

**AN ASSESSMENT OF FAMILY PLANNING PROGRAM DATA
QUALITY:
A CASE OF TARIME DISTRICT**

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QUALITY:
A CASE OF TARIME DISTRICT**

**By
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**An Evaluation Submitted to the School of Public Administration and Management
(SOPAM) in Partial/Fulfilment of Requirements for Awards of the Degree of
Master's of Health Monitoring and Evaluation of Mzumbe University**

2018

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled "*An assessment of family planning program data quality*" in partial/fulfilment of the requirements for award of the degree of Master's of Health Monitoring and Evaluation of Mzumbe University.

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DEAN SCHOOL OF PUBLIC ADMINISTRATION AND MANAGEMENT

DECLARATION

I, **Magetta S. Sufian**, I declare that this report is my own original work and that it has not been presented to any other learning Institution/University for similar or any other Academic Award.

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DEDICATION

This work is a dedication to my family, especially my beloved wife Bertha Saimony Msanzya for creating a conducive environment and sensible advice during my field study, our Children Maria, Irene, Steven, Evalyne, Jacklyne and Terezia for their cheerful contribution and calmness during the entire period of my research period, may God bless you.

LIST OF ABBREVIATION

RMNCAH	Reproductive maternal newborn child and adolescent health
AIDS	Acquired immune deficiency syndrome
CPR	Contraceptive prevalence rate
DHIS	District Health Information system
ECA	Economic Commission for Africa
FP	Family planning
HSSP	Health sector strategic plan
HIV	Human Immune Virus
MOHSW	Ministry of Health and social welfare
NBS	National bureau of statistic
NFPGST	National Family planning Guideline standard in Tanzania
STI	Sexual Transmitted Infections
NFPRAT	National family planning Research Association in Tanzania
NFPCIP	National family planning coasted Implementation plan
UNFPA	United Nations Fund for population Activities
UNDES	United Nations Department of Economic and social
WHO	World Health Organization
UMATI	Family Planning Association of Tanzania
SSA	Sub Saharan Africa
SDG	Sustainable Development Goals
ICPD	International Conference on Population and Development
DQA	Data quality assessment
QIT	Quality improvement team
CPAC	Comprehensive post abortion care

ABSTRACT

BACKGROUND

Family planning encompasses the accessibility of services, policies, information, attitudes, practices and commodities, that gives women, men, couples, and adolescents the ability to avoid unintended pregnancy and choose whether and or when to have a child and the preferable number of children. It is a cross-sectoral intervention that can hasten progress across the sustainable development goals (Starbird, 2016). Inadequate information and poor data quality on family planning intervention program seems to affect contraceptives uptake records across different level of response. Investing on family planning program data quality assessment can bridge up the gap between the observed differences.

OBJECTIVES

The aim of this evaluation study was to determine the tools used by health care providers in recording and reporting family planning data at facility levels, to assess how data collected at different levels with different organisation have similarities, and exploring how different organizations assess family planning data quality collected at different levels.

METHODS

The study was conducted at Tarime District in the DMO's office, 19 health facilities, RMO's office and Program's office. Qualitative research design was used in this study, purposive sampling methods applied, the researcher used both primary and secondary data through questionnaires and documentary review respectively, and lastly data analysed by excel and Atlas.ti software.

RESULTS

Family planning data recording and data reporting tools was available in all public health facilities visited, however, there were data disparity between health facility and district level, as well as District and Regional office. Though data similarities were observed between District office and program office. Data quality assessment was not

done in the health facilities for almost 90% but seems to be done at the District and in the Regional levels in collaboration with partners.

CONCLUSION

The findings concluding that Family planning program use MTUHA book no 8 which consist of three books namely registers, tally sheet and summary report books as a data recording and data reporting tools in the health facilities, despite that tools are available but still the quality of data remained doubtful due to data disparities observed in the documentary review across different level of response. Family planning data quality assessment is only performed at the District and in the Region level but rarely and improperly conducted at facility levels due to some observed challenges like inadequate knowledge for FP DQA, lack of skilled team, lack of standardized data quality assessment tools, mistrust of data collectors at different levels, data manipulation to fulfil donors requirements, parallel reporting and report overburden at the health facilities.

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OPERATIONAL DEFINITION

Family planning according to Wikipedia Dictionary defined as "educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved, family planning may involve consideration of the number of children a woman wishes to have, including the choice to have no children, as well as the age at which she wishes to have them.

Program Evaluation

Is the application of social science research procedures to judge and improve the ways in which social policies and programs are conducted, from the earliest stages of defining and designing programs through their development and implementation (Rossi and Freeman, 1993).

Conceptual framework

Is the basis for identifying appropriate program indicators and specifying the pathways by which program inputs produce program outputs and ultimately changes in the behaviours of the target population, it is a causal- effects chain, A conceptual framework describing the linkages between family planning program components and fertility change and health impacts in a target population (Bertrand et al, 1996).

Quality assessment is the measurement of the quality of healthcare services. A quality assessment measures the difference between expected and actual performance to identify opportunities for improvement. Performance standards can be established for most dimensions of quality, such as technical competence, effectiveness, efficiency, safety, and coverage. Where standards are established, a quality assessment measures the level of compliance with standards. For dimensions of quality where standards are more difficult to identify, such as continuity of care or accessibility, a quality assessment describes the current level of performance with the objective of improving it.

Data quality assessment

Is the determination of accuracy, reliability, completeness, uniqueness, consistency, precision and validity of the data for the organization (Bruce, 2014).

Contraceptive prevalence

Percentage of all couples of childbearing age between 15-49 who are currently using any method of modern contraception for the purpose of preventing unwanted pregnancy.

CHAPTER ONE

INTRODUCTION

1.1 Background Information

Family planning encompasses the accessibility of services, policies, information, attitudes, practices, and commodities, including contraceptives, that give women, men, couples, and adolescents the ability to avoid unintended pregnancy and choose whether and/or when to have a child, family planning is a cross-sectoral intervention that can hasten progress across the 5 sustainable development goals (5SDG) themes of People, Planet, Prosperity, Peace, and Partnership (Starbird, 2016), It is a decision made by both men and women in relation or one of them on when to have a child and the number of children they are wishes in their life time.

In 2012 London family planning summit World leaders were committed to reach at least 120 million modern contraceptive users in year 2020 to a slogan called FP2020. Relevant stakeholders reviewed the progress that was made in the past 20 years following the International Conference on Population and Development (ICPD) following post 2015 MDG's agenda.

They all promised to contribute more funds as initiatives to make great changes on family planning globally. Some civil society organizations expressed concerns that the numeric goal of reaching 120 million new contraceptive users could signal a threat from the human rights-centred approach that underscored the 1994 ICPD.

Achieving the goal of reaching millions of women and men worldwide with voluntary family planning services that respect and protect human rights will take concerted and coordinated efforts among diverse stakeholders over the next decade and beyond. It will also take a new programmatic approach that has the support of both the public health and human rights communities. The principle of voluntarism has been a long-standing cornerstone of international support for family planning, and the need to respect, protect, and fulfill an expanded list of reproductive rights has been articulated, particularly since the 1994 ICPD (Hardee et al, 2013).

Over the past 50 years, fertility has declined in most developing countries but remains high in much of sub-Saharan Africa, averaging 5.2 children per woman in her lifetime. While recent empirical evidence has indicated an increase in contraceptive and family-planning knowledge in Sub-Saharan Africa, the actual use still remains suboptimal with little effect on total fertility rates, several factors contribute to this high fertility rate, such as poverty, low education, and high child mortality, geographical differences, inadequate supply of family planning commodities, lack of political will, shortage of health staff and cultural aspects. Family planning advocates link high fertility to harming women's health and limiting their ability to work, and thus limiting their ability to contribute to household income and national economic development. However, specific evidence on how family planning affects economic growth in Africa and other developing countries has been lacking (Longwe-ngwira, 2014).

Tanzania is among the Sub-Saharan countries that for a long time made several changes in the health policy and programmes with intention to regulate rapid increase in population through family planning services in the component of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH).

The provision of these services is reflected in various Tanzanian government documents such as, the Tanzania Development Vision (2025), Health Sector Strategic Plan III (2009-2015), National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania-One Plan (2008 – 2015), and Family Planning Costed Implementation Plan (2010-2015). However, the total demand for family planning among currently married women age 15-49 in Tanzania has increased significantly over time, rising from 38% in 1991-92 to 61% in 2015-16. Met need for family planning has also increased significantly over the same period, most of the need has been met with modern methods, rising from 7% in 1991-92 to 32% in 2015-16. The factors contributed to the rise of contraceptive uptake in the Country includes decentralization of the family planning services to the lower levels, high supply of commodities based on demand creation, engaging community and other stakeholders, Partnership between private sectors and FBO's (PPP), capacity building to the health care providers, health education, community sensitization and political will, however, the

Government of Tanzania through Ministry of Health made an effort to ensure that 99% of women of child bearing age have knowledge on family planning purposely to control rapid population growth (TDHS, 2016).

Currently National target for family planning (modern contraceptives) is 60%, contraceptive users differed significantly across different geographical location of the regions. Lindi Region scored the highest (98.8 %) of modern contraceptive uptakes, Dar es Salaam Region scored the lowest percentage of modern contraceptives users (16.7 %), however, among 25 regions, only 5 regions scored above the national target modern contraceptive use, the rest 20 regions lagged behind the national target including Mara region which scored (35.2%) (DHIS2, 2016)

Improving family planning services is very essential in reducing pregnancy-related risks. Scale-up in this regard requires policy implementation and political commitment and addressing traditional norms and cultural malpractices, multilateral involvement, along with an improvement of commodity supply at the health facility level and capacity building to improve accessibility and quality services (MoHCDGEC, 2016).

1.2 Description of the Program Evaluated

Project Background



The U.S. Agency for International Development’s Bureau for Global Health’s flagship Maternal and Child Survival Program (MCSP) focuses on 25 high-priority countries with the ultimate goal of preventing child and maternal deaths. MCSP introducing and supporting high-impact, sustainable reproductive, maternal, newborn and child health (RMNCH) interventions in partnership with Ministries of Health and other partners. In addition to contributing to high-level technical and policy dialogue at the global level, MCSP provides tailored technical assistance to help countries meet specific priorities and contextual needs of local, sustainable RMNCH programs.

USAID launched its flagship on Maternal and Child Survival Program (MCSP) in Tanzania particularly in Mara and Kagera Regions to address reproductive, maternal, newborn and child health (RMNCH). The project Led by Jhpiego in collaboration with consortium of partners (USAID & CDC) focused to scale up key interventions for reducing maternal and newborn mortality.

The project aims to support the MoHCDGEC to implement and scale up key interventions purposely to reducing maternal and newborn mortality. The objectives of the program was to improve the environment for RMNCH services through technical leadership and coordination, to strengthen key health systems to deliver quality RMNCH services and strengthen the involvement of civil society, support institutions in RMNCH and improve uptake of innovations. MCSP expected to work nationally with the MOHSW on technical areas of maternal and newborn health, immunization, pre-service education, health information systems, management and coordination. Best practices demonstrated and documented in Kagera and Mara Regions—two Regions with the

poorest MNCH indicators—and modelled for scale-up throughout the country. Over three years, MCSP planned to increase access and coverage of high-quality health services for pregnant women and their children in Mara and Kagera Region.

At the Regional and District level, the GOT in collaboration with its implementing partner Jhpiego focused on expanding coverage of the community linkage interventions that have the greatest impact to the community saved in those geographic areas with the worst RMNCH indicators. By supporting Regional (RHMT) and District Health Management Teams (CHMT) and Local Government Authorities (LGA) in the decision-making and implementation of RMNCH services. The project focused to strengthen a sustainable system for delivering essential interventions to every mother, newborn and child (www.jhpiego.org).

1.2.1 Tarime District

1.2.2 Demographic information

Tarime District is one of the 7 Districts and among 9 Councils in Mara Region with a total population of 339,693 people, 163,052 males, 176,641 females, WCBA 84,923 and growth rate of 2.2 per year (2012 census). Meanwhile the CPR is 28% (DHIS2, 2016).

Jhpiego at Tarime District, launched a three years program (2014-2016) Maternal and Child Survival Program (MCSP) aiming to strengthen a sustainable system for delivering essential interventions to every mother and newborn to accelerate the reduction of maternal death from 30/100,000 to 10/100,000 live births, newborn and child deaths by focusing on high impact, evidence-based interventions through:- Increased Family Planning utilization, Increased Immunization coverage, Early Antenatal booking and attendances, Pre-service education, improved Health Information System, Improved knowledge to the health care providers.

1.2.3 Project Goals

The goal is a statement with purpose, usually general and abstract, of a desired state toward which a program is directed, a goal may be stated in terms of the activities of an

entire agency, or it can be specific to a particular intervention ((Rossi and Freeman, 1993).

- The project aims to support the MoHCDGEC and other stakeholders to implement and scale up sustainable key interventions to improve maternal and newborn health.
- At the Regional and District level, the Local Government in collaboration with its implementing partner Jhpiego focused on expanding coverage of the interventions that have greatest impact on lives saved in those geographic areas with the worst RMNCH indicators.

1.2.4 Expected Program Effects

Program outcomes are the set of results expected to occur at the population level due to program activities and the generation of program outputs (Rossi, 1993).

The MCSP project expected to improve reproductive, maternal and child health services at all levels of response in (RMNCH) indicators and the following results were intended to occur; Increased Contraceptive Prevalence rates, reduce fertility rate, improved Health Information System, improved knowledge of the health care providers, reduction in maternal and child mortality rates and improved quality of health care services.

1.2.5 Program Major Strategies

Strategies is a high-level plan to achieve one or more goals under conditions of uncertainty (<https://en.wikipedia.org/wiki/Strategy>)

In order to improve the environment for RMNCH services the following strategies were used by the JHPIEGO in MCSP program as follows:

Capacity building to CHMT members and health care providers through training, mentoring, coaching and supportive supervision, technical assistance and support, involvement of civil society and Community engagements, program integration and accountability, gender programming and institutions support, quality improvement and Behaviour Change Communication (BCC) with related groups. Strengthen key health systems to deliver quality RMNCH services, construction and rehabilitation of

CEMONC centres at Muriba and Nyarwana HC' Distribution of medical equipments and products, curriculum review, provision of national guidelines, SOP's manual and health policy books.

1.2.6 Program Activities

MCSP program constitutes several activities towards improving reproductive, maternal and child health (RMNCH) at Tarime such as: Training of the Health care providers on post partum family planning counselling and IUCD insertion (PPFP), Advocacy and community sensitization. Construction and rehabilitation of CEMONC centres at Nyarwana and Muriba HC's, mentorship and on job training, joint supportive supervision, data quality assessment, sharing and feedback meetings, printing of register/forms to capture number of pregnant mothers and under-five children, identification of the health providers who were supported in upgrading their surgical skills, assisted in creation and impose by laws which protected health of pregnant mothers and under five children within the locality, and provision/distribution of guidelines/SOP's manual/BCC, Provision of commodities, medical equipments and supplies.

1.2.7 Program resources

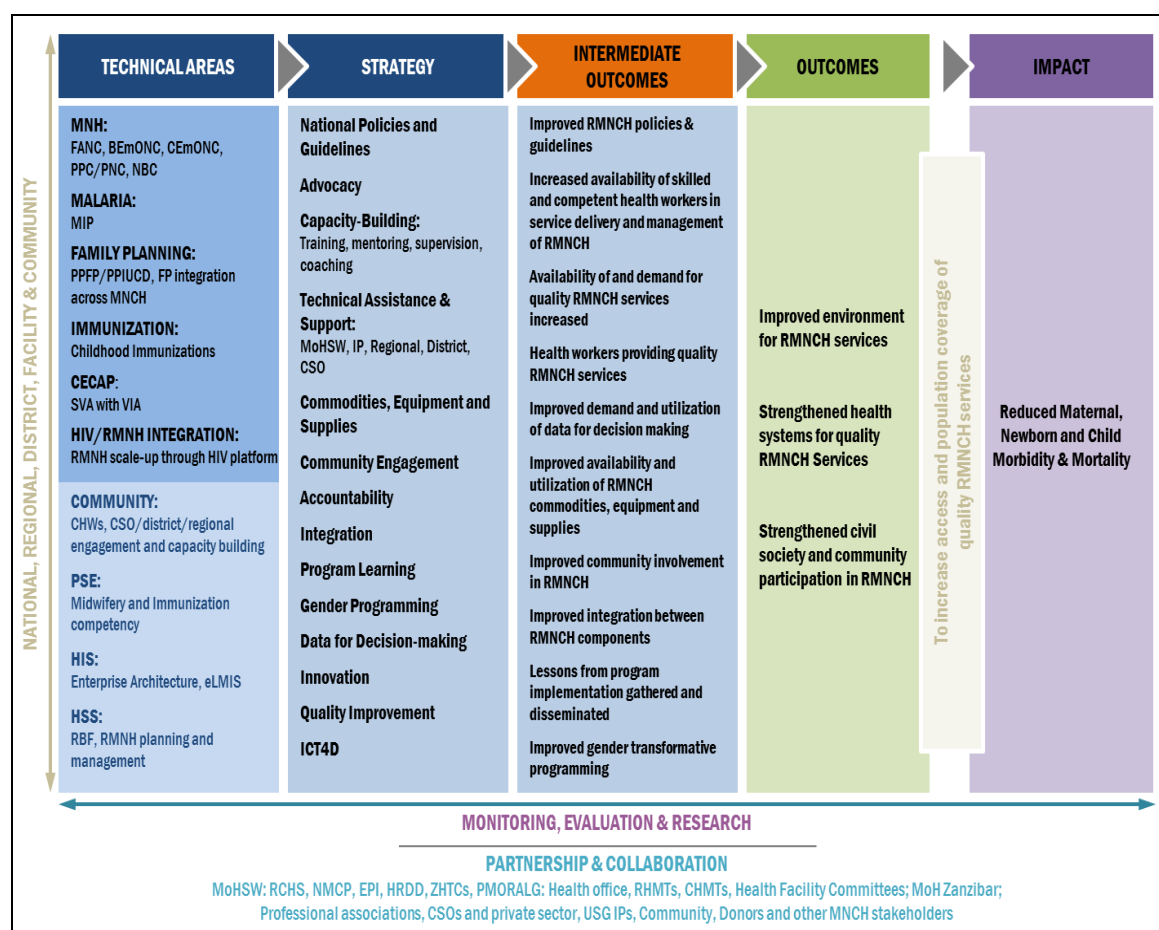
The MCSP program implementation carried out through various resources;-
Fund that supported program activities, skilled staff, guidelines and policy for family planning training and syllabus. Availability of infrastructures, offices/ units, vehicles and fuel for supportive supervision and distribution of commodities.

1.2.8 Programme Logic model

A Logic Model is a simplified model of an intervention that indicates how and why we believe the programme will work – what the relationship is among the resources we have to deliver the programme, the activities to be implemented and the outcomes or changes/effects that we hope to achieve or it can be defined as a diagrammatic representation of a program according to Rush and Ogborn (As cited in Hyndman B. 2000).

A logic model usually indicates the relationships between the main activities, or program and the associated goals, objectives resources and indicators.

Figure 1.1 Program logic model-MCSP



Source (Jhpiego, 2013)

1.2.9 Stakeholders analysis

Stakeholders are individuals, groups, or organizations having significant interest on how well a program functions, they are the one who affected by the project either positively or negatively. Those with decision making authority, funders, personnel, clients or intended beneficiaries, Stakeholders can be those involved in implementing the program, those served or affected by the program and Primary users of the evaluation (CDC, 1999).

The MCSP project stakeholders has been categorised based on their level of interest and their powers in the program or Participation level (H, M, L).

- High (Stakeholders participate in decision making)
- Medium (Implementers)
- Low (Information only)

Table 1.1 Stakeholder's analysis matrix

S/N	Stakeholders	Role in the program	Interest or Perspective on in evaluation	Role in the evaluation	Means of communication	Powers (H,M,L)
1	MOHCDGEC	Policy & guidelines	FP Implementation gaps	Decision Making, policy adjustment	Emails, DHIS2, Conference	H
2	RHMT	Supervisor	FP Implementation Report & gaps	Technical Advisor, Report book, Decision making	Meeting, Conference & Official letters	H
3	JHPIEGO	Funder, Supervisor & implementers	FP data quality & adherence Implementation report	Program implementation report, Guidelines& SOPs manual	Official letter, Meeting, Emails	H
4	CHMTs	Implementers & supervisors	FP data quality, Implementation report	FP implementation report, checklist DHIS report, Manuals, policy & guidelines	Official letter, Meeting & interviews	H&M
6	Health care providers	Implementers	FP data quality Adherence to SOPs	Recording tools Report book, SOPs manual	Meetings, interviews	M
7	Community	beneficiaries	CPR, no of FP clients	FP enrolment	Exit meeting & feedback	L
8	MSD	implementers	FP commodity availability	FP commodity supplies, ILS, R&R	Official letter, Emails.	M

1.3 Statement of the Problem

The global population has been increasing at higher rates since the industrial revolution, the growth characterized by different structure of the population size of the Regions that imposing the alarming trend resulted to serve the effects of social, economic and environmental degradations. Unintended pregnancy, resulting from unmet need for contraception, threatens the lives and wellbeing of women and their families' globally. The great adoption of use of family planning to cut down the increased population took place during the 20th century which provided an opportunity for couples to space for their children (Isabella, 2012).

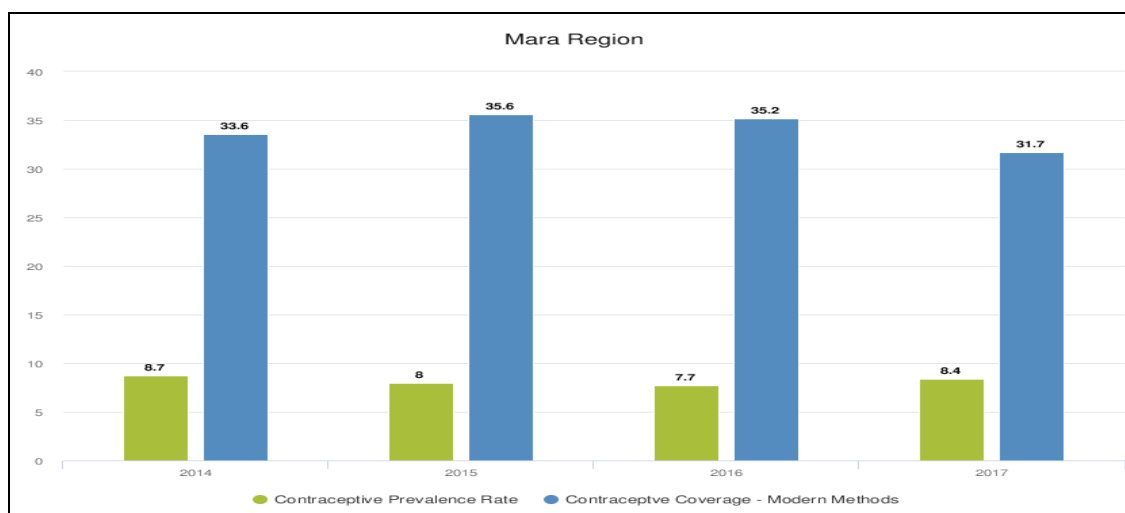
Globally there is an increase of unmet need for family planning services, each year, as many as 220 million women worldwide have an unmet need for contraception as a consequence, 40% of the 210 million annual pregnancies are unintended consequently posing the hardship for families and affects millions of women and children, however, effective and accessible family planning (FP) services can bridge this important gap, with public health benefits that extend beyond the prevention of pregnancy alone, averted maternal morbidity and mortality, including from unsafe abortion, diminished infant morbidity and mortality via increased inter-pregnancy intervals and delayed first birth and lower burden of paediatric AIDS in high HIV prevalence settings (Gener et al, 2015).

With 2012 census, Tanzania population has been increased significantly to 44.9 million, though the 2016 projection population were 50.1 million, current annual rate of growth is 2.9 percent, by 2025 the population is projected to reach 65 million. This indicates that, there is a substantial increase in population of Tanzania almost four times compared to its earlier size in the past four decades. In 1967, the average population density was 14 persons per square kilometre, by 2012, it had increased to 51 persons per square kilometre, the high population growth rate in Tanzania has been brought about by high fertility, (TFR) in Tanzania is 5.2 children per woman, childbearing peaks at age 20-24 at 236 births per 1,000 women, and drops steadily reaching 15 births per 1,000 women at age 45-49. However, rural women have been lagged behind with 2.2 more children on

average than urban women due to geographical differences, this it means that rural women has 6.0 versus 3.8 children to urban women (TDHS, 2016).

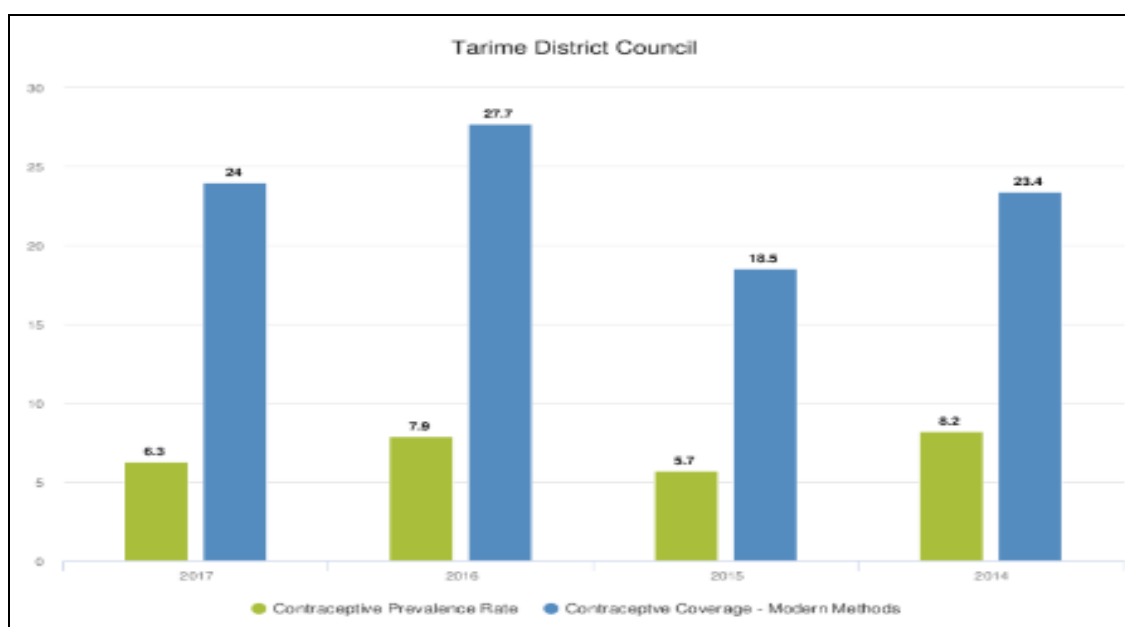
A continuing high rate of population growth leads to major challenges on social and economic development in Tanzania, according to the National Bureau of Statistics (NBS, 2012), early initiation of child bearing and a high rate of fertility which is more worse in the urban areas are the major factors contributing to this rapid population growth, putting increased strain on overstretched health and education services, infrastructure and food supply, that increasing negative effects on the health of women, children and the environmental degradation (NBS, 2012). Demand for family planning among currently married women aged 15-49 in Tanzania has substantially increased over time, rising steadily from 38% in 1991- 92, to 61% in 2015-16, unmet need for family planning declines steadily with increasing education level, falling from a high of 27% among currently married women with no education to a low of 17% among those women with secondary or higher education. Unmet need for family planning also declines with increasing wealth status, from 29% among currently married women in the lowest economical status to 17% among those with the highest economic status, moreover, unmet need for family planning among currently married women ranges from 10 percent in the Southern Zone Regions to high above 30% in the Lake Zone Regions (TDHS, 2015).

Mara Region is among the Lake Zone regions with the lowest contraceptive prevalence rate (CPR) of 8.7% in 2014, 8% in 2015, 7.7% in 2016 and 8.4% in 2017. Meanwhile the contraceptive coverage by modern methods is ranging between 33.6% in 2014, 35.6% in 2015, 35.2% in 2016 and 31.7% in 2017 also has almost twice the national unmet need for family planning which is 34%.



(Source, DHIS2 field data 2018)

Tarime District scored the lowest contraceptive prevalence rate (CPR) in the Region ranging from 8.2 % in 2014, 5.7% in 2015, 7.9% in 2016 and 6.3% in 2017. Meanwhile the contraceptive coverage by modern methods is not increasing steadily as hereunder: 23.4% in 2014, 18.5% in 2015, 27.7% in 2016 and 24% in 2017.



(Source, DHIS2 field data 2018)

Mara Region recognizes its roles and responsibilities in improving family planning availability and uptake was imperative for significant reduction of pregnancy-related deaths. Scale-up in this regard required consideration of addressing traditional norms and

practices (acceptability) along with an improvement in supply of the commodities at the health facility level to ensure accessibility, the ultimate goal of which was to accelerate the reduction of maternal and newborn morbidity and mortality by 2015.

Despite that multilateral initiatives and efforts have been made towards Family planning intervention program at Tarime District, but still fertility rate is relatively high above 5 children per woman, Contraceptive prevalence rate is relatively low with 6.3% in 2017, as well as modern contraceptive rate scored 24% in 2017, Likewise, unmet need for contraceptives is also a high though dearth of information about contraception uptakes out of the facilities has been a major concern. This means that there is no community based tracking tools provided by the governments or health facility to capture contraceptive users who went in the private pharmacies or local shops. Quality in FP service provision has been long recognized as a central component to increase contraceptive uptake, prevalence and continuation, though in many parts of the country like Tarime District this is still doubtful where necessary intervention at all levels is needed to fill the identified gaps.

1.4 Evaluation, Questions, Objectives and Significance

1.4.1 General evaluation question

What is the quality of data on family planning intervention programme at Tarime District?

1.4.2 Research questions:

1. What tools do health care providers use in recording and reporting Family planning data at facility level?
2. How do data collected at different level with different organizations have similarities?
3. How do different organizations assess family planning data quality collected at different levels?

1.4.3 General objective of the Evaluation

Assessment of quality of family planning intervention programme data at Tarime District.

1.4.4 Specific objectives

The specific objectives of the evaluation study are:

1. To determine the tools used by health care providers in recording and reporting family planning data at facility level.
2. To assess how data collected at different levels with different organisation have similarities.
3. To explore how different organizations assess family planning data quality collected at different levels.

1.4.5 Significance of Evaluation

The purpose of the evaluation is to determine the effectiveness of a program if it has achieved the intended goals of intervention, also to measure the degree of change attributable to a given program. Hence it will provide feedback information to different stakeholders to understand the effectiveness of the family planning project that was implemented in the District. Moreover, evaluation results will help administrators and managers to learn what they are doing right, identify shortcomings to be corrected, and make informed decisions about the future direction of their programs, evaluation results will point out to the most rational use of scarce resources—human and materials to achieve expected results of the future projects. Furthermore, an evaluation will generate information that will be used by other Health researchers as a baseline data in evaluating health projects with the same intent, notwithstanding that the information will be used for evidence based decision making but also will help to inform policy makers to regulate health related policy to improve quality service provision to the community in need and also for the academic and learning purposes.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The primary purpose of reviewing relevant literature is to gain insight and a broad understanding of the available information about evaluation research topic that have been done by other scholars. It will help the researcher to find out what others have learned and reported on the problem under the study.

The literature review was done to enhance focus on the research topic, to improve the research methodology and to broaden the knowledge base by obtaining information on studies that have been undertaken globally on family planning implementation data quality.

2.2 Theoretical Literature Review

Family planning is defined as the voluntary, responsible decision made by individuals and couples as to the desired family size and timing of births. Family planning may be on the micro level which means children are born because they are wanted and provided for and on the macro level it contributes to the betterment of human life (Dumindin JB, 2012).

Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility (www.who.int).

Family planning is all the measures undertaken to limit and space births, in this regard, “limitation of births” referred to controlling the number of births, whereas “stopping births” meant ending deliveries by a definite or permanent method. On another hand, contraception was defined as prevention of conception, by any method used not to become pregnant. (Devota, 2011).

Family planning supports the rights of all people to accurate, unbiased information on contraceptive methods that can help them achieve their reproductive preferences (Starbird et al, 2016).

Fertility rates have declined tremendously over the past few decades in some parts of the world including North America, Europe, and more recently Asia and Latin America (Snow et al., 2015). Globally, the present total fertility rate (TFR) is 2.5 children per woman, in Sub Saharan- Africa, the regional total fertility rate is 4.5 children per woman (You et al, 2015). High fertility rate, defined as a total fertility rate of greater than 5.0 births per woman, has not only a large impact on the population growth rate of a developing country, but on the lifetime health, education, and economic livelihood of the mother and her children as well

Sub-Saharan Africa has the highest average fertility rate in the world. In 2009 the total fertility rate (TFR), or the average number of births per woman was 5.1—more than twice that in South Asia (2.8) or Latin America and the Caribbean (2.2) (World Bank 2009).

The average contraceptive prevalence rate (22%) is less than half that of South Asia (53%) and less than a third that of East Asia (77%) (World Bank, 2009). Population in the region continues to grow at a faster rate (2.3 %t) than in other regions, including both Asia and Latin America (1.1 percent each) (UN DESA, 2008). These dismal indicators at the aggregate level conceal ongoing and imminent fertility transitions that are taking place at the country level. Contrary to the popular perception, there is evidence of progress in fertility decline in many countries across Africa (Cohen, 1998).

Within sub-Saharan Africa, use of family planning and unmet need vary greatly. In Southern Africa, where the contraceptive use rate is 58 percent, almost exclusively of modern methods, unmet need for family planning is a relatively low 16 percent. In Western Africa, in contrast, only 8 percent of women use modern family planning, 5 percent use traditional methods, and the unmet need is 23 percent. Of course these averages mask the variation within geographic areas: In Western Africa, for example, more than 14 percent of women in Ghana use a modern method, compared with less than

5 percent of women in Sierra Leone. In Eastern Africa, unmet need is high in Uganda, at 41 percent, and in Madagascar, it is 23 percent. An analysis of modern contraceptive prevalence rates (CPR) in recent Demographic and Health Surveys shows that three countries have achieved a much more rapid increase in CPR than any other countries in sub-Saharan Africa; these Countries are Ethiopia, Malawi, and Rwanda. The annual increase in CPR of modern methods among married women of reproductive age was 2.3% in Ethiopia (2005-2011), 2.4% in Malawi (2004-2010), and a dramatic 6.9% in Rwanda (2005-2010). Millennium Development Goal 5B calls for universal access to reproductive health including Family Planning. These three countries are moving more rapidly toward this goal than any others in sub-Saharan Africa. Such progress is helping these countries move closer to what the development community calls “the demographic dividend,” a concept highlighted in the 2011 International Conference on Family Planning (ICFP) in Dakar that links progress in family planning with larger development goals (African bureau and USAID, 2012).

2.3 Empirical Literature review

According to Africa Bureau worked with the Ministry of Health and the USAID Mission in Ethiopia, Malawi, and Rwanda, along with the three country teams that attended the ICFP meeting in Dakar Senegal, the success was contributed by: Data review in DHIS and key documents related to each of the three countries, Ministry of Health officials presented a summary of the findings at a USAID meeting on November 28, 2011, just before the ICFP opened in Dakar. About 125 people attended the USAID meeting, including teams from 21 sub-Saharan Africa Countries. A summary of key DHS data over time shows the common trends in the three countries, a second major common theme among the three countries in the DHS reports involves demand and unmet need. The overall demand for family planning in all three countries has increased in recent years, and even with this increase, unmet need has declined steadily, unmet need for family planning (counting all methods) is 29% in Ethiopia, 26% in Malawi, and 24% in Rwanda – still sizable percentages. But in Ethiopia and Rwanda, the decline in unmet need has been remarkably sharp according to the DHS, from 36% to 29% in Ethiopia (2005 to 2011) and from 39% to 24% in Rwanda (2005 to 2010).

The decline has not been as sharp in Malawi, but demand there has jumped to 72%. The increase in demand suggests that family planning has essentially become a cultural norm in all three countries (USAID, 2012).

Hence, the success behind was contributed by: improved data quality system, training of extension health care workers linked to community, community engagement, capacity building to the health care providers, demand creation, increased availability of contraceptives at all levels, Leadership and Improved Systems, Health sector financing, contraceptive security, Political Commitment to Family Planning, Reaching youth with family planning USAID,2012).

Bruce and Jain outlined a more comprehensive definition of quality as “the way individuals and clients are treated by the system providing services” and identified six key elements of quality for FP, including choice of methods, information given to clients, technical competence, interpersonal relations, follow up and continuity mechanisms, and the appropriate constellation of services. The Bruce-Jain framework has remained the cornerstone for assessing quality within FP programs, particularly among public sector health services, contacts from reproductive health programs and Ministries in Bangladesh, Côte d’Ivoire, Tanzania, Kenya, and Nigeria. Country contacts confirmed that quality is assessed, at least minimally, in their programs through the use of routine FP indicators such as: Stock management and commodity statistics, Contraceptive prevalence rate (CPR), Proportion of new users, Proportion of continuing users and unmet need for FP.

These indicators are generally collected through health management information systems (HMIS), such as DHIS 2, or logistic management information systems (Schriver and Janine, 2016).

2.4 Evaluation Gaps

In Tanzania, family planning (FP) is the key indicator to reproductive maternal, newborn and child health (RMNCH), when used properly are critical for the improvement of the health status of women and children, and the reduction of both maternal and child mortality. The level of use of family planning services is measured using the

contraceptive prevalence rate CPR). This is the percentage of women of reproductive age who are currently using, or whose sexual partner is currently using, at least one contraceptive method regardless of the method being used. It provided to the women aged 15 to 49 who are married or in relationship (MOHCDGEC, 2016).

To reduce the number of missed opportunities, three services are integrated with family planning services. These include reproductive cancers (breast and cervical cancer), HIV counselling and testing and post abortion care services. Indicators from DHIS2 in the year 2014 shown that, the percentage of modern contraceptive users differed significantly across regions. Dar es Salaam region scored the lowest percentage of modern contraceptives users (16.7 %); whereas Lindi region scored the highest (98.8 %) (MoHCDGEC, 2016).

Among 25 regions, only 5 regions scored modern contraceptives use rate above the national target, whereas the rest regions scored below the national target of 60 %, Moreover, only a few regions attained satisfactory levels of family planning users, though some regions in the Lake and western zones scoring the lowest.

Contraceptive rate outlays in Dar and Lindi suggest that some data quality issues exist, and more notably those associated with capturing of the primary data, and those associated with denominators (MOHCDGEC, 2016).

Findings in the literature review from the Ministry of Health,Community Develo‍pment,Gender,Elderly and Children annual health sector performance profile report 2014/15 revealed that:

- Tanzania was off track to attain the contraceptive prevalence rate target of 60 % by end of year 2015.
- The percentages of modern contraceptive users by end of year 2014 shown that the majority of the regions had values that are lower than the set target for year 2015.
- Data quality issues are suspected during capturing of the primary data, and around determination of denominators from population projections.

- The data collected and compiled using HMIS/DHIS from health facilities was not well suited to estimate the contraceptive prevalence rate because it underestimates this indicator by not including contraceptives use from pharmacies, social marketing sources and shops.
- In this respect, a proxy for the contraceptive prevalence rate was used by calculating the percentage of female and male clients who were using modern contraceptive in 2014 regardless of the method used;
- Measured against the population of women of reproductive age (15 to 49 years) while excluding male involved in FP, hence data quality remain doubtful till proven otherwise.
- Use of contraception by men makes up a relatively small subset of the above prevalence rates. The modern contraceptive methods for men are limited to male condoms and sterilization vasectomy (UNFPA, 2012).

2.5 The challenges of unmet need for FP

Large family size is regarded as a national obligation. Women are caught up in a vicious cycle of high fertility and a high rate of child mortality. Determinants of large family size include:- Social and cultural practices, Clan lineage and Compensation for loss of family members. There are three strategies that have been used to increase family size: marry several women, Husbands taking care of women, and financial stability.

Consequences of big families include: Financial burden, Fear of losing children, Borrowing children and Husband shirking responsibility (Elmusharaf et al 2010)

In the developing countries, 81% of unwanted pregnancies are a result of having an unmet need for contraception (i.e., either using no contraception or a traditional method) (Singh et al., 2014).

Childbirth in early life is especially dangerous. An estimated 16 million adolescents, ages 15 to 19, give birth each year; in the developing world, the leading cause of death among adolescent females is complications from pregnancy, birth, and unsafe abortion.

Among women 25 and younger living in the developing world, maternal sepsis and hemorrhage are common causes of death (Krashin, Tang, Mody, & Lopez, 2015).

2.6 Benefits of Family Planning program/ Contraception

Family planning is immediately relevant to development because it influences the birth rate and slows population growth rate of a country, and therefore has far reaching impacts on economic, social, and environmental well-being in society (Fabic et al., 2015; WHO, 2015). Sound development policies recognize not only the importance of investments in population health and education, but in FP programs as well to provide information and access to modern contraceptives so that couples can achieve their fertility preferences. In 1999, the Centers for Disease Control and Prevention (CDC) named family planning one of the ten greatest public health achievements of the century, for not only health, but also social and economic benefits for both woman and family (Tsui et al., 2010).

2.7 Preventing pregnancy-related health risks in women

A woman's ability to choose if and when to become pregnant has a direct impact on her health and well-being. Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing. It prevents unintended pregnancies, including those of older women who face increased risks related to pregnancy such as unsafe abortion. 75% of the eight million unsafe abortions that occurred in 2008 in women ages 15 to 24 could have been prevented if access to modern contraceptive could have been available (Krashin et al., 2015).

2.8 Reducing infant mortality

Family planning can prevent closely spaced and ill-timed pregnancies and births, which contribute to some of the world's highest infant mortality rates. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health. Using FP methods to properly space births could result in a ten percent reduction in child deaths (Cleland, 2009).

2.9 Helping to prevent HIV/AIDS

Family planning reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans. In addition, male and female condoms provide dual protection against unintended pregnancies and against STIs including HIV (Tsui et al., 2010).

2.9.1 Empowering people and enhancing education

Family planning enables people to make informed choices about their sexual and reproductive health. Family planning represents an opportunity for women to pursue additional education and participate in public life, including paid employment in non-family organizations. Additionally, having smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings.

2.9.2 Reducing adolescent pregnancies

Pregnant adolescents are more likely to have preterm or low birth-weight babies. Babies born to adolescents have higher rates of neonatal mortality. Many adolescent girls who become pregnant have to leave school. This has long-term implications for them as individuals, their families and communities.

2.9.3 Slowing population growth

Family planning is the key slowing unsustainable population growth and the resulting negative impacts on the economy, environment, and national and regional development efforts. A woman's ability to choose if and when to become pregnant has a direct impact on her health and well-being of her families. Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing and improve their lives conditions

2.9.4 Poverty Alleviation

The findings reflect the broader role that family planning can play in fostering development by affecting demographic structures; different authors found that access to

family planning can strengthen economic growth and global competitiveness. It can also advance inclusive growth and build resilience for families, communities, and nations by closing the fertility gap between the rich and the poor and stabilizing national population growth rates.

Thus, Prioritising family planning in the District health budgets (CCHP) can:

- Bring outreach services closer to the community through Community Health Workers (CHWs) and increase contraceptive prevalence rate.
- Expand family planning services to reach adolescents and young people to reduce pregnancy related complications.
- Increase the skills of healthcare workers to provide the full range of family planning methods, including mentorship and supervision.
- Ensure the availability of management protocols and guidelines on the provision of family planning, linked to supportive supervision and professional bodies to ensure accountability
- Provide better availability of the range of family planning methods, including long-term methods, especially in lower-level facilities.
- Strengthen the supply chain and avoid stock outs of family planning commodities.
- Help to reduce unmet need for family planning and reduce fertility rates.
- Reduce maternal, newborn and under five mortality rate in the district.
- Improve quality of life and economic status of the women and family members.

2.9.5 The Conceptual model of Evaluation

An evaluation was conceptualized in a narrative way based on data quality assessment on family planning intervention program at Tarime DC. Thus, the researcher did the following:-

2.9.6 Tools used in recording and reporting FP data.

The researcher will determine tools used by health care providers in recording and reporting FP data at facility level (facility based data), also tools will be assessed whether they are filled properly and captured detailed information and produce reports for evidence based decision making at all levels to improve FP utilization. Data consistence was assessed at the District level as aggregate report into the DHIS2, in JHPIEGO Regional Program office (program implementation report 2014-2017) was assessed for data verification and at the Regional level (program implementation report) was assessed for FP Regional indicators (2014-2017).

2.9.7 Similarities of data collected at different levels with different organization.

The researcher will assess the extent to which FP data collected at different levels with different organisation are similar. The researcher will use cross tabulation analysis method to compare data relevance and consistence at multi-levels (registers and report book at facility level, monthly report and DHIS2 at the District level, program document at the program office, and program report at Regional level).

2.9.8 Data quality assessments on FP at different organization.

Te researcher will explore how different organizations assess family planning data quality collected at different levels putting into account data accuracy, reliability, completeness, consistency, precision and validity, presence of data quality assessment tools used by health care providers in the facility, District level (CHMT) and Regional level, whether the data produced could be comparable over time and across different levels with regards to National standards.

CHAPTER THREE

EVALUATION METHODOLOGY

3.1 Introduction

This chapter lays out the methodology that was used in the study, describes the method in the evaluation research and mainly focused on the study design, approach, area of the study and data collection techniques and sampling procedures as well as data analysis procedures used in the project evaluation.

3.2 Description of the Study area: Tarime District

This is the area where the research was conducted by the researcher; the place was chosen to understand holistically the natural phenomenon concerning family planning program data quality in their natural settings. Secondly, it is the place which is well known by the researcher, hence the cost of living could be relatively low.

The District is situated in the North-West of Tanzania and lies between latitudes $1^{\circ}00''$ - $1^{\circ}45''$ S and longitudes $33^{\circ}30'$ – $35^{\circ}00'$ E, with a total area of 1,489.08 km². The District is boarded by Kenya (Trans-Mara and Kurya District) to the North, Serengeti district to the East, Rorya District to the west and Musoma District to the south. 270 km² of its area is covered by Serengeti National Park (Lamai Area). The District comprises of 4 divisions, 32 wards, and 86 villages with 500 hamlets. Tarime District has two Councils, Tarime District Council and Tarime Town Council.

Population: According to 2012 census the District Council has a population of about 339,693 with a growth rate of 2.2 per annum and birth rate 4.6%, children under five years 21%, WCBA (15-49yrs) 37.4%, young people (10-24) 32% and 5% (16,985) of the total population are elderly people aged 60 and above. These populations are served by a total of 36 Health facilities (HF's) of which 22 HF's are public owned facilities (5 Health Centers and 17 dispensaries), 12HF's are Private owned and FBO's (1 private HC, 2FBO HC's, 5dispensary-FBO and 4-private dispensary).

3.3 Evaluation period

This evaluation was conducted at Tarime District effectively from February 2018 to August 2018.

3.4 Evaluation Approach

Program evaluation entails the use of scientific methods to measure the implementation and outcomes of programs for decision-making purposes” (Rutman, 1984). Thus, the researcher uses outcome evaluation approach to determine the quality of data of family planning intervention program implemented at Tarime District led by Jhpiego, specifically tools used in recording and reporting family planning data at facility level, quality of family planning data collected at different levels by different organisation and the extent to which those data are similar based on intervention.

3.5 Evaluation design

The evaluation used in the study was Qualitative exploratory program evaluation design, the qualitative evaluation design was chosen purposely to enable the researcher to understand the family planning intervention holistically through data quality assessment to MCSP project implemented by Jhpiego (MCSP) at Tarime District.

3.6 Focus of evaluation and dimensions

The evaluation focused on the assessment of family planning program data quality implemented by JHPIEGO at Traime DC, tools used by HCW’s for FP data recording and reporting, the extent of data similarities across different level of organisation and the way it affects FP indicators, the way family planning data quality are assessed at different level of organisation.

3.7 Units of analysis

Evaluation included more than one unit of analysis in one case as follows:-

- Health care providers in the facility level- (implementers)
- Management at the District level/DHIS2- (implementers/Administrators)
- Management/ at the Regional level - (Technical assistant & Decisional makers)
- Management/ at the project office – (implementing partners/funders).

Table 3.1 Variables and their measurements

Variable	Measurements	Source of data
Jhpiego MCSP program performance	What was the situation? (Baseline indicators) Did the program met an expected outcomes (performance indicators)	Program document review Program report
Health care providers	FP data recording/reporting	Registers/report book
District management	Contraceptive Prevalence Rate	DHIS2, interview
Regional management	Regional FP indicators	Report book, interview

3.8 Study Population and Sampling

Study population is defined as the group of people under which the study is to be conducted (Sullivan, 2012). Sampling is the process of selecting a number of study units from a defined study population. Hence, the Study population will comprise Health care providers in the health facilities, members of CHMT at the DMO's office, Members of RHMT and members in the program office who are dealing with reproductive health data.

3.9 Target population

In this study, the target population focused all health care providers dealing with Family planning at Facility level, DRCHCO office and HMIS focal person at District level, RRCHCO office at Regional level, JHPIEGO Program manager/program coordinator.

Their involvement is based on their roles and responsibilities concerning family planning related issues.

3.9.1 Study unit and sampling unit

Study unit comprises RMNCH service providers at facility level, DRCHCO and HMIS FP at District level, RRCHCO at Regional level and Program manager at Regional program office.

3.9.2 Sampling techniques

In this evaluation study, purposive sampling method was used, informants were facility RCH in charge, DRCHCO, RRCHCO and project coordinator. Respondents were selected by virtue of their position and believed to provide relevant information for this evaluation study.

3.9.3 Inclusion and exclusion criteria

- **Inclusion criteria**

- Health care providers who coordinating RMNCH in the facility
- CHMT members who coordinating Reproductive Health
- RHMT members who coordinating Reproductive Health
- FP program coordinator/program manager in the program office
- HMIS focal person at district/regional level

- **Exclusion criteria**

- All health staff who are not dealing with reproductive health at the facility
- CHMT members who are not dealing with DHIS and reproductive health

3.9.4 Data collection

The researcher used both primary and secondary data. Primary data collected by the researcher himself in the field, the researcher used in-depth interview to get insight from the informants on the topic of interest, meanwhile, secondary data obtained through documentary review such as, registers, tally sheets and report book in the facility, report book in the RMO's and program's office, program documents and DHIS2 in the DMO's Office.

Table 3.2 Matrix for data collection on family planning intervention program

SN	Information Required	Informant	Data source
1	FP data recording & reporting tools	facility RCH Nurse	Registers/tally sheet/report book
2	FP indicators (2014-2016)	DHIS FP/DRCHCO	Annual report/DHIS2
3	FP indicators (2014-2016)	RHIS FP/RRCHCO	Report book/DHIS2
4	FP indicators (2014-2016)	Program manager (Jhpiego)	Program report
5	FP data quality assessment	HFI/C/RCH Nurse	DQA tools
6	FP data quality assessment	DMO/DHIS FP/DRCHCO	DQA tools
7	FP data quality assessment	Program Manager (Jhpiego)	DQA tools
8	FP data quality assessment	RMO/RHIS FP/RRCHCO	DQA tools

3.9.5 Development of data collection tool

Semi structured questions with probing prepared and rapport was created to establish relationship between a researcher and informants.

- **Interview**

An in-depth interview is a conversation with a purpose, a conversation between researcher and informant, focusing on the informant's perception of self life and experience, and expressed in his or her own words. In depth interviews were used to collect information from participants dealing with reproductive health in the facility, in the DMO's office, program coordinator and in the RMO's office and those who are dealing with family planning data at all levels in order to get their insight to the topic under the study.

- **Documentary review**

The researcher used secondary data that were collected at different levels of response to get more information on family planning, Facility registers, tally sheet and report book reviewed, DHIS2, program document and regional annual report were also reviewed purposely to understand how data are recorded and reported, similarity of data across organizations and how data quality assessment are conducted at different levels.

3.9.6 Data collection field work

Semi-structured questions with probing was developed purposely for in- depth interview to the study participants who have rich information concerning Reproductive maternal and child health services and HMIS FP at Facility level, DMO's office, Program's office, RMO's office,

To ensure data quality, tools was pre tested to validate the data collection tools before the evaluation started.

3.9.7 Data management and analysis

Refers to an administration process by which the required data is acquired, validated, stored, protected, and processed, and by which its accessibility, reliability, and timeliness is ensured to satisfy the needs of the data users (Business Dictionary.com).

Data analysis is an attempt by the researcher to summarize collected data, analysis not left until the end of the field, it helped the researcher to avoid collecting data that was not important.

However, to ensure data reliability the researcher created rapports with informants and other study participants, trained researcher assistants on how to collect required data, Prepare an inventory of what one has, Check completeness of data "verbatim, Labeling were done, Quality of data counter-checked and back-up copies of the primary data were taken into account.

3.9.8 Data entry

The Qualitative data transcribed and translated from Swahili to English language and uploaded into Atlas.ti software for analysis. Data were analyzed through contextual analysis/thematic analysis approach by identifying the responses relevant to the main questions asked during in depth interview. An approach involved shortening of the texts and creating categories. Data were analyzed by reading through the data, organizing and coding from which the codes with same concept were grouped together to form a category and lastly data was interpreted to have a clear meaning.

Other quantitative data obtained during the study was analyzed by the assistant of Microsoft excel so as to organize the data and make them easier for interpretation and to have a clear meaning.

3.9.9 Data cleaning

Every day immediately after field data collection, the data sport checking was conducted to ensure completeness, reliability, precision and integrity, data cleaning was done before, during and after data entry. The qualitative data was imported into Atlas.ti software, then cleaned before analysed to avoid mismatch and inconsistency of the data and themes, also during the process where there was missing, inconsistent or invalid data the researcher got back to capture the lost information, hence, data generated was cleaned before the process of analysis.

3.10. Data analysis

In this evaluation study, data compilation and analysis was performed by using Atlas.ti software after transcription. The raw data collected was transcribed and translated into English language prior entering them into data analysis software.

The Atlas.ti software package were used during the analysis of data collected in the field, the tools help to organize the data and help the researcher to see the patterns.

This was done by the following steps: first; importing the transcribed data, secondly; the researcher reading and re reading the data and writing memos, thirdly; identifying patterns and applying codes and keeping writing memos, fourthly; interpretation of data

and finally produce Atlas.ti output, however, data analysis often started during data collection and not left until the end.

3.10.1 Ethical consideration

Ethical consideration: Informed consent and prior-written permission to the authorities, information obtained kept strictly confidentially and no informants names appeared in any materials used in data forms.

3.10.2 Evaluation dissemination plan.

Dissemination of health-related information is the active and targeted distribution of information or interventions via determined channels using planned strategies to a specific public health or clinical practice audience. Dissemination has been characterized as a necessary but not sufficient antecedent of adoption and implementation. In contrast to diffusion, which is a passive informal process, dissemination is a formal planned process with the intent of spreading knowledge and associated evidence-based interventions to stimulate adoption and enhance the integration of the evidence, information, intervention, or combinations of these into routine practice (McCormack et al, 2013).

The researcher used the following matrix to disseminate evaluation report to the target audiences.

Table 3.3 Evaluation dissemination plan

SN	Stakeholders	Information needed	Dissemination format	Ways of communication
1	RHMT	Implementation report, data quality	Hard & soft copy, oral presentation	E – mail, Feedback meeting
2	CHMT	Data quality, DHIS2 FP indicators	Oral presentation, Hard & soft copy	Feedback meeting,
3	JHPIEGO	FP indicators, implementation report	Oral presentation, Hard & soft copy	Feedback meeting, Emails
4	Health providers	Data quality, FP indicators	Oral presentation, hard copy	Feedback meeting

CHAPTER FOUR

PRESENTATION OF THE FINDINGS

4.1 Introduction

This chapter four represents the findings of the data collected in the field based on evaluation objectives, the general objective of this evaluation research was to assess the family planning program data quality in the project that was implemented at Tarime District as analysed hereunder:

4.2 Tools used by the health care providers in recording and reporting family planning data.

In this evaluation study, the researcher intended to determine tools used by health care providers in recording and reporting family planning data to all clients who were attended in the public health facilities under the projects.

Tools were determined at the Reproductive and Child Health in charges office at all visited public health facilities providing family planning services in the District. Thus the researcher determined presence of MTUHA book no 8 consisting of registers, tally sheet and summary report book

Figure 4.1: Book 8 register used for family planning data recording at facility level

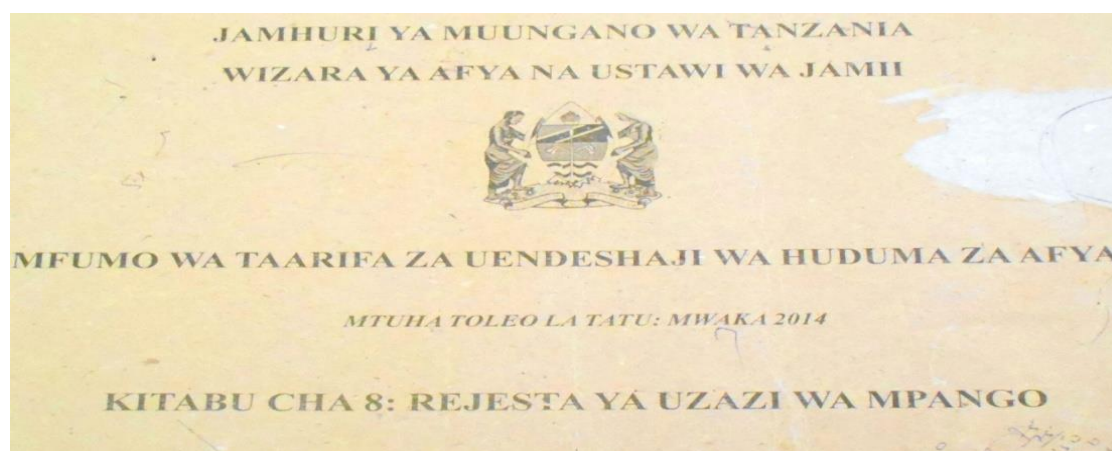
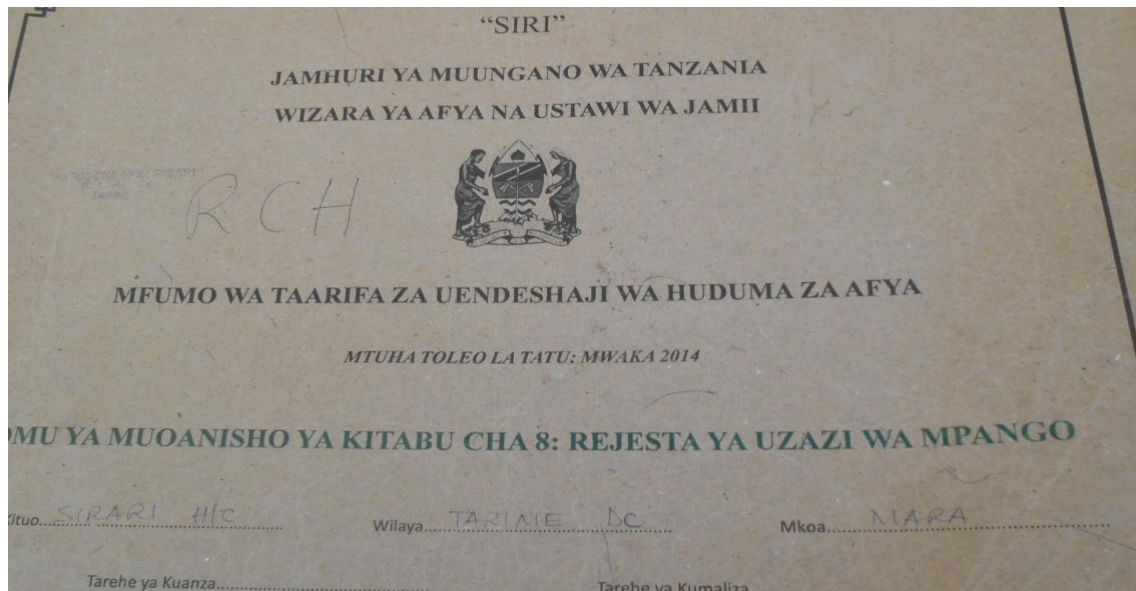


Figure 4.2: Book 8 tally sheet used for family planning data tallying between register book



The image shows the cover of a 'SIRI' (Summary Report) book. The text on the cover is as follows:

“SIRI”
JAMHURI YA MUUNGANO WA TANZANIA
WIZARA YA AFYA NA USTAWI WA JAMII

RCH

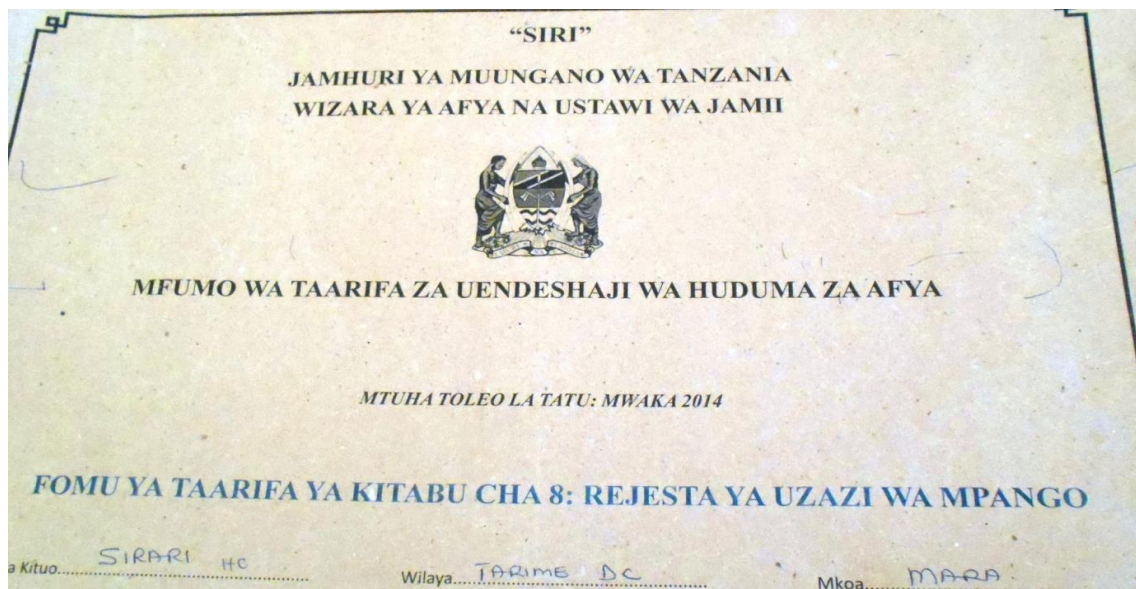
MFUMO WA TAARIFA ZA UENDESHAJI WA HUDUMA ZA AFYA
MTUHA TOLEO LA TATU: MWAKA 2014

MU YA MUOANISHO YA KITABU CHA 8: REJESTA YA UZAZI WA MPANGO

Kituo... *SIRARI HC* Wilaya... *TARIME DC* Mkoa... *MARA*

Tarehe ya Kuanza..... Tarehe ya Kumaliza.....

Figure 4.3: Book 8 summary report used for monthly family planning data reporting.



The image shows the cover of a 'SIRI' (Summary Report) book. The text on the cover is as follows:

“SIRI”
JAMHURI YA MUUNGANO WA TANZANIA
WIZARA YA AFYA NA USTAWI WA JAMII

MFUMO WA TAARIFA ZA UENDESHAJI WA HUDUMA ZA AFYA
MTUHA TOLEO LA TATU: MWAKA 2014

FOMU YA TAARIFA YA KITABU CHA 8: REJESTA YA UZAZI WA MPANGO

Kituo... *SIRARI HC* Wilaya... *TARIME DC* Mkoa... *MARA*

The above presented findings are the sample of family planning data collection and reporting tools (no1 register, no2 tally sheet, no3 summary report book) that used at facility level to collect family planning data, compare the data and reporting data to the higher level, all books were available at all visited facilities.

Table 4.1: Observation Checklist for family planning data recording and data reporting tools used by health care providers at facility level.

SN	Name of facility	Family planning services		FP data recording tools		FP reporting tools	
		provided	Not provided	available	not available	available	not available
1	SIRARI HC	provided		available		available	
2	MURIBA HC	provided		available		available	
3	MAGOTO HC	provided		available		available	
4	NYARWANA HC	provided		available		available	
5	NYANGOTO HC	provided		available		available	
6	MTANA DISP	provided		available		available	
7	SURUBU DISP	provided		available		available	
8	BUMERA DISP	provided		available		available	
9	KIONGERA DISP	provided		available		available	
10	KUBITERERE DISP	provided		available		available	
11	NYASARICHO DISP	provided		available		available	
12	NYABISAGA DISP	provided		available		available	
13	KITAGUTITI DISP	provided		available		available	
14	NYANTIRA DISP	provided		available		available	
15	NYAMWAGA DISP	provided		available		available	
16	MATONGO DISP	provided		available		available	
17	NKEREGE DISP	provided		available		available	
18	NYAMONGO DISP	provided		available		available	
19	GIBASO DISP	provided		available		available	

(Source: Field data 2018)

From the field data source, it was indicating that all public health facilities from which the data were collected they were providing family planning services, whereby, family planning data recording and data reporting tools were also available in those facilities. Thus, all public health facilities providing family planning services in the District had both data recording and data reporting tools.

Table 4.2: Summary for observation checklist for FP data recording and data reporting tools available at facility level

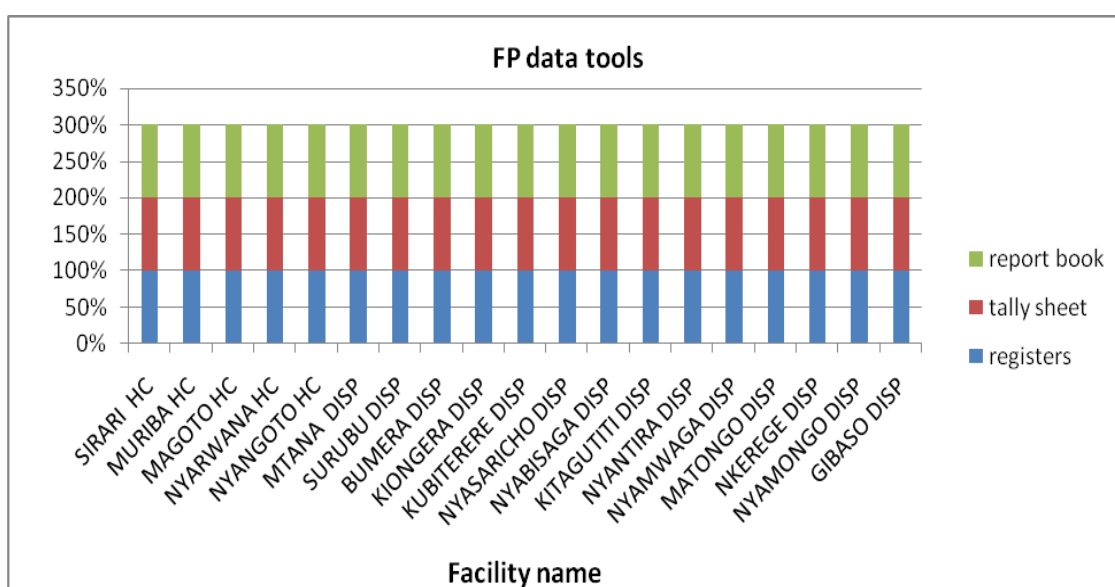
SN	Type of Facility Visited	No of Facility visited	Facility with FP recording tools	Facility Without FP recording tools	Facility with FP reporting tools	Facility Without FP Reporting tools	Total facility with FP tools	Total facility without FP tools
1	Health Centre	5	5	0	5	0	5	0
2	Dispensary	14	14	0	14	0	14	0
Total Facility		19	19	0	19	0	19	0

(Source: field data 2018)

From the research data presented above, 19 health facilities were visited to determine availability of tools for recording and reporting family data, among the facility visited 5 health facilities were Health centres and 14 were Dispensaries.

All 19 (100%) facilities providing family planning services had FP data recording tools and also data reporting tools for family planning data. (100%), however, there was some shortage of summary report books not only for family planning but also other books.

Figure 4.4: %age of FP tools availability for data recording and data reporting at facility level



(Source, field data 2018)

4.3 How data collected at different levels by different organisation have similarities.

One of the objectives of family planning data quality assessment in the MCSP program was to assess the extent to which data collected at different levels by different organisation are similar, Data quality are the most essential components in determination of the areas of intervention and for evidence based decision making to improve community health especially on reduction of maternal and under five mortality rates.

Table 4.3: Data for Family planning clients attended at the health facilities from the year 2014-2017

SN	Facility Name	Fp Clients 2014		FP CLIENTS 2015		FP CLIENTS 2016		FP CLIENTS 2017	
		New Users	Continuing Users	New users	Continuing users	New users	Continuing users	New users	Continuing users
1	Mtana Disp	383	173	408	158	346	127	373	117
2	Surubu Disp	432	75	500	133	316	125	621	195
3	Bumera Disp	433	60	339	40	439	11	349	29
4	Kiongera Disp	335	47	492	39	511	61	408	62
5	Kubiterere Disp	441	67	491	94	582	70	467	94
6	Nyasaricho Dis	6	-	336	57	447	92	296	65
7	Nyabisaga Disp	297	76	381	67	278	90	508	43
8	Kitagutiti Disp	347	78	352	97	508	128	372	99
9	Nyantira Disp	234	18	727	138	591	205	746	194
10	Nyamwaga Disp	490	62	551	21	685	49	642	117
11	Matongo Disp	57	-	3	3	215	12	210	40
12	Nkerege Disp	-	-	219	3	465	27	321	3
13	Nyamongo Disp	656	54	820	83	655	83	657	150
14	Gibaso Disp	253	52	230	74	312	103	222	28
15	Sirari Hc	482	126	532	201	513	157	757	150
16	Muriba Hc	261	81	638	182	1,032	157	941	147
17	Magoto Hc	689	153	605	148	804	211	703	272
18	Nyarwana Hc	440	25	532	83	477	84	567	64
19	Nyangoto Hc	708	168	1,409	251	1,204	146	1,327	145
Total FP users attended		6,944	1,315	9,565	1,872	10,380	1,938	10,487	2,014
Total client per year		8,259		11,437		12,318		12,501	

(Source, Field data 2018)

The above presented findings indicates that 8,259 family planning Clients were attended in the year 2014 at the health facilities, 11,437 clients were attended in the year 2015, and 12,318 family planning clients were attended in the year 2016, meanwhile 12,501 family planning clients were attended in the year 2017.

Table 4.4: Data for Family planning clients attended at the health facilities that were collected at the District level (DHIS2 Database).

SN	Facility Name	FP CLIENTS 2014		FP CLIENTS 2015		FP CLIENTS 2016		FP CLIENTS 2017	
		new	continuing	new	continuing	new	continuing	new	continuing
1	Mtana Disp	450	121	541	152	584	90	571	85
2	Surubu Disp	446	85	428	95	654	127	572	184
3	Bumera Disp	435	91	317	48	468	41	411	27
4	Kiongera Disp	720	170	800	60	717	94	465	46
5	Kubiterere Disp	449	85	483	104	511	67	443	94
6	Nyasaricho Disp	145	9	361	70	454	77	297	36
7	Nyabisaga Disp	356	81	352	37	339	80	506	33
8	Kitagutiti Disp	419	138	347	64	276	107	590	78
9	Nyantira Disp	600	96	516	106	733	175	773	177
10	Nyamwaga Disp	437	74	619	21	783	50	743	123
11	Matongo Disp	0	0	0	0	331	32	370	38
12	Nkerege Disp	0	0	0	0	498	19	275	0
13	Nyamongo Disp	525	87	628	57	588	34	525	115
14	Gibaso Disp	422	100	438	96	540	96	475	88
15	Sirari Hc	603	186	452	167	745	158	845	111
16	Muriba Hc	610	146	609	169	1040	157	881	180
17	Magoto Hc	689	142	786	163	926	214	743	228
18	Nyarwana Hc	560	100	411	39	607	139	701	53
19	Nyangoto Hc	830	176	1707	233	1246	150	1043	128
Total new &continuing users		8,696	1,887	9,795	1,681	12,040	1,907	11,229	1,824
Total clients per year		10,583		11,476		13,947		13,053	

(Source, field data 2018)

The above findings are family planning data that was collected at the District level in the DHIS2 database indicating that family planning clients who were given modern contraceptives in the year 2014 at all health facilities visited above was 10,583. In the year 2015 family planning clients who were given modern contraceptives were 11,476, and in the year 2016 a total number of 13,947 family planning clients were given modern contraceptives, meanwhile in the year 2017 family planning clients who were given modern contraceptives was 13,053.

Table 4.5: Data for Family planning clients attended at Tarime health facilities that were collected in the Regional level (RRCHCO)

SN	Number of FP clients attended in 2014	Number of FP clients attended in 2015	Number of FP clients attended in 2016	Number of FP clients attended in 2017
1	15,219	17,814	13,947	13,053

(Source: Field data 2018)

The findings above indicating that the total family planning clients attended in the facilities by the year 2014 at Tarime District were 15,219. While the number Family planning clients attended in the year 2015 was 17,814. In the year 2016 the family planning clients who were attended was 13,947 and lastly, the family planning clients who were attended in the District was 13,053.

Table 4.6: Data for Family planning clients attended at Tarime health facilities that were collected in the Program office (JHPIEGO – Program Coordinator)

SN	Number of clients attended in 2014	Number of clients attended in 2015	Number of clients attended in 2016	Number of clients attended in 2017
	10,583	11,476	13,947	13,053

(Source: Field data 2018)

The data in the table above represents all family planning clients who were attended at different Health facilities at Tarime District. In the year 2014 the total family planning clients who were given modern contraceptives reached 10,583, meanwhile the clients given FP services by the year 2015 the number was 11,476, in the year 2016, the total number of family planning clients attended was 13,947, while the family planning clients attended in the year 2017 scored 13,053.

Table 4.7: Summary for FP data that were collected during the field study at different levels indicating the number of clients given modern contraceptives from the year 2014 to 2017

SN	FP data point (Data base)	FP clients (2014)	FP clients (2015)	FP clients (2016)	FP clients (2017)	Total FP clients in 2014-2017
1	Facility level	8,259	11,437	12,318	12,501	44,515
2	District level	10,583	11,476	13,947	13,053	49,059
3	Regional level	15,219	17,814	13,947	13,053	60,032
4	Program Office	10,583	11,476	13,947	13,053	49,059

(Source: Field data 2018)

The findings from the health facilities above indicating that, total number of family planning clients who were attended at different health facilities at Tarime District from the year 2014-2017 reached 44,515, while the data collected at the District level denotes that in the year 2014-2017 the total number of family planning clients who were given modern contraceptives in the facilities were 49,059, the data collected at the Regional level indicating that family planning clients at Tarime District health facilities who were given modern contraceptive in the year 2014-2017 are 60,032, meanwhile the data collected in the Program Office indicating that the family planning clients who were given any method of contraceptives from the year 2014-2017 was 49,059

4.4. How different Organizations assess family planning data quality collected at different levels.

One of the objectives of my evaluation studies was to explore how different Organisation assess family planning data quality collected at different levels, and it was among the technical areas that the project intent to improve. The data qualities are the one that indicating what has been observed from the point of collection and should assist evidence based decision making to effects project implementation with positive outcomes and long impacts to the community at large.

Table 4.8: DQA for FP at Facility level

SN	Facility Name	FP DQA		Tools for FP DQA		Skilled staff for FP DQA		Monthly FP DQA Report available	
		Conducted	Not conducted	Available	Not available	Available	Not available	Available	Not available
1	Mtana Disp	Yes		Yes		Yes		Yes	
2	Surubu Disp	No		Yes		No		No	
3	Bumera Disp	Yes		Yes		No		No	
4	Kiongera Disp	No		Yes		No		No	
5	Kubiterere Disp	No		Yes		No		No	
6	Nyasaricho Disp	No		Yes		No		No	
7	Nyabisaga Disp	No		Yes		No		No	
8	Kitagutiti Disp	Yes		Yes		No		No	
9	Nyantira Disp	No		Yes		No		No	
10	Nyamwaga Disp	Yes		Yes		No		No	
11	Matongo Disp	No		Yes		No		No	
12	Nkerege Disp	No		Yes		No		No	
13	Nyamongo Disp	No		Yes		No		No	
14	Gibaso Disp	No		Yes		No		No	
15	Sirari Hc	Yes		Yes		Yes		No	
16	Muriba Hc	Yes		Yes		No		No	
17	Magoto Hc	No		Yes		No		No	
18	Nyarwana Hc	No		Yes		No		No	
19	Nyangoto HC	No		Yes		No		No	

(Source: Field data 2018)

The findings presented above indicates that 6 Health facilities (31.6%) were doing data quality assessment, and the rest 13 facilities (68.4%) were not doing data quality assessment, however, during assessment of the tools for family planning data quality assessments, almost all facilities (100%) has tools for DQA which is locally available, moreover, in assessing the presence of skilled staff at facility level, only two facilities (10.5%) has skilled staff who is capable of doing Family Planning data quality assessments. Furthermore, in assessing availability of DQA report, only one facility (11%) has monthly data quality assessment report, the rest (89%) has no data quality assessment report available at their facilities.

Table 4.9 FP data quality assessment tracking tool at the District level (DRCHCO)

SN	FP DQA		Tools for FP DQA		FP DQA Team		Monthly FP DQA report available	
	conducted	not conducted	available	not available	available	not available	available	not available
1	YES		YES		YES		NO	

(Source: Field data 2018)

The above presented findings indicates that family planning DQA are conducted at the District level, tools are available and the DQA team is present, however, there was no monthly neither quarterly family planning DQA report available in the DRCHCO office.

Table 4.10 FP data quality assessment tracking tool at the Regional level (RRCHCO)

SN	FP DQA		Tools for FP DQA		FP DQA Team		Monthly FP DQA report available	
	Conducted	Not conducted	Available	Not available	Available	Not available	Available	Not available
1	YES		YES		YES		YES	

(Source: Field data 2018)

The above presented findings indicates that family planning DQA are conducted at the Regional level, tools are available and the DQA team is present, the family planning DQA quarterly report was also available in the RRCHCO office.

Table 4.11 FP data quality assessment tracking tool at the program office (Program Coordinator)

SN	FP DQA		Tools for FP DQA		FP DQA Team		Monthly FP DQA report available	
	Conducted	Not conducted	Available	Not available	Available	Not available	Available	Not available
1	YES		YES		YES		YES	

(Source: Field data 2018)

The above presented findings indicates that family planning DQA are conducted at the program office, tools are available and the DQA team is present, the family planning DQA quarterly report was also available in the program coordinator.

Table 4.12: Summary report for FP DQA at different levels of Response

SN	Level of response	FP DQA conducted monthly or quarterly		Tools for FP DQA available		FP DQA skilled team available		Monthly / quarterly FP DQA report available		Adherence to six dimensions of DQA	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1	Facility level	6 /19		YES		2/19		1/19		YES	
2	District level	YES		YES		YES		NO		YES	
3	Regional level	YES		YES		YES		YES		YES	
4	Program Office	YES		YES		YES		YES		YES	

(Source: Field data 2018)

The findings presented above was the summary reports of FP DQA explored at different level of response, hence it indicates that only 6 (31.6%) of all health facilities out of 19 that were visited are doing family planning DQA either monthly or quarterly, all health facilities has DQA tools and only 2 facilities (10.5%) have skilled team capable of doing Family planning DQA, while only 1 facility (5.3%) has monthly DQA report, in adherence to 6 dimension of DQA less than 50% of all health facilities scored 5 and above dimension of DQA termed (completeness, consistence, precision, timeliness, accuracy and integrity).

In the District, Regional and Program office all levels are performing FP DQA, they have also sufficiency tools for DQA, skilled team for DQA and quarterly report for DQA were present in the office, nevertheless, they are all abide to 6 dimensions of DQA.

4.5 How different Organizations assess family planning data quality collected at different levels.

4.6 Description of the data evaluated from different informants.

One of the objectives of my evaluation studies was to explore how different Organisation assess family planning data quality collected at different levels, and it was among the technical areas that the project intent to improve. The data qualities are the one that indicating what has been observed from the point of collection and should assist evidence based decision making to effects project implementation with positive outcomes and long

impacts to the community at large. One of the informant from the Health centre contributed what she knew about family planning data quality assessments.

“We are normally assessing data as a team to ensure data accuracy, you know to assess data quality as an individual there is a great chance of error. However, we started DQA last month (June 2018), when we started to enter data into electronic data base system (DHIS2), after that we used to upload the DQA tools from the DHIS2, not only family planning data, nooh!, it is all data that we produced during that month in a facility and then we compare our data that we entered into a system and those data collected in three books MTUHA, though in family planning we are using book no 8 (i.e registers, tally sheet and summary report book) if their data looks the same hen we say there is quality” (Sirari HC RCH I/C, 2018).

The family planning data quality assessments are rarely conducted in the facility level, one of the informants explained that they only do DQA once quarterly.

“You know what I can say, I have been working here as RCH I/C for three years now, but we did FP DQA only once when the team came from the ministry of Health, you know we are busy all the time, and we have shortage number of staff in our facility, so sometimes we are just using tally sheet to see if there is data consistency from that written in the register books” (Bumera Disp RCH I/C, 2018).

During evaluation study, the researcher asked if there is quality improvement team (QIT) in the facility and how was team members selected, and if they are skilled in family planning data quality assessment and the kind of tools used for DQA. The informant in one of the Health centre facility explained:

“Yes, We have quality improvement team (QIT) in our facility, we are not skilled in DQA but during selection of QIT members, the criteria used was based on departments, every head of section example OPD, IPD, RCH, Labour ward, CTC in charges, pharmacy, laboratory and other departments were automatically selected to be a member of QIT, though there is a facility QIT leader, the main reasons of selecting head of sections was to assist their subordinates and ensure provision of quality of services in their departments, we have no specific tool for family planning data quality assessment, we are just using three books in DQA, registers, tally sheet and summary report book, that is all I know” (Kubiterere Disp RCH I/C, 2018).

At the Dispensary level when the researcher asked if the facility was doing family planning data quality assessment and if there is a skilled team which is capable of doing DQA and tools for quality assessments, one of the informant explained how they do data

quality assessment in their facility and how the quality improvement team members were selected.

“We usually do data quality assessment on 2nd day of every month before report submission to the DMO’s office, also we have quality improvement team (QIT) that consist of five members, but not all of them are skilled, our team was created immediately after 5S KAIZEN training provided by development partners to the nurse who went on that training from our facility, then according to the QIT guideline all head of department/section, including matron and health facility in charge became members of QIT, however, there is no specific tool for family planning DQA, we normally use MTUHA book no 8 which including registers, tally sheet and report book as a tool for DQA” (Mtana Disp RCH I/C, 2018).

At the District level when the researcher asked informant if they were doing family planning data quality assessment, how often and if there is a skilled team which is capable of doing DQA, and tools for quality assessments specifically for Family planning in her office, and how QIT members were selected, the informant said.

“Yes we do, the DQA starts at facility level, before we start data quality assessment, we upload the DQA tools from the DHIS2 and then we compare the data at facility level to see if the indicators were filled properly and then we compare the registers, tally sheet and report summary to ensure quality of data at the facility level. In the District level we have a special day at the beginning of every month during report submission from the facilities, all data clerks came with their data and then we discuss together their data accuracy and we all agreed together, lastly the assessed data entered into DHIS2 data base system, however, we use their data collection tool and data reporting tools to see if the data were filled properly in the facility. Normally we do DQA quarterly as per guideline, though we also do it at the early of every month before entering data into DHIS2. The methods we use based on the type of family planning used by our clients such as IUCD, minlap, insertion, injection depo, pills and other methods and we compare what has been written in the data collection tools, we count new users and continues users to know exactly the total number of our clients who were attended in the facility”

“We normally use HMIS book 8 that including Registers, tally sheet and report book to ensure family planning data quality, although we sometimes use special DQA tools from DHIS2 to asses certain indicators including family planning indicators”

“We have skilled QIT team, there is Chairperson, secretary and other members of QIT who representing their sections such as DLT, DRCHCO, Malaria FP, DACC and DTLC all attended DQA training and there is a special guideline from the Ministry of Health that indicating composition of members of the QIT in the

District and their attributes, though, the DMO used to select the QIT focal person based on the QIT guideline”(Tarime DC DRCHCO, 2018).

At the Regional level when the researcher asked informant if they were doing family planning data quality assessment, how often and if there is a skilled team which is capable of doing DQA, and tools for quality assessments specifically for Family planning in her office, and how QIT members were selected, the informant explained briefly that.

“Yes we do DQA before entering data into the DHIS2 were we must check its quality first, we do it monthly in our Hospital, though sometimes we do it quarterly in collaboration with different stakeholders and implementing partners. We also have QIT team that was created immediately after quality improvement training, members were selected from different departments with different cadres such as Doctors, lab technicians, radiologist, dentist, pharmacist, nurses and medical attendants, the essence was to have uniformity at all levels so as to make it more collaborative and easy to implement the QI in our institution. We normally use HMIS book 8 that including Registers, tally sheet and report book to ensure family planning data quality, although we sometimes use special DQA tools from DHIS2 to asses certain indicators including family planning indicators” (Mara Region RRCHCO, 2018)

The findings above indicating that, data quality assessment is generally done in the District and Regional levels, they have skilled team, QIT team, DQA tools though not specific to family planning alone meanwhile, in the Dispensaries and health centres the DQA rarely done, no skilled team and also no DQA tools specifically for family planning.

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter representing discussion of the findings that were collected in the field and presented in the chapter four. The discussion focused into specific objectives of the evaluation studies that were carried out in the field work as it follows: To determine tools used by Health care providers in recording and reporting family planning data at facility level, to assess the extent to which data collected at different levels with different organisation are similar, to explore how different organisations assess family planning data quality collected at different levels.

5.2 Tools used by Health care providers in recording and reporting family planning data at facility level.

During the field study at Tarime District, the researcher was impressed to determine tools used by health care providers in recording and reporting Family Planning data in the public health facilities that were benefited by the MCSP projects. The total of 19 public health facilities were selected for evaluation research, two levels of health facilities were involved in the study which included 14 Dispensaries and 5 Health Centres located in the rural settings.

Health data record specifically family planning data were obtained to the RCH I/C who dealing with provision of family planning services at facility level. The researcher determined how family planning data were documented as well as reported to the next level of response. During documentary review the researchers got across three books that were used by the health care providers in recording family planning data named **MTUHA book 8** (registers, tally sheet and summary report book).

The FP register book no 8 used for documentation of all necessary information about clients who were attended in the facility, while the tally sheet used to count and compare the number of clients attended in the facility before documenting the data into summary report book for submission to the District level.

The summary report book used for compilation of the methods of family planning modern contraceptives that were given to the clients, the number of clients attended, new users, continuing users and their respective age groups. Lastly, original copy was submitted to the District level for further submission into electronic database DHIS2.

The diversity of quality assessment methods, especially in light of inconsistent data collection, makes comparison of quality assessment tools challenging (Nickerson et al. 2014).

Notwithstanding that the family planning data recording and reporting tools being available in all health facilities studied, but still there was a gap of data mismatching that was observed among three books used for data collection, tallying and data reporting book which was submitted to the District and higher level of authority for decision making.

With due facts above, much more attention has to be paid not only to the tools used to collect and reporting family planning data but also to the health care workers who spent most of their time filling those books without proper knowledge and skills on how to produce accurate data, and the importance of data they are dealing with in their daily routine.

5.3 How data collected at different levels by different Organisation have similarities.

Based on the findings from the field studies as presented in chapter four, there was a great disparity of family planning data that was observed between Health facility and the District level, more marked difference was also observed between the District and the Regional level as well as between facilities and Regional data. Reducing the gap between what was known and what was implemented – the evidence to action gap – has long been a concern of the family planning community (Simmons et al. 2002). Despite of the gap observed there was a similarity of data between District level and Program office, this indicating that the district coordinator was easily communicating with the program coordinator rather than facility RCH in charges.

The data presented hereunder reveals the gap of data noted during the study.

The total number of family planning clients who were attended at different health facilities at Tarime District from the year 2014-2017 were 44,515, while the data collected at the District level denoted that in the year 2014-2017 the total number of family planning clients who were given modern contraceptives in the respective facilities were 49,059, the data collected at the Regional level indicating that family planning clients at Tarime District health facilities who were given modern contraceptive in the year 2014-2017 are 60,032, meanwhile the data collected in the Program Office indicating that the family planning clients who were given any method of contraceptives from the year 2014-2017 was 49,059. The possible contributing factors for the observed gap were mistrust between the facility RCH I/C and DRCHCO, miscommunication between facility in charges and the District health management team this were seen on data differences between the facility data and the District data, while they look alike with the program data but they were different with facility and Regional data. Lack of competency on data assessment, unfriendly data collection tools, lateral data system, lack of commitment, lack of awareness on the importance of data and lack of uniformity in data collection between implementing partners and the government system.

5.4 How different organizations assess family planning data quality collected at different levels.

From the data analysis presented in chapter four, data quality assessment was the major concern that were observed during the field study at the health facilities whereby only 6 (31.6%) facilities performing DQA and the rest 13 (68.4%) did not conduct DQA at the facility levels. However, during assessment of the tools for family planning DQA almost all facilities (100%) had tools for DQA though they were not real specific tools to evaluate the quality of family planning data as it was likely to be, what they did, they were using the same data collection and data reporting tools to evaluate the quality of data through cross checking what was written in the registers, what was documented in the tally sheet and what it was in the summary report book, moreover, in assessing the presence of skilled staff at facility level, only two facilities (10.5%) had skilled staff who were capable of doing FP DQA though they were not real skilful for family planning data

quality assessment alone, they were called skilled team because they have attended several training on general data quality assessment to enable them to use local available tools to evaluate if the data was documented clearly in all three books called registers, tally sheet and summary report book. Furthermore, in assessing availability of DQA report, almost all facilities did not have DQA report that could be seen physically except one facility (11%) called Mtana Dispensary had monthly general DQA including FP report summary kept in a special file, the rest (89%) had no DQA report available at their facility and this indicating that DQA at the facility level had been kept a side. However, the observed differences in some of health facilities were possibly contributed by different factors such as inadequate skilled staff, lack of customized data quality assessment tools specifically on family planning DQA tool, unfavourable environment that did not permit DQA process. Shortage of staff and work overload, lack of commitment, lack of motivation and too much paper work.

At the District level and Regional level they were doing DQA quarterly in a jointly team with donors and other stakeholders who supporting different projects in the Region, they had special DQA tools to assess specific projects supported by donors and some are integrated projects where the Ministry of Health in collaboration with donors has developed special tools used for DQA in order to monitor the progress of those projects they support. In the Program coordinator's office they were performing FP DQA basically in their area of interest that were called post partum family planning, they had also sufficiency tools for DQA, skilled team for DQA and quarterly report for DQA were present in the office though they were not very cooperative enough to explain in details, nevertheless, they are all abide to 6 dimensions of DQA though in the public facilities data were not real kept safely.

CHAPTER SIX

SUMMARY, CONCLUSION, RECOMENDATIONS AND POLICY IMPLICATION

6.1 Introduction

This chapter presents the research summary, conclusion, suggestions, recommendation and policy implication whereby scholars, researchers, decision and policy makers and other interested people can work upon it to build new ideas for improving what has been observed.

6.2 Summary

This evaluation study focused on assessment of Family planning intervention program data quality at Tarime District specifically to meet three objectives which includes, determination of tools used by health care providers in recording and reporting family planning data, the extent to which data collected at different levels with different organisations are similar, and how different Organisations assess family planning data quality collected at different levels.

The research design was qualitative though it contained some quantitative data to make a clear meaning in some areas, Study population involved health care providers at the health facilities, CHMT members at the DMO's office, RHMT members at the RMO'S office and Program coordinator in the program office. Study unit involved RMNCH I/C at facility level, DRCHCO at the District level, RRCHCO at the Regional level and program coordinator, purposive sampling used to select people who had experience with the research topic and able to provide detailed information.

Primary data was collected in the field through in-depth interviews and direct observation of the tools used to document family planning data, meanwhile secondary data were collected through documentary review on the MTUHA no 8 registration book, tally sheet and summary report book at facility level, report form in the DRCHCO's office and DHIS2 data base and annual report book in the RRCHCO's office and

program document in the program office, computer assisted qualitative data analysis by using Atlas.ti software used to analyze the transcribed in-depth interview data.

Findings from data analysis indicated that tools for family planning data collection and data reporting were available at all public health facilities almost (100%) though there is some challenges of inadequate supplies of report books where facility in charges needed to produce copies by using their own funds which was sometimes very expensive and unable to afford. The issue of family planning data similarities was more challenging, there was data disparity between the document observed at the facility level and data observed at the District level in DHIS2 as well as data mismatch between the District and the Regional annual report book that were sent by DRCHCO, however, there was similarities of data between the District data base and the data in the program coordinator's office possibly due to close communication between the district coordinator and the program coordinator though the reliable source of data was suppose to be those comes from the facility level.

Exploration of the family planning data quality assessment by different organisations revealed that, almost 90% of all health facilities in the District they were not doing data quality assessment due to inadequate knowledge of DQA, lack of skilled team, lack of customized FP DQA tools, report overburden, parallel reporting and also due to facility work overload. Meanwhile, at the District level they are performing jointly FP DQA quarterly with partners and Regional team, they have skilled team and FP DQA tools were available, though there was no DQA summary report seen during the field study. In the Regional level and program office they were doing jointly DQA quarterly, they had special tracking tool for Family planning DQA and report was available for verification.

6.3 Conclusions

Data is a fuel to foster sustainable development goal to overcome global health challenges. The findings concluded that Family planning program use MTUHA book no 8 which consist of three books namely registers, tally sheet and summary report books as a data recording and data reporting tools in the health facilities, despite that tools are available but still the quality of data remained doubtful due to data disparities that were

observed in the documentary review across different level of response. Family planning data quality assessment was only performed at the District and in the Region level but rarely and improperly conducted at facility levels due to some observed challenges like inadequate knowledge for FP DQA, lack of skilled team, lack of standardized data quality assessment tools, mistrust of data collectors at different levels, data manipulation to fulfil donors requirements, parallel reporting and report overburden at the health facilities.

6.4 Recommendations

- i. Due to some challenges observed during the field study, it is recommended to improve the health care provider's skills and knowledge through capacity building on proper recording and provision of accurate report to the higher level to avoid data variation.
- ii. Data collected at the health facilities should not be manipulated at the District level to avoid data distortion.
- iii. Family planning data quality assessment tools should be standardized and customized to suit different level of response to create data uniformity from lower level to higher level.
- iv. All data books in the facility levels should be kept secured in a locker and key to avoid unauthorized personnel to access the data without permission and to avoid manipulation and misplacement of the data tools.
- v. Management should take initiatives to produce and supply sufficient report books to avoid inconsistency of data produced in the facilities due to improper reporting tools.
- vi. It is recommended to have a single source of data in the District to avoid incoherent due to parallel reporting system that may affect the quality of data.
- vii. CHMT's through supportive supervision recommended to assist the health care providers in the facility how to perform data quality assessment so as to produce a quality health reports.

6.5 Policy Implication

To enhance sustainability of family planning data quality produced, all donor projects need to be integrated in Ministry of Health and use a single source of data to avoid lateral data.

6.6 Limitation of the evaluation

During the field study, the researcher faced three limitations, financial challenges, shortage of time for evaluation and low response rate of informants especially in the program office.

6.7 Area for further evaluation

Further evaluation need to be carried out to establish the course of data disparities between different levels of response in the District.

REFERENCES

- Calverton, Maryland (2007). ICF Macro National Bureau of Statistics (NBS) and Macro International Inc.
- Campbell, J., Fauveau, V., Hoope- Bender, P., Mathews, Z., McMannus, J. (2011). *The State of the World's Midwifery 2011: Delivering Health, Saving lives*. UNFPA & WHO Global Atlas of the Health Workforce
- Hancock *et al.* Contraception and Reproductive Medicine (2016) 1:10
- Kowalewski M., Jahn A., Kimatta SS. (2000)
- Lloyd, C. and J. Ross. (1989). "Methods for Measuring the Fertility Impact of Family Planning Programs: The Experience of the Last Decade." Research Division Working Papers, No. 7. NY: The Population Council.
- Mselle L., Moland K., Mvungi A., Evjen-Olsen B., Kohi T. (2013) Why give birth in a health facility? Users' and providers' accounts of poor quality of birth care in Tanzania. *BMC Health Services Research* 13:174
- National Audit Office (2008) *A Performance Audit Report on the Management of Primary Healthcare: A case study of health centres*. Office of the Controller and Auditor General, Dar es Salaam, Tanzania
- National Bureau of Statistics of Tanzania (NBS), ICF Macro (2011).
- NFPCIP (2010) The National Family Planning Costed Implementation Program 2010-2015
- NFPRAT (2013) The National Family Planning Research Agenda in Tanzania 2013 - 2020.
- Tanzania Demographic and Health Survey 2010.*
- Tanzania Service Provision Assessment Survey 2006*. Dar es Salaam, Tanzania: National Bureau of Statistics and Macro International Inc.

United Republic of Tanzania Ministry of Health and Social Welfare (2008). *The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (2008 - 2015) - One Plan*. Dar es Salaam, Tanzania: MOHSW

WHO (1985), Appropriate Technology for Birth, *The Lancet* 326 (8452) 436-437

Why do at-risk mothers fail to reach referral level? Barriers beyond distance and cost. *African Journal of Reproductive Health* 4(1):100-9

<http://www.familyplanning2020.org>. c2017.

<http://www.un.org/en/development/desa/population/theme/family-planning/index.shtml>

www.ghspjournal.org

APPENDICES

Appendix 1: Observation checklist for data collection and data reporting tools at facility level.

OBJECTIVE 1: To determine the tools used by health care providers in recording and reporting family planning data at facility level.

Interviewer Name.....

Level of Data collection.....

Date.....

INFORMED CONSENT

Dear Sir/ Madam

Greetings to you, First of all I would like to introduce myself. I am a student from Mzumbe University pursuing Master of Science in Health Monitoring and Evaluation, My research title is Data quality assessment on family planning intervention program. *“To determine tools used in recording and reporting family planning data at facility level”*. A case study of Tarime District. This evaluation study is for academic purpose so as to fulfil a requirement for the award of Master’s Degree. Thus, I kindly request you to participate in this study, any contribution from you towards success of this study will be valued positively, however, I assure you that all information collected from you will be kept strictly confidentially.

Social-Demographic information of the Health care providers in the Facility (Participants)

1: Age.....

2: Sex.....

3: Cadre.....

4: Qualification.....

5: Position.....

6: Working experience in family planning unity.....

7: Permanent working in family planning unity..... (a) Yes (b) No

Table 1: Observation Checklist for family planning data recording and data reporting tools used by health care providers at facility level.

SN	Facility name	Family planning services		FP data recording tools		FP reporting tools	
		provided	not provided	available	not available	available	not available

Table 2: Summary for observation checklist in FP data recording and data reporting tools available at facility level

SN	Facility name	Facility with FP recording tools	Facility Without FP recording tools	Facility with FP reporting tools	Facility Without FP Reporting tools	Total facility with FP tools	Total facility without FP tools

Appendix 2: Tables for Data similarities

Objective 2: To assess the extent to which data collected at different levels with different organisation are similar.

Interviewer Name.....

Level of Data collection.....

Date.....

INFORMED CONSENT

Dear Sir/ Madam

Greetings to you, First of all I would like to introduce myself. I am a student from Mzumbe University pursuing Master of Science in Health Monitoring and Evaluation, My research title is Data quality assessment on family planning intervention program. *“To assess the extent of data similarities collected with different organisation”*. A case study of Tarime District. This evaluation study is for academic purpose so as to fulfil a requirement for the award of Master’s Degree. Thus, I kindly request you to participate in this study, any contribution from you towards success of this study will be valued positively, however, I assure you that all information collected from you will be kept strictly confidentially.

Table 3: Data collection form for FP clients attended in the year 2014-2017 at Tarime DC (Facility level-RCH Nurse/HF IC)

SN	Facility name	number of clients attended in 2014		number of clients attended in 2015		number of clients attended in 2016		number of clients attended in 2017	
		continuing users	new users	continuing users	new users	continuing users	new users	Continuing user	new users

Table 4: Data collection form for FP clients attended in the year 2014-2017 at Tarime DC (District level-DRCHCO)

SN	Facility name	number of clients attended in 2014		number of clients attended in 2015		number of clients attended in 2016		number of clients attended in 2017	
		continuing users	new users	continuing users	new users	continuing users	new users	Continuing user	new users

Table 5: Data collection form for FP clients attended in the year 2014-2017 at Tarime DC (District level- DHIS2 data base)

SN	Facility name	number of clients attended in 2014		number of clients attended in 2015		number of clients attended in 2016		number of clients attended in 2017	
		continuing users	new users	continuing users	new users	continuing users	new users	Continuing users	new users

Table 6: Data collection form for FP clients attended in the year 2014-2017 at Tarime DC (Regional level - RRCHCO)

SN	number of clients attended in 2014	number of clients attended in 2015	number of clients attended in 2016	number of clients attended in 2017

Table 7: Data collection form for FP clients attended in the year 2014-2017 at Tarime DC (Regional program office JHPIEGO – Program Coordinator)

SN	number of clients attended in 2014	number of clients attended in 2015	number of clients attended in 2016	number of clients attended in 2017

Table 8: Summary form for different Organisation FP Data collected between 2014-2017

SN	FP data point (Data base)	FP clients (2014)	FP clients (2015)	FP clients (2016)	FP clients (2017)	Total FP clients in 2014-2017
1	Facility level					
2	District level					
3	DHIS2					
4	Regional level					
5	Program Office					

Appendix 3: Tables for Data quality verification

Objective 3: To explore how different organizations assess family planning data quality collected at different levels.

Interviewer Name.....

Level of Data collection.....

Date.....

INFORMED CONSENT

Dear Sir/ Madam

Greetings to you, First of all I would like to introduce myself. I am a student from Mzumbe University pursuing Master of Science in Health Monitoring and Evaluation, My research title is Data quality assessment on family planning intervention program. *“How the Organisation assess FP data quality”*. A case study of Tarime District. This evaluation study is for academic purpose so as to fulfil a requirement for the award of Master’s Degree. Thus, I kindly request you to participate in this study, any contribution from you towards success of this study will be valued positively, however, I assure you that all information collected from you will be kept strictly confidentially.

Table 9: FP data quality assessment checklist at Facility level (Facility name.....)

SN	FP DQA		Tools for FP DQA		Skilled staff for FP DQA		Monthly FP DQA report available	
	conducted	not conducted	available	not available	available	not available	available	not available
	Use FP data recording, tally sheet and report book to verify DQA report							
	1:Data completeness		2:Data reliability(consistence)		3:Data Timeliness		4:Data accuracy	
	complete	not complete	consistence	No consistence	timely	not timely	valid	not valid
	Use FP data recording, tally sheet and report book to verify DQA report							
	5: Data precision (detailed)		6: Data integrity (protected)					
	sufficient	not sufficient	protected	Not protected				

Table 10: FP data quality assessment checklist at District level (DRCHCO)

S N	FP DQA		Tools for FP DQA		FP DQA Team		Monthly FP DQA report available	
	conducted	not conducted	available	not available	available	not available	available	not available
	Use FP reports form from the facility to verify DQA at the District level							
	1:Data completeness		2:Data reliability(consistence)		3:Data Timeliness		4:Data accuracy	
	complete	not complete	consistence	not consistence	timely	not timely	valid	not valid
	Use FP reports form from the facility to verify DQA at the District level							
	5: Data precision (detailed)		6:Data integrity (protected)					
	sufficient	not sufficient	protected	Not protected				

Table 11: FP data quality assessment checklist at Regional level (RRCHCO)

SN	FP DQA		Tools for FP DQA		FP DQA Team		Monthly FP DQA report available	
	conducted	not conducted	available	not available	available	not available	available	not available
	Use FP quarterly reports from the district to verify DQA at the Regional level							
	1: Data completeness		2:Data reliability(consistence)		3:Data Timeliness		4:Data accuracy	
	complete	not complete	consistence	not consistence	timely	not timely	valid	not valid
	Use FP quarterly reports from the district to verify DQA at the Regional level							
	5: Data precision (detailed)		6: Data integrity (protected)					
	sufficient	not sufficient	protected	Not protected				

Table 12: FP data quality assessment checklist at the Program Office (Program coordinator)

SN	FP DQA		Tools for FP DQA		FP DQA Team		Monthly FP DQA report available	
	conducted	not conducted	available	not available	available	not available	available	not available
	Use FP quarterly reports from the district to verify DQA at the program office							
	1: Data completeness		2: Data reliability (consistence)		3: Data Timeliness		4: Data accuracy	
	complete	not complete	consistence	not consistence	timely	not timely	valid	not valid
	Use FP quarterly reports from the district to verify DQA at the program office							
	5: Data precision (detailed)		6: Data integrity (protected)					
	sufficient	not sufficient	protected	Not protected				

Table 13: Summary form for FP DQA at different levels of Response

SN	Level of response	FP DQA conducted monthly or quarterly		Tools for FP DQA available		FP DQA skilled team available		Monthly / quarterly FP DQA report available		Adherence to six dimensions of DQA	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1	Facility level										
2	District level										
3	Regional level										
4	Program Office										

INTERVIEW GUIDE

(Health care providers/DRCHCO/HMIS FP/RRCHCO & Program Coordinator)

First of all, thank you for giving me a time to share with you an experience. I would like to ask you some questions about data quality assessment on family planning intervention program. My interest is to hear from your experiences, opinions and beliefs in your own words. In case of any question or doubt that make you feel uncomfortable, please don't hesitate to tell me and we can skip over those questions.

Questions:

- 1: What do you know about Family planning?
- 2: For how long have you been working in Reproductive and Child health?
- 3: Have you ever heard about Family planning data quality assessment?
- 4: Are you performing data quality assessment in your office? If yes how often?
- 5: How do you ensure FP data accuracy?
- 6: For how long have you been trained on FP DQA?
- 7: When do you perform data quality assessment in your Organisation?
- 8: Do you have tools for Family Planning DQA? If yes, can I see them? If no why?
- 9: Do you have a skilled Quality Improvement Team (QIT) in your Organisation? If yes. How was it selected? If no why?
- 10: Do you know the principles of DQA? If yes, can you explain?

THANK YOU