, was not preserved. In addition, during the audit the M&E Officer for Cash transfer at MoGCCD and the districts themselves reported that no monthly reports using the recommended template were made during the reporting period under review. The only monthly report received for the period under review was from Likoma district. A report from Likoma for the month of March 2010 was received in July 2010. In the end, the PR and MoGCCD were unable to conclusively explain source of data used to compile the PU/DR.

Recommended Action for correction:

MoGCCD should prepare reports that are supported by accessible audit trail. As part of transparency data quality issues ought to be included in reports. If estimates or assumptions were made during the determination of the indicator value then this ought to be reported. A culture of sharing should be promoted through centralized storage of data that can be accessed by more than one person. Regular joint review meetings should be held to share and review data quality issues. Reported data should be copied to several other to avoid loss of crucial information should a single data handler leaves without proper handover.

Procedures to address incomplete, inaccurate, missing data/reports and or late reports should be documented and implemented

2. Poor Design of Data Collection and Reporting Tools

Level: M&E Unit	Relevant Indicator(s): OVC
Classification: Major	M&E Functional Area: Data Collection and Reporting Forms / Tools

Explanation of Data Quality Finding:

In order to correctly report on the number of OVC whose households received cash transfers linked data on the (1) number of children (2) proof of payment needs to be collected. However, the payment form (Form 5) that has proof of payment does not have details on the children living in the beneficiary households. The Form 1 that has the number of children living in households does not have proof that the household actually received cash transfers. Due to the large number of households receiving cash transfers the manual linking of the beneficiary household data to the OVC data collected on Form 1 is a tedious process. A functional relational database can ease the process of linking the children and payments but these databases are only in place in two districts and even in these places they are electronic databases are not current enough to produce reports. With regard to reporting a template for monthly monitoring reports is provided but M&E officers at district level do not use them due to reported difficulties in completing the report template.

Recommended Action for correction:

As it may take a little longer to have all the districts universally use the MS Access relational database the PR should re-design Form 5 to capture details of children living households that have proof of cash transfers. Alternatively the implementations of the relational database need to be accelerated and scaled up in all the districts. Clear procedures need to be elaborated on how such a database will be handled, including the keeping of audit trail on the status of the children at a particular point in time. Clear instructions ought to be provided regarding the preparation of reports. The reporting tools should be easy to complete but more so important the source data for the indicator should be accessible.

3. Lack of Documented Indicator Definitions

Level: All Levels	Relevant Indicator(s): OVC
Classification: Major	M&E Functional Area: Indicator Definitions and Reporting Guidelines

Explanation of Data Quality Finding:

The indicator "Number of Orphans and Vulnerable Children whose households receive social cash transfers" has not been properly defined. Data on number of children and on number of orphans residing in households that receive SCTP funds is collected, but it was unclear to the audit team if the final reported number represents orphans only or all the children. Children living in the SCTP-targeted ultra poor and labor constrained households can be considered vulnerable. There was also lack of clarity regarding the appropriate age of eligible children for the indicator.

Recommended Action for correction:

The PR should operationally define the indicator on the number of OVC whose households receive social cash transfers; document the definitions including the inclusion and exclusion criteria; and share such definitions with all reporting levels. Procedures for manual aggregation and manipulation, including the linkage of Form 5 with Form 1, at the district or national level, need to be documented.

4. Lack of Documented Data Flow

Level: All Levels	Relevant Indicator(s): OVC
Classification: Major	M&E Functional Area: Data Management Processes
Explanation of Data Quality Finding: Both the PR and SR appeared disorganized and lacking in knowledge of the status of the cash transfer program and the data flow for the indicator on the number of children whose households receive cash transfer. It took the audit team two visits to MoGCCD, punctuated by a futile visit to the PR, to access a copy of the prepared PU/DR for the reporting period. Some of the reports given to the audit team did not have data on the indicator under review. Clear roles and responsibilities for data management have not been documented.	
Recommended Action for correction: The data flow for the indicator and data management roles and responsibilities should be correctly documented and shared at all levels.	
5. Incomplete Records and Reports	
Level: M&E Unit	Relevant Indicator(s): ART
Classification: Medium	M&E Functional Area: Data Management Processes
Explanation of Data Quality Finding: The dates of main treatment outcomes are not always recorded in both patient master cards and the registers. Supervisory visits can sometimes take place three weeks after the facility has prepared the quarterly reports leading to discrepancies between adverse outcomes reported by facilities and that of the supervisor's as adverse outcomes may have occurred and recorded during the intervening period. Challenges are identified during the facility visit. Data is cleaned on-site, but there is no written standard on how to address incomplete or missing cards. When errors or discrepancies are noticed, changes are made without documenting the found errors and how they were resolved. The audit team had to confirm details of missing data in the patient master cards using the registers but in some cases the dates of when certain adverse outcomes were put on record remained inconclusive. The main reason for the discrepancies at the M&E unit was that the available report forms from supervisors were not complete. These reports did not have the values for the "number and alive and on treatment". In such circumstances, the national office possibly used values from the clinic (if available) and not the checked one from the supervisor; or used the values derived from secondary outcomes for patients alive and on treatment e.g. number on 1st line treatment.	
Recommended Action for correction: Supervisors should ensure all records are updated during the quarterly visits. Reports from supervisors should also be subjected to further checks just in case there are introduction of new errors and found gaps addressed. The M&E Unit should develop error logs to document how the gaps were addressed. In addition, facilities should keep summaries of adverse outcomes recorded and the dates of recording during the quarter for easier cross-check during the	

cumulative cohort analysis.

6. Confidentiality of Patient Data	
Level: Service Delivery Sites	Relevant Indicator(s): ART
Classification: Medium	M&E Functional Area: Data Management Processes
Explanation of Data Quality Finding: All source documents contain the names of patients. The names are essential for tracking patients. Facilities make efforts to secure the documents. Services are recorded on patient master cards and these cards are used to update registers. However, the use of patient names in registers poses risks in breaching patients' confidentiality should the registers be opened and used while attending to a patient. In addition, there are no confidentiality agreements implemented especially for non-clinical staff.	
Recommended Action for correction: Patient identifiable information should be limited to patient master cards and use unique patient codes in registers. Staff should be made to sign confidentiality agreements. Such agreements heighten awareness of the importance of maintaining confidentiality of patients.	

VI. Final Data Quality Classification

Each indicator is reported through a separate system to a specific government ministry using different reporting systems. While the ART Program is well organized and managed and produces data of very high quality, the Social Cash Transfer indicator data quality was highly suspect. Therefore, the audit team feels compelled to issue separate classifications for each indicator, lest a highly functional system be penalized unfairly by association with a poorly functioning one.

Data Quality Classification of the ART Program

No Data Quality Issues	⇨ Verification Factor above 90% (of the sampled sites); and ⇨ No major weaknesses in data-reporting systems.

Data Quality Classification of the OVC Cash Transfer Program

Major Data Quality Issues	⇨ Verification Factor below 70% (of the sampled sites); or ⇨ Indication of fraud or intentional data falsification.

VII. Country Response to DQA Findings

The PR has made several useful comments regarding the draft report. Based on the PR's comments the audit team corrected some errors that had been made by the audit team during the drafting of the report. In addition, the audit team utilized the PR's comments to clarify issues in the draft report that had been questioned by the PR. The PR's comments and the responses from the audit team are attached in this report as Annex A.

VIII. Proposed Systems Strengthening Plan

The following proposed plans to strengthen the data management and reporting systems for the OVC Cash transfer program

- To hold regular joint review meetings should be held to share and review data quality issues.
- To centralize the storage of data that can be accessed by authorized relevant data management staff.
- To establish and document procedures to address incomplete, inaccurate, missing data/reports and or late reports.
- To re-design Form 5 to capture details of children living households that have proof of cash transfers.
- To accelerate the implementation of the MS Access database in all the districts.
- To provide clear indicator definitions, reporting guidelines and instructions
- To document the desired data flow for the OVC indicator.
- To develop and maintain error logs documenting identified gaps and how such gaps were addressed.

Specific Comments on the draft DQA report on Malawi (MLW-102-G01-H, MLW-506-G03-H) grants

IX. Annex A: Country Response to DQA Findings and Audit Team Responses

The comments provided by PR of the Round 1 and Round 5 Malawi HIV grants are given below:

OVC
PR's Comment:

- **Page v**: It is not correct to insinuate that 'Both the PR and SR appeared disorganized and lacking in knowledge of the status of the cash transfer program and the data flow for the indicator on the number of children whose households receive cash transfer'. It was made very clear to the Auditors how the programme operates and indeed how the data flows as provided for in the Guidelines for the Cash Transfer Scheme whose copy was provided to the Audit Team and which has been duly acknowledged in the subsequent sections of the Audit Report. It is also our contention that both the PR and SR were quite clear on how a Progress Update/Disbursement Request (PUDR) for the Round 5 Grant is prepared and the Audit Report does acknowledge this in Table 1 on page 6 and Figure 2 on page 7 of the subsequent chapters. It is therefore surprising that the Audit Report claims in the Executive Summary and other sections that this was not made clear. What both the PR and SR did acknowledge was the loss of institutional memory and information occasioned by the departure of a key member of the cash transfer secretariat for further studies and the poor interface among the various players within the SR which should have facilitated continuity and data/report exchange.

Audit Team's Response:

- ***Guidelines for the Cash Transfer Scheme:*** The audit team acknowledges that elaborate guidelines are in place. However, the audit team established that no monthly reports using the recommended template were made during the reporting period under review. The only monthly report received for the period under review was from Likoma district. The Likoma report was for the month of March 2010 and was received in July 2010.
- ***Figure 2: Illustration of Data Flow for the OVC Indicator:*** The audit team gradually pieced together this illustrated data flow after visiting the PR, SR and the sites.
- ***Preparation of PU/DR:*** The audit team does not question the ability of PR in preparing PU/DR for the Round 5 Grant. What the audit team sought and failed to get was how the OVC program coordinator got the data on OVC beneficiaries from the absent Cash Transfer program coordinator. The audit team established that the former/absent program coordinator received data from the districts and would then pass on this data to the overall OVC program M&E Officer at MoGCCD. The M&E Officer in turn would prepare the PU/DR. After the Coordinator left on study leave (2 weeks before the audit), an M&E officer for the Cash Transfer program was supposed to receive data from the districts and forward it to the OVC program M&E Officer so that he could prepare the PU/DR.

  It took the audit team two visits to MoGCCD, and a futile visit to the PR, to access a copy of the prepared PU/DR for the reporting period and some reports from three districts that did not have indicator data. During the first day of the audit, the audit team met with the

OVC M&E Officer who referred the audit team to the Cash Transfer M&E Officer who informed the audit team that no OVC beneficiary data had been reported during the period under review and only a report from Likoma was belatedly submitted in July 2010. It is only on the second day that the OVC M&E Officer was made available by the PR to respond to the audit team's questions. Even then, the OVC M&E Officer could not explain how he got the data from the program coordinator nor could he explain the whereabouts of the data, if at all he had received any, from the Cash Transfer program coordinator. It's the audit team's argument that even in the absence of the Cash Transfer program coordinator then the OVC M&E Officer should have had records of data sent to him by the program coordinator as the basis for preparing the PU/DR. Thus the OVC M&E officer should have been in possession of electronic or hardcopy reports received from the absent Cash Transfer program coordinator.

- ***Acknowledgement of loss of institutional memory and poor interface among the various players within the SR:*** The audit team recognizes this acknowledgement of loss of institutional memory and this is what could have lead to the disorganization and lack of knowledge of data flow for the indicator *"the number of children whose households receive cash transfer".* In addition, since the PR was notified of the audit and data for the indicator was requested a month prior to the arrival of the audit team in Malawi there should have been sufficient time to access the records from the program coordinator before his departure. The PR and SR were not prepared for the audit though sufficient time was available.

- **Page v**: The Principal Recipient welcomes among other recommendations the consideration for instituting a unique ID link between the Master Cards and the registers, which is presently being piloted in a few sites with electronic data capturing system capability. However, exactly how this could be done in a predominantly paper based system is not very clear and we would welcome concrete tips on how this could be done.

Audit Team's Response:

- Just as in automated systems, manual record keeping can make use of Unique Patient Identifiers. Unique identifiers function best when the program uses electronic records and when services are offered at fixed sites such as ART clinics which provide on-going client service. A Unique Patient Identifier eliminates repetitive use and disclosure of an individual's personal identification information (i.e. name, age, sex, race, marital status, place of residence, etc.) and protects the privacy of the individual.

  The identification information is entered into a master card. Manual linkage at the ART clinic level is possible as the patient identifier can be used to quickly look up the index to recognize an individual. Thus if master cards exist there is no need to repeat the identifiers in the registers which hold a number of patients' names on a page and there is a possibility of such names been seen by patients while being attended to.

- **Page v**: "Patient identifiable information should be limited to patient master cards and linked to registers through unique patient IDs". Is this feasible in a paper-based environment?

Audit Team's Response:

- See the above response. Manual linkages are possible at the lowest level of use. It is only with multiple providers that manual linkage becomes difficult.

- **Page 21**: The staff member in question is on study leave and not resigned.

Audit Team's Response:

- The audit team has rectified this reference to resignation to reflect the staff member in question was on study leave on page 20 and page 28.

- **Page 34:** This is not true and undermines the efforts of people who are working so hard to ensure the cash transfer programme further succeeds beyond its current scope.

Audit Team's Response:

- The audit team recognizes that the Social Cash Transfers is one of the innovative approaches to Social Protection and further acknowledges the success of the cash transfer program since it was first piloted in 2006 and grew to its current status. The audit team acknowledges the strengths of the Cash Transfer as evidenced by statements such as:
    - Page 15: "*Description of services is comprehensively documented in 'Manual of Operations for the Malawi Pilot Social Cash Transfer Scheme' dated August 2007".*
    - Page 15: "*Guidelines for Internal Monitoring and reporting have been written and are periodically revised, most recently in January 2010 'Malawi Social Cash Transfer Program: Guidelines for Internal Monitoring' Revised Version, January 2010".*
    - Page 34 "*The SR has dedicated staff for the management of data for the indicator*' and *"the districts audited appeared motivated, reasonably equipped and trained".*
    - *Page 34: "the initial program managed by UNICEF and the Global Fund financed follow-on Program are highly popular with beneficiaries and seem to be alleviating poverty to some degree"*

ART:

- **Page iv**: "*Data accuracy for the ART indicator ranged from 90% to 101% at the SDPs and was 99.2% at the M&E Unit, suggesting the program had over-reported by only 0.8%*". We need an explanation here for this 'over-reporting'. We had explained to the DQA team that this was likely an artifact due to inclusion of adverse outcome in the DQA review that were updated in the patient records only after our quarterly cohort analysis had taken place. This is inevitable as there is always a delay in notification about deaths, stops or transfers out. While the dates of adverse outcomes are recorded in patient cards and registers, the dates of ascertainment are not, and a later review of these documents is likely to include adverse outcomes that occurred in the period evaluated, but that were only ascertained after the cohort analysis was conducted. I suggest a short sentence here that this level of 'over-reporting' is inherent in the method used for the DQA.

Audit Team's Response:

- The recount was done at the head office level where the recorded adverse outcomes should have been constant at the time of reporting and recounting. Several reasons contributed to the over-report including minor arithmetic errors, copying errors, failure to have indicator data recorded and the use of proxies. Such proxies include the total

number of clients registered and clients recorded as on 1st line treatment. The major over-report was however due to one report that had no verified data since the verified data had been erased. While this report had clinic's own data amounting to 1,438 clients, this data was not used for recounting as only verified data is used for reporting purposes.

Facility No.	Facility	Reported	Recounted	Audit Team's Comments
3017	Kanyezi HC	21	22	Possible minor arithmetic error.
3092	Kapelula HC	5	0	Nothing recorded for the indicator. 5 clients captured as total registered.
3091	Mpepa HC	6	0	Nothing captured for the indicator. 6 clients captured as total registered.
2960	Mwansambo HC	59	49	Possible copying error
3087	Life Line Kasese HC	32	0	Nothing recorded on the indicator. 32 clients recorded as 1st line (Start) ARV.
3074	Chankhungu HC	157	0	Nothing recorded on the indicator. 157 clients recorded as 1st line (Start) ARV.
3083	Mtengowanthenga Dream Project	1,438	0	The verified data had been erased while 1,438 was captured as clinic own data. Clinic own data was not used for recounting as only verified data is used for reporting purposes.
Total Over-Report (Reported- Recounted)		1,647		

Table 4: Facilities with Different Reported and Recounted Numbers at the National Level

- **Page v**: "*Minor breaches of confidentiality were noted in the use of patient names in commonly used registers, sometimes visible to other patients*" - This assessment may need to be better justified. It is necessary to record patient identifiers on patient treatment cards and in the ART clinic register to allow for clinical management and follow-up. Both sets of documents are confidential and only accessed by ART clinic staff or the patient. I thought that all reasonable precautions are in place to protect this confidentiality.

Audit Team's Response:

- Since master cards exist there is no need to repeat the identifiers in the registers as it is possible to use the patient identifier to quickly look up the index to recognize an individual. Registers hold a number of patients' names on a page and there is a possibility of such names been seen by patients while being attended to.

- **Page v**: "*Facilities should keep summaries of adverse outcomes and the dates of recording such outcomes during the quarter for easier cross-check during the cumulative cohort analysis*" - These additional data collection methods may be desirable from an analytical stand point, but it would be useful to qualify these recommendations, acknowledging that this may not be feasible considering that over 350,000 records need to be reviewed and updated each quarter with minimal staff.

Audit Team's Response:

- The audit team made this recommendation for the individual facilities to keep a summary of new registrations and adverse outcomes for the quarter based on the fact that as records increase over time it will become increasingly difficult for facilities to always go back to record number 1 to establish the status of clients. The audit team takes note of the SR comments that this system would miss out on patients who have missed visits. The Statement was made as a recommendation and it should only be adhered to if it is feasible and in the best interest of the program.

- **Page 1**: "*HIV infection predominantly transmitted through heterosexual intercourse*" - But about 15% of new infections are MTCT.

Audit Team's Response:

- The audit team has added the MTCT transmission rate in the paragraph on Page 1

- **Page 1**: "*Although the HIV and AIDS prevalence rate seems to have stabilized in Malawi, the number of orphans and vulnerable children will increase*" - 2010 epid projections actually show that the total number of orphans has started to decrease in 2009. This is due to the high ART coverage.

Audit Team's Response:

- The audit team has added a footnote to reflect this new projection.

- **Page 5**: "*When a patient comes for a follow up visit, the regimen and patient status (i.e. alive and on treatment, transferred out, stopped, defaulted or died) is recorded on the Patient Master Card*" - This is not entirely correct: only stops and transfers out may be recorded during a patient visit. The other adverse outcomes get updated during quarterly cohort analysis and/or after active follow up. (we don't get many visits by dead patients…)

Audit Team's Response:

- The audit team has duly corrected the sentence.

- **Page 11**: "*It was also noticed that systems at facilities do not eliminate the possibility of double counting, especially the possibility for it to happen across facilities. For example, if an individual can willfully enroll in more than one facilities for ARVs*" - But no system that does not use biometric identification can safeguard against that – this does not seem an appropriate goal for Malawi and other countries in the region.

Audit Team's Response:

- Double counting results in over-reporting (i.e. reporting more services or beneficiaries than were actually provided or served) and this can be detrimental to program planning and data-driven decision making. The audit team fully recognizes that double-counting cannot be eliminated but it can be minimized. In turn, awareness of possibilities of double counting is a first step towards minimizing instances of double counting and hence the audit team made the above observation.

- **Page 12**: *"Facilities do not use their unique ID numbers for reporting and in some cases, these ID numbers for the facility are not known (even though they do exist)"* - It would be

useful to have some qualifying statement here regarding the pros and cons of unique IDs – it is presented here as if this was the undisputed goal of ART programs to have this in place.

Audit Team's Response:

- A facility identifier enables unique and consistent identification of a facility and identifies information for the facility specified. A national standard for a unique facility identifier is a desirable goal and as such the use of Unique Facility IDs is assessed through the DQA tool at the facility level. The audit team recognizes the problems faced while using these numbers but the team believes gradually these problems can be overcome through standard facility definitions, maintenance of exhaustive list of such facilities, use of a standard alpha/numeric designation and field sizes, maintenance of a standard process, and a body, for maintaining these identifiers.

- **Page 13**: "*Suggested Action: each quarter, facilities could report only changes in patient registers by ART number (dead, TO, default, stop, TI, and new registrations) which would be recorded by supervisor and could be cross-checked if needed. This will greatly affect the amount of time needed to cross check every record ever registered*." - But this system would miss out on the greatest source of error: patients who have missed visits, but that were not reviewed and classified as loss to follow-up by clinic staff. There is no way of avoiding systematic review of patient treatment cards that were classified as alive and on treatment. We are considering a LQAS method to do a random sample based review to measure the error rate and decide if a comprehensive review of all cards is needed during supervision.

Audit Team's Response:

- The audit team made this comment based on the assumption that data on new events in a given quarter would be readily available for patient management purposes. However, the audit team concedes that this information may not be readily available in all facilities and thus, may lead to under-reporting of adverse events and inevitably lead to over-reporting of the people on treatment. The audit team has thus deleted the recommendation from the report. The audit team also notes that the SR is aware of the time demanding process of reviewing all records and is considering using LQAS method during supervision if the method is found appropriate.

- **Page 14**: "*Recommendation: create an error log, rather than making changes with no documentation*" This may not be feasible record by record. However, there is a formal assessment made and documented on the supervision form: 98% of outcomes correctly updated Y/N and 98% of outcome dates correctly specified Y/N. Creating a complete audit trail for edits to over 350,000 records would be an enormous task for a limited benefit?

Audit Team's Response:

- Error logs should be maintained by facility staff that work daily on data and the source documents. The audit team noted that when errors or inconsistencies / discrepancies were noted during the audit, changes are made immediately with no documentation to that effect. The audit team acknowledges that supervisors cannot nearly capture all changes that are made on registers, files and other data management tools at the facility level.

- **Page 24**: "*Total number of individuals reported by the M&E unit to The Global Fund was 206,805 individuals, but when reports from the SDPs were aggregated, the audit team found the total number of PLWA alive and on treatment as reported by facilities (available reports) was 205,158 individuals. This resulted in a verification factor of 99.2%*" - If I remember correctly, this was due to one misfiled cohort reporting form? It might be useful to offer an explanation here, because the correct figure is likely 206,805.

Audit Team's Response:

- The misfiled cohort reporting form from Ahi Private Clinic had only 18 clients alive and on treatment. The discrepancy that was found at the national level amounts to 1,647 clients. Refer to Table 4 for audit team's comments on the found discrepancies.

X. Annex B: Comments from Global Fund Staff and Audit Team Responses

- Please provide information who is the PR for the round 1 and round 5 HIV grants in the background of the program.

Audit Team's Response:

- This has been done. The audit team has added made reference to The National AIDS Commission as the Principal Recipient (PR) for HIV Round 1, HIV Round 5 and HIV Round on pages IV and 2.

- Page 23: "the program had an availability factor of 99.3%. Of the 276 reports expected by the M&E unit, 276 were received and these were verified by the audit team" – could you please check? It should be 100%.

Audit Team's Response:

- At the time of the audit the database had 277 listed ART sites and 275 reports were reviewed giving rise to the 99.3% availability. However, following the audit debriefing during the close-out meeting the SR sent, via e-mail dated 14th September 2010, the audit team scans of one of the two missing reporting form from AHI Clinic for Q1 2010. This report form had ostensibly been misfiled.

  Regarding the second missing form (Matope Health Centre), the SR explained in the same e-mail that at the time of scheduling the April 2010 visits (for Q1 reports) it was unclear if Matope HC had actually started providing ART. The SR decided to visit the facility anyway to check if drugs were in stock and if they were ready to start. It turned out that they had not started and the supervisors ended up not filling the supervision form. However, in order to document the visit, the SR entered a 'null-report' on the database. This means that Matope should have not been counted as an ART site for Q1 2010.

  The audit team has changed the statement on page 25 to reflect 100% availability.

XI. Annex C: Sampling Details for Round 1 Indicator PLWA on ART

Global Fund DQA Malawi Sept 2010

PLWA on ART – Sampling

zone_id	district_name	hfacility_name	Alive total	divide by 100	running sum
	BALAKA Total		5229	52	52
	BLANTYRE Total		26770	268	320
	CHIKWAWA Total		6674	67	387
	CHIRADZULU Total		17461	175	561
	CHITIPA Total		1434	14	576
	DEDZA Total		3807	38	614
	DOWA Total		5197	52	666
	KARONGA Total		3789	38	704
	KASUNGU Total		4367	44	747
	LIKOMA Total		177	2	749
	LILONGWE Total		31133	311	1060
	MACHINGA Total		5766	58	1118
	MANGOCHI Total		8672	87	1205
	MCHINJI Total		4018	40	1245
	MULANJE Total		7755	78	1322
	MWANZA Total		1971	20	1342
	MZIMBA Total		12066	121	1463
	NENO Total		2455	25	1487
	NKHATABAY Total		2654	27	1514
	NKHOTA-KOTA Total		3954	40	1553
	NSANJE Total		5173	52	1605
	NTCHEU Total		6093	61	1666
	NTCHISI Total		1677	17	1683
	PHALOMBE Total		3410	34	1717
	RUMPHI Total		3128	31	1748
	SALIMA Total		4264	43	1791
	THYOLO Total		15430	154	1945
	ZOMBA Total		12281	123	2068
			206805	2068	

Sampling Interval	689
Random Start	192
1st Cluster	192
2nd Cluster	881
3rd Cluster	1571

Cluster 1: Lilongwe District

zone_id	district_name	order	hfacility_name	Alive total	
central west	LILONGWE	1	LIGHTHOUSE	6187	Stratum 1 - Large
central west	LILONGWE	2	BWAIRA HOSPITAL	6019	
central west	LILONGWE	3	PARTNERS IN HOPE CLINIC	1804	
central west	LILONGWE	4	BAYLOR CHILDRENS CENTRE OF EXCELLENCE IN MALAWI	1593	
central west	LILONGWE	5	ST GABRIEL MISSION HOSPITAL	1588	
central west	LILONGWE	6	LIKUNI MISSION HOSPITAL	1511	
central west	LILONGWE	7	AREA 25 HEALTH CENTRE	1390	
central west	LILONGWE	8	KAWALE HEALTH CENTRE	1245	
central west	LILONGWE	9	NKHOMA MISSION HOSPITAL	1000	
central west	LILONGWE	10	SOS CLINIC	888	
central west	LILONGWE	11	MACRO LILONGWE	844	
central west	LILONGWE	12	MITUNDU COMMUNITY HOSPITAL	773	
central west	LILONGWE	13	AREA 18 HEALTH CENTRE	764	
central west	LILONGWE	14	KABUDULA RURAL HOSPITAL	759	
central west	LILONGWE	1	KAMUZU BARRACKS	744	Stratum 2 - Medium
central west	LILONGWE	2	PARTNERS IN HOPE CLINIC	731	
central west	LILONGWE	3	KAMUZU CENTRAL HOSPITAL	499	
central west	LILONGWE	4	NATHENJE HEALTH CENTRE	450	
central west	LILONGWE	5	AFRICAN BIBLE COLLEGE CLINIC	449	
central west	LILONGWE	6	MLALE MISSION HOSPITAL	381	
central west	LILONGWE	7	LILONGWE CITY ASSEMBLY CHINSAPO	291	
central west	LILONGWE	8	CHILEKA (LILONGWE) HEALTH CENTRE	220	
central west	LILONGWE	9	AREA 30 POLICE CLINIC	160	
central west	LILONGWE	10	LILONGWE PRIVATE CLINIC	147	
central west	LILONGWE	11	DR DAVID LIVINGSTONE MEMORIAL CLINIC	89	
central west	LILONGWE	12	DISCOVERY MEDI CLINIC	75	
central west	LILONGWE	13	CITY CENTRE CLINIC	71	
central west	LILONGWE	14	LIMBE LEAF TOBACCO CLINIC LILONGWE	68	
central west	LILONGWE	1	SSH CLINIC	55	Stratum 3 - Small
central west	LILONGWE	2	MASM MEDI CLINIC LILONGWE	53	
central west	LILONGWE	3	KAWALE MEDICAL SERVICES	47	
central west	LILONGWE	4	ALLIANCE ONE CLINIC	42	
central west	LILONGWE	5	LINGADZI PRIVATE CLINIC	40	
central west	LILONGWE	6	BUNDA COLLEGE	36	
central west	LILONGWE	7	DaeYang Luke Hospital	29	
central west	LILONGWE	8	LILONGWE HEALTH CLINIC	23	
central west	LILONGWE	9	TACHIRA PRIVATE CLINIC	18	
central west	LILONGWE	10	CCK HEALTH CLINIC & DIAGNOSTIC CENTRE	14	
central west	LILONGWE	11	ESCOM CLINIC LILONGWE	13	
central west	LILONGWE	12	CARLSBERG / SOBO CLINIC LILONGWE	12	
central west	LILONGWE	13	DaeYang Luke Hospital	11	
central west	LILONGWE	1	CHIWAMBA HEALTH CENTRE	0	Excluded - No Service Delivery
central west	LILONGWE	2	Maula Prison Health Centre	0	

Cluster 2: Blantyre District

zone_id	district_name	order	hfacility_name	Alive total	
south west	BLANTYRE	1	QUEEN ELIZABETH CENTRAL HOSPITAL	7043	Stratum 1 - Large
south west	BLANTYRE	2	BLANTYRE DREAM PROJECT	3407	
south west	BLANTYRE	3	MLAMBE MISSION HOSPITAL	3133	
south west	BLANTYRE	4	MACRO BLANTYRE	1820	
south west	BLANTYRE	5	LIMBE HEALTH CENTRE	1770	
south west	BLANTYRE	6	NDIRANDE HEALTH CENTRE	1760	
south west	BLANTYRE	7	BANGWE HEALTH CENTRE	1477	
south west	BLANTYRE	8	CHILOMONI HEALTH CENTRE	1046	
south west	BLANTYRE	9	CHILEKA HEALTH CENTRE BLANTYRE	659	
south west	BLANTYRE	10	BLANTYRE ADVENTIST HOSPITAL	630	
south west	BLANTYRE	11	BLANTYRE CITY ASSEMBLY CLINIC	562	
south west	BLANTYRE	12	MPEMBA HEALTH CENTRE	476	
south west	BLANTYRE	13	MWAIWATHU PRIVATE HOSPITAL	402	
south west	BLANTYRE	1	MTENGOUMODZI PRIVATE HOSPITAL	353	Stratum 2 - Medium
south west	BLANTYRE	2	MDEKA HEALTH CENTRE	313	
south west	BLANTYRE	3	CHITAWIRA PRIVATE HOSPITAL	278	
south west	BLANTYRE	4	MASM MEDI CLINIC LIMBE	193	
south west	BLANTYRE	5	PRESS COOPERATION CLINIC	193	
south west	BLANTYRE	6	Blantyre District Health Office	176	
south west	BLANTYRE	7	MWACHIRA PRIVATE CLINIC	174	
south west	BLANTYRE	8	LIMBE DIAGNOSTIC CENTRE	167	
south west	BLANTYRE	9	CHICHIRI ESCOM CLINIC	111	
south west	BLANTYRE	10	CHIKOWA HEALTH CENTRE	84	
south west	BLANTYRE	11	LAFARGE CEMENT CLINIC	67	
south west	BLANTYRE	12	MALMED PRIVATE CLINIC	65	
south west	BLANTYRE	1	BLANTYRE WATER BOARD CLINIC	63	Stratum 3 - Small
south west	BLANTYRE	2	LUNGU PRIVATE CLINIC	63	
south west	BLANTYRE	3	CITY HEALTH CLINIC	52	
south west	BLANTYRE	4	CARLSBERG / SOBO CLINIC BLANTYRE	47	
south west	BLANTYRE	5	LUNZU BLM	45	
south west	BLANTYRE	6	SOS Childrens Village Blantyre	43	
south west	BLANTYRE	7	POLYTECHNIC BLANTYRE	40	
south west	BLANTYRE	8	LIMBE LEAF TOBACCO CLINIC LIMBE	21	
south west	BLANTYRE	9	Nyambadwe Private Hospital	16	
south west	BLANTYRE	10	MADZIABANGO HEALTH CENTRE	9	
south west	BLANTYRE	11	CENTRAL EAST AFRICAN RAILWAYS CLINIC	8	
south west	BLANTYRE	12	UNILEVER SOUTH EAST COMPANY CLINIC	4	

Cluster 3: Nsanje District

zone_id	district_name	order	hfacility_name	Alive total	
south west	NSANJE	1	NSANJE DISTRICT HOSPITAL	2009	**Large**
south west	NSANJE	2	TRINITY MISSION HOSPITAL	1203	
south west	NSANJE	3	KALEMBA COMMUNITY HOSPITAL	862	
south west	NSANJE	1	TENGANI HEALTH CENTRE	431	**Medium**
south west	NSANJE	2	NDAMERA HEALTH CENTRE	390	
south west	NSANJE	1	MAKHANGA HEALTH CENTRE	189	**Small**
south west	NSANJE	2	SORGIN HEALTH CENTRE	89	