

IntraHealth

Data Quality Assessment Report

MEASURE Evaluation

JL Consultancy, Ltd.

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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
DQA	data quality assessment
HIV	human immunodeficiency virus
M&E	monitoring and evaluation
MVC	most vulnerable children
NGO	nongovernmental organization
OVC	orphans and vulnerable children
PSW	para-social worker
USAID	U.S. Agency for International Development

EXECUTIVE SUMMARY

This study was intended to assess implementation of the Tanzania Human Resource Capacity Project implemented by IntraHealth. The study focused on assessing the accuracy of data collected by Intrahealth during training of para-social workers (PSWs) / supervisors, as well as data collected by PSWs to inform decisionmakers. The assessment was also intended to build the capacity of Intrahealth staff involved in monitoring and evaluation (M&E) activities to carry out the assessment for their project without external support. Identified gaps from the assessment will be used to plan and conduct related M&E capacity building among project implementers at all levels.

The data quality assessment (DQA) team applied the Monitoring and Evaluation System Strengthening Tool, Routine Data Quality Assessment Tool, and Trace and Verify Tool to implement the assessment.

The Monitoring and Evaluation System Strengthening Tool comprises five parts: program strategy and the M&E plan, goals and objectives of the program/project, M&E indicators in the program/project, data dissemination and transparency, and M&E budget. The findings showed that the M&E plan was strong and had addressed 90 percent of areas in the M&E plan. The DQA team only found weaknesses in the goals and objectives of the M&E plan; these were not time bound or measureable, and the plan had not documented partners who had participated in its development had not been documented.

The Routine Data Quality Assessment Tool uses a standard set of questions to assess the organization's strengths and weaknesses in data collection and reporting. It has two sections: data verification (quantitative) of specific indicators, and a data management system assessment (qualitative). Both qualitative and quantitative results showed that the IntraHealth M&E system was strong. In the quantitative section, all reports from partners were available and filled out completely, and only a few of them were submitted late. In the qualitative section, IntraHealth scored full system strength in the functional areas of M&E structure, functions, and capabilities; indicator definitions and reporting guidelines; data collection and reporting forms and tools; evidence-based decisionmaking; and linkages with the national reporting system. Data management processes was the only functional area found to have weaknesses, as the M&E Unit had not documented procedures for addressing late, incomplete, inaccurate, or missing reports at every reporting level.

The Trace and Verify Tool (appendix IV) involved asking nine questions of PSWs in the three regions where IntraHealth implements the project. The team also asked PSWs and their supervisors for their perspectives on the major challenges they face and their suggestions on how to improve the program. Using the Trace and Verify Tool, the team found that most of the PSWs were working in their areas and had attended training, and most of them had kept all reports since they had started working as PSWs. The majority of PSWs also showed the ability to use information collected in their own decisionmaking

The DQA team concluded that IntraHealth's M&E system is strong; the project only needs to focus on ways for government, nongovernmental organizations, community-based organizations, communities, and other stakeholders to identify comprehensive strategies to help PSWs implement the project smoothly.

1. INTRODUCTION

About 8 percent of all children are considered vulnerable, as identified within the framework of *The National Costed Plan of Action for Most Vulnerable Children*.¹ An estimated 140,000 children in Tanzania under the age of 15 are infected with human immunodeficiency virus (HIV) / acquired immune deficiency syndrome (AIDS), according to a 2008 UNAIDS survey estimate.

In 1998 the Center for Population Health and Nutrition at the U.S. Agency for International Development (USAID) began to examine the role of capacity building in the population and health sector. Capacity building has become central to USAID health sector assistance strategies. Experience suggests that achieving better health outcomes requires both an injection of resources and adequate local capacity to use those resources effectively. Capacity is also critical to sustaining health outcomes and reducing reliance on external assistance.²

The Tanzania Human Resource Capacity Project is an IntraHealth-led human resources project funded by the President's Emergency Plan for AIDS Relief (United States) that works to train para-social workers (PSWs) and other health workers on the Tanzania mainland and Zanzibar. The project supports the Ministry of Health and Social Welfare to strengthen human resources for health in Tanzanian districts. IntraHealth is working with several partners, including the Benjamin William Mkapa HIV/AIDS Foundation, to implement this project. This foundation is leading the component on strengthening district human resources for health to improve the capacity of district leaders to plan for the health workforce, address bottlenecks in hiring systems, and improve work climate and staff management to boost staff morale, productivity, and retention.³

IntraHealth has two reporting levels: the Monitoring and Evaluation (M&E) Unit and partner level. At the partner level, coalition partners collect primary data on the activities implemented using training registration forms and assessment tools and compile and submit quarterly reports to the IntraHealth M&E Unit. At this level, the project supervisor reviews quarterly reports if needed, before submitting them to the IntraHealth program manager.

At the M&E Unit, the IntraHealth program manager and M&E specialist review the quarterly reports from partners and document any errors or inconsistencies in the data; they then revise the report after discussion with the responsible partner. M&E staff (program manager and M&E specialist) compile semiannual and annual progress reports on the project. They submit them to the project country director, who reviews and revises them if needed, after consultation with the program manager and M&E specialist, and then submits the reports to USAID (figure 12, appendix II).

1 Tanzania (2008). Please also see Tanzania HIV/AIDS HIV/AIDS and Malaria Indicator Survey, 2007–2008 by the Tanzania Commission for AIDS, Zanzibar AIDS Commission, National Bureau of Statistics, Office of the Chief Government Statistician, and Macro International (2008).

2 Brown, LaFond, and Macintyre (2001).

3 Benjamin William Mkapa HIV/AIDS Foundation (2010).

USAID recognizes the need for programs to collect quality data that are accurate, reliable, and timely; however, it also recognizes that many implementing partners know their data management systems have problems, but have been unsure how to address these shortcomings systematically.

MEASURE Evaluation designed the data quality assessment (DQA) tools to identify strengths and weaknesses of the M&E system and support organizations in improving their M&E systems. Beginning in 2008, USAID sponsored a series of DQAs to help USAID gauge the quality of data reported by implementing partners and to assess the strengths and weaknesses of implementing partners' M&E systems as a first step toward building their capacity. In 2011 USAID directed MEASURE Evaluation, in collaboration with JL Consultancy, to conduct a data quality assessment at IntraHealth's M&E Unit and trace and verify survey for three regions: Dodoma, Mwanza, and Iringa.

The objectives of the data quality assessment were as follows:

- Assess strengths and weaknesses in data collection, compilation, and reporting at all levels: from service delivery points to reporting to USAID
- Improve the capacity of M&E systems and ultimately the quality of data reported by implementing partners
- Build M&E sustainability by strengthening the capacity of implementing partner M&E staff to continue to carry out DQAs without external support

The data quality assessment was based on services provided between October 1, 2010 and March 31, 2011. Indicators assessed include the following:

- H2.2.D "Number of community health and para-social workers who successfully completed a pre-service training program (disaggregated by sex)"
- H2.3.D "Number of healthcare workers who successfully completed an in-service training program within the reporting period"

2. METHODOLOGY

The DQA team worked at the M&E Unit in Dar es Salaam before visiting Dodoma, Iringa, and Mwanza to interview PSWs. This enabled the team to know how Intrahealth had been training and working with PSWs. Using a computer-generated randomization scheme, 79 PSWs were selected from Dodoma, Mwanza, and Iringa for interviews.

2.1 M&E Plan Assessment

As part of the assessment of the M&E Unit, the team applied the Monitoring and Evaluation System Strengthening Tool. This tool includes three checklists that programs or projects can use to assess (1) their M&E plan, (2) the capabilities of the M&E Unit to manage data on program implementation, and (3) data collection and reporting systems on program areas, including the ability to report valid, high-quality data.

2.2 Routine Data Quality Assessment

The team also applied the Routine Data Quality Assessment Tool at each reporting level, including the M&E Unit, to assess the ability of the given site visited to collect and report quality data. This tool has a quantitative and qualitative section, respectively, for data verification of a specific indicator and data management system assessment, as discussed below.

2.2.1 Data Verification

The DQA team reaggreated the numbers from available reports and compared those with the numbers reported to USAID. The verification factor—a measure of accuracy of the data collected—is expressed as a percentage of the reaggreated number to the number reported to USAID. A verification factor higher than 100 percent indicates underreporting by an organization, whereas a factor less than 100 percent means overreporting; a verification factor of 100 percent indicates perfect accuracy in reporting.

Using the documentation review method, the DQA team also determined the availability, completeness, and timeliness of reports at each site to assess whether the sites were collecting and reporting data completely, accurately, and in a timely manner.

2.2.2 Data Management System Assessment

This qualitative part of the assessment involved six functional areas: M&E structure, functions, and capabilities; indicator definitions and reporting guidelines; data collection and reporting forms and tools; data management processes; evidence-based decisionmaking; and linkages with the national reporting system.

The Routine Data Quality Assessment Tool has a standard set of questions to assess the organization's strengths and weaknesses in data collection and reporting. Each question can be scored either "yes, completely," "mostly," "partly," "no, not at all," or "not applicable," based on the evidence available. The sources of evidence include the documents reviewed, personal observation of adherence to the procedures, dissemination of the documents, and responses given by the respondents. The scores for each functional area are distributed as follows: full (maximum) system strength scores 4.0; areas of

above-average system strength score between 3.0 and 3.9; areas of partial system strength score between 2.0 and 2.9; and areas of weak system strength score between 1.1 and 1.9. When nothing is in place, the implementing partner scores 1.0 or no system strength. Areas that are not applicable score zero.

2.3 Trace and Verify Tool

In addition, the DQA team applied the Trace and Verify Tool in interviews with PSWs in the three regions. This tool consists of nine questions, eight questions of which are open ended (appendix IV). During the interviews, the DQA team noted down interesting stories and recommendations given by PSWs/supervisors (appendix I); section 3 of this report on results includes some quotations from the interviews. The data collected were analyzed and organized into the tables and charts provided later in this report.

3. RESULTS

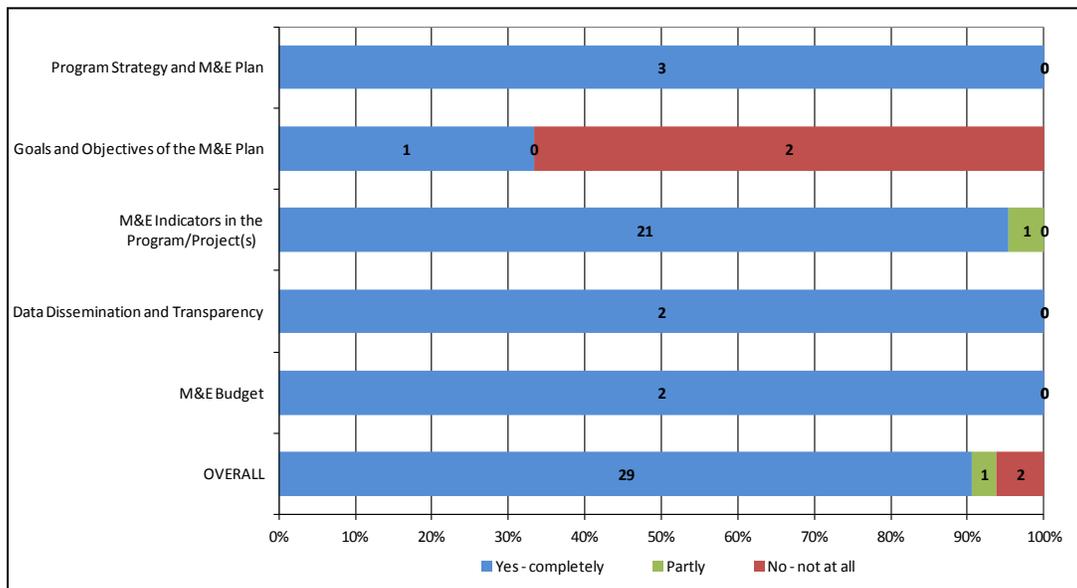
The results from the M&E plan assessment, data verification and documentation review, data management system assessment, and trace and verify survey helped to identify priority areas for technical assistance and strategies for IntraHealth management to further support implementation of the IntraHealth project.

3.1 M&E Plan Assessment

The DQA team used the M&E System Strengthening Tool to assess the M&E plan in five key functional areas: program strategy and M&E plan, goals and objectives of the program/project, M&E indicators in the program/project, data dissemination and transparency, and M&E budget.

The dashboard shown in figure 1 presents the assessment results. The bottom bar of the dashboard (overall results) shows that the project had addressed 90 percent of areas in the M&E plan: of 32 questions assessed in the M&E plan document, 29 questions scored “yes, completely,” one question was addressed in large part, and two questions were not addressed at all.

Figure 1: M&E plan assessment, 2011 DQA



Note: The blue area in each bar indicates the number of questions/responses in the M&E System Strengthening Tool relating to issues that are completely addressed by the M&E plan; green indicates issues that are partly addressed, but require major improvements; and red indicates issues that are not addressed by the M&E plan. The number of questions/responses used to generate a given colored area is indicated within that section of the bar. The diagram does not reflect questions that were not applicable.

3.2 Data Verification and Documentation Review for the M&E Unit

The M & E Unit achieved an excellent performance with a perfect verification factor for availability and completeness (table 1). The M&E Unit had monitored the availability of data and completeness of reports well. However, it had not monitored timeliness as well and hence scored only 75 percent for timeliness.

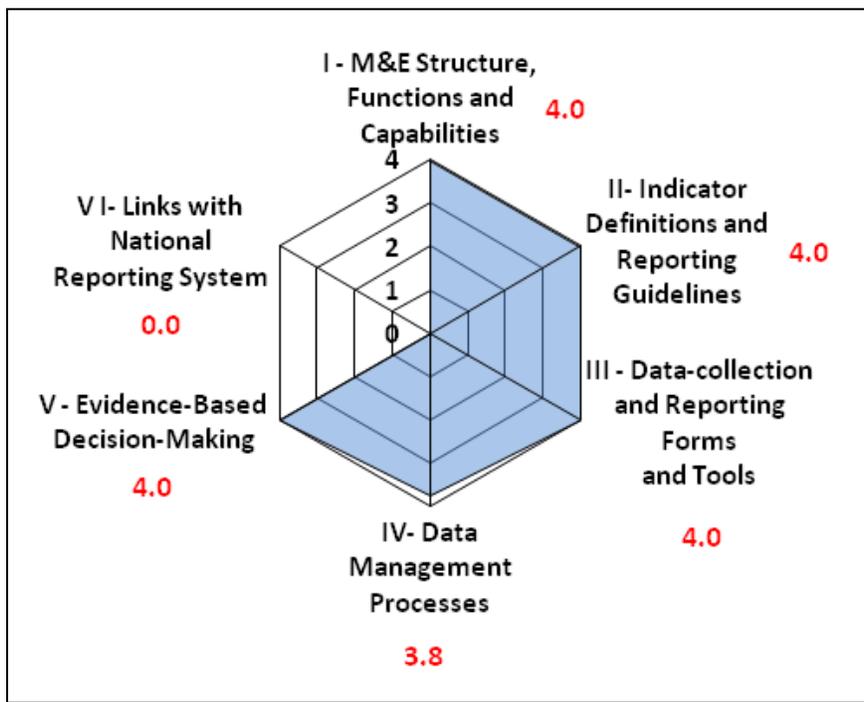
Table 1: Data verification and documentation review for the M&E Unit, 2011 DQA

Category	H2.2.D (%)	H2.3.D (%)
Verification factor	100	100
Availability	100	100
Completeness	100	100
Timeliness	75	75

3.3 Data Management System Assessment for the M&E Unit

As summarized in figure 2, the M&E Unit showed impressive findings in all six functional areas assessed. Four functional areas scored full system strength (4.0): these were M&E structure, functions, and capabilities; indicator definitions and reporting guidelines; data collection and reporting forms and tools; and evidence-based decisionmaking. The functional area of data management processes scored above-average system strength (3.8). The remaining functional area—linkages with the national reporting system—scored not applicable (0) because PSWs carried out responsibilities for reporting to the national reporting system.

Figure 2: Data management system assessment for the M&E Unit, 2011 DQA



Note: The spider diagrams score system strength on a scale of 0 to 4. The stronger the system, the larger the area colored blue in the diagram. An aggregate score of 4.0 in a functional area indicates full system strength; 3.0 to 3.9 indicates issues that are mostly addressed and above-average system strength; 2.0 to 2.9 indicates partially addressed issues and partial system strength; 1.1 to 1.9 indicates weakly addressed issues and weak system strength. When nothing is in place, the implementing partner scores 1.0 or no system strength. A score of 0 indicates that this functional area is not applicable at this level of the organization.

3.4 Trace and Verify Tool among Para-Social Workers

With assistance from IntraHealth staff, the DQA team conducted a trace and verify study in Dodoma, Iringa, and Mwanza. The team conducted interviews and focus group discussions with each PSW to explore the depth and nuances of opinions about the challenges and successes they had experienced since starting work as PSWs. PSWs, PSW supervisors, and community development officers also provided valuable suggestions during focus group discussions on improving this program. The DQA team managed to interview 51 PSWs or 65 percent of the PSWs sampled (table 2).

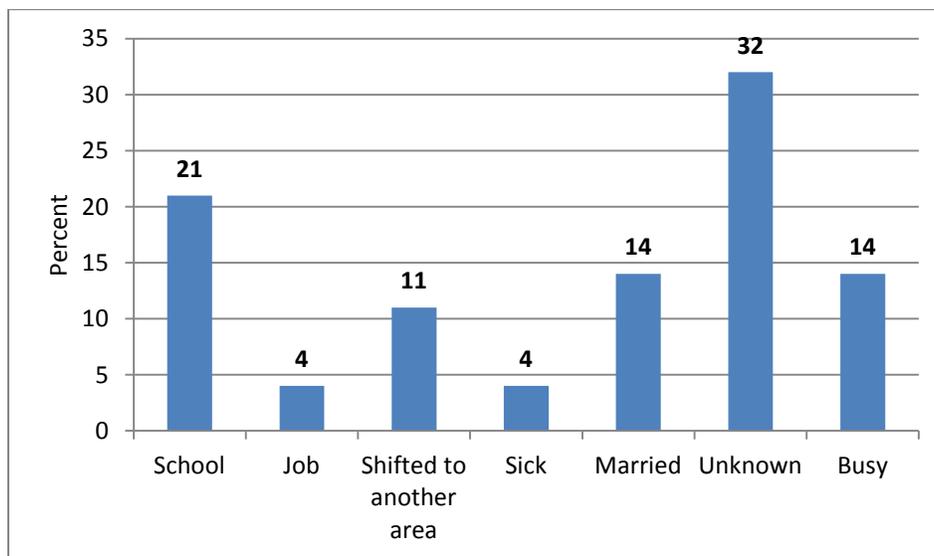
Table 2: Para-social workers interviewed by region, 2011 DQA

Regional	Target number	Number interviewed	Percentage
Iringa	29	23	79
Dodoma	30	14	47
Mwanza	20	14	70
Total	79	51	65

3.4.1 Reasons for Missing PSWs

As summarized in figure 3, the whereabouts of 32 percent of the 28 PSWs who were not interviewed was not known. The next largest group of missing PSWs comprised those who had left to attend further studies (21 percent), followed by those found to be too busy to participate (14 percent) and those who went to get married in other villages (14 percent). A few PSWs had migrated to other villages for other reasons and could not be interviewed.

Figure 3: Reasons for missing PSWs

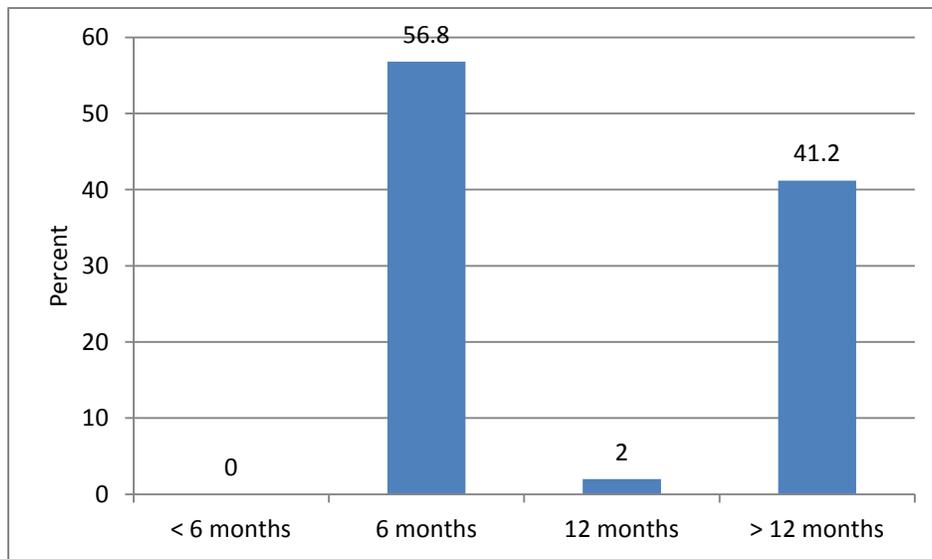


3.4.2 PSW Responses during Interviews

This section presents information based on the questions asked of PSWs on their experience working as PSWs, their training, the completeness and availability of data collection tools, their knowledge on using the data collected, and regular collection of data. Table 3 in appendix III summarizes all the data in one table.

As summarized in figure 4, well more than half of the PSWs interviewed responded they had started working six months ago (56.8 percent), followed by those who had started working as PSWs more than 12 months ago (41.2 percent), and a minority (2 percent) who had started working from 6 to 12 months ago. None of the PSWs interviewed had started working within the past six months.

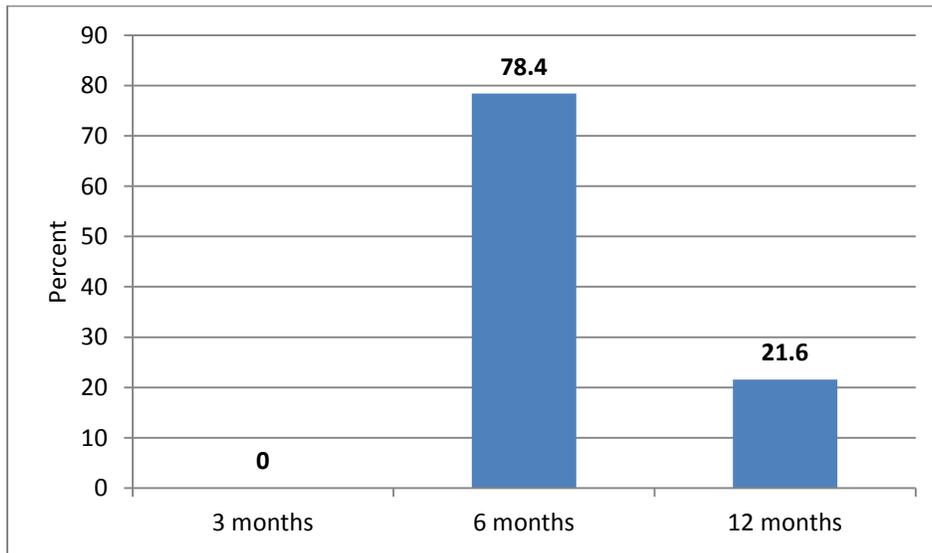
Figure 4: Length of time worked as para-social workers



3.4.3 Attendance of Para-Social Workers at Training

When queried about the last day they had attended training, more than three-quarters (78.4 percent) of the 51 PSWs who responded to this question said they had attended training in the past six months, a few (21.6 percent) said they had attended training in the past 12 months, and none had attended training in the past three months (figure 5).

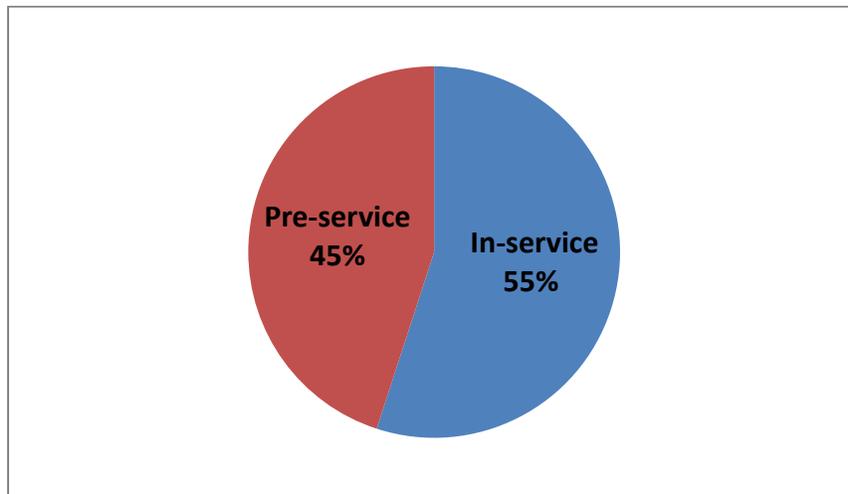
Figure 5: Last time para-social workers attended training



3.4.4 Types of Training Attended by PSWs

Of 51 respondents who were questioned about training, more than half had received in-service training and the rest pre-service training (figure 6).

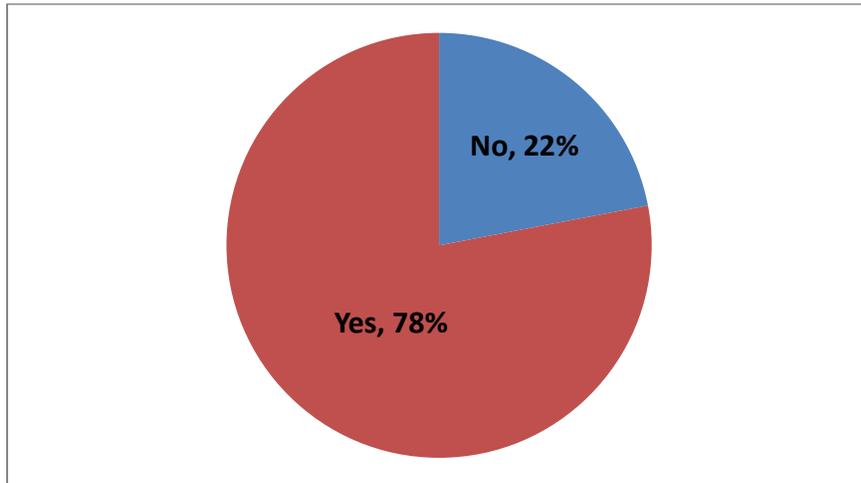
Figure 6: Type of training attended by PSWs



3.4.5 Service Delivery Forms Reviewed by PSWs

Documentation review for 51 PSWs to assess the completeness of their service delivery forms showed that 78 percent of their service delivery forms were filled out completely and 22 percent were incomplete (figure 7).

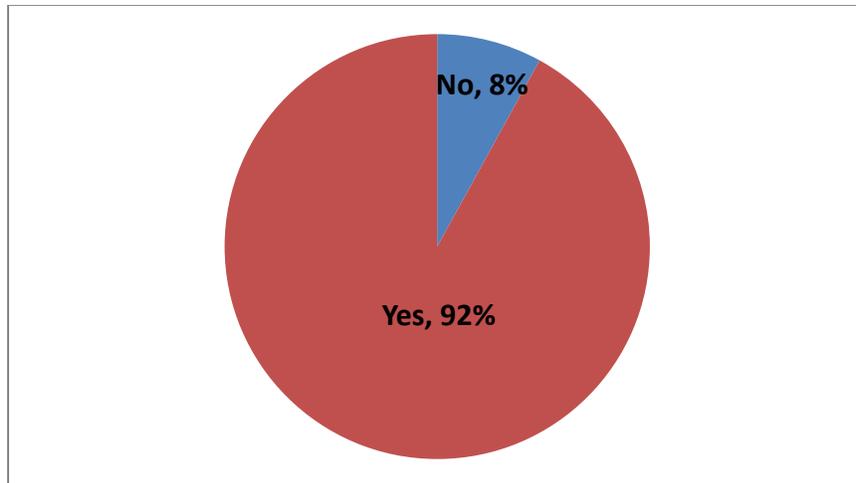
Figure 7: Documentation review of service delivery forms by PSWs



3.4.6 Provision of Services in the Past Three Months by PSWs

The DQA team also asked the PSWs if they had provided services in the past 3 months. Of those responding, 92 percent said they had provided services in the past three months and 8 percent had not (figure 8).

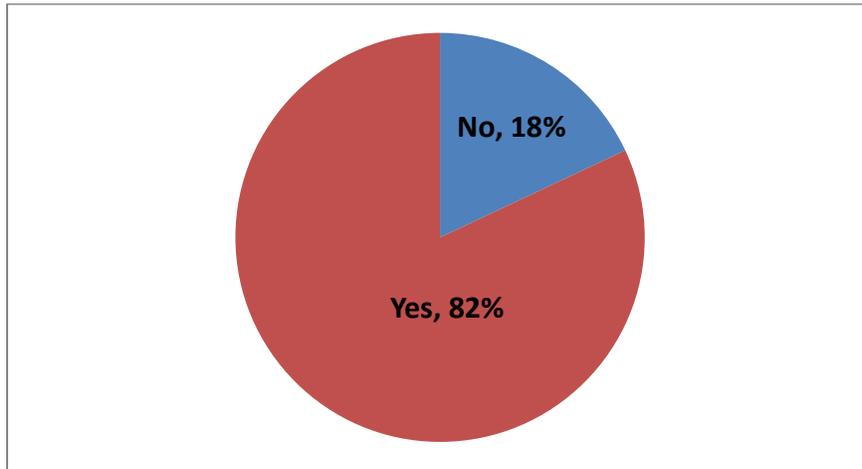
Figure 8: Provision of services in the past three months by PSWs



3.4.7 Completeness of the Monthly Report Forms Reviewed

The DQA team assessed the monthly reports of 51 PSWs for completeness. Most of their monthly summary forms (82 percent) were filled out completely and 18 percent were incomplete (figure 9).

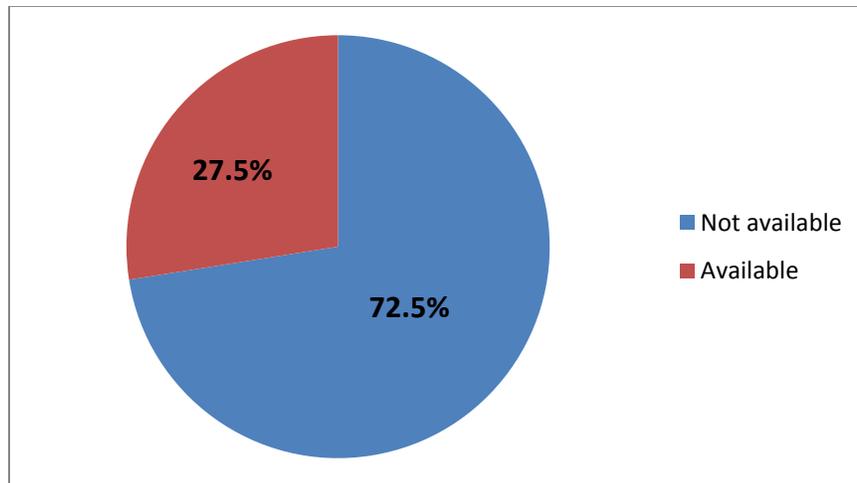
Figure 9: Completeness of monthly reports by PSWs



3.4.8 Monthly Reports Kept by PSWs

Nearly three-quarters of PSWs kept all their monthly summary forms since they had started working as PSWs and fewer than 30 percent of the PSWs did not have all their monthly summary forms since starting (figure 10).

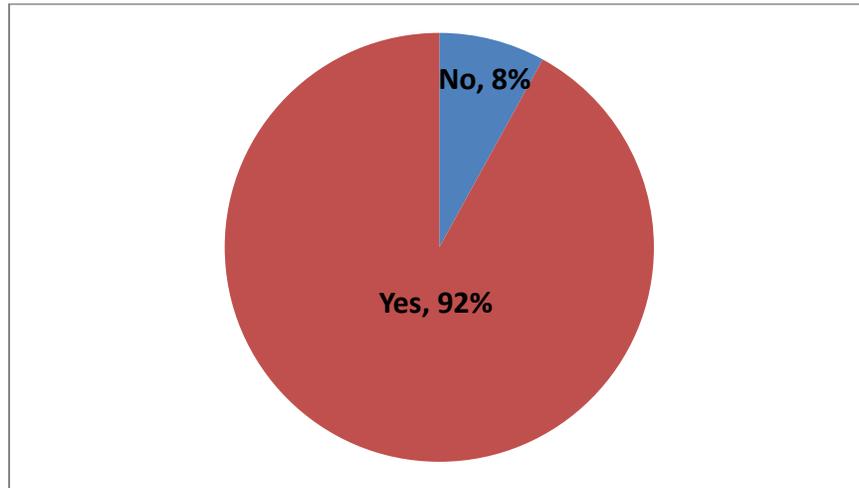
Figure 10: Availability of source documents retained by PSWs



3.4.9 Information Used by PSWs

When queried about their ability to use information collected on MVC, the majority (92 percent) responded that they had used information they collected and 8 percent said they had never used the information they had collected since starting work as PSWs (figure 11).

Figure 11: Use of information collected by PSWs



4. DISCUSSION

The DQA team assessed the IntraHealth project's performance by using the M&E System Strengthening Tool involving five functional areas. The DQA team also used the Routine Data Quality Assessment Tool to assess data verification, review documentation, and assess the M&E data management system in six functional areas. The team also used the Trace and Verify Tool and focus group discussions to collect data from PSWs and other related staff.

4.1 M&E Plan Assessment

As illustrated in figure 1, the M&E Unit had an extremely strong M&E plan as the project had addressed 90 percent of areas in the M&E plan. This percentage reflects the presence of the required program-level indicators and methods to be used to evaluate the project upon its completion; data collection tools disaggregated by sex, age, and catchment area; indicators drawn from the President's Emergency Plan for AIDS Relief (United States); and an M&E budget.

This excellent performance was bolstered by the presence of methods on evaluating the quality of training provided to PSWs, a baseline values program-level indicator, program-level indicators with targets, and a data use and dissemination plan.

Despite these strengths, the DQA team found two weaknesses in the M&E plan: the goals and objectives of the plan were not time bound or measureable, and the plan did not document partners that had participated in its development.

4.2 Data Verification and Documentation Review for the M&E Unit

Data verification showed an excellent performance by the M&E Unit due to the availability of all semiannual progress reports and reagggregated numbers that were consistent with numbers reported to USAID. The unit also had high scores on completeness. Only timeliness received moderate scores because the reports from the Christian Social Services Commission and Aga Khan Foundation were late.

4.3 Data Management System Assessment for the M&E Unit

Findings showed that the M&E Unit data management system was strong, largely due to the presence of and adherence to policies, procedures, and protocols. Areas that were particularly strong included routine feedback to the lower levels, adherence to the retention policy and filing system, availability of trip reports or supportive supervision checklists, and availability of indicator reference sheets. The M&E Unit also had a reporting structure and all positions in M&E were filled. Additionally, staff were responsible for reviewing incoming and outgoing reports, and charts and tables showed project performance.

4.4 Trace and Verify among Para-Social Workers

A minority of PSWs were not interviewed. Of 28 PSWs who had not been interviewed, 16 (57 percent) were from the Dodoma region, and 12 (43 percent) were evenly split between Iringa and Mwanza. Most

of the PSWs reported as “unknown” were considered dropouts. The DQA team also found that some PSWs were attending various colleges.

The DQA team managed to interview Mr. Yasini—a district PSW supervisor and district community development officer. He proposed that Intrahealth not restrict their recruiting for PSWs to only to secondary school graduates and consider recruiting primary school graduates and other religious leaders willing to work as PSWs. He noted that volunteers from other organizations mostly used primary school graduates, most of whom are committed to their work and do not consider further studies; they therefore may work longer and do better as PSWs. In contrast, secondary school graduates more often wish to pursue further studies through the support that Intrahealth had promised in their contracts. Secondary school graduates also often think of starting their own home businesses.

The majority of PSWs had attended in-service training. This training session had greatly expanded the capabilities of PSWs in filling out summary forms and monthly reports completely, as demonstrated in section 3.0 on results.

Retention of project documents was high among the PSWs interviewed, as a majority had kept summary forms and monthly reports since they had started work as PSWs. The majority of PSWs were actively involved in identifying MVC within their work areas, as demonstrated in section 3.0 of this report, in that only about 8 percent were inactive (i.e., did not provide services in the past three months).

Many PSWs showed an ability to use data collected on MVC. Most of them reported that they shared the information they had collected with ward executive officers and village executive officers. Sharing of information with government officers is important so site-level work can be transformed into knowledge for improving MVC services. PSWs also reported that this information was used to enable stakeholders and decisionmakers to understand how many MVC have been linked with and served by other organizations.

Many PSWs reported that the lack of incentives, such as reimbursement of transportation costs, stationery, and other expenses, was a demoralizing aspect of their work. They needed to travel on foot from one village to another to visit or identify MVC, and some used their own money to photocopy the data collection tools. One PSW during an interview said:

I can only work well if secured financially to cover transportation, stationery, and other expenses. Considering that the majority of our family are poor, it is not logical for me to spend most of my time doing voluntary work

The DQA team learned that PSWs were offering psychosocial support to MVC. During the discussion with the PSWs, most said they do encounter serious cases that need immediate help, for example, sick MVC, but they cannot help them, as they do not even have painkillers to give to the children. One of the PSWs commented:

It is very demoralizing to visit OVC [orphans and vulnerable children] empty handed and we understand very well the voluntary work entails that we are not supposed to be paid.

But we need some assistance to be in a position to assist these children at least with painkillers or any kind of medication.

A few cases of household member abuse of PSWs were reported; it was thought that households did not want PSWS to visit if they could not provide material support.

Double counting of MVC was possible when two implementing partners served the same area. The DQA team learned that some PSWs were working in the same area with volunteers from other partners. For example, PSWs worked in Nyalumbu, where volunteers for the Ilula Orphans Program and compassionate volunteers also worked. When each of these partners sends its report to USAID or the national system at the end of the reporting period, those receiving the reports may not have any way of knowing that the individuals reported had received services or been reported by more than one partner. To avoid this, IntraHealth should find underserved areas in which to implement the program or discuss with other partners the use of trained PSWs instead of recruiting and training volunteers. Child-related intervention agencies must share information, experience, and collectively map out strategies on how to improve the situation for OVC.

Stigma and local beliefs continued to be a major challenge in enrollment of MVC, regardless of how long HIV/AIDS has existed in Tanzania. Some PSWs said that some families were reluctant to participate or register their children in a program for fear their child will be labeled as HIV positive, and some people were ashamed of being known as having a child in need. During the interview, Hyela J. Mkonda, a PSW at Matahalawe village, Nyalumbu Ward, Kilolo District said:

I find it difficult to identify some OVC in Nyalumbu-Kilolo district, as family members believe that I'm writing the names of children in order to kill or take them later.

In addition, knowledge among community members is limited on the criteria for identifying MVC and those who should receive extra help; some believe all children should receive help. The government through its village and executive officers should educate the community on the criteria used to enroll MVC.

It is difficult for PSWs to link MVC with other organizations, as they have their own volunteers for MVC identification and their own fixed budget to serve these MVC. Some nongovernmental organizations (NGOs) in Iringa required MVC to be church members and others required orphans to write application letters to request donations.

5. RECOMMENDATIONS

- Motivate PSWs to retain and increase their work morale. Provision of incentives to PSWs was cited by the majority of the assessment participants, including PSWs themselves, as a way to fully implement activities of agencies.
- Provide PSWs medications and other services with which to assist OVC. Most of the PSWs reported they found it difficult to discharge their caring duties, as they did not have the means to alleviate OVC suffering, for example, through medications.
- Encourage local authorities under whose jurisdiction IntraHealth operates to divide geographical and program areas among implementing partners in order to reduce overlapping efforts.
- Encourage NGOs, government, and other well-wishers involved in child-related interventions to educate communities not to stigmatize OVC, in order for advocates to increase participation of all MVC in the program.
- Encourage and educate community members and other activists to contribute or take care of MVC, instead of depending only on donors.
- Identify areas that are still relatively underserved and implement the project in those areas to avoid overlapping with other NGO volunteers.
- Conduct more advocacy to encourage other NGOs to use PSWs to implement community-based projects, instead of recruiting new volunteers for this purpose.
- Respond to PSW interest in further studies as promised by IntraHealth management, by creating more opportunities for further studies among PSWs and checking with government officials whether they really plan to employ PSWs after completion of their studies.

6. CONCLUSION

In general, the IntraHealth M&E system is good. The DQA team hopes that the IntraHealth team will address the few gaps identified by the DQA. More efforts are still necessary to educate communities, NGOs, and government leaders on the role of PSWs in serving MVC.

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APPENDIXES

Appendix I: Stories from the Field

Hyela J. Mkonda is a PSW at Matahalawe village, Nyalumbu Ward, Kilolo District, in Iringa Region. “There are many cases concerning the killing and disappearing of children in mysterious environment. This led me to face some difficulties during the identification and during the visit because most of the parents were not cooperative fearing that maybe I’m writing the names of children either to kill or take them,” noted Ms. Mkonda during the interview. She needed to be accompanied by the village executive officer at each visit.

Mr. Yasini, a district PSW supervisor and community development officer in Iringa Town, expressed his views. “PSWs were promised to attend various colleges to be employed by the government as community development officer but in my district none of these has attended any colleges,” said Mr. Yasini. Linking the MVC identified by PSWs with other organizations is very difficult, as most of the NGOs in Iringa have their own areas of operation and own volunteers for identification and aid donation purposes. When asked to comment on the contribution of the government, he said government is facing financial problems, but sometimes they do offer donations to MVC. Furthermore, Mr. Yasini proposed that Intrahealth recruit primary school graduates and religious leaders to work as PSWs, more than secondary school graduates. Secondary school graduates who become PSWs, according to him, are troublemakers in report submission, compared with volunteers from other programs, who tend to submit reports on time. Primary school graduates also have little chance of going on to further studies. He proposed giving PSWs some financial assistance for transportation and for communications with MVC and other PSWs.

Laurence Mahenge is a PSW from Dodoma Road Village, Kihesa Ward, Iringa municipality Iringa region. It has been one year since he started working as a PSW. Mr. Mahenge is also a pastoralist and must travel to Mafinga to take care of his hens and cows. “I don’t have time because I’m too busy with my project and this is contributed by lack of incentive from MVC Project” said Mr. Mahenge. He added that “sometimes I do acquire loans from other people for bus fare in order to [return to] Iringa to identify MVC and to write monthly reports.” Mr. Mahenge commented that financial assistance and transportation is greatly needed in this work. After he pointed out the above problems, he told the interviewer that “since I started working as a PSW, I never linked MVC to other organizations because it is difficult, and yet PSWs are not well known by most of the community-based organizations.”

Matiasi Kalawais is a PSW from Mwautwa Village, Mtwivila Ward, Iringa municipal. There is a problem during home visits as parents and guardians are too busy with their daily activities. “Sometimes they do hide children for identification and most of them think that their children will be labeled HIV positive and other do not want us to visit MVC as we are not providing any material to support them.” said Mr. Kalawa. He proposed that IntraHealth provide them with medications, as sometimes their MVC are sick and there is no one to give a child even a panadol. He also noted that friends who are volunteers for other NGOs are given incentives to cover transportation and stationery costs, while PSWs receive nothing, which is very discouraging. Mr Kalawa also said new NGOs need to use PSWs instead of

recruiting and training volunteers, as PSWs can do the same work. He concluded by saying “it is difficult to link these MVC to other NGOs, as they have their own volunteers who identified their MVC and they have a fixed budget and cannot help extra MVC.”

Robert Tachave is a PSW supervisor from Nyalumbu Village, Kilolo, Kilolo District, in Iringa region; he told the interviewer that PSWs are facing difficulties, especially in linking MVC with other organizations, as they have rules and regulations; for example, some community-based organizations require MVC to write a letter before receiving a donation and another maintains that only church members can apply for donations. A lack of incentives also demoralizes these PSWs. He proposed that IntraHealth talk with other organizations to get them to use recruited PSWs, instead of training volunteers, while working in the same area as PSWs. He also said that having PSWs and volunteers working in the same area confuses them, as they are serving nearly the same people, and yet some areas remain underserved.

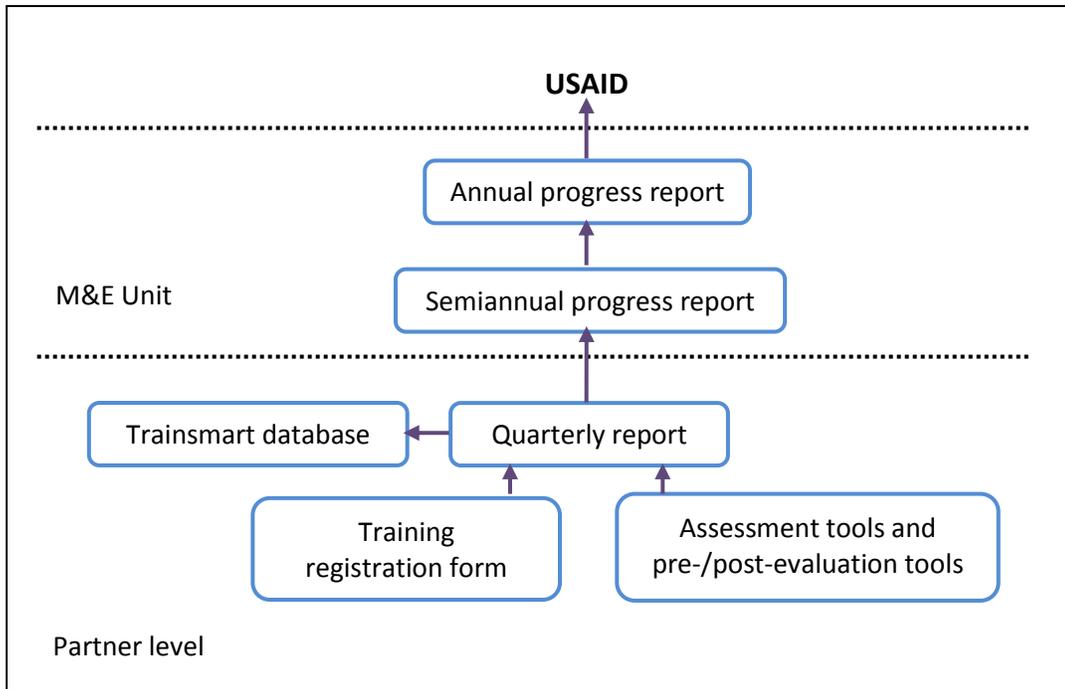
Winnie R. Mshegamo is a ward executive officer in Dodoma region who started working as a PSW in 2009 before she retired. Her answer was similar to that of the previous respondent when asked to explain the major challenges they had been facing since starting work. “There is no quick way of linking the MVC with other well-wishers or other NGOs, as most of them already have their own maximum number of volunteers.” This government officer also highlighted the lack of transportation and other incentives to motivate PSWs as an obstacle to the PSWs implementing the project effectively.

Alfonse Benedict from Kondoa in Dodoma region expressed views on transportation costs. Mr. Alfonse told the interviewer that he usually travels almost three hours to reach one village, so every day he manages to visit only two villages. “If PSWs were provided transportation costs or equipment we could manage to visit more villages compared with current situation where we visit only one village.”

Pascal Joseph, ward executive officer, called for education “as community members are still thinking that MVC are supposed to be helped by the government and other foreign people only.” Community members should be educated on the importance of helping and taking care of MVC. He told the team that he and two other volunteers of Africare and Kiwajaka have been working together to serve MVC at the same village. He requested more stakeholders come and support more MVC, as the problem seems to be large and available community-based organizations cannot serve all children.

Appendix II: Data Flow Diagram

Figure 12: IntraHealth data flow diagram



Appendix III: PSW Trace and Verify Assessment

Table 3: Trace and verify assessment for para-social workers, 2011 DQA

Area assessed	Response choice	Number of volunteers	Percentage
Volunteers interviewed	Male	31	60.8
	Female	20	39.2
Duration of work	< 6 months	0	0.0
	6 months	29	56.8
	12 months	1	2.0
	>12 months	21	41.2
Period since training attended	3 months	0	0.0
	6 months	40	78.4
	12 months	11	21.6
Type of training attended	Pre-service	23	45.1
	In-service	28	54.9
Service delivery forms completely filled out	Yes	40	78.4
	No	11	21.6
Services provided in the past three months	Yes	47	92.2
	No	4	7.8
Monthly reports completely filled out	Yes	42	82.4
	No	9	17.6
All monthly reports kept	Yes	37	72.5
	No	14	27.5
Information collected used in decisionmaking	Yes	47	92.2
	No	4	7.8

Appendix IV: Trace and Verify Tool for Para-Social Workers

Para-Social Worker No: _____ Sex: _____ Date: _____

Village _____ Ward _____ District _____ Region _____

1. Did you find the sampled para-social worker? Yes No
 - a. If no, end questionnaire

2. When did s/he start working as a para-social worker?
 - a. Less than 6 months have passed
 - b. 6 months have passed
 - c. 12 months have passed
 - d. More than 12 months have passed

3. When did s/he last attend para-social worker training?
 - a. 3 months have passed
 - b. 6 months have passed
 - c. 12 months have passed

4. Was it a refresher(in-service) or sensitization (pre-service) training?

5. Ask to see her/his completed PSW service delivery forms. Are they filled out completely? Yes No

6. Have services been provided in the past 3 months? Yes No

7. Ask to see their completed monthly summary of PSW forms. Are they filled out completely? Yes No

8. Is there one for each month since s/he started working as a para-social worker? Yes No

9. Does s/he use the information collected on the MVC? Yes No
 If yes, please explain how and show examples. Please document the findings.