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PERFORMANCE MONITORING PLAN

Strategic Objective 1: *Increased Use of FP/MCH & HIV/AIDS Preventive Measures*

USAID/Tanzania

April 19, 2002

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PRICEWATERHOUSECOOPERS 
1616 North Fort Myer Drive
Arlington, VA 22209
(703) 741-1000



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SECTION I. INTRODUCTION

A. BACKGROUND

In 1997 USAID/Tanzania developed the present Country Strategic Plan (CSP) for the period of FY1998–2003. The Mission’s Program Goal for the 1998 – 2003 strategy period is “ Real Economic Growth and Improved Human Welfare.” The Health Strategic Objective (SO 1) in support of the goal is **“Increased use of family planning (FP), maternal and child health (MCH), and HIV/AIDS preventive measures.”** The SO 1 Team designed a strategy aimed at leveraging changes in the policy and legal environment to support expansion of, and demand for, quality services; while contributing directly to the availability of quality services; and the creation of public demand for them. Changes within the GOT, USAID’s program emphasis, and supporting activities led the SO1 Team to decide to revise its indicators and its Performance Monitoring Plan (PMP). The SO1 team requested consulting support from PricewaterhouseCoopers (PwC) under the Integrated Managing for Results (IMR) contract to align the PMP with current reality and increase its value as a strategic management tool.

Objective of the Consultation

Update and Finalize SO1’s Existing PMP to include:

- ❖ Review all relevant background materials.
- ❖ Work with the SO1 Team and partners to refine the existing indicators as appropriate.
- ❖ Review or develop methodology for conducting data quality analysis for all top tier indicators that could be included in the Annual Report.
- ❖ Conduct data quality analysis for data submitted by partners in support of the top tier indicators.
- ❖ For all new indicators with baseline data and no targets, assist the Mission and partners with target setting and plans for data collection and quality assessment.
- ❖ Conduct a final debriefing consensus meeting with SO1 partners.

To achieve these objectives, a PwC consultant team led by Jerry Harrison-Burns used the following process:

- Reviewed background materials
 - Current Results Framework
 - SO Team Structure
 - Draft “Revised indicators”
 - SO1 Budget/Financial Plan
 - 2001 Annual Report
 - Problem/Epidemiological Data
 - Indicators recommended by Synergy/UNAIDS
 - Administrator’s cable on HIV/AIDS
 - Global indicators for Annual report
 - Partner monitoring information, indicators, and targets
- Conducted partner interviews on reporting, monitoring and evaluation
- Identified and reviewed issues concerning the existing indicators with the SO Team
- Facilitated a one-day workshop for the SO Team to explore indicator issues with partners
- Consulted Cooperative Agreement Regional Advisors
- Proposed indicator options resulting from the above process
- Assisted SO Team members to develop Indicator Reference Sheets for the indicators SO1 Team chose to include in this PMP
- Facilitated a meeting with the SO1 Team for review of the PMP and definition of next steps



The following Performance Monitoring Plan is organized as follows:

- ❖ Section I introduces the PMP and provides background information;
- ❖ Section II presents the Results Framework, indicators, logical consistency of the framework, and the critical assumptions underpinning it;
- ❖ Section III describes how the SO 1 Team manages its program for results and covers issues such as responsibilities for various performance management tasks, including data collection, reporting, and analysis;
- ❖ Section IV contains Performance Indicator Reference Sheets for all results-level indicators first tier Intermediate Results, and
- ❖ Section V focuses on next steps and identifies outstanding issues that will be completed at a later date.

B. GUIDING PRINCIPLES OF THE PMP

The Performance Monitoring Plan (PMP) is an important tool for managing and documenting portfolio performance. It enables timely and consistent collection of comparable performance data, which allows the SO Team to make informed program management decisions. The principles governing this PMP are based on the Agency's guidelines for assessing and learning (ADS 203.3.2.2):

A tool for self-assessment: This PMP has been developed to enable the SO1 team to actively and systematically assess its contribution to USAID/Tanzania's program results and take corrective action when necessary. At its core are practical tools such as indicator reference sheets and a performance management task schedule.

Performance-informed decision-making: The PMP is designed to inform management decisions. The indicators chosen, when analyzed in combination, will provide data to demonstrate or disprove the basic development hypothesis. The hypothesis is that a favorable policy/legal environment; increasing availability of quality, preventive health services; and increasing demand for those services; will cause people to change behavior and increase the use of health promoting, preventive measures. The increased use of those scientifically proven preventive measures will contribute to the Tanzanian population's improved health status. Data will provide information on the effectiveness of activities in advancing the three pillars of the strategy, policy improvements, increased quality services, and demand. Health statistics and surveillance data will provide information at a level of results above the Strategic Objective against which to SO1 Team's effectiveness over a long time horizon will be determined.

Candor and transparency: To increase transparency, indicator and data quality assessments have been or will be conducted wherever possible, and any known limitations documented in the PMP. Efforts were also made to ensure that first tier Intermediate Results-level indicators selected can reasonably be attributed to USAID efforts.

Economy of effort: When selecting indicators, efforts were also made to streamline and minimize the burden of data collection and reporting. As such, efforts were made to utilize data that are already being collected by partners. In addition, the principle of "management usefulness" was applied to ensure that only data that would be useful for decision-making would be collected.

Participation: Finally, the PMP has been developed in a participatory manner. Implementing Partners participated in the discussion of issues with the prior set of indicators and the generation of new indicator options. The PMP Indicator Reference Sheets (IRS) document plans for continued partners' involvement in the analysis of performance data.



C. BUDGETING FOR PERFORMANCE MANAGEMENT

The SO1 team has allocated resources for monitoring and evaluation in all funding mechanisms negotiated to date. As a rule of thumb, current ADS 203 guidance recommends allocating *three to ten percent* of total program resources for performance monitoring and evaluation. (During activity start-up and early implementation, these costs could be even higher due to development of appropriate management information systems.)

There is almost always a trade-off between cost and data quality. This trade-off was taken into consideration when selecting indicators and methods for data collection, and efforts were made to select the most cost-effective approaches. As such, most indicators draw on ongoing data collection efforts by partners and impose only minimal or no additional data collection requirements. Where primary data is collected (such as the Demographic and Health Survey) a relatively large investment in data provides benefits of trend analysis over a long history and comparative data with other African countries.

SECTION II. STRATEGIC OBJECTIVE ONE-TEAM RESULTS FRAMEWORK

A. GRAPHICAL REPRESENTATION

SO1 Team's Strategic Objective is **"Increased use of Family Planning, Maternal and Child Health, and HIV/AIDS Preventive Measures."** The objective will be achieved through three Intermediate Results, which in turn will be realized through a series of lower tier Intermediate Results achieved through collaborative activities with implementing Partners. The Framework includes contributions of results from other Partners (GOT and other donors) as well as from the USAID Democracy and Governance Team (SO3)

The graphical representation on the following page illustrates this Results Framework. The subsequent page lists the indicators for the SO and for all first tier Intermediate Results.



SO 1 Framework

Increased use of FP/MCH & HIV/AIDS preventive measures

IR1
Policy and legal environment improved

IR2
Availability of quality services increased

IR3
Demand for specific quality services increased

IR1.1
CSO advocacy

IR1.2
GOT capacity to develop and implement policies strengthened

IR2.1
Provision of information and services increased

IR2.2
Practitioners' skills and knowledge increased

IR2.3
Program Management Improved

IR3.1
Customer knowledge of

IR3.2
Social support for RCH practices increased

SO3
DG activities

Health Systems Support:
•Supervision
•HMIS/Surveillance
•MSD (logistics)
•Financing
•Personnel

Supply of STI drugs

Infrastructure/supplies meet standards for safe delivery, post abortion services

Abbreviations Key:
CSO- Civil Society Organizations
DG- Democratic Governance
FP/MCH-Family Planning Maternal Child Health
GOT: Government of Tanzania
HMIS - Health Management Information Systems
IR- Intermediate Result
MSD- Medical Stores Department
RCH- Reproductive and Child Health, including HIV/AIDS

SO: Strategic Objective
STI- Sexually Transmitted Infection
[March 1999]



<p>SO1: Increased use of FP/MCH & HIV/AIDS preventive measures</p> <ol style="list-style-type: none"> 1 Contraceptive Prevalence Rate (CPR) 2 Couple Years of Protection (CYP) 3 Percentage of pregnant women who were given 2 doses of presumptive malaria medication (SP) during antenatal visits 4 Vitamin A supplementation among children aged 6 – 59 months 5 Condom use at last higher risk sex 6 Median age at first sex among young men and women 		
<p>IR 1: Policy and legal environment improved</p> <ol style="list-style-type: none"> 1 Index score of policy and legal environment disaggregated by: <ol style="list-style-type: none"> a. RCH National b. RCH district level, c. HIV/AIDS National d. HIV/AIDS district level 2 Policy and legal objectives' milestones 	<p>IR 2: Availability of quality services increased</p> <ol style="list-style-type: none"> 1. Ratio of service delivery points (SDPs) that meet or surpass a minimum quality score to all SDPs: disaggregated by service: <ol style="list-style-type: none"> a. Long term & permanent FP methods b. HIV voluntary counseling & testing c. Selected RCH services. 2. Sentinel stock-outs of selected FP/MCH & HIV/AIDS drugs and commodities 3. Condoms available at high risk sites 	<p>IR 3: Demand for specific quality services increased</p> <ol style="list-style-type: none"> 1. Number of acceptors of long term & permanent FP methods in the last year 2. Number of first time HIV VCT clients counseled and tested 3. Number of socially marketed condoms distributed 4. Risk perception for HIV/AIDS among youth

B. LOGICAL CONSISTENCY OF THE RESULTS FRAMEWORK

The Strategic Objective concerns two kinds of change (results). One involves the population at large as the direct customers of preventive measures that individuals might take to avoid risks to personal health and increase their chances of good health. Such preventive measures include family planning and protection from HIV/AIDS infection (the greatest cause of death in Tanzania.) The result is individual behavior change to use preventive health measures. Indicators to track the use of such measures are:



1. Contraceptive Prevalence Rate (CPR)
2. Couple Years of Protection (CYP)
5. Condom use at last higher risk sex
6. Median age at first sex among young men and women

The Demographic and Health Survey (DHS) measures CPR approximately every 5 years. CPR data represent the proportion of women in a national survey who report using (or their partner using) a modern method of contraception at the time of the survey. CYP provides a proxy measure of CPR by calculating the estimated amount of protection against pregnancy provided by family planning services during a one-year period, based on the volume of contraceptives dispensed to clients during that period. There is considerable evidence that spacing childbirth and lower birth rates reduce health risks to women. DHS data demonstrate that the risk of HIV/AIDS infection is high among youth. In Tanzania, youth begin sexual activity at a very young age and the risk of infection drops with increased age of first sex. The risk of infection increases with an increase in the number of sexual partners. The last two indicators above measure the extent to which the general population, and youth in particular, mitigate those risks of HIV/AIDS infection.

The second type of change (result) concerns people and organizations managing health care for the general population. One of the greatest killers of children within the first year of life in Tanzania is malaria. If the mother is infected, malaria also leads to fetal wastage. Two doses of malaria medication during antenatal visits greatly reduce the risk. Research has demonstrated that 2 doses of vitamin A per year for children under 5 years have tremendous positive impact on child growth, health, and eyesight. The general population benefits to the extent that the health care delivery system incorporates those two maternal and child health (MCH) interventions into their program. There are two indicators to track the extent to which the health care system incorporates them:

3. Percentage of pregnant women who were given 2 doses of presumptive malaria medication (SP) during antenatal visits
4. Vitamin A supplementation among children aged 6 – 59 months

The SO1 Team development hypothesis is that three results are necessary and sufficient to cause the SO level behavior change and health care organizational change to occur. They are:

- IR1: Policy and legal environment improved**
- IR2: Availability of quality services increased**
- IR3: Demand for specific quality services increased**

Improvement in the **policy and legal environment** means that obstacles are reduced and incentives increased for adopting the SO level behavior and organizational changes promoted. Changes in laws, policies, and implementing institutions can reduce obstacles to the availability of quality services and create incentives for their increase. Policies also create incentives and disincentives for the general population to demand those services. Demand is a product of perceived benefit in relation to cost, whether the cost is financial, time, emotional, or bureaucratic transaction. The strategy focuses on policy changes that will increase the cost/benefit ratio of increasing the availability of quality services in Family Planning; Reproductive, Maternal and Child Health; and HIV/AIDS services. The strategy also promotes changes in the policy environment that will encourage the general population to change their perception of the benefits of the preventive health measures in relation to the health risks involved to the point at which they are willing to assume the real costs to them of behavior change. SO1 measures improvement in the policy and legal environment result with two indicators:



1. Index score of policy and legal environment disaggregated by: a. RCH National, b. RCH district level, c. HIV/AIDS National, and d. HIV/AIDS district level
2. Policy and legal objectives' milestones

The index score is produced by four groups of key informants who are knowledgeable about the real effects of policy change on incentives and disincentives for providing quality services. They also have knowledge of the perceived cost/benefit ratio of behavior change implied for the general population to use those services. Groups are formed around the areas of expertise implied by the disaggregations of the index score data: 1. Reproductive and Child Health issues at the National level, 2. A second group on the same theme at the district level, 3. HIV/AIDS issues at the National level, and 4. A second group on the same theme at the District level. The key informants use an assessment tool to rate their opinions on the state of the policy and legal environment and the trend in the ratings over time indicates whether the environment has improved. The same key informants provide information on obstacles and opportunities in the policy and legal environment for the SO1 Team to consider as potential objectives for policy and legal change, which informs the second indicator (Policy and legal objectives' milestones). The SO1 Team consults their stakeholders informally continuously and formally at least once in an annual strategy meeting. Information from the key informants who produce the policy index score is included in those formal and informal meetings. The product of the consultations is a SO1 Team policy agenda with objectives and milestones marking the process to achieve each objective. The indicator tracks milestones passed on the road to achieve policy and legal objectives. Policy objectives achieved should produce some change in the Index score of policy and legal environment after some lag time for implementation and perception of the effects by the key informants. The two indicators together provide sufficient data to make informed judgments about whether the environment has improved.

Key services must be available to support the behavior and organizational change required to achieve the SO. Furthermore, the services need to be of quality to contribute to improved health and to avoidance of health risks. The second result is **IR2: Availability of quality services increased** and those services fall into three categories: Family planning, HIV voluntary counseling and testing for HIV/AIDS, and Selected reproductive and child health services. The SO1 strategy includes investment in increasing quality and availability of services in those areas. The provision of services in the three areas is dependent upon the availability of selected drugs and commodities as the services cannot be provided without them. SO1 (in collaboration with other donors) invests in providing some of those drugs/commodities and in strengthening the national distribution system to ensure they are available at the service delivery points (SDP). An identifiable site for higher risk sexual behavior in Tanzania is bars and guesthouses. As part of the SO1 strategy to reduce the risk of HIV/AIDS infection, SO1 invests in promotion of condom sales in such high-risk sites. The assumption is that the link between sales of condoms and use is very close for patrons of bars and guesthouses. The indicators tracking this result are:

1. Ratio of service delivery points (SDPs) that meet or surpass a minimum quality score to all SDPs: disaggregated by service: a. Long term & permanent FP methods, b. HIV voluntary counseling & testing, c. Selected RCH services.
2. Sentinel stock-outs of selected FP/MCH & HIV/AIDS drugs and commodities
3. Condoms available at high risk sites

The first indicator provides information on the number of service delivery (SDPs) that achieve a floor level quality score (or above) in an annual quality review process compared to a universe of SDPs that SO1 intends to improve. SO1 assists in the development and application of "Quality Standards" if required in order to measure the availability of quality services. The second indicator tracks whether the essential



drugs and commodities are available to be able to offer the quality services. The third indicator gives a measure of availability of condoms in high-risk sites for HIV/AIDS infection.

The third result in the strategy below the level of the SO is **IR3: Demand for specific quality services increased**. Even though the policies may be supportive and quality services are available, increased use of preventive measures will not occur without demand. SO1 invests in behavior change communication (BCC), community action, and social promotion to influence the level of demand. At grass roots levels promotion activities are designed to increase Civil Society Organization (CSO) advocacy to change the policy and legal environment in favor of increasing both availability of, and demand for, quality services. This result is difficult to measure directly since it includes both those who use a service (or commodity) as well as those who have the felt need to do so but for various reasons have not satisfied it. Surveys offer one method of measurement but the utility of knowing “felt need” may not justify the cost, given that user data and data from the ratio of service delivery points that provide quality services indicate when demand exceeds supply. Resource alignments can be adjusted accordingly. Under the theory that risk-taking behavior by an individual is inversely related to a level of perception of risk, SO1 invests in activities to increase the perception of risk among the general population with an emphasis on youth. An indicator for it is included as a proxy measure of demand, given the assumption that increased perception of risk reduces risk-taking behavior, i.e., increases the use of preventive measures. All three Intermediate Results are interactive in that results in one affect results in the other two. The indicators for the demand result are:

1. Number of acceptors of long term & permanent FP methods in the last year
2. Number of first time HIV VCT clients counseled and tested
3. Number of socially marketed condoms distributed
4. Risk perception for HIV/AIDS among youth

The first two are direct measures of the use of services for preventive measures representing USAID investment and contribute to the National data used to monitor results at the SO level. They may provide data for exploring the issue of attribution. The third indicator measures the “use “ of condom sales services, also directly attributable to USAID. The fourth indicator is indirect, provides a measurement of movement toward either using preventive services or adopting preventive behavior directly.

The second tier Intermediate Results illustrated in the Results Framework identify results that contribute to the three pillars of policy and legal environment, availability of quality services, and demand. The framework also identifies necessary results from other donors and highlights cooperation with the Democracy and Governance Team (SO3). Individual Activity Managers monitor those results within a program Management Information System (MIS) and data for those indicators do not appear in this PMP.

C. CRITICAL ASSUMPTIONS

The following fundamental assumptions underpin the activities that will be implemented by the Health SO Team:

- ❖ Exogenous factors (civil unrest, military conflict, refugees, and natural disasters) do not increase the present baseline of health risks in Tanzania.
- ❖ Counterparts within agencies of government participating in USAID-financed activities and other donors will work collaboratively and in good faith with implementing partners.
- ❖ Administrative and regulatory reform continues to be a high priority of the Government of Tanzania



SECTION III. MANAGING SO 1 FOR RESULTS

USAID staff and partners have specific roles and responsibilities in the overall performance monitoring system. The following table outlines these responsibilities for each of the major steps in the monitoring process, which are further discussed in detail in this section:

MAJOR STEPS	RESPONSIBILITY
Collecting performance data	USAID partners; SO1 Team
Conducting evaluations and special studies	SO1 Team
Reviewing performance information	USAID partners; SO1 Team
Reporting performance results (<i>annual report</i>)	SO1 Team
Assessing data quality	SO1 Team
Reviewing and updating the PMP	SO1 Team

A. COLLECTING PERFORMANCE DATA

1. Levels of Performance Data - A PMP measures performance data at three levels:

- ❖ **Results-level** indicators refer to indicators of program results that can be reasonably attributable to USAID efforts and for which USAID is willing to be held accountable. Attribution exists when the causal linkages between USAID activities and measured results are clear and significant. These indicators directly correspond to the SO and IRs laid out in the Results Framework and also serve as the basis for performance reporting to USAID/Washington.
- ❖ **Activity-level** indicators refer to indicators that provide useful data for ongoing, continuous management of activities by the SO Team. These indicators generally provide more operational data than results-oriented data. Activity-level data can therefore be used to assess partner performance and address operational issues. These indicators are primarily drawn from the agreements and work plans agreed upon by USAID and its activity partners. This SO1 PMP does not reach to the activity level and data on activities will be found in individual managers' files and information systems.
- ❖ **Goal or Context** indicators are measures that provide a broader perspective on the context within which USAID assistance is being provided. Goal indicators measure results at levels higher than the Strategic Objective. Sometimes they are indicators of development results that are influenced by multiple factors, such as donor assistance, government action, or climatic conditions, and therefore cannot be directly attributed to USAID assistance. Context indicators could also be measures of assumptions that underpin USAID's development strategy in a given country. In general, context indicators are macro-statistics that provide valuable information on the environment in which USAID operates. USAID Global Bureau guidance on HIV/AIDS indicates that Missions will be asked assure that some reliable source provides epidemiological data on the spread of HIV/IDS. In Tanzania that source may be the product of CDC's work with the GOT. Collectively, these indicators represent the performance data needed for both reporting and management purposes.



2. Data Collection Responsibilities

Partners provide much of the data that serves as the basis of USAID’s results-level monitoring and reporting.

B. CONDUCTING EVALUATIONS & SPECIAL STUDIES

Regular, scheduled performance monitoring requires a level of simplicity and practicality in data collection efforts, which makes it difficult to assess more complex issues of management concern. Furthermore, performance indicators are only able to “indicate” progress and cannot be used to determine “why” a certain result occurs. Evaluations and special studies are ways in which the SO1 team can complement its routine performance monitoring efforts with more rigorous, in-depth analysis on topics of special interest. Some special studies such as the Demographic and Health Survey provide data for indicators. Potential future evaluations and special studies include:

SUBJECT OF EVALUATIONS/SPECIAL STUDIES	POTENTIAL METHODOLOGY	TIMELINE
Demographic and Health Survey	Standard with key changes negotiated by SO1 Team	2003/4
Sexual behavior survey (Amy to fill in)		
Youth HIV/AIDS Survey (Amy to fill in)		
Female condom social marketing (Amy fill in)		
District Assessments (Patrick/Michael to fill in)		

C. REVIEWING PERFORMANCE INFORMATION

To help make effective management decisions, the SO1 Team must internally review and analyze performance data during the course of the year. Depending on the results of these reviews, the SO Team may need to adjust its programming and activities.

SO1/Tanzania has two scheduled opportunities whereby the team reflects on program performance. The Annual Strategy Meeting with stakeholders focuses on issues, strategy and program implementation. Preparation for the Annual Report focuses on SO and IR level results, issues, and strategy. The first has no reporting responsibilities. Both reviews occur in January/February or 1st quarter of the calendar year.

The revised ADS 200 guidance requires each SO team to conduct an annual portfolio review. The portfolio review is defined as: “ a required systematic analysis of the progress of an SO by the SO Team and its Operating Unit. It focuses on both operational and strategic issues and examines the robustness of the underlying development hypothesis and the impact of activities on results. It is intended to bring together various expertise and points of view to arrive at a conclusion as to whether the program is “on track” or if new actions are needed to improve the chances of achieving results.” (ADS 203.3.3). At a minimum, a portfolio review must examine the following:



- ❖ Progress towards SO achievement and expectations regarding future results achievement;
- ❖ Evidence that outputs of activities are adequately supporting the relevant IRs and ultimately contributing to the achievement of the SO;
- ❖ Adequacy of inputs for producing activity outputs and efficiency of processes leading to outputs;
- ❖ Status and timeliness of input mobilization efforts;
- ❖ Status of critical assumptions and causal relationships defined in the results framework, along with the related implications for performance towards SOs and IRs;
- ❖ Status of related partner efforts that contribute to the achievement of IRs and SOs;
- ❖ Status of the operating unit’s management agreement and the need for any changes to the approved strategic plan;
- ❖ Pipeline levels and future resource requirements;
- ❖ SO team effectiveness and adequacy of staffing; and
- ❖ Vulnerability issues and related corrective efforts.

(From ADS 203.3.3)

Clearly, the requirements of the portfolio review go significantly beyond the strategy meeting that the SO1 team currently undertakes. However, with some enhancements, the two exercises (Strategy Meeting and Annual Report) together could be improved to meet the requirements set forth in ADS 203.3.3. Each may cover part, and between them address all, of the operational and strategic issues required in ADS 203.3.3. Partner participation is strongly recommended and already incorporated into the Strategy Meeting. The SO1 team should consult ADS Tables 203 A, 203 B, and 203 C for ideas on how to improve the portfolio review process.

The following table outlines scheduled SO1 Team performance reviews:

TYPE OF REVIEW	WHEN	PURPOSE
Partner Activity Progress Review	Monthly/quarterly (depending on activity)	❖ Informal monitoring of partner activities through review of partner progress reports and discussion
Annual Report	Annually 1st quarter	❖ Strategic Review – assess progress towards results, review development hypothesis, examine interface between strategy and tactics.
Annual Strategy Meeting	FY 2002 (1st quarter)	❖ Stakeholder review of the SO1 strategy/program



D. REPORTING PERFORMANCE RESULTS: The Annual Report

USAID uses performance information not only to assess Operating Unit progress but also as the basis of its resource request for subsequent years and to share knowledge and enhance learning throughout the organization. Like other Operating Units, USAID/Tanzania submits an annual report on its performance against expected results, including both its successes and areas identified for improvement.

The annual report is prepared in accordance with the specific guidance for that year issued by the Agency. The report uses two main sources of information: (a) SO and IR performance indicator data; and (b) the portfolio review process described earlier. The PMP is a key document in preparing for the report since it contains information on all SO and IR performance indicators, including indicator and data quality assessments, responsibilities for data collection and analysis, and the management utility of each indicator. Agency guidance requires that all indicators meet Agency standards for indicator quality and data quality if data are used to support assertions in the report. These standards are described in ADS 203.3.6.5.



E. ASSESSING DATA QUALITY

Internal USAID standards for data quality have become increasingly rigorous, primarily due to growing scrutiny of USAID resource use and performance results by external reviewers – namely, Congress, OMB, and the public. Poor-quality data poses a two-fold problem: (1) it prevents accurate decision-making by management; and (2) it skews information used for reporting purposes. In order to measure and attribute results accurately – for both reporting and management needs – the Health SO Team must ensure that data meet certain criteria, as outlined in ADS 203 guidance:

- ❖ **Validity:** Data must clearly, directly, and adequately represent the result that it intends to measure. Measurement errors, unrepresentative sampling, and simple transcription errors can negatively impact data validity.
- ❖ **Reliability:** Data must reflect stable, consistent data collection and analysis processes over time. Variations in data collection methods over time can interfere with efforts to judge performance progress accurately. (One test of data reliability is whether a different person can go back to the same raw data set and come up with the same answer as the original researcher.)
- ❖ **Timeliness:** Data must be available with enough frequency and must be sufficiently current so it can inform management decision-making. Infrequently collected, out-of-date information yields little useful information for making decisions. *As a rule of thumb, data should be available quarterly if used for management decisions;* data collected on an annual basis might be helpful for long-term management but is usually not as effective for making shorter-term, operational decisions.
- ❖ **Precision:** Data must be accurate enough to present a fair picture of performance. Normally, data measurements fall into a range (the “margin of error”) around the real value. Two issues related to precision should be given consideration. First, the change being measured (e.g., a 10% increase in revenue) must be greater than the margin of error (e.g., 5%). Second, a +/- 10% accuracy range is generally acceptable, particularly for data drawn from large international data sets.
- ❖ **Integrity:** Mechanisms should be in place to reduce the possibility that data will be manipulated for political or personal reasons. This is admittedly difficult to assess, but it remains an issue to keep in mind when setting up systems to collect and review data.

The minimum requirement is that any data used to support assertions in the Annual Report must meet the Agency’s standards for data quality. Data quality should be assessed initially when indicators are being established and baseline data are collected and re-assessed at least every three years. (ADS 203.3.6.6). Good practice recommends that this be undertaken for *all* indicators so that the SO Team’s confidence in the data increases. The SO1 team reviewed data quality assessment procedures and documented past and planned assessments in the relevant indicator reference sheets.

Data Quality Assessment Procedures: The SO1 Team integrates data quality assessment into ongoing activities (e.g., combines a random check of partner data with a regularly scheduled site visit). This minimizes the costs associated with data quality assessment. When conducting data quality assessments, team members use the Data Quality Checklist as a guide. Findings are written up in a short memo (as part of the trip report form) and filed in the team’s performance management files. If the SO Team determines any data limitations exist for performance indicators (either during initial or periodic assessments), it corrects the limitations to the greatest extent possible. The SO Team documents any actions taken to address data quality problems in the appropriate Performance Indicator Reference Sheet(s). If data limitations prove too intractable and damaging to data quality, the SO Team seeks alternative data sources, or develops alternative indicators.



F. REVIEWING AND UPDATING THE PMP

The PMP serves as a “living” document that the Health SO uses to guide its performance management efforts. As such, it is updated as necessary to reflect changes in strategy and/or activities. PMP implementation is therefore not a one-time occurrence, but rather an ongoing process of review, revision, and re-implementation. The PMP is reviewed and revised at least annually and as necessary. This is done during the Annual Strategy Meeting. When reviewing the PMP, the SO Team considers the following issues:

- ❖ Are the performance indicators working as intended?
- ❖ Are the performance indicators providing the information needed?
- ❖ How can the PMP be improved?

If the SO Team makes major changes to the PMP regarding indicators or data sources, then the rationale for adjustments are documented. For changes in minor PMP elements, such as indicator definition or responsible individual, the PMP is updated to reflect the changes, but without the rationale.



G. OVERALL PERFORMANCE MANAGEMENT TASK SCHEDULE

KEY TO SYMBOLS: "☑" = scheduled task
 "E" = episodic task

PERFORMANCE MANAGEMENT TASKS	Episodic	FY 2002				FY 2003				FY 2004				NOTES
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
COLLECT PERFORMANCE DATA: RESULTS-LEVEL INDICATORS														
SO1: Increased use of FP/MCH & HIV/AIDS preventive measures														
1. Contraceptive Prevalence Rate (CPR)														
2. Couple Years of Protection (CYP)														
3. Percentage of pregnant women who were given 2 doses of presumptive malaria medication (SP) during antenatal visits														
4. Vitamin A supplementation among children aged 6 – 59 months														
5. Condom use at last higher risk sex														
6. Median age at first sex among young men and women														
IR 1: Policy and legal environment improved														
1. Index score of policy and legal environment disaggregated by: a. RCH National, b. RCH district level, c. HIV/AIDS National, d. HIV/AIDS district level														
2. Policy and legal objectives' milestones														
IR 2: Availability of quality services increased														
1. Ratio of service delivery points (SDPs) that meet or surpass a minimum quality score to all SDPs: disaggregated by service														



PERFORMANCE MANAGEMENT TASKS	Episodic	FY 2002				FY 2003				FY 2004				NOTES
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
2. Sentinel stock-outs of selected FP/MCH & HIV/AIDS drugs and commodities														
3. Condoms available at high risk sites														
IR 3: Demand for specific quality services increased														
1. Number of acceptors of long term & permanents FP methods in the last year														
2. Number of first time HIV VCT clients counseled and tested														
3. Number of socially marketed condoms distributed														
4. Risk perception for HIV/AIDS among youth 15- 24 years.														
COLLECT PERFORMANCE DATA: ACTIVITY-LEVEL & CONTEXT INDICATORS														
Gather activity data/partner progress reports														
Gather contextual data	E													Most contextual data will be collected prior to the annual report each year. However, collection of some contextual data might be episodic.
CONDUCT EVALUATIONS & SPECIAL STUDIES														
Demographic and Health Survey														
Sexual behavior survey														
Youth HIV/AIDS Survey														
Female condom social marketing														
District Assessments														
Non-Mandatory Financial Audits														
Mandatory Financial audits														
REVIEW PERFORMANCE INFORMATION														
Partner Activity Progress Review														Informal review of monthly/quarterly



PERFORMANCE MANAGEMENT TASKS	Episodic	FY 2002				FY 2003				FY 2004				NOTES
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
														partner progress reports.
Annual Strategy Meeting														This represents the operational level assessment of the required annual portfolio review
Annual Report Review														This represents the strategic/result level assessment of the required portfolio review.
Country Strategic Plan Review (Washington)														
REPORT PERFORMANCE RESULTS														
Budget Justification														
Annual Report														
ASSESS DATA QUALITY														
Assess quality data	E													Mandatory for indicators used in Annual Report at the start of the activity and at least every three years. Recommended for all.
REVIEW & UPDATE PMP														
Review PMP and update if necessary	E													The PMP is a living document and is reviewed and updated as required. (Strategy Meeting as minimum)



SECTION IV. PERFORMANCE INDICATOR REFERENCE SHEETS

The following section contains detailed Performance Indicator Reference Sheets (IRS) for each **results-level** indicator. If current results-level indicators are refined and/or additional indicators developed, the Health SO Team creates new indicator sheets based on this template. Each reference sheet is fully consistent with the guidance (mandatory and suggested) contained in ADS 200 and provides information on:

- ❖ Indicator definition, unit of measurement, and any data disaggregation requirements;
- ❖ USAID data acquisition method, data sources, timeline for data acquisition, and USAID staff responsible for data acquisition;
- ❖ Plans for data analysis, review, and reporting;
- ❖ Any data quality issues, including any actions taken or planned to address data limitations; and
- ❖ Notes on baselines, targets, and data calculation methods.

A complete table of performance data (baselines, targets, and actuals) for all **results-level** indicators is at the end of the set of IRS.

Note on Baselines and Targets

Indicators that do not yet have a baseline need to be updated as they are defined. At a minimum, targets must be set for 2002 and 2003. The specific indicators requiring action are noted in Section V of this PMP – “Next Steps”.



A. SO 1 RESULTS-LEVEL INDICATORS

Strategic Objective 1:

Increased Use of FP/MCH & HIV/AIDS Preventive Measure

- ❖ *Indicator 1:* Contraceptive Prevalence Rate (CPR)
- ❖ *Indicator 2:* Couple-Years of Protection (CYP)
- ❖ *Indicator 3 :* Percentage of pregnant women who were given 2 doses of presumptive malaria medication (SP) during antenatal visits
- ❖ *Indicator 4:* Vitamin A supplementation among children aged 6 – 59 months
- ❖ *Indicator 5:* Condom use at last higher risk sex
- ❖ *Indicator 6:* Median age at first sex among young people 15-24



**SO1: Increased Use of FP/MCH & HIV/AIDS preventive measures
Contraceptive Prevalence Rate**

Performance Indicator Reference Sheet

Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures

Intermediate Result: N/A

Indicator: Contraceptive Prevalence Rate

DESCRIPTION

Precise Definition(s): Proportion of women of reproductive age (15-49 yrs) who report using (or report partners using) a modern method of contraception (as listed in DHS) at the time of the survey.

Unit of Measure: Percent

Disaggregated by: Age, method, region (as disaggregated by DHS)

Justification/Management Utility: direct measure of a result at the strategic objective level, provides trend data on the use of modern methods of contraception. Used to track the use of family planning services

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: Populations survey

Method of Acquisition by USAID: Official Tanzania Demographic Health Survey report

Data Source(s): Measure DHS+ and National Bureau of Statistics

Frequency/Timing of Data Acquisition: Every 5 years; next one 2003/04

Estimated Cost of Data Acquisition: \$ 1,500,000.00

Responsible Individual(s) at USAID: Amy Cunningham, Vicky Chuwa

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: 1991/92

Known Data Limitations and Significance (if any): DHS surveys are standard worldwide and of good quality.

Actions Taken or Planned to Address Data Limitations: N/A

Date of Future Data Quality Assessments: 2003/04

Procedures for Future Data Quality Assessments: standard with each survey

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: MEASURE DHS+ & National Bureau of Statistics conduct standard analysis of raw data

Presentation of Data: Tables, graphs, charts as per standard DHS reports. Key findings summaries in power point presentations, brochures, posters using appropriate sub-sets of tables, graphs and charts

Review of Data: Initial SO1 team review and analysis with MEASURE and NBS consultants. SO1 team members continuously conduct analysis as needed. Analyzed by participants at national dissemination workshop sponsored by USAID within two months of submission of final report. MEASURE DHS+ summarizes key findings in user-friendly format for analysis by key government, NGO and political stakeholders.

Reporting of Data: Annual report, budget justification, annual strategy meeting presentations, missions strategy/portfolio reviews, and other external USAID presentations

OTHER NOTES

Notes on Baselines/Targets: **Set in 1991/92. Actual was 5.9%; Target 2003 – 20%**

Location of Data Storage: **HPOPUB/PMP database/WORKSHEET 6 - CPR**

Other Notes: **Next DHS scheduled for 2003 or 2004. Estimated cost \$1,500,000.00**

THIS SHEET LAST UPDATED ON: 04 /18/02



**SO1: Increased Use of FP/MCH & HIV/AIDS preventive measures
Couple-Years of Protection (CYP)**

Performance Indicator Reference Sheet

Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures

Intermediate Result: N/A

Indicator: Couple-Years of Protection (CYP)

DESCRIPTION

Precise Definition(s): Couple-Years of Protection (modern methods). Estimated amount of protection against pregnancy provided by family planning services during a one-year period, based on the volume of contraceptives dispensed to clients during that period. CYPs are calculated by multiplying the quantity of each method distributed by a method specific conversion factor, which yields the estimated overall protection (in couple-years) from all methods combined. Conversion factors currently used in USAID system are: Oral Contraceptives 15 cycles per CYP; CU "T" 380-A IUD inserted; Norplant implant 3.5 cycles per implant; condoms – 150 units per CYP; Vaginal foaming tablets – 150 tablets per CYP; sterilization – 10 CYP per sterilization procedure, Depo-Provera (injectible) – 4 "doses" (1ml) per CYP

Unit of Measure: Couple-years of protection (numbers)

Disaggregated by: *method (modern methods) list methods*

Justification/Management Utility: Proxy measure of a result at the strategic objective level, provides trend data on the use of modern methods of contraception. CYP used to track progress only for those years that CPR is not available. Provides useful trend information for years between surveys.

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: RCHS/MOH collect data through routine system (Request & Report forms of the MOH logistics system). Voluntary sector partners collect data from their grantees on a monthly and quarterly basis.

Method of Acquisition by USAID: Quarterly & annual reports submitted to USAID activity manager by partners. Annual partner PMP meeting held where annual indicators submitted and analyzed.

Data Source(s): Program service data and logistics management information systems. RCHS, UMATI and CARE VSHP.

Frequency/Timing of Data Acquisition: Quarterly & annually

Estimated Cost of Data Acquisition: Low cost – part of ongoing data collection efforts of implementing partners

Responsible Individual(s) at USAID: Activity Managers, Michael Mushi & Janis Timberlake

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: RCHS 1998; UMATI 1994; CARE VSHP 2002

Known Data Limitations and Significance (if any): Public sector data unreliable, reporting is low.

Actions Taken or Planned to Address Data Limitations: Limited with what can be done with public sector, but have had to send people to the field to collect reports, which is not sustainable nor cost effective. CYP for public sector reported for national level. Private sector CYP limited to few facilities receiving USAID support.

Date of Future Data Quality Assessments: routine through quarterly and annual reviews, site visits.

Procedures for Future Data Quality Assessments: For public sector data future plans include data validation exercises to calculate margin of error and its effect on final data. Plans are underway to strengthen MOH logistics system through TA from Deliver & JSI. For other ongoing programs, standard data quality assessment procedures through, quarterly, annual reviews, site visits, financial audits.

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: Summarized data from partners analyzed at USAID by activity managers.

Presentation of Data: Tables, graphs, charts showing targets and actuals, as well as disaggregation.

Review of Data: Data submitted to USAID reviewed and analyzed during quarterly and annual reviews

Reporting of Data: Annual report, budget justification, annual strategy meeting presentations, missions strategy/portfolio reviews, and other external USAID presentations

OTHER NOTES

Notes on Baselines/Targets: **baseline 1996 – 671,429; Target for 2002 1,159,790**

Location of Data Storage: **PMP database**

Other Notes: **Targets need to be re-adjusted as have been exceeded**



THIS SHEET LAST UPDATED ON: 04 /18/02



**SO1: Increased Use of FP/MCH & HIV/AIDS preventive measures
Malaria Medication (SP) during antenatal visits**

Performance Indicator Reference Sheet

Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures

Intermediate Result: N/A

Indicator: Percentage of pregnant women who were given 2 doses of presumptive malarial medication (SP) during antenatal visits

DESCRIPTION

Precise Definition(s): The percentage of pregnant women who attend a public/private health facility and are given two doses of presumptive malarial medication using MOH standards. *(In late 2001 MOH through NMCP changed standard treatment guideline for malaria from chloroquine to SP at second and third trimester)*

Unit of Measure: Percent

Disaggregated by: (for availability) by district, public/private, urban/ rural, and for quality by trimester of pregnancy.

Justification/Management Utility: It measures a key preventive RH service for malaria (Intermittent Presumptive Treatment) that is a major cause of maternal morbidity and anemia and mortality and of neonatal morbidity (causes low birth weight, anemia, intrauterine and perinatal mortality).

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: For the public sector the District Assessment Tool can be used as a baseline and could possibly be used for periodic assessments in the two USAID funded regions. The private sector could also use this tool to measure baseline and periodically in their populations. The baseline can be further triangulated with the district level routine/quarterly data reported in the districts of the two MOH regional data collection system reported monthly from facilities. Baseline for the PVO population could use the same method. The RCHS currently provides quarterly reports to USAID: INTRAH could assist to improve quality for monitoring information on a quarterly basis. The PVOs could...

Method of Acquisition by USAID This is a new initiative. Plans to consider: The District assessment tool could be modified and data collected from sentinel sites representative of the regions providing services in the public and private sectors and reported annually. Other tool could be use as sentinel site data collection on an annual basis.

RCHS & INTRAH data collection system will be supported in the quality improvement activities supported by USAID. They currently report quarterly on district and facility level data: that allows quarterly reports on this indicator in the MOH districts. PVOs will report data on this indicator for their regions on a semi annual basis. ?

Data Source(s): The DHS captures these data every 5-6 years. The RCHS routine data collection system can report for monitoring purposes. PVOs will report on their populations.

Frequency/Timing of Data Acquisition: Routine data collection at the district level is collected quarterly on this indicator. RCHS/INTRAH reports of these data could be provided to USAID bi annually. PVOs could develop a separate reporting mechanism for their populations.

Estimated Cost of Data Acquisition: Approximately 5-10 % of project cost. Baseline survey costs for the District Assessment is xxx for the two MOH regions. Baseline for the PVO populations is estimated at xxxx depending on their methodology. Ongoing data collection and reporting costs are estimated at...for the two MOH districts. For the PVO population the estimated costs for data acquisition is...

Responsible Individual(s) at USAID: Project management specialist (Public sector)

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: This is a new activity. Initial quality assessment is currently planned before June 2002 for the District Assessment Tool. This will allow USAID to assure that it includes the Malaria data item in the two MOH regions. If the PVOs use the District Assessment tool, the initial quality assessment will serve for both. If the PVOs use another data collection tool, the quality assessment of their tool will be done separately and will need to be scheduled.

Known Data Limitations and Significance (if any): The District Assessment tool may be appropriate as a broad baseline for quality improvement including the Malaria component. The routine data collection from RCHS/INTRAH will need to be strengthened for quality. If USAID plans to repeat the tool annually or bi- annually the component to measure malaria may not be able to be separated for periodical monitoring purposes. If the PVOs decide to use the same tools, the population may be tool small for it to be appropriate unless used as a baseline for the districts/regions in which they work.



Action Taken or Planned to Address Data Limitations: USAID could plan discussions with RCHS & INTRAH on the current District Assessment tool. Depending on tool and methodology chosen by the PVOs and their population, the discussions can be done

Date of Future Data Quality Assessments: TBD

Procedures for Future Data Quality Assessments: TBD

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: RCHS with support from INTRAH will analyze and report data summaries in quarterly reports to USAID. Currently individual staff at USAID review and analyze summary data. Semi annual meetings for internal IR Team review and use for management decisions is planned.

Data from PVO populations are collected by the NGOs and reported to CARE who summarizes and plans to report? Quarterly... to USAID for their review, analysis and feedback.

Presentation of Data: Data can be presented as bar charts, showing trend lines each year, showing public/private SDP and by urban/rural setting

Review of Data: Data to be reviewed by the SO team. *Joint partner USAID/T as part of program management review*

Reporting of Data: Use USAID annual report, *reported to AID Washington to contribute to Global indicator?*

OTHER NOTES

Notes on Baselines/Targets: **TBD**

Location of Data Storage: **HPOPUB/PMPDATABASE/malaria**

Other Notes:

THIS SHEET LAST UPDATED ON: April 2002



**SO1: Increased Use of FP/MCH & HIV/AIDS preventive measures
Vitamin A supplementation**

Performance Indicator Reference Sheet

Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures

Intermediate Result: N/A

Indicator: Vitamin A supplementation among children aged 6-59 months

DESCRIPTION

Precise Definition(s): Percent of children age 6-59 months receiving two doses of vitamin A supplements in the last 12 months. (*consider number of children*)

Unit of Measure: Percent or number?

Disaggregated by: sex, age, urban/rural, routine/campaign/USAID supported districts

Justification/Management Utility: direct measure of a result at the strategic objective level, provides trend data on number of children supplemented with Vitamin A. Vitamin A is important in reducing child morbidity and mortality, especially deaths related to measles and diarrhea.

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: Population survey and bi-annual national vitamin A campaign days by EPI program of the MOH

Method of Acquisition by USAID: Official Tanzania Demographic Health Survey report and reports from national biannual national vitamin A campaign activities

Data Source(s): Measure *DHS+* and Ministry of Health Expanded Program of Immunization

Frequency/Timing of Data Acquisition: Annually from the MOH/EPI; Survey data once every 5 years,

Estimated Cost of Data Acquisition: Annually for the campaigns \$100,000.00; Next DHS \$1,500,000

Responsible Individual(s) at USAID: Senior Project Management Specialist, Michael Mushi

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: DHS 1991/92, National campaigns EPI 2001

Known Data Limitations and Significance (if any): DHS surveys are standard worldwide and of good quality.

Actions Taken or Planned to Address Data Limitations: N/A

Date of Future Data Quality Assessments: Next DHS 2003/04; Bi annual campaigns - June 2002 & December 2002

Procedures for Future Data Quality Assessments: standard with each survey; spot checks & financial audits

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: MEASURE DHS+ & National Bureau of Statistics conduct standard analysis of raw data; campaign data analyzed by EPI and disseminated at workshops

Presentation of Data: Tables, graphs, charts as per standard DHS reports. Key findings summaries in power point presentations, brochures, posters using appropriate sub-sets of tables, graphs and charts. Bi-annual campaign reports with tables.

Review of Data: Initial SO1 team review and analysis with MEASURE and NBS consultants. SO1 team members continuously conduct analysis as needed. Analyzed by participants at national dissemination workshop sponsored by USAID within two months of submission of final report. MEASURE DHS+ summarizes key findings in user-friendly format for analysis by key government, NGO and political stakeholders. Campaign data reviewed twice a year.

Reporting of Data: Annual report, budget justification, annual strategy meeting presentations, missions strategy/portfolio reviews, and other external USAID presentations.

OTHER NOTES

Notes on Baselines/Targets: **Baseline 2001: 85% (9,931,209 children out of 11,663,913 were supplemented)**

Location of Data Storage: **HPOPUB/PMP database/WORKSHEET 6 – vitamin A**

Other Notes:

THIS SHEET LAST UPDATED ON: 04 /18/02



**SO1: Increased Use of FP/MCH & HIV/AIDS preventive measures
Condom use at last higher risk sex**

Performance Indicator Reference Sheet
<p>Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures Intermediate Result: N/A Indicator: Condom use at last higher risk sex</p>
DESCRIPTION
<p>Precise Definition(s): Percent of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months Unit of Measure: Percent Disaggregated by: Age (15-19), (20-24), 15-49/59, sex, urban/rural Justification/Management Utility: direct measure of a result at the strategic objective level. This indicator tracks changes in condom use with high-risk sex. Informs if behavior change communication campaigns including condoms promotion are having the desired effect. Could eventually include results of voluntary counseling and testing effect on behavior change.</p>
PLAN FOR DATA ACQUISITION BY USAID
<p>Data Collection Method: Populations surveys Method of Acquisition by USAID: Official Tanzania Demographic Health Survey report Data Source(s): Measure DHS+ and National Bureau of Statistics Frequency/Timing of Data Acquisition: Every 5 years; next one 2003/04 Estimated Cost of Data Acquisition: \$1,500,000.00 for DHS; potential for Sexual Behavior Survey - \$200,000? Responsible Individual(s) at USAID: Amy Cunningham; Vicky Chuwa</p>
DATA QUALITY ISSUES
<p>Date of Initial Data Quality Assessment: 1991/92 Known Data Limitations and Significance (if any): DHS surveys are standard worldwide and of good quality. Actions Taken or Planned to Address Data Limitations: N/A Date of Future Data Quality Assessments: DHS 2003/04; potential for Sexual Behavior Survey in 2003? Procedures for Future Data Quality Assessments: standard with each survey</p>
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
<p>Data Analysis: MEASURE DHS+ & National Bureau of Statistics conduct standard analysis of raw data Presentation of Data: Tables, graphs, charts as per standard DHS reports. Key findings summaries in power point presentations, brochures, posters using appropriate sub-sets of tables, graphs and charts Review of Data: Initial SO1 team review and analysis with MEASURE and NBS consultants. SO1 team members continuously conduct analysis as needed. Analyzed by participants at national dissemination workshop sponsored by USAID within two months of submission of final report. MEASURE DHS+ summarizes key findings in user-friendly format for analysis by key government, NGO and political stakeholders. Reporting of Data: Annual report, budget justification, ambassadors presentation, annual strategy meeting presentations, missions strategy/portfolio reviews, and other external presentations</p>
OTHER NOTES
<p>Notes on Baselines/Targets: Baseline set in 1996: Women – 17.2%; Men 34.0 Target 2003: Women 25%; Men 40% Location of Data Storage: HPOPUB/PMP database/worksheet 6/condom use Other Notes: Next DHS scheduled for 2003 or 2004, estimated cost \$1,500,000.00</p>
<p>THIS SHEET LAST UPDATED ON: 04 /16/02</p>



**SO1: Increased Use of FP/MCH & HIV/AIDS preventive measures
Median age at first sex among young people 15-24**

Performance Indicator Reference Sheet
<p>Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures Intermediate Result: N/A Indicator: Median age at first sex among young men and women</p>
DESCRIPTION
<p>Precise Definition(s): The age by which one half of young men and young women aged 15-24 have had penetrative sex (median age), of all young people (15-24) surveyed. Unit of Measure: Median age at first sex Disaggregated by: Age and sex (as disaggregated by DHS). Justification/Management Utility: Direct measure of a result at the strategic objective level, provides trend data on delay of first sex (abstinence) among youth and effectiveness of BCC programming. SO1 is investing heavily in behavior change communications activities along with other partners and in support of TACAIDS – to effect change in youth sexual behavior. In particular, BCC targets youth for delay of first sex in addition to condom use. USAID SO1 is also supporting the distribution of condoms through social marketing. SO1 also supports numerous non-governmental organizations in five regions, many of which have components of behavior change communication for youth.</p>
PLAN FOR DATA ACQUISITION BY USAID
<p>Data Collection Method: Population based surveys, youth behavioral surveillance surveys, and smaller youth survey in 2002. Method of Acquisition by USAID: Official Tanzania Demographic Health Surveys, interim surveys, other as above Data Source(s): Measure DHS+ and National Bureau of Statistics Frequency/Timing of Data Acquisition: Every 5 years; next one 2003/04. Possibility of interim sexual behavior survey in 2002/3 and likely BCC youth survey in 2002. Estimated Cost of Data Acquisition: (\$200,000) Responsible Individual(s) at USAID: Amy Cunningham, Communication and Project Management Specialist</p>
DATA QUALITY ISSUES
<p>Date of Initial Data Quality Assessment: 1999 with DHS Known Data Limitations and Significance (if any): Data limitations identified for each survey (check with NBS) Actions Taken or Planned to Address Data Limitations: Check with NBS Date of Future Data Quality Assessments: 2003/04 or sooner if sexual behavior survey carried out. Procedures for Future Data Quality Assessments: standard with each survey</p>
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
<p>Data Analysis: MEASURE DHS+ & National Bureau of Statistics conduct standard analysis of raw data Presentation of Data: Tables, graphs, charts as per standard DHS reports. Key findings summaries in power point presentations, brochures, posters using appropriate sub-sets of tables, graphs and charts Review of Data: Initial SO1 team review and analysis with MEASURE and NBS consultants. SO1 team members continuously conduct analysis as needed. Analyzed by participants at national dissemination workshop sponsored by USAID within two months of submission of final report. MEASURE DHS+ summarizes key findings in user friendly for analysis by key stakeholders at various annual regional, zonal and district meetings conducted by RCHS and potentially TACAIDS. Reporting of Data: Annual report, budget justification, annual strategy meeting presentations, missions strategy/portfolio reviews, and other external presentations</p>
OTHER NOTES
<p>Notes on Baselines/Targets: In 1999, median age at first sex is 16.6 years for girls and 17.9 for boys. No targets set as yet. Location of Data Storage: PMP database Other Notes: Next DHS scheduled for 2003 or 2004 with an interim sexual behavior survey contemplated 2002/3. Data will also be presented as and percentage of who had first intercourse by exact age.</p>



THIS SHEET LAST UPDATED ON: 04 /18/02



B. IR 1 RESULTS-LEVEL INDICATORS

Intermediate Result 1:

Policy and Legal Environment Improved

1. Index Score of policy and legal environment disaggregated by:
 - a. RCH National
 - b. RCH district level
 - c. HIV/AIDS National
 - d. HIV/AIDS district level

2. Policy and legal objectives milestones



**IR1 Policy & Legal Environment Improved
Index Score of policy & legal environment**

Performance Indicator Reference Sheet

Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures

Intermediate Result: Policy and legal environment improved

Indicator: Index score of policy and legal environment

DESCRIPTION

Precise Definition(s): The index used at national level will be an adaptation for Tanzania of Policy's AIDS Program Effort Index, with indicators under seven components including political support, policy formulation, legal and regulatory framework, organizational structures, program resources, program components and program monitoring, evaluation and research. Indicators within each heading are rated by respondents using a Likert scale. USAID/Tanzania and Policy will modify this index to collect information at district levels. USAID will work with Policy and its Tanzania-based consultants to adapt the national index and create the district level index.

Unit of Measure: Numerical score, Qualitative narrative

Disaggregated by: scores obtained from national and district-level respondents; and scores obtained for RCH and HIV/AIDS sectors.

Justification/Management Utility: First, the index score will be used to measure overall changes in the policy and legal environment for RCH and HIV/AIDS. Secondly, by breaking indicators down in to 7 distinct headings, it allows USAID to track progress in specific areas and identify where its investments are either needed, or most likely to effect change. Thirdly, the data collection methodology and locations will inform the milestone agenda in indicator 2. In addition, the index data can be used in policy dialogue with stakeholders.

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: Individual and group interviews with key informants using the same instrument for each of the four disaggregations.

Method of Acquisition by USAID: Bi-annual reports including index scores and brief narrative analysis to be submitted to USAID by CA Policy II project.

Data Source(s): Policy II project staff and consultants.

Frequency/Timing of Data Acquisition: Every two years to be received no later than December 15.

Estimated Cost of Data Acquisition: (Chuck Pill to provide budget)

Responsible Individual(s) at USAID: Lisbeth Loughran, health sector advisor

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: 2001 (report not in final form yet; most recent draft report is dated 6/2001)

Known Data Limitations and Significance (if any): Assessment found API difficult to use. There were validity issues; data source issues (selection of key informants); and imprecise (index scores alone do not tell the story).

Actions Taken or Planned to Address Data Limitations: Validation and adaptation of instrument for use in Tanzania at the national level and development of instrument for use at district level; USAID will require approval of procedures and criteria for selecting key informants; and analysis will include both scores and narrative.

Date of Future Data Quality Assessments: 6/2004.

Procedures for Future Data Quality Assessments: Formal and informal consultations to check that respondents are still considered key informants; rapid assessment to confirm continued validity of the tool through focus group discussions.

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: (Chuck Pill: define); analysis will be conducted by staff and consultants of Policy II project; data analysis should be completed by November 15 for December 15 submission of report to USAID.

Presentation of Data: Disaggregated scores by headings for each of the four sets of different respondents; and showing trend over time. Narrative should explain the scores and highlight any relationship between scores and milestones achieved in the policy arena; identify issues for consideration as additions to policy objectives in indicator 2; and describe variance from prior year scores.

Review of Data: annually as part of SO1 team's annual portfolio review for internal review; through inclusion of policy as agenda item in regularly scheduled quarterly reviews with relevant implementing partners at national and district levels.



Reporting of Data: Internal Democracy and Governance (SO3) reports will feature data from this indicator. It might support the annual report.

OTHER NOTES

Notes on Baselines/Targets: **Because the June 2001 assessment recommended validating and adapting the current instrument, a new baseline will be established in October/November 2002. (Targets: ask Chuck Pill)**

Location of Data Storage: **PMP database**

Other Notes:

THIS SHEET LAST UPDATED ON: 04/ 16 /02



IR 1: Policy & Legal Environment Improved
 Policy & Legal Environment milestones passed

Performance Indicator Reference Sheet
<p>Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures Intermediate Result: Policy and legal environment improved Indicator: Policy and legal environment objectives' milestones passed.</p>
DESCRIPTION
<p>Precise Definition(s): Policy objectives support achievement of stakeholder and implementing partner results. They are defined through internal and stakeholder consultations in annual strategy meeting and information from indicator 1. SO1 team and health sector advisor defines milestones for each objective. Objective measures to indicate milestone achievement will be identified for each milestone. Unit of Measure: Completion of categories of milestones Disaggregated by: Policy objective Justification/Management Utility: Use of milestones to track progress on individual policies allows USAID to focus on specific issues to improve the policy and legal environment for achievement of USAID SO1 results. Given the long-term nature of policy change activities in Tanzania, use of milestones allows USAID to periodically assess its strategy to achieve specific policy and legal objectives and revise its approach (milestones).</p>
PLAN FOR DATA ACQUISITION BY USAID
<p>Data Collection Method: reports on events that served as triggers to demonstrate that milestones were passed by health sector advisor in SO team meetings; reports by Democracy and Governance (SO3) at monthly joint SO1/SO3 team meeting. Method of Acquisition by USAID: periodic reports from health sector advisor Data Source(s): Defined by different triggers (i.e., media for gazetted items, personal communications, development partner for a) Frequency/Timing of Data Acquisition: Data will be received as it occurs. Estimated Cost of Data Acquisition: Included in health sector advisor costs. Responsible Individual(s) at USAID: Health sector advisor.</p>
DATA QUALITY ISSUES
<p>Date of Initial Data Quality Assessment: (Check Shirley) Known Data Limitations and Significance (if any): Reliance on personal communications presents significant risk of bias. Actions Taken or Planned to Address Data Limitations: Triangulation with other data sources. Date of Future Data Quality Assessments: Continuous Procedures for Future Data Quality Assessments: Data quality assessment for policy milestones is built into SO1 management process by crosschecking information with other team and other SO members.</p>
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
<p>Data Analysis: Health sector advisor will judge relative progress against prospective timetable, using CA resources as needed for additional investigation of the problems and redefinition of milestones. Presentation of Data: Narrative and graphic (timelines) presentation actual milestones passed compared to projected disaggregated by selected policy. Review of Data: annually as part of SO1 team's annual portfolio review for internal review; through inclusion of policy as agenda item in regularly scheduled quarterly reviews with relevant implementing partners at national and district levels. Reporting of Data: Internal Democracy and Governance (SO3) reports will feature data from this indicator. It might support the annual report.</p>
OTHER NOTES



Notes on Baselines/Targets: **Baselines and targets to be established (Chuck Pill & Liz)**

Location of Data Storage: **PMP database**

Other Notes:

THIS SHEET LAST UPDATED ON: 04 /16 /02



C. IR 2 RESULTS LEVEL INDICATORS

Intermediate Result 2:

Availability of quality services increased

1. Ratio of service delivery points (SDPs) that meet or surpass a minimum quality score of all SDPs:
Disaggregated by service:
 - a. Long term and permanent family planning methods
 - b. Voluntary counseling & testing
 - c. Selected RCH services
2. Sentinel sites without stock outs of selected FP/MCH/ and HIV/AIDS drugs and commodities in the last 12 months.
3. Condoms available at high risk sites



IR2: Availability of quality services increased

Ratio of LT/P P methods SDPs that meet or surpass the minimum quality score out of all LT/P FP SDPs.

Performance Indicator Reference Sheet

Strategic Objective: Increased use of FP/MCH & HIV/AIDS preventive measures

Intermediate Result: Availability of quality services increased

Indicator: Ratio of service delivery points (SDPs) that meet or surpass a minimum quality score to all SDPs - LT/P FP

DESCRIPTION

Precise Definition(s): Ratio of LT/P FP service delivery points that meet or surpass a minimum quality score (of 70%) out of all LT/P service sites.

Unit of Measure: Proportion of LT/P service site.

Disaggregated by: *public /private, rural /urban*

Justification/Management Utility: Ratio will be used to measure change in the number /availability of service delivery points that meet established standards compared to the total national "universe" to be reached. Measuring quality using established standards allows all providers to improve quality and allows program managers to target low performing sites.

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: UMATI and the MOH will use the already developed LTFP Quality Assessment Tool working to cover all eligible LT FP services at the site.

Method of Acquisition by USAID: Quarterly reports UMATI currently reports on all LT FP program sites. Starting FY 2002 MOH will report on public sector sites (universe of 138) and UMATI will continue to report on private sector sites. (universe 12).

Data source: UMATI and MOH reports working with Engender Health, annual reports

Frequency/Timing of Data Acquisition: Quarterly reports by UMATI & MOH & annual reports

Estimated Cost of Data Acquisition: Ten percent of program costs

Responsible Individual(s) at USAID: Michael Mushi

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: During 2000 meeting with UMATI with TA from Engender Health.

Known Data Limitations and Significance (if any): N/A

Actions Taken or Planned to Address Data Limitations: Data still do not capture numbers to be served with this service. Demand projections have been requested to be done by May 30th, 2002.

Date of Future Data Quality Assessments: Before July 2002, the data quality assessment will be done of the tool and the process of data collection because the responsibility for data collection will now be done by the MOH and UMATI. The initial Engender Health tool was a global tool adapted for use in Tanzania by UMATI. Now the tool and the process of data collection will need to be assessed for quality and appropriateness to be used by the MOH.

Procedures for Future Data Quality Assessments: A Memo of Understanding between Engender and MOH will be developed to clarify roles and responsibilities for the program. This will be followed by discussions on the process for assessing the quality of the tool and process for data collection in the future by the MOH and UMATI.

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: UMATI currently collects all raw data and analyze it. Summary reports are provided to USAID quarterly.

Presentation of Data: Tables , graphs, bar charts and other charts are used to present the data to the MOH, other donors, USAID Washington, and others.

Review of Data: the Program Officer will do activity level reviews with implementing partners Engender Health , UMATI and MOH. The data are shared in house in the public sector part of the SO team. Currently there is not a mechanism for sharing in the portfolio review. Next year the SO team will review these data as part of the Portfolio review.

Reporting of Data: presentations of the data in briefings will be presented as part of briefing to Cooperating agencies, other donors and other government officials including US ambassador. These data will also be used as part of the presentation of data to influence the policy dialogue and to influence the Policy Index under IR1.



OTHER NOTES

Notes on Baselines/Targets: Baseline: **1998 - 98 SDPs**; Target: **2003 – 120 SDPs**

Location of Data Storage:

Other Notes: **Baseline set by MOH, UMATI & Engender Health**

THIS SHEET LAST UPDATED ON: 04/18 /02



IR2: Availability of quality services increased

Ratio of quality VCT sites that meet or surpass the minimum quality score out of all targeted VCT sites

Performance Indicator Reference Sheet
<p>Strategic Objective: Increased Use of FP/MCH & HIV/AIDS Preventive Measures</p> <p>Intermediate Result: IR2. Availability of Quality Services Increased</p> <p>Indicator: Ratio of service delivery points (SDPs) that meet or surpass a minimum quality score to all SDPs – HIV VCT</p>
DESCRIPTION
<p>Precise Definition(s): SDPs are 15 targeted sites under SO1 Quality VCT expansion program. Program will define a set of quality standards and translate them into an assessment tool. Quality services are those services provided by those sites that attain a minimum quality score or above using the tool. Those that pass the score compared to all targeted sites provide the ratio.</p> <p>Unit of Measure: ratio</p> <p>Disaggregated by: public/private/stand alone, regions.</p> <p>Justification/Management Utility: This is a direct measure of the results of the quality VCT expansion program. It additionally allows comparison between quality achievement in both public, private and stand-alone sites. Disaggregation by region will allow tracking of access by regions covered and numbers of sites needed by regions in response to demand. (as measured by IR3).</p>
PLAN FOR DATA ACQUISITION BY USAID
<p>Data Collection Method: Annual assessment of targets sites against the quality assessment tool</p> <p>Method of Acquisition by USAID</p> <p>Data Source(s): AMREF Annual Reports</p> <p>Frequency/Timing of Data Acquisition: Annual (March)</p> <p>Estimated Cost of Data Acquisition: (check)</p> <p>Responsible Individual(s) at USAID: Project Management Specialist</p>
DATA QUALITY ISSUES
<p>Date of Initial Data Quality Assessment: 2002</p> <p>Known Data Limitations and Significance (if any): This is a new tool and may go through a process refinement to ensure its reliability.</p> <p>Actions Taken or Planned to Address Data Limitations: Try tool with three implementers and compare results for reliability.</p> <p>Date of Future Data Quality Assessments: Tool developed by June 2002. Baseline in initial X sites by November.</p> <p>Procedures for Future Data Quality Assessments: See actions taken above and will apply reliability validation by January 2003</p>
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
<p>Data Analysis: Comparisons among disaggregated data will provide significant information where to focus program interventions to ensure quality services. Comparisons with projected targets will also provide information on effectiveness and availability of quality services. Comparison with demand data will allow targeting of resources for expansion.</p> <p>Presentation of Data: Ratio changes over time in graph format tacking numerator against the target.</p> <p>Review of Data: Quarterly and Annual reviews with program. Prior to USAID annual reporting.</p> <p>Reporting of Data: Annual report assuming included in results reporting</p>
OTHER NOTES
<p>Notes on Baselines/Targets: Baseline and targets will be set in November. (Janis & AMREF).</p> <p>Location of Data Storage: PMP database hpopub/pmpdatabase</p> <p>Other Notes:</p>
THIS SHEET LAST UPDATED ON: 04 /16/02



**IR2: Availability of quality services increased
Sentinel stock-outs of drugs and commodities.**

Performance Indicator Reference Sheet
<p>Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures</p> <p>Intermediate Result: Availability of quality services improved</p> <p>Indicator: Sentinel stock-outs of selected FP/MCH & HIV/AIDS drugs and commodities</p>
DESCRIPTION
<p>Precise Definition(s): Ratio of sentinel sites with a zero balance of selected FP/MCH/ and HIV/AIDS drugs and commodities from representative SDP in the USAID focus areas. SDP will be public or private in urban and rural areas <i>essential commodities are: currently defined as vitamin A, Sulfadoxine Pyramethamine (SP), ORS, ARI/IMCI antibiotics, and all FP supplies (depo provera etc), AND STI drugs/Syphilis test reagents? OR stock out precise definition in consultation with MOH and DELIVER.</i></p> <p>Unit of Measure: Ratio or percent of service delivery point?</p> <p>Disaggregated by: public/private, by commodity, by urban and rural</p> <p>Justification/Management Utility: Provides single best measure of availability of essential stocks to provide quality preventative service. Triangulates with the routine commodity logistics management system. Allows management decisions on modifying resource allocation, systems improvement, <i>donor coordination, and discussions with partners.</i></p>
PLAN FOR DATA ACQUISITION BY USAID
<p>Data Collection Method: annual survey by PSU/MSD/RCHS with DELIVER at representatively selected sites in USAID supported districts and triangulate with the ongoing logistics management system that measures stocks only at national level. The second data collection method will be the quarterly reporting of the current RCHS/DELIVER report and requisition (RR) tracking system.(currently tracks FP commodities and will have to add other essential HIV/AIDS commodities)</p> <p>Method of Acquisition by USAID: RCHS with DELIVER survey data reports with analysis annually from representative SDP. RCHS DELIVER quarterly reports summarized data to USAID. For private sector will report....??</p> <p>Data Source(s): RCHS & DELIVER for both the annual survey and for the routine data reporting. CARE for its NGOs service delivery points? UMATI</p> <p>Frequency/Timing of Data Acquisition: Annually for survey data during the last three months of the calendar year. Quarterly for routine RCHS data. L</p> <p>Estimated Cost of Data Acquisition: RCHS/DELIVER current survey costs \$30,000 per year. Additional commodity items will not significantly increase the cost. Routine data collection for last year was \$ 88,900 that is 8.5% of the total budget support to RCHS. Data collection for the PVOs has not been defined.</p> <p>Responsible Individual(s) at USAID: Project management specialist (Public sector)</p>
DATA QUALITY ISSUES
<p>Date of Initial Data Quality Assessment: The PSU/MOH with DELIVER survey quality assessment was done Targets. The MOH does quality assessment of tools used for data collection May 2000, MOH & Deliver conducted a baseline for commodity availability to assess the distribution system from district to service delivery points. The annual tool has been used for more than three years. Both of these tools were reviewed by the MOH using with TA from DELIVER of the MOH to assure its quality. The routine data collection system is assessed by the RCHS with DELIVER and it the future.</p> <p>Location of Data Storage: USAID</p> <p>Other Notes:</p> <p>Known Data Limitations and Significance (if any): Not all service delivery points report out (80% do report). Data quality previously under RCHS was estimated at 90% for the monitored commodities (FP) with the intensive TA for Deliver. Adding more essential commodities and transferring this task to the integrated commodities monitoring systems of the PSU and will require quality control to continue for the next year intensively assure the data quality does not decline. Routine data systems in PSU MOH require periodic training of staff, ongoing quality of data checks and other quality controls</p> <p>Data collection and quality control by PVOs will be developed??</p>



Actions Taken or Planned to Address Data Limitations: DELIVER will be requested to provide additional TA to support the expanded and now integrated into PSU and the tracking of additional commodities committed by the Government of Japan. They are expected to arrive in the last quarter of 2002.

Date of Future Data Quality Assessments: TBD

Procedures for Future Data Quality Assessments: TBD

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: Data summarized and analyzed by MOH PSU with JSI/DELIVER TA and other partners from the annual survey and reported to USAID in the last quarter of the calendar year. The routine data are collected, analyzed and reported to USAID by PSU/MOH with DELIVER on a quarterly basis.

PVO logistics systems support to NGOs and to the districts within their population has not yet been defined. In surveys should be submitted to USAID. USAID SO Team will compile from all partners? Semi annually?

Presentation of Data: Data can be presented as bar charts, showing trend lines each year, showing public/private SDP and whether in urban/rural setting

Review of Data: Stock outs reviewed by team then with Partners: action for management response defined. Partner implements action USAID and reports at next semi annual meeting.

Reporting of Data: Use USAID annual report

OTHER NOTES

Notes on Baselines/Targets the **MOH does quality assessment of tools used for data collection May 2000, MOH & Deliver conducted a baseline for commodity availability to assess the distribution system from district to service delivery points. The annual tool has been used for more than three years. Both of these tools were reviewed by the MOH using with TA from DELIVER of the MOH to assure its quality. The routine data collection system is assessed by the RCHS with DELIVER and it the future.**

If private sector funds to channels essential commodities to increase availability of health services, a baseline will be needed? Baseline for condom stock outs in the CSM and quality measurement of the tool and process?

Location of Data Storage: **USAID**

Other Notes:

THIS SHEET LAST UPDATED ON: 16/04/2002



IR2: Availability of quality services increased
Condoms available at high-risk sites.

Performance Indicator Reference Sheet
<p>Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures Intermediate Result: IR2: Availability of quality services increased Indicator: Condoms available at high risk sites in the last 12 months</p>
DESCRIPTION
<p>Precise Definition(s): Proportion of high-risk sites (bars and guesthouses) in selected areas that stock condoms (either social marketing, public sector or commercial). Unit of Measure: Ratio of selected bars/guesthouses that stock condoms to the total B/G in selected areas. Disaggregated by: Bar, guesthouse, or combined site; region/area Justification/Management Utility: Direct measure of result to improve availability of a quality service. Provides an indication of about increased use of prevention for HIV at known high risk and high transmission sites.</p>
PLAN FOR DATA ACQUISITION BY USAID
<p>Data Collection Method: MEASURE Evaluation/WHO/PSI Compiled Condom Availability and Quality Protocol or PSI retail either by itself or in combination with PSI Tanzania annual retail survey. Method of Acquisition by USAID: Annual report from PSI Tanzania or special report from DELIVER Project. Data Source(s): Research International/PSI Tanzania or DELIVER project. Frequency/Timing of Data Acquisition: Annually Estimated Cost of Data Acquisition: if PSI annual retail survey, built into existing collaborating agency structure. If DELIVER Project implements, costs will come from field support – estimate USD \$15,000. Responsible Individual(s) at USAID: Amy Cunningham, Communication Technical Advisor</p>
DATA QUALITY ISSUES
<p>Date of Initial Data Quality Assessment: 2002 Known Data Limitations and Significance (if any): Multiple data sources with different protocol for collection. Actions Taken or Planned to Address Data Limitations: Data analysis to take this into consideration Date of Future Data Quality Assessments: 2003/04 Procedures for Future Data Quality Assessments: cross check with quarterly and annual sales and bar and guesthouse coverage data.</p>
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
<p>Data Analysis: PSI Tanzania with Research International OR DELIVER Project will compile and analyze raw data Presentation of Data: Tables depicting percent coverage of the disaggregated and aggregated data. Review of Data: The retail survey will be initially reviewed by SO1 team and PSI Tanzania and/or DELIVER project. SO1 team members analyze MIS programmatic data quarterly through the quarterly review process. Reporting of Data: Annual report, budget justification, ambassador’s presentation, annual strategy meeting presentations, mission’s strategy/portfolio reviews, and other internal and external presentations</p>
OTHER NOTES
<p>Notes on Baselines/Targets: PSI Tanzania and SO1 will set target for 2002 and 2003 by May 2002. Location of Data Storage: PSI/Tanzania and PMP database Other Notes: Although there is no regulation for bars and guesthouses to stock condoms, making condoms available at locations closest to where high-risk sex takes place, is seen to increase the proportion of protected sex acts. There must clearly be an effort to encourage bar and guesthouse managers to stock condoms (either for sale, as part of the entire guesthouse price, or for free). PSI is implementing a massive blitz/sales program in 4 regions.</p>
<p>THIS SHEET LAST UPDATED ON: 04 /16/02</p>



D. IR 2 RESULTS LEVEL INDICATORS

Intermediate Result 3:

IR3: Demand for specific services increased

1. Number of acceptors of long term and permanent FP methods in the last year
2. Number of first time VCT clients counseled & tested
3. Number of socially marketed condoms distributed
4. Risk perception for HIV/AIDS among youth



IR3: Demand of specific quality services increased
 Number of acceptors of LT/P FP methods

Performance Indicator Reference Sheet
<p>Strategic Objective: Increase use of FP/MCH & HIV/AIDS preventive measures. Intermediate Result: Demand for specific quality services increased. Indicator: Number of acceptors of LT/P FP methods in the last year.</p>
DESCRIPTION
<p>Precise Definition(s): An acceptor of LT/P FP method is anybody who uses Norplant, or they have undergone male or female surgical contraception. A long term and permanent family planning method is one of the following, Norplant, Vasectomy and female tubal ligation. The last year is the period from January 1 to December 31 ?? Unit of Measure: Cumulative Numbers Disaggregated by: By method, age, urban and rural Justification/Management Utility: This will allow us to measure effectiveness of demand creation and the actual use of these methods. The numbers assist the program managers to identify and address variance in demand between and among sites.</p>
PLAN FOR DATA ACQUISITION BY USAID
<p>Data Collection Method: Clinic register , which records actual procedure by method. Method of Acquisition by USAID: UMATI quarterly reports, annual PMP report. From July 2002 MOH will also be sending reports on the public sector sites to USAID. Data Source(s): UMATI and MOH Frequency/Timing of Data Acquisition:; Quarterly and annual. Estimated Cost of Data Acquisition: It is between 5-8% of the total budget. Responsible Individual(s) at USAID: Michael Mushi.</p>
DATA QUALITY ISSUES
<p>Date of Initial Data Quality Assessment: 1998 Known Data Limitations and Significance (if any): NA Actions Taken or Planned to Address Data Limitations: NA Date of Future Data Quality Assessments: June 2002 Procedures for Future Data Quality Assessments: Field data check up which is done twice per year. Check report data against registers, supply inventory against performed procedures and checking the registers for internal consistency.</p>
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
<p>Data Analysis: UMATI analyses data against targets, justification for supply needs and panning for out reach services. We use it for resource planning and general program management. Presentation of Data: Graphs, bar charts, tables.</p> <p>Review of Data: Quarterly update with SO1, Engender Health ,UMATI, RCHS and MOH in a joint meeting. Reporting of Data: Quarterly and annual reports, budget justification, annual strategy meetings and other external presentations.</p>
OTHER NOTES
<p>Notes on Baselines/Targets: 1993 the baseline was zero. 2002 target = 84,924? Location of Data Storage: PMP database Other Notes:</p>
<p>THIS SHEET LAST UPDATED ON: 04 /17/02</p>



**IR3: Demand for specific quality services increased
Number of first time VCT clients counseled and tested**

Performance Indicator Reference Sheet

Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures

Intermediate Result: Demand for specific quality services increased

Indicator: Number of first time VCT clients counseled and tested (and receiving results)

DESCRIPTION

Precise Definition(s): First time VCT clients means the first visit to any one of the 15 VCT SDPs funded by SO1 whereby the client has participated in both pre and post test counseling and was tested. A subsequent visit to a different VCT site within the 15 identified VCT SDPs would also be considered a first visit.

Unit of Measure: Number

Disaggregated by: Age, sex, region, quality vs. Non quality site (vis-à-vis IR2), first time & subsequent visits

Justification/Management Utility: This will allow measurement of effectiveness of demand creation and actual use of VCT SDPs. There is equally the ability to assess the need for increased VCT SDPs if demand exceeds quality standard capacity as defined in IR2-VCT.

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: Client card as registered by receptionist at the end of visit where both pre and posttest counseling and actual test has been documented.

Method of Acquisition by USAID: Quarterly reports/reviews from Amref

Data Source(s): AMREF

Frequency/Timing of Data Acquisition: Quarterly

Estimated Cost of Data Acquisition: (check)

Responsible Individual(s) at USAID: Project Management Specialist

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: Quarterly field visits to selected SDPs

Known Data Limitations and Significance (if any): None

Actions Taken or Planned to Address Data Limitations: N/A

Date of Future Data Quality Assessments: On going

Procedures for Future Data Quality Assessments: see above

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: AMREF M&E section analyze raw data on an on-going monthly basis

Presentation of Data: Bar graphs with disaggregations over time to show trends. Cross tabs will be presented as tables.

Review of Data: Quarterly update with SO1, prior to annual reporting, with key partners, government and policy stakeholders.

Reporting of Data: Annual report, external presentations

OTHER NOTES

Notes on Baselines/Targets: **2001 - 9,396; Targets need to be set**

Location of Data Storage: **PMP database**

Other Notes: **Baseline begins with 9,396 due to AMREF taking over a SDP previously funded by another USAID supported partner.**

THIS SHEET LAST UPDATED ON: 04 /16/02



**IR3: Demand for specific quality services increased
Number of socially marketed condoms distributed**

Performance Indicator Reference Sheet

Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures

Intermediate Result: Demand for quality services increased

Indicator: Number of socially marketed condoms distributed in the last 12 months

DESCRIPTION

Precise Definition(s): Total number of condoms distributed in the last 12 months. Socially marketed condoms are sold rather than distributed freely. Distributed means sold to institutions (NGOs, CBOs, etc.) or private sector suppliers.

Unit of Measure: Number

Disaggregated by: regional and institutional sales vs. private sector suppliers, monthly & quarterly.

Justification/Management Utility: direct measure of a result to increase access to and demand for a key HIV prevention measure through nationwide social marketing. Research has shown that condoms sold are more likely to be used than condoms made available for free by certain populations.

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: Sales information.

Method of Acquisition by USAID: Quarterly reports and annual reports from PSI/Tanzania

Data Source(s): Population Services International Tanzania

Frequency/Timing of Data Acquisition: quarterly and annually

Estimated Cost of Data Acquisition: (check) no additional cost; part of cooperative agreement

Responsible Individual(s) at USAID: Amy Cunningham, Communication Technical Advisor

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: 1997

Known Data Limitations and Significance (if any): n/a

Actions Taken or Planned to Address Data Limitations: n/a

Date of Future Data Quality Assessments: 2003/4

Procedures for Future Data Quality Assessments: review of cooperating agency data collection procedures, review of methodology and reporting.

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: PSI Tanzania processing the data and generates reports, tables and graphs.

Presentation of Data: Tables and graphs depicting overall national coverage and regional variation, disaggregated by sales to NGOs vs. sales to wholesalers.

Review of Data: USAID/Tanzania SO1 reviews data jointly with PSI/Tanzania and within the mission through the annual reporting process.

Reporting of Data: Annual report, budget justification, ambassadors presentation, annual strategy meeting presentations, missions strategy/portfolio reviews, and other external presentations

OTHER NOTES

Notes on Baselines/Targets: **Targets were set in 1997 at 14 million. Actual was 11 million. Target for 2001 was 19,300,000 (actual sales/distribution exceeded the target at 20,177,856 sold/distributed). Target for 2002 & 2003 TBD by USAID & PSI by**

Location of Data Storage: **PSI Tanzania and USAID/Tanzania SO1 PMP database**

Other Notes:

THIS SHEET LAST UPDATED ON: 04 /18/02



**IR3: Demand for specific quality services increased
Risk perception for HIV/AIDS among youth**

Performance Indicator Reference Sheet
<p>Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures Intermediate Result: IR3 Demand for quality services increased Indicator: Risk perception for HIV/AIDS among youth.</p>
DESCRIPTION
<p>Precise Definition(s): Proportion of youth (15-24 yrs) who report that they are at risk for HIV infection of all youth surveyed. Unit of Measure: Percent Disaggregated by: Age, sex, sexually active, region/area and degree of risk (great, moderate, small, none). For pop based survey as disaggregated by DHS. Justification/Management Utility: intermediate measure of a result at both the SO level (median age at first sex and condom use at last higher risk sex) and directly contributes to increased demand for quality services. Based on BCC theory and research, where youth feel personally at risk for HIV, they will be more likely to take the next steps to change their behavior; either delaying first sex or using a condom every time they have sex. Only 5% of youth in Tanzania say they are at great risk for HIV, despite the fact that over 50% practice unprotected sex.</p>
PLAN FOR DATA ACQUISITION BY USAID
<p>Data Collection Method: Population surveys and smaller surveys as needed (PSI.CARE, ISHI). Method of Acquisition by USAID: Official Tanzania Demographic Health Survey report and smaller surveys Data Source(s): Measure DHS+ and National Bureau of Statistics and others for smaller surveys as necessary. Frequency/Timing of Data Acquisition: Every 5 years; next one 2003/04. A smaller survey is planned in 2002 to be carried out by PSI Tanzania and JHUCCP. Estimated Cost of Data Acquisition: up to USD 50K for a smaller survey and as part of the regular DHS. Responsible Individual(s) at USAID: Amy Cunningham, Technical Advisor Communication and Project Management Specialist</p>
DATA QUALITY ISSUES
<p>Date of Initial Data Quality Assessment: planned 2002 for small survey. Known Data Limitations and Significance (if any): Data limitations identified for each survey. Multiple data sources with different data collection protocols. Actions Taken or Planned to Address Data Limitations: address with NBS/MEASURE DHS+ and others Date of Future Data Quality Assessments: 2003/04 Procedures for Future Data Quality Assessments: standard with each population based survey. Data will also be crosschecked with reports from exit interviews of community events, focus group discussions and any qualitative research carried out as part of programs.</p>
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
<p>Data Analysis: For population based survey, MEASURE DHS+ & National Bureau of Statistics conduct standard analysis of raw data. For smaller surveys, designated partner will conduct analysis. Presentation of Data: Tables, graphs, charts possible as per standard DHS reports. Key findings summaries in power point presentations and written report. Possibility of producing brochures, posters using appropriate sub-sets of tables, graphs and charts. Review of Data: Initial SO1 team review and analysis with survey implementers. SO1 team members conduct or delegate further analysis as needed. Information is also shared with local partners in government and non-governmental organizations (e.g. in the case of the national BCC activity, "ISHI" partners would be central in reviewing data). Reporting of Data: Annual report, budget justification, ambassador's presentation, annual strategy meeting presentations, mission strategy/portfolio reviews, and other internal and external presentations</p>
OTHER NOTES



Notes on Baselines/Targets: **Baseline for youth expressing great risk for HIV/AIDS in 1999 was 5%.**

Location of Data Storage: **PMP database**

Other Notes: **Next DHS scheduled for 2003 or 2004; smaller survey in 2002.**

THIS SHEET LAST UPDATED ON: 04 /16/02



E. ACTIVITY-LEVEL INDICATORS

Activity level indicators are contained in the agreements and/or work plans agreed between the Health SO Team and each of its partners. The purpose of these indicators is mainly to monitor operational progress on a relatively frequent basis. Depending on the activity, this is either monthly or quarterly. The agreements/agreements for each activity should be consulted for more detail on the specific indicators for each activity.

F. CONTEXT INDICATORS

In addition to results-level and activity-level measures, several context indicators were identified in the PMP development process. These indicators provide information on reality above the level of the SO in the country at large. Included here are some indicators that Global Bureau is collecting worldwide. The context indicators identified to date are as follows:

Level	CORRESPONDING CONTEXT INDICATORS
National Health Statistics	CDC/GOT Epidemiological data on HIV/AIDS
Regional Study	AMMP Mortality and Morbidity
Global Program Level	Wild polio, etc.
	<i>Jerry to clarify whether conduit of all and any data from any source or USAID funded only by April 30.</i>
	<i>Vicky pre-select from Global list those easy to do as conduit by May 3</i>



SECTION IV: G. SO1 Performance Data Table

Indicator		Year					
		Base	02	03	04	05	06
SO 1: Increased use ...	Target	91/92		20.0			
	Actual	5.9					
1. CPR	Target	1996	1,159.8				
	Actual	671.4					
2. CYP (000's)	Target	TBD	TBD				
	Actual	TBD					
3. % pregnant women malaria medication	Target	2001	TBD				
	Actual	9.9/85					
4. # and % children 2 doses Vitamin A (000,000's) / %	Target	1996	25				
	Actual	17.2					
5. % condom use risky sex - Female	Target	1996	40.0				
	Actual	34.0					
Male	Target	1999	TBD				
	Actual	16.6					
6. Median age at first sex among young men and women - Women	Target	1999	TBD				
	Actual	17.9					
Men	Target	2002	TBD				
	Actual	TBD					
IR1: Policy	Target	2002	TBD				
	Actual	TBD					
1. Index score –Total (Average of a,b,c,d)	Target	2002	TBD				
	Actual	TBD					
a. RCH National	Target	2002	TBD				
	Actual	TBD					
b. RCH District	Target	2002	TBD				
	Actual	TBD					
c. HIV/AIDS National	Target	2002	TBD				
	Actual	TBD					
d. HIV/AIDS District	Target	2002	TBD				
	Actual	TBD					
2. Objectives' milestones	Target	TBD	TBD				
	Actual	TBD					
IR2: Availability	Target	TBD	TBD				
	Actual	TBD					
1. Ratio of quality SDP/total SDP (Sum a,b,c)	Target	1999	120/150				
	Actual	98/98					
a. LTP/FP	Target	2002	TBD				
	Actual	TBD					
c. VCT	Target	TBD	TBD				
	Actual	TBD					
d. Selected RCH services	Target	TBD	TBD				
	Actual	TBD					
2. Sentinel stock-outs Drugs and commodities	Target	TBD	TBD				
	Actual	TBD					
3. Condoms in bars/guest houses	Target	2002	TBD				
	Actual	TBD					



Indicator		Year					
		Base	02	03	04	05	06
IR3: Demand 1. # acceptors of LTP/FP (000's)	Target	1993	84.9				
	Actual	0					
Female	Target	1993	?				
	Actual	0					
Male	Target	1993	?				
	Actual	0					
2. # VCT clients (000's)	Target	2001	TBD				
	Actual	9.4					
Female	Target	2001	TBD				
	Actual	?					
Male	Target	2001	TBD				
	Actual	?					
3. # socially marketed condoms distributed (000,000's)	Target	1997	TBD				
	Actual	11.0					
3. Risk perception HIV/AIDS youth 15 – 21 (%)	Target	1999	TBD				
	Actual	5.0					

SECTION V. NEXT STEPS

NEXT STEPS	RESPONSIBILITY	COMPLETE BY:
General: Data quality assessment form designed and included in trip report form	Vicky/Amy	May 25
General: SO 1 and partners set targets for 2002, 2003 or document plan to do it by "x" deadline. Document plan in IRS	Indicator Captains	May 30
SO 1 Indicator 3: Check to see that % pregnant women 2 doses malaria medication (SP) is in Ministry Quality Assessment tool. Check that SP is in the standards for quality	Patrick/Michael	May 25
SO 1 Indicator 3: Consult with DHS on inclusion of question on this indicator	Amy	May 25
SO 1 Indicator 3: Consult with CARE on tracking this indicator	Janis	April 30
SO1 Indicator 4: Get information from EPI on vitamin A	Michael/Patrick	May 5
SO1 Indicator 4: Review District Quality monitoring tool for this indicator	Patrick/Michael	May 25
SO1 Indicator 4: Define the universe	SO 1- John	May 25
SO1 Indicator 4: Consult with CARE on tracking this indicator	Janis	April 30
SO1 Indicator 4: Check age categories with DHS. Clarify how median age defined	Amy	May 25
IR1 Policy Indicator 1: Decide whether National and District Scores are comparable (can be averaged into composite score)	Liz	May 25
IR1 Policy Indicator 2: Consider grouping milestones into stages of "life" of the objective: Initial, Formative, Achievement	Liz	May 25



NEXT STEPS	RESPONSIBILITY	COMPLETE BY:
Availability Indicator 1: Create another IRS that represents the composite score of a, b., and c. (sum of numerators to sum of denominators)	Vicky	May 25
Availability Indicator 1c: Create an IRS for 1. c - Research	Michael/Patrick	May 22 - 25
Availability Indicator 1c: Create an IRS for 1. c – Clarify/decide	SO1 Patrick (lead) Michael, Janis, John	May 29
Availability Indicator 2: Create precise definition of stock-outs w/ PSU, MOH and Deliver	Patrick	April 25
Availability Indicator 2: Get Deliver input on final list of drugs/ commodities and on the universe, frequency of audit.	Patrick	April 25
Availability Indicator 3: Decide among 3 options for data collection: PSI annual, PSI tag on to retail survey, Deliver Cost?	Amy	April 25
Demand Indicator 1: Are IUDs in or out – Check w/ MOH and send Jeff Spieler and email	Michael	April 25
Demand Indicator 2: Define the “bingo”: received results vs. tested or walk-ins disaggregated by counseled, tested, received results, 1 st , repeat	Janis	May 8
Demand Indicator 4: What is data collection method? Clarify real options	Amy	May 8



SECTION VI. ANNEXES

ANNEX I. MODIFICATIONS TO FY2003 INDICATORS

(For a more complete discussion of each indicator included in the PMP, see the Performance Indicator Reference Sheets in Section IV.)

INDICATOR FOR FY2002	SUBSTANTIAL CHANGES TO INDICATOR?	NEW FY2003 INDICATOR	REASON FOR MODIFICATION
SO1: Percentage of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabitating partner in the last 12 months	NO	SO1: Condom use at last higher risk sex	More easily communicated and understood. Precise Definition is technically the same.
SO1: Percentage of pregnant women receiving one dose of tetanus toxoid vaccine during antenatal visits	YES Dropped		Tetanus toxoid dosages have become standard practice, no longer reflect USAID investment, and the risk of tetanus infection greatly reduced.
SO1: Percentage of pregnant women who were given malaria medication during antenatal clinic visits	NO	SO1: Percentage of pregnant women who were given 2 doses of presumptive malaria medication (SP) during antenatal visits	This is essentially the same indicator but more directly measures what was intended to measure. Two doses are specified as that is the technical requirement to be effective. The preferred treatment (SP) is specified. "Presumptive" added to indicate standard practice whether indicated by symptoms or not. The word "clinic" was dropped to capture antenatal visits of pregnant women outside of clinics.
.SO1: Exclusive breastfeeding for infants under 6 months	YES Dropped	SO1: Vitamin A supplementation among children aged 6 – 59 months	Vitamin A supplementation is a more direct measure of present USAID investment in Child Health
	NEW	SO1: Median age at first sex among young people.	USAID increased investment in Behavior Change Communication with a focus on youth intends to create behavior change in the form of delayed sexual debut. Indicator will measure impact.



INDICATOR FOR FY2002	SUBSTANTIAL CHANGES TO INDICATOR?	NEW FY2003 INDICATOR	REASON FOR MODIFICATION
<p>IR1: Index of political support for RCH and HIV/AIDS at national level and within selected districts</p> <p>IR1: Index of policies and plans for RCH and HIV/AIDS AIDS at national level and within selected districts</p> <p>IR1: Index of RCH and HIV/AIDS national program, organization, management, and monitoring and evaluation.</p>	<p>NO</p>	<p>IR1: Index score of policy and legal environment disaggregated by: a. RCH national, b. RCH district level, c. HIV/AIDS National, d. HIV/AIDS district level</p>	<p>Restatement of the 3 indicators in more operational terms as one indicator, disaggregated. The categories of the instrument to poll key informants includes the categories of information identified by the 3 previous indicators.</p>
	<p>NEW</p>	<p>IR1: Policy and legal objectives' milestones</p>	<p>The additional indicator makes prior practice more formal and focused. SO1 has always pursued specific policy and legal objectives and this indicator will add discipline to the art and documentation of results. Creation of the objectives in collaboration with stakeholders increases synergy among the three IRs.</p>
<p>IR2: % of service delivery points providing long-term and permanent family planning methods that meet or surpass the minimum quality score</p> <p>IR2: Percentage of targeted HIV voluntary counseling & testing sites that meet the quality certification standard</p>	<p>YES</p>	<p>IR2: Ratio of service delivery points (SDPs) that meet or surpass a minimum quality score to all SDPs, disaggregated by service: a. LT/P FP b. HIV/VCT, c. Selected RCH services</p>	<p>Two indicators combined into a standard indicator to measure quality service annually and show proportion of those targeted services that achieve the quality standard. The ratio gives an indication of availability of quality services. Selected RCH services are added under the same standard of measurement. Each service will measure quality by its appropriate standards.</p>



INDICATOR FOR FY2002	SUBSTANTIAL CHANGES TO INDICATOR?	NEW FY2003 INDICATOR	REASON FOR MODIFICATION
IR2: Percentage of eligible facilities offering post abortion care with MVA	YES Dropped	See above	The indicator is absorbed by the quality standards to be applied to Selected RCH services and measured by the indicator above.
<p>IR2: Number of service delivery point participating in antenatal care performance improvement program</p> <p>IR: Number of district engaged in the quality recognition program</p> <p>IR2: Percentage of service delivery points with at least 1 trained FP/RH provider</p>	YES Dropped	See above	These three were proxy measures for what will now be measured directly at the point of service delivery by the indicator above
	NEW	IR2: Sentinel stock-outs of selected FP/MCH & HIV/AIDS drugs and commodities	Availability of quality services has been compromised in the past by shortages of essential drugs and commodities. USAID is investing heavily in a reliable distribution system and needs to track the extent to which it works, plus identify bottlenecks for improving the distribution system.
	NEW	IR2: Condoms available at high risk sites	Risky sex (multiple partners) correlates with increased HIV infection rates. In Tanzania there is a known set bars and guesthouses that facilitate multiple partners. Increasing condom use in such facilities may have an impact on infection rates. USAID will monitor availability of condoms to begin to test the hypothesis
IR3: Percentage of pregnant women making 4 visits for antenatal care	YES Dropped		The percentage of pregnant women making at least 2 antenatal care visits is captured at the SO level.
	NEW	IR3: Risk perception for HIV/AIDS among youth.	Data collected for this indicator will begin to test the hypothesis that increased perception will lead to demand and increased use of preventive measures.



ANNEX II - DATA QUALITY CHECKLIST

The SO Team will use the following checklist to assess the quality of performance data, specifically in terms of validity, reliability, timeliness, precision, and integrity:

CRITERIA CATEGORY	CHECKLIST QUESTIONS FOR DATA QUALITY ASSESSMENT	COMMENTS
VALIDITY	<p>Check for Face Validity:</p> <ul style="list-style-type: none"> ❖ Is there a solid, logical relation between the activity or program and what is being measured, or are there significant uncontrollable factors? 	
	<p>Check for Measurement Error:</p> <p><i>Sampling Error (only applies when the data source is a survey):</i></p> <ul style="list-style-type: none"> ❖ Were samples representative? ❖ Were the questions in the survey/questionnaire clear, direct, easy to understand? ❖ If the instrument was self-reporting were adequate instructions provided? ❖ Were response rates sufficiently large? ❖ Has non-response rate been followed up? <p><i>Non Sampling Error:</i></p> <ul style="list-style-type: none"> ❖ Is the data collection instrument well designed? ❖ Were there incentives for respondents to give incomplete or untruthful information? ❖ Are definitions for data to be collected operationally precise? ❖ Are enumerators well trained? How were they trained? Were they insiders or outsiders? Was there any quality control in the selection process? ❖ Were there efforts to reduce the potential for personal bias by enumerators? 	
	<p>Check for Transcription Error:</p> <ul style="list-style-type: none"> ❖ What is the data transcription process? Is there potential for error? ❖ Are steps being taken to limit transcription error? (e.g., double keying of data for large surveys, electronic edit checking program to clean data, random checks of data entered by supervisors for partner data) ❖ Have data errors been tracked to their original source and mistakes corrected? <p><i>If raw data must be manipulated to produce data required for the indicator, then:</i></p> <ul style="list-style-type: none"> ❖ Are the correct formulae being applied? ❖ Are the same formulae applied consistently from year to year, site to site, data source to data source (if data from multiple sources need to be aggregated)? ❖ Have procedures for dealing with missing data been correctly applied? ❖ Are final numbers reported accurate (e.g., does a number reported as a "total" actually add up)? 	



CRITERIA CATEGORY	CHECKLIST QUESTIONS FOR DATA QUALITY ASSESSMENT	COMMENTS
VALIDITY (cont'd)	<p><i>Check for Representativeness of Data:</i></p> <ul style="list-style-type: none"> ❖ Is the sample from which the data are drawn representative of the population served by the activity? ❖ Did all units of the population have an equal chance of being selected for the sample? ❖ Is the sampling frame (i.e., the list of units in the target population) up to date? Comprehensive? Mutually exclusive (for geographic frames)? ❖ Is the sample of adequate size? ❖ Are the data complete (i.e., have all data points been recorded)? 	
	<p><i>Check for Consistency in Processes:</i></p> <ul style="list-style-type: none"> ❖ Is a consistent data collection process used from year to year, location to location, data source to data source (if data come from different sources)? ❖ Is the same instrument used to collect data from year to year, location to location? If data come from different sources are the instruments similar enough that the reliability of the data are not compromised? ❖ Is the same sampling method used from year to year, location to location, data source to data source? 	
RELIABILITY	<p><i>Check for Internal Quality Controls:</i></p> <ul style="list-style-type: none"> ❖ Are there procedures to ensure that data are free of significant error and that bias is not introduced? ❖ Are there procedures in place for periodic review of data collection, maintenance, and processing? ❖ Do these procedures provide for periodic sampling and quality assessment of data? 	
	<p><i>Check for Transparency:</i></p> <ul style="list-style-type: none"> ❖ Are data collection, cleaning, analysis, reporting, and quality assessment procedures documented in writing? ❖ Are data problems at each level reported to the next level? ❖ Are data quality problems clearly described in final reports? 	
TIMELINESS	<p><i>Check for Frequency of Collection:</i></p> <ul style="list-style-type: none"> ❖ Are data available on a frequent enough basis to inform program management decisions? ❖ Is a regularized schedule of data collection in place to meet program management needs? 	
	<p><i>Check for Currency of Data:</i></p> <ul style="list-style-type: none"> ❖ Are the data reported in a given timeframe the most current practically available? ❖ Are data from within the policy period of interest? (i.e., are data from a point in time after intervention has begun?) ❖ Are the data reported as soon as possible after collection? ❖ Is the date of collection clearly identified in the report? 	



CRITERIA CATEGORY	CHECKLIST QUESTIONS FOR DATA QUALITY ASSESSMENT	COMMENTS
PRECISION	<ul style="list-style-type: none"> ❖ Is the margin of error less than the expected change being measured? ❖ Is the margin of error acceptable given the likely management decisions to be affected? (consider the consequences of the program or policy decisions based on the data) ❖ Have targets been set for the acceptable margin of error? ❖ Has the margin of error been reported along with the data? ❖ Would an increase in the degree of accuracy be more costly than the increased value of the information? 	
INTEGRITY	<ul style="list-style-type: none"> ❖ Are mechanisms in place to reduce the possibility that data are manipulated for political or personal reasons? ❖ Is there objectivity and independence in key data collection, management, and assessment procedures? ❖ Has there been independent review? ❖ If data is from a secondary source, is USAID management confident in the credibility of the data? 	

ADDITIONAL RESOURCES

When the SO Team begins the process of assessing data quality, it can use the following USAID and U.S. Government resources for additional help:

- ❖ ADS 203, "Assessing and Learning";
- ❖ TIPS No. 12, "Guidelines for Indicator and Data Quality";
- ❖ GAO, "Performance Plans: Selected Approaches for Verification and Validation of Agency Performance Information"; and
- ❖ GAO, "The Results Act: An Evaluator's Guide to Assessing Agency Annual Performance Plans".



ANNEX III. INDIVIDUALS / ORGANIZATIONS Represented in Workshop

USAID/Tanzania STAFF

Rob Cunnane SO Team Leader	Lizbeth Loughran Policy	Michael Mushi Public Sector	Patrick Swai Public Sector	Amy Cunningham Social Marketing/ BCC
	Vicky Chua M& E/ Census	Janis Timberlake Private/NGO Sector	Pat Rader Program Office	

USAID PARTNERS

Reproductive and Child Health

Cyprian Mpemba
Elizabeth Mapella

CARE VSHP

Michelle Kouletio
Dr. Kangi
Hawa Mshana

Policy Project

Dr. Kimambo – TPHA
Dr. Simbakalia - HealthScope

AMREF VCT

Dr. Anne Kisesa
Dulle Robert

PSI

Consonata Nyashaly
Deo K. Ng'wanansahi

CAs

Grace Lusiiola – Engender Health
Peggy Chibuye – INTRAH
Lawrence Gikaru - JHU

National Institute of Medical Research

Dr. Mbuji
Dr. Leonard Mboera
UMATI
Dr. Kiwele
Mr. John Simbamwaka

Behavior Change Communication

Dr. Justin Kimambo
Taj Liundi
Peter Riwa

Africare/Tanzania

Vanessa Williams
Tatu Mtambalike
Asha Aboud

Tanzania Public Health Association

Dr. Adeline I. Kimambo



ANNEX IV. SCOPE OF WORK