M&E Strengthening – 5 Year Strategy

2015 - 2020

DRAFT

Working Document for Input from Stakeholders
A Tanzanian Platform for Health Information and Accountability

07 May, 2015

1. Document History

Date	*Document Description*	*Comments*
June 26, 2014	Template Outline	*Rough outline created to have stakeholders start contributing*
Oct 23, 2014	*Zero Draft*	*Initial draft of ideas based on input received to date*
Nov 17, 2014	Zero.1 Draft	Shared with M&E TWG for input and additional information
Dec 31, 2014	Zero.2 Draft	Updated based on discussions with smaller working group. Created tables for summarizing objectives and outcomes, activities and outputs. These will be used for refined costing for HSSP IV. All group members requested to make sure their disease program area priorities are represented. High level document so not too much detail please...
Apr 20-25, 2015	Zero.3 Draft	Updated based on working meeting on 14 April, 2015 with the larger team. Moving more of Situational Analysis detail for each section into Appendices. Separated Surveys from Surveillance. Included input from NBS, RITA and DSW. Missing final review from NMCP, TB/L, IHI, NSS and RCHS.

2. Acknowledgements

Stakeholders provided input
IHP Monitoring Framework Guidance
M&E TWG Zero Draft presentation review

3 Acronyms

AIS	Aids Indicator Survey
BRN	Big Results Now
BRS	Birth Registration System
CBDMS	Community Based Data Management Systems
CCHP	Comprehensive Community Health Plan
CDC	Centers for Disease Control
CHMT	Council Health Management Team
CPD	Continuous Professional Development
CRVS	Civil Registration and Vital Statistics
DD&U	Data Dissemination and Use
DED	District Executive Director
DHP	District Health Profile
DHS	Demographic Health Survey
DHSS	Demographic and Health Surveillance Systems
DMO	District Medical Officer
DPP	Directorate of Policy and Planning
DQA	Data Quality Assessment
DSS	Demographic Surveillance System
EA	Enterprise architecture
EBDM	Evidence Based Decision Making
EKN	Embassy of the Kingdom of the Netherlands
EMR	Electronic Medical Record
FBO	Faith Based Organization
GOT	Government of Tanzania
HCW	Health care workers
HDSS	Health Demographic Surveillance Sites
HFR	Health Facility Registry
HIE	Health Information Exchange
HMIS	Health Management Information System
HoMIS	Hospital Management Information Systems
HR	Human Resources
HRH	Human Resource for Health
ICT	Information Communication Technology
IDSR	Integrated Disease Surveillance reporting
JAHSR	Joint Annual Health Sector Review
L&D	Labor and Delivery

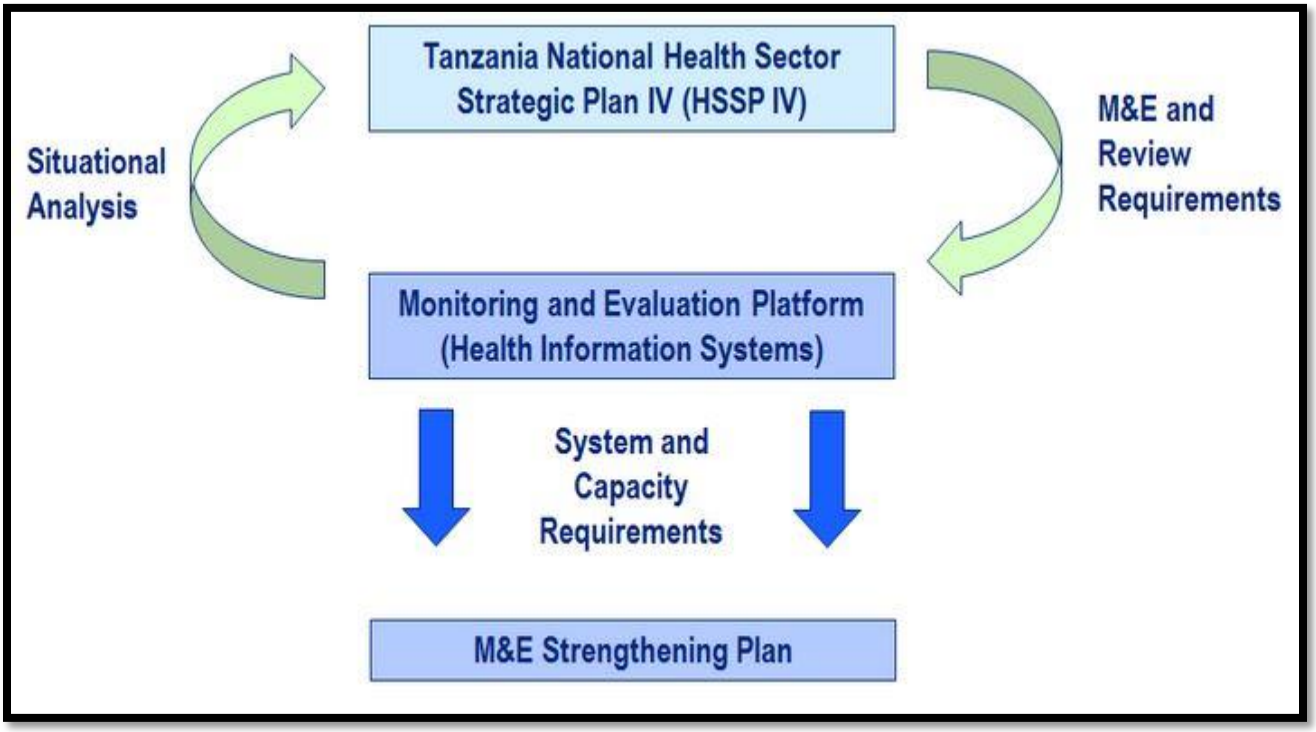
LAN	Local Area Network
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MDA	Ministries, Departments and Agencies
MIS	Malaria Indicators Surveys
MOHSW	Ministry of Health and Social Welfare
NBS	National Bureau of Statistics
NeHSC	National eHealth Steering Committee
NIDS	National Indicator Data Set
NMSF	National Multi-Sectoral Strategic Framework
OGP	Open Government Partnership
PMTCT	Prevention of Mother to Child Transmission
RHMT	Regional Health Management Team
RITA	Registration Insolvency and Trusteeship Agency
SARA	Service Availability and Readiness Assessment
STI	Sexually transmitted infections
TAIS	Tanzania Aids Indicator Survey
THMIS	Tanzania HIV and Malaria Indicator Survey
TIIS	Training Institution Information System
TKAPS	Tanzania Knowledge, Attitudes and Practice Survey
TNMC	Tanzania Nurses and Midwifery Council
TSMP	Tanzania Statistical Master Plan
TSPA	Tanzania Service Provision Assessment
TWG	Technical Working Group
USSD	Unstructured Supplementary Service Data
WAN	Wide Area Network
WHO	World Health Organization

3. Aim of the Document

The Health Sector Monitoring and Evaluation (M&E) Technical Working Group (TWG) is working together in a coordinated way through the M&E Strengthening Initiative to produce a new long term strategic plan for M&E. The M&E TWG envisions that this strategic plan informs

prioritization discussions for HSSP IV and serves as the coordinating plan for all stakeholders contributing to M&E developments related to the health sector for the period 2015 – 2020.

4. A Tanzanian Platform for Health Sector Information and Accountability



1. **Tanzanian Platform for Health Sector Information and Accountability**

A Tanzanian platform for health sector information and accountability needs to provide the situational analysis that informs the development of a national health strategy and is responsive to monitoring, evaluation, and review requirements derived from the national health strategy. The M&E stakeholders in Tanzania are preparing this initial draft of a five-year M&E strategy as part of the development of the National Health Strategy and health stakeholders provide ongoing review of the strategies outlined in this document as the Tanzanian HSSP IV is developed.

5. Background – Health Sector M&E Situational Analysis

The Health Sector Strategic Plan III (HSSP III) covered a period from 2009 to 2015. The health sector stakeholders established the M&E SI in 2010 to coordinate inputs and activities to achieve the HSSP III M&E strategies and the Mid Term Review of the HSSP III concluded that the health sector had made significant progress towards the HSSP III objectives through the M&E SI. The Health Sector currently developing a fourth Health Sector Strategic Plan (HSSP IV) and M&E systems have to support the strategic planning process and meet the ongoing monitoring needs of the new plan once it is established.

HSSP III called for a renewed emphasis on monitoring and evaluation concluding that it was essential for measuring progress towards all other health sector objectives and targets. The HSSP III (M&E Chapter) articulated a new vision – to develop a culture of monitoring and evaluation that ensures decision makers at all levels use quality data for planning and management of health sector activities.

The HSSP M&E chapter outlined five strategies:

1. To develop a comprehensive M&E and Research Strategy for the health and social welfare sector
2. Strengthen integrated systems for disease surveillance (IDSR)
3. Strengthen integrated routine HMIS
4. Introduce data aggregation and sharing systems based on ICT
5. Enhance surveys and operational research

In 2013 - 2014 the external reviewers for a mid-term review of HSSP III found the following in relation to M&E:

1. There is a viable strategy for developing M&E into the health sector in Tanzania. Innovative disease surveillance and sentinel information systems are under development with a potential to get in-depth knowledge on health issues.
2. The HMIS is developing well and when integrated into planning and decision-making processes, it can become the backbone for evidence-based management and accountability and thus play a role in performance management systems.
3. The culture and capacities for a data-for-decision-making approach are not yet in place at district and facility level.
4. Research is increasing and reports are better available. Feedback loops for evidence-based policy-making still need to be established.
5. The developments with regard to Information Communication Technology (ICT) are promising and have a potential to change the face of health service delivery, but still require huge investments and capacity building in the country.

2. M&E Strengthening Initiative (M&E SI)

The Health Sector M&E TWG and a consortium of implementing and funding partners joined together under the leadership of the Ministry of Health and Social Welfare (MOHSW) M&E section to create the M&E Strengthening Initiative in 2009/2010.

The M&E SI was organized into 8 different work packages (technical areas). M&E SI key achievements as of 2014 include:

- Indicator Harmonized across 15 Health Information System (MTUHA) tools, and printing and distributing to all 25 regions for the years 2013/2014 and 2014/2015. (Details summary of registers in table __).
- Trained 28,750 health care workers and 2,395 CHMT/RHMT on using the revised HMIS tools
- The major review of routine HMIS tools and DHIS2 software was customized and successfully introduced to 6,963 health facilities and DHIS2 to 163 council. Today over 85%

of all health facilities report on monthly data enable health managers to make informed decisions

- The M&E SI funds supported ICT services in the health sector, 46 councils received ICT support for Networking connectivity, Virus protection and other ICT related service. These funds also supported the improvements of the MOHSW HQ central server and Local Area Network (LAN) infrastructure.
- Integration of HMIS training manual into Health Training Institutions curricular in order to ensure that all graduates from health colleges have knowledge on HMIS. Trainings were conducted, manuals printed and distributed to institutions.
- Supported the Integration of Human Resource for Health (HRH), HIV/AIDS, TB, Malaria and Prevention of Mother to Child Transmission (PMTCT) into DHIS2-MTUHA reporting system to allow a single repository source of information (data warehouse).
- Established District Health Profile (DHP) whereby already 36 Districts have been oriented and have produced the annual DHP 2012 and are able to produce DHP annually.
- Implementing the revised MTUHA in DHIS2 iteratively, and training 888 Council Health Management Team (CHMT) and Regional Health Management Team (RHMT) staff on using DHIS2; DHIS2 has been in use for a year with current 10 books reporting rate of 83.5%
- Created and launched the draft eHealth Strategy
- eIDSR mobile reporting developed and 18 districts making use of mobile reporting with Unstructured Supplementary Service Data (USSD) interface direct to DHIS.
- Trained 401 CHMT/RHMT staff on the Health Facility Registry (HFR) paper tool, system and Geographical positioning system. Data entry is ongoing with expected public portal launch date of 1 Dec, 2014
- Revised Supportive Supervision tools and used in 8 regions in summer 2014
- The Annual Health Sector Performance Profile Report was produced for 2011 and 2013, with the Mid Term Review for 2012
- RCH scorecard launched in May 2014 makes use of routine HMIS data to support evidence based decision making
- M&E masters has taken their second intake at Mzumbe University
- M&E offices at the MOHSW were rehabilitated
- Semi-annual and Annual M&E SI reports prepared and submitted
- Newly introduced community based forms in use in SAVVY/ Demographic Surveillance System (DSS) at 23 sites
- Service Availability and Readiness Assessment (SARA) results disseminated in May 2014

The budget originally presented for the 5 year M&E SI, including funds from Norway, US Government Centers for Disease Control (CDC), Global Fund Round 8 and Round 9, Embassy of the Kingdom of the Netherlands (EKN) and World Bank totaled 32.5 B TZS.

Funds disbursed:

SUMMARY OF FUNDS RECEIVED							
FUNDING	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	TOTAL	
Global Fund Round 9	2,138,327,473.89	5,529,717,634.50	6,469,295,756.00	0	1,027,326,326.10	TZS	15,164,667,190.49
EKN	1,199,700.00	0	1,945,558.40	1,810,857.75		USD	4,956,116.15
CDC COAG TO M&E SI	150,000.00	150,000.00	150,000.00	150,000.00		USD	600,000.00
M-HEALTH IDSR		150,000.00	150,000.00	150,000.00		USD	450,000.00
CDC - RTI	100,000.00	250000	450,000.00	400,000.00	600,000.00	USD	1,450,000.00
SAVVY - CDC TO MESI VIA IHI	750,000.00	750,000.00	750,000.00	750,000.00		USD	3,000,000.00
GOT	0	0	0	0	0		-

2. **M&E Strengthening Funds Disbursed 2010 - 2014**

3. Emerging Priorities, Challenges and Gaps

1. Disease Program M&E Strategies and Requirements

Refer to ***Appendix A*** which summarizes the current disease program, social welfare and research M&E strategies for the 2015-2020 period. As part of the group working on this document these stakeholders provided input and review of this integrated M&E strategy and plan. The groups included NACP, NMCP, TB/L, RCHS including PMTCT, TACAIDS, PMORALG, DSW, WASH, NBS, RITA, NIMR, ICT/eHealth, MOHSW M&E/HMIS including Surveys and Surveillance and DHR. This also included the following partners of CDC, USAID, IHI, MDH, and Measure Evaluation.

2. Midterm Analytical Review M&E Recommendations

The Midterm Analytical Review (MTR) of the Performance of the Health Sector Strategic Plan III (July 2009- June 2015) captured the recommendations from workshop participants for priority actions for data sources, analytical capacity, and data communication and use. The recommendations based on the comprehensive overview of the current status of the health sector in Tanzania mainland, using all available data from the health management information system, household surveys and many other sources.

Area	Main achievement	Priority for action
Surveys	Regular surveys provide wealth of information	Need for 10-year costed plan for population and facility surveys, driven by country information needs More emphasis on survey analysis
HMIS	Improved availability of data from districts and regions which can be used for review	Complete roll-out of DHIS to enhance HMIS; regular reviews of the functioning of HMIS; regular interaction with stakeholders; further integration of parallel data systems; continued training program, with regional responsibilities or institutionalization of courses
Birth and death registration	Not present but sentinel panel of district is beginning to fill the gap; HDSS provide timely high quality data	ICD-10 coding needs to be introduced in HMIS register of deaths; continue SPD and SAVVY; support Civil registration system roll-out (RITA)
Administrative data	HRH information system improving; NHA becoming regular (institutionalized)	Use of facility registry service by all; also financial tracking and logistics management systems
Disease surveillance	System in place for surveillance of notifiable diseases	Integration of mobile reporting and IDSR tracking into DHIS/HMIS;
Analytical capacity	Ifakara Health Institute, NIMR can provide technical assistance to MoHSW	More emphasis on district and regional capacity; facilitate data analysis in DHIS
Data communication and use	Annual review and program reviews are key vehicles for data use and demand good statistics and analyses	Use new HMIS to effectively communicate data through dashboard, visualization etc.; continue to invest in conducting comprehensive analysis for annual reviews

3. **HSSP III MTR M&E Related recommendations**

3. Big Results Now

The Health sector spent 6 weeks in Big Results Now Prioritization process and performance management emerged as one of four key priorities. To address the performance management issues the BRN aims to ensure 80% of primary health facilities at 1- & 2- Star to be 3-Star and above by 2017/2018.

Key results targets for BRN performance management priority are:

- Assess all primary level health facilities by June 2015
- Develop specific intervention program for health facilities rated 1 & 2 by end-March 2015
- Implement the intervention program for 12 specific regions – Kigoma, Katavi, Tabora, Singida, Shinyaga, Geita, Mwanza, Simiyu, Mara, Kagera, Pwani and Dar es salaam

2014 Joint Annual Health Sector Review (JAHSR) Policy Recommendation

In line with the BRN priorities, the 2014 Joint Annual Health Sector Review Process concluded with Accountability as one of its high level policy statements

> *"M&E systems continue to be strengthened with harmonization of information systems and improved data quality with increased accessibility by stakeholders for validation of health sector performance. Promote innovations and research for empowering communities and apply evidence based health care practices for better health outcomes"*

5. Open Information and M&E Policy and Guidelines

The Government of Tanzania (GOT) has committed to the Open Government Partnership (OGP).

Tanzania Open Government Partnership (OGP) Second National Action Plan 2014/15 - 2015/16

Tanzanian Government Commitment:
To establish an open data system by December 2016.
Key steps to operationalizing this commitment include the following:
(i) Establishing a coordinating body or working group under the Ministry of Finance for exploration of this issue.
(ii) Supporting guidelines issued, followed by legislative resolutions demonstrating support for transparent operations and the integration of open data into policy considerations, including provision of data in machine readable formats.
(iii) Establishment of a user-friendly, interactive open data portal data.go.tz.
(iv) Publication of key datasets on data.go.tz, particularly related to the education, health and water sectors, including data from Basic Education Statistics in Tanzania (BEST) and national examinations (NECTA), medical facilities and Medical Stores Department (MSD), water points, company registrations, NBS census and survey data and GIS data on village and ward boundaries; and with all data an emphasis on provision of disaggregated data at the facility level so as to be meaningful to citizens

4. **Tanzania Open Government Partnership**

Currently the National Health policy addresses some of the following technical areas, but this has not been revised since 2007 and several changes have happened around the world in relation to these areas, which will need review and revision.

1. Data Protection or Data Security
2. Data Access and Use Policy
3. Data Sharing Agreements
4. Record Keeping and Storage

Publishing frequently requested data in an open format allows people to self-serve, and preserves internal staff time for more pressing needs, and also allows people to share their own analysis of this data and any gaps or opportunities identified.

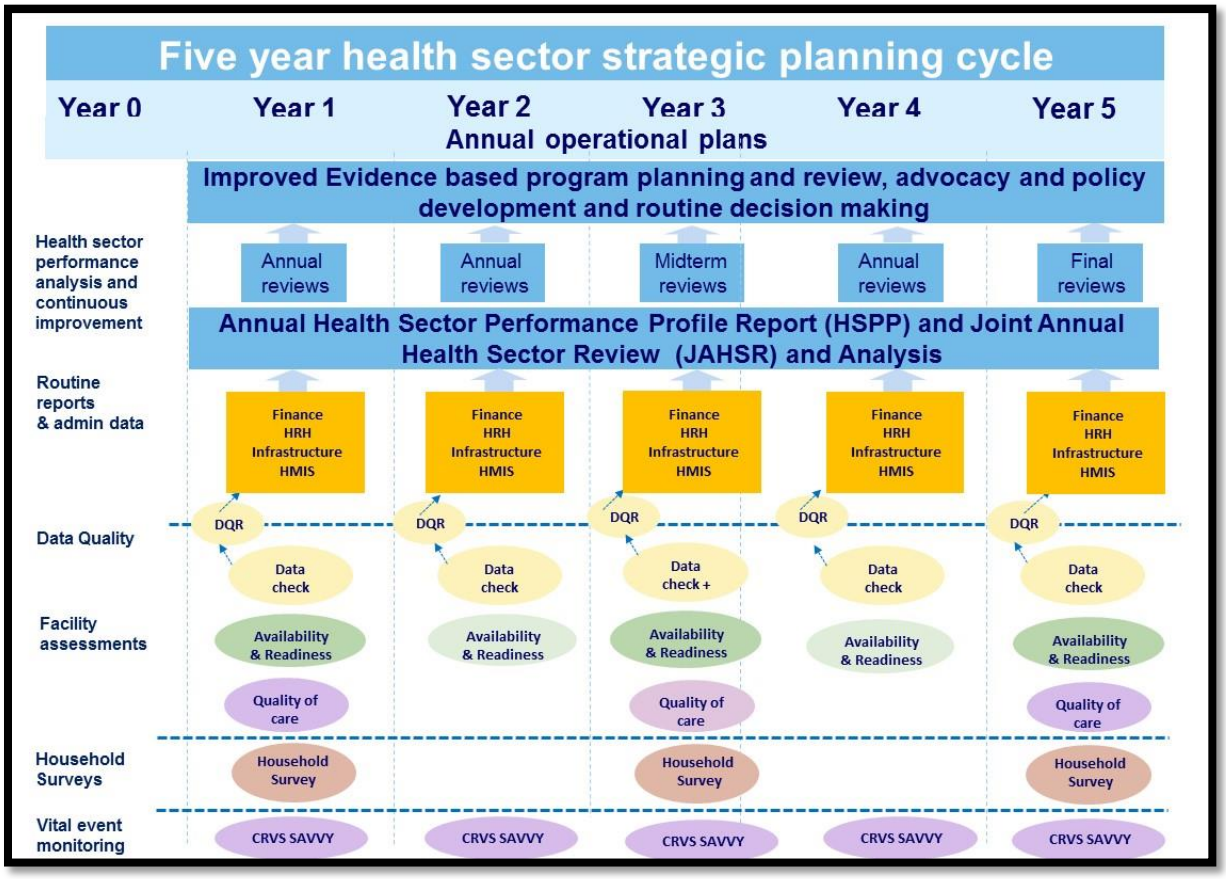
Governments that release open data can leverage both their local developer communities and the efforts of developers elsewhere to bring useful apps to their citizens. Finally, governments that share open data with outside consumers lay the foundation for a different, equally important, and kind of sharing – sharing data across government agencies.

The Ministry of Health and Social Welfare is committed to sharing analyzed data and the M&E section will take steps to establish a data sharing portal to improve all stakeholder access.

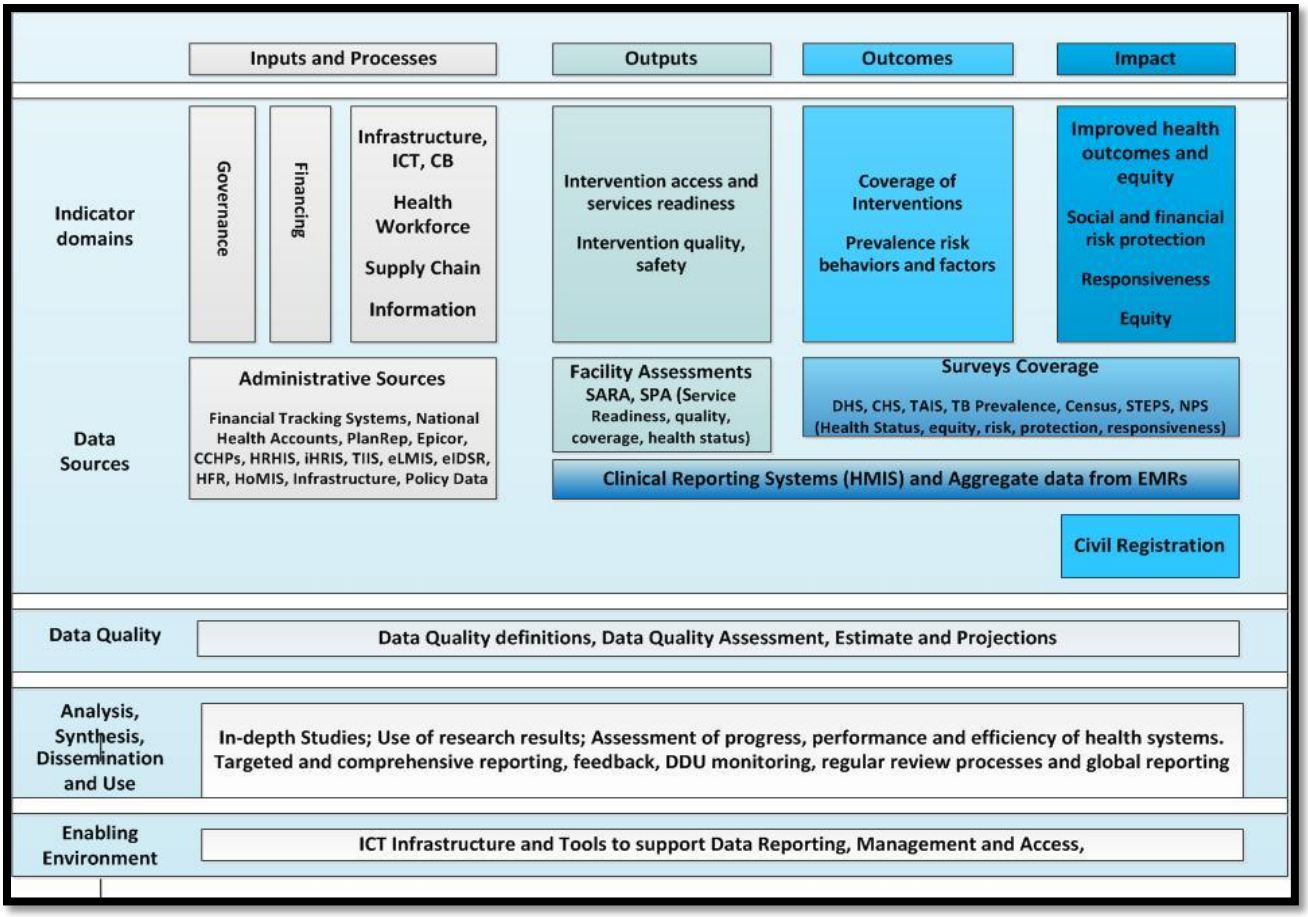
6. M&E Vision

A comprehensive Tanzanian platform for health Information, evidence based decision making and accountability for results.

7. M&E Platform and the HSSP IV Planning Cycle



5. **M&E Systems and HSSP IV**



6. **Health Sector M&E Framework for M&E Strengthening and HSSP IV Monitoring**

Data Sources:

"Sources of health data can be divided into two broad groups: (i) those that generate data relative to populations as a whole; and (ii) those that generate data as an outcome of health-related administrative and operational activities. Other sources of information such as health systems research and longitudinal community studies may also feed into the M&E system. The goal is that all countries have in place the range of data sources needed to generate a critical data set." (IHP Monitoring Framework)

The following sections describe the Situational Analysis, Five Year Vision, the HSSP IV priorities, the Objectives and Outcomes and proposed Activities, Outputs and budget for each functional area:

1. Routine Health Management Information System (HMIS): Clinical and Administrative Data
2. Surveys: Facility Assessments, Health Surveys and Population Data
3. Surveillance
4. Civil Registration and Vital Statistics (CRVS))
5. Data Quality
6. Data Dissemination and Use & Evidence Based Decision Making
7. Information Systems Integration and ICT Infrastructure to Support M&E
8. Systematic and Continuous Professional Development (CPD) for M&E

8. Routine Health Management Information System (HMIS): Clinical and Administrative Data

Situational Analysis

Refer to ***Appendix B*** for a more detailed Situational Analysis.

Overview

Tanzania facilities use Health Management Information System (HMIS) registers to document information about patient visits to their facilities, and then report aggregate summaries to districts using monthly summary forms that are entered into the MOHSW DHIS by districts. This health information is used by policy makers and health managers to understand the current health status of the population and make informed health decisions.

Administrative data, including finance, human resources (HR), laboratories, drugs and commodities, are managed by relevant directorate or sections and many have separate processes and systems for managing administrative data. Administrative data and HMIS data are used together to understand the resources used and gaps in service delivery to target interventions to improve health outcomes.

Current Status

Service data is gathered through a routine national Health Management Information System (HMIS). The HMIS includes paper registers and tally sheets used at the facility level to record patient interactions, monthly summary forms used to submit aggregate data to the district level and the MOHSW DHIS software (Implemented by UDSM/UiO) used to manage and analyze routine aggregate service delivery data reported by health facilities. Administrative data is managed by relevant directorate or section. Examples include Human Resource Information System (HRHIS) and e-LMIS to manage deployment and data related to logistics management.

During each year, the MOHSW and stakeholders continue to harmonize indicators and related tools, to minimize duplicate data collection and reporting. Recently the MOHSW has worked with the HIV/AIDS, TB/L, malaria and PMTCT to harmonize reporting in DHIS2. The MOHSW worked with stakeholders to refine the HMIS Supportive Supervision tools and these are now implemented in DHIS. The M&E Section in the MOHSW disseminates quarterly HMIS results to all regions, councils, vertical programs and the M&E TWG, and now includes the Reproductive, Maternal Newborn and Child Health (RMNCH) Score Card that is disseminated quarterly to all regions and councils since May 2014. and Child Health Score Card (RCH) since May 2014. The MOHSW provides training to health workers on the use of the printed tools and DHIS, and provides ongoing support for both the printed tools and DHIS software.

Refer to ***Appendix B*** for the completed DHIS2 status of all modules. ANC, L&D, Postnatal, IPD, OPD, Child Register, DTC, FP, tracer medicine and HR have all been in use since Oct 2013. The eye and Dental register are in use since Oct 2014. The Lab and Dispensing registers have been revised and finalized pending printing starting July 2015. The NACP CTC form is in use since October 2014. TB and leprosy district quarterly report forms were integrated into DHIS2 October 2015, used to generate the 2014 report.

Gaps and Challenges

All regions and districts of Tanzania have been reporting DHIS since October 2013, and the reporting rates continue to improve. There are ongoing challenges identified including

Insufficient/incorrect printed tools distributed to all districts/facilities (distribution of tools did not match the allocation formula), new staff have not received training (printed or DHIS2), limited funds for supervision, poor internet connectivity and limited funds to sustain connections, the new districts did not receive motorbikes, disease programs and HMIS have different supportive supervision forms, vertical programs still having duplicate reporting in some areas, limited training in ICD-10,

Data Quality is an issue - comparing physical registers with aggregate summary information has differences. There are multiple HR systems in place, HRHIS (MOHSW), iHRIS (PMORALG) and Lawson (POPSM). Limited capacity at the district level for developed realistic budgets for costing HMIS/DHIS routine and new activities to ensure there are adequate funds to meet expected targets. Research results and data sets not linked to HMIS or made accessible to use in further studies or routine data analysis and donors fund research in certain areas that is not always aligned with the MOHSW priorities.

Five Year Vision

Quality and reliable data from routine health delivery system (HMIS and Administrative) is available and accessible to stakeholders at all levels for synthesis of information and use.

HSSP IV

Priority issue/area of work	**Key Programmatic Interventions (Refer reader to specific section of M&E 5 year strategy)**	**Indicators and targets and M&E systems needed**
Improved Efficiency of HMIS Systems and Processes to meet all health sector M&E requirements	Printing, Training, on Tools, Use Reduce burden of HMIS on HCW by prioritizing data elements and expanding use of electronic tools. (include both electronic registers for aggregate data and use of electronic medical records with automated aggregate reporting)	# and % of facilities with timely and complete HMIS reports.(Disaggregated by form, service area or disease program) Consider an indicator that measures clinician or nurse work load related to data collection and reporting.
~~HMIS Data Quality: Strengthen accuracy, of data.~~	~~Refer to Data Quality Section for details~~	~~Refer to Data Quality Section for details~~

7. **Health Sector M&E Framework for M&E Strengthening and HSSP IV Monitoring**

Objectives and Outcomes

Objective	Outcome Indicator	2014 Baseline	2020 Target
Improved Efficiency of HMIS to meet all health sector M&E requirements	# and % of facilities with timely and complete HMIS reports. Disaggregated by disease program. Consider an indicator that measures clinician or nurse work load related to data collection and reporting. Total Number of Data Elements reported across all **paper** tools (excludes data elements automatically submitted to DHIS: current approximately 1400? to be confirmed? including added forms for DSW Number of sites using electronic systems to automatically submit aggregate data to DHIS and % of client interactions.	Overall: RCH: PMTCT: HIV: TB&L: Malaria: (include baseline for full 2014 and last quarter) Total Number of Data Elements reported across all **paper** tools:? 1400? 0 Sites # and % patients reported via electronic systems HIV C&T: TB Patients: RCH Continuum: Immunization:	Overall: 98% RCH: 98% PMTCT: HIV: 98% TB&L: 98% Malaria: 98% DSW:? Total Number of Data Elements reported across all paper tools: 700 2000 Sites # and % of patients reported via electronic systems: HIV C&T:80% TB Patients:80% RCH Continuum:80% Immunization: 80%

Refer to ***Appendix B*** for additional measurable outcomes that were considered but not included.

Activities, Outputs and Budget

	Objective	**Improved Efficiency of HMIS Systems and Processes to meet all health sector M&E requirements**		
	Activity	**Measurable Output**	**Sustain, HSSP IV Priority, Development Priority**	**Other Info to inform costing**
1	Printing and Distribute and/or set up council procurement for paper M&E tools.	All facilities have required paper tools	Sustain	Included in MESI budget

2	Formal, documented Annual Review Process for HMIS tools to create, update, integrate paper tools and ensure paper tools evolve as health sector requirements and priorities evolve (includes all disease programs, DSW, WASH). Reduce data reported over time to reduce impact on HCW shortage.	Annual Review report posted on MOHSW website includes summary of change requests and soft copy of updated tools	Sustain	Meetings included in MESI Budget
3	Training for new HCW on use of paper tools and use of DHIS by new District and Regional Officials		Sustain	Trainings included per year in MESI budget based on expected rate of transition or new appointments
4	Modifications to DHIS to stay aligned with paper tools, DHIS stakeholder meetings to prioritize new developments, training for stakeholders all according to formal documented process and formal testing/release management process. Improved mechanism for sharing new DHIS2 features and whether MOHSW wants to consider using.		Sustain	Additional UDSM funds included in MESI budget (software support contract, hours required per form, hourly rate)
5	Computer Equipment and motorcycles for districts.		Sustain	TBD Computers, laptops and motorcycles for new districts. Planned for equipment considering expected life? Example, computers 3-4 years, motorcycles 5-8 years? Included in MESI budget

6	Strengthen the DHIS2 - HMIS data web based reporting and publish data and reports in a public portal - including mortaility data		HSSP IV - Priority	In MESI budget planning workshop, requirements documentation systems analyst, level of effort for contract
7	Additional MTUHA and DHIS2 training (refresher training, more training to improve data quality, revised books, additional CHMT and health staff) –		HSSP IV - Priority	In MESI budget
8	Integration of admin systems with DHIS for sharing of aggregate monthly summaries for HR, Drugs and Commodities Distribution, Finance, PlanRep, Epicore, Tanzania , Train smart, Health insurance Data (CHF/TIKA)	Aggregate summary data available within DHIS. (Completion and timeliness?)	HSSP IV - Priority	In MESI budget Stakeholder agreement on priority data elements, systems requirements, software updates for automated extraction, transformation and loading,
9	Training Regional and District Hospitals on using DHIS2 for HMIS and administrative data reporting		HSSP IV - Priority	Included in MESI budget already (GF R9 PII)
10	Piloting use of electronic record systems for larger clinics with automated reporting.		Development Priority	Not in MESI budget - in eHealth budget
11	Strengthen Routine Reporting of Deaths including update of Tanzania ICD-10 codes list, guidelines for causes and coding and related training		HSSP IV - Priority	Included in MESI budget (new GF budget)
12	Using mHealth platforms to assist with HMIS reporting		Development Priority	Included in MESI budget
13	Develop a comprehensive guideline, training materials and train health workers on ICD 10	Death reports are accurately, complete filled and timely submitted	Sustain	Extend the existing efforts done by NACP. Not in MESI budget

The HMIS Data Quality Objective and activities are included in the Data Quality section.

Other Activity Ideas to be considered?

Status of HMIS Modules

Ministry of Health and Social Welfare through the Directorate of Human Resource Development (DHR) in partnership with the HMIS Unit of the M&E Section of the Policy and Planning Department (DPP) made efforts and introduced the facility based data collection and reporting system (HMIS) as one of the module to be taught to all Health Training Institutions in Tanzania. The aim is to impart clear knowledge about how HMIS operates in the country. Training to Participants from health training institutions and MOHSW staff particularly from Directorate of Human Resource Development has been conducted. The purpose of HMIS training is to enhance knowledge and skills on how to use the Health Management Information System (HMIS) and train students in their respective health training institution. Students will finally be able to use the knowledge acquired on how to store, report, access, share and use data and information available on the health management information system.

9. Population and Facility Surveys

As outlined in figure ___, typically input and process indicators rely upon administrative and routine data systems; outputs and outcomes are measured through routine data and survey, while impact indicators rely upon population-based survey data.

Situational Analysis

Population-based health surveys provide information on service coverage, equity and population health outcomes. The Bureau of Statistics maintains a Tanzania Statistics Master Plan and the most recent plan covers the period from 2009/10 to 2013/14. The health sector currently does not have a health sector specific survey plan. WHO guidance and Health Information System performance plans require a 10-year costed plan for population and facility surveys, driven by country information needs. The MTR analytical report also called for more emphasis on survey analysis.

Over the last 10 years Tanzania has completed a range of surveys that provide data to inform health monitoring and evaluation. (See Table Below). Refer to ***Appendix C*** for a more detailed description of all of these surveys.

Survey	***Year***
Demographic Health Surveys (DHS)	*2015 (ongoing), 2010, 2004 - 05, 1999, 1996, 1991 - 92*
Aids Indicator Survey (AIS) and Malaria	*2011 - 2012, 2007 - 2008, 2003 - 2004*

Indicator Survey (MIS)	*(AIS Only)*
Tanzania Service Provision Assessment (TSPA)	*2014 (ongoing), 2006*
Tanzania Knowledge, Attitudes and Practice Survey (TKAPS)	*1994*
Facility Service Availability and Readiness Assessment (SARA)	*2012-**2013***
TB Prevalence Survey	*2012*
Population and Housing Census	*2002, 2012*
STEPwise Approach to Surveillance (STEPS) - NCDs	*2011*
National Panel Survey (NPS)	2015 (NPS)
Household Budget Survey	2012

The Tanzanian Health Sector 'Big Results now' plan calls for a star rating system for health facilities and stipulates that 6760 health facilities should be rated by June 2015. By May 2017, 60% of health facilities within identified regions are expected to have been elevated from level 1 and 2 to level 3 and above and by 2018 80% of primary health facilities to be rated 3 Stars and above.

There is an opportunity to establish a coordinated approach to facility star rating system and facility surveys.

Five Year Vision

Tanzania maintains a costed 10 year population and facility health survey plan that is integrated with the national statistics plans and includes specific details on contents, funding, and execution and surveys are implemented according to plan using global standards.

HSSP IV

Priority issue/area of work	**Key Programmatic Interventions Included in HSSP IV (included in Budgeting) (Update as HSSP IV gets refined)**	**Indicators and targets and M&E systems needed**
Coordinated approach to population and facility surveys across MDAs and timely	Coordinated approach for health sector that addresses all facility assessment requirements and	June 2015: 6,760 Health facilities rated 2016 - 2020: % of health

dissemination of survey results and sharing of survey data sets.	merges different methods (SARA, TSPA, BRN Star Rating)	facilities rated according to BRN star rating on an annual basis
Use of Surveys nationally representative evidence on population health status	Coordinated approach to sustaining and increasing use of Survey Data (DHS, TAIS, etc) correlated to routine data	2016 - 2020: Number and Percentage of Surveys disseminated within 12 months of Health Sector Survey Plan scheduled completion

Objectives and Outcomes

Objective	Outcome Indicator	2014 Baseline	2020 Target
Coordinated approach to facility Assessments across disease programs, directorates and methods.	2016 - 2020: % of health facilities rated according to BRN star rating on an annual basis	0	By May 2017, 60% of health facilities within identified regions are expected to have been elevated from level 1 and 2 to level 3 and above and by 2018 80% of primary health facilities to be rated 3 Stars and above.
Use of Surveys provide nationally representative evidence on community health status and vital statistics	Number and Percentage of Surveys disseminated (report prepared, CDs, media coverage, brochures etc) within 12 months of Health Sector Survey Plan scheduled completion.	0	DHS, TB, 2xNPS, TAIS, 2xTSPA, 5xFacAssessment

Activities and Outputs - 10 Year Survey Plan

Survey	Year and Indicative Budget	Comments
Demographic Health Survey (DHS) Comprehensive Health Survey (CHS)	2015 DHS/MIS - approx. 5 Million USD 2020 (CHS) - approx. 5 Million USD	The planned 2015 TDHS/MIS will include Malaria Indicator Survey and Nutrition modules

	2020 (DHS/MIS) - approx. 6 Million USD 2025 (CHS) - approx. 5 Million USD	CHS is similar to DHS but includes STEPS - NCDS
Tanzania Aids Indicator Survey (TAIS) or HIV Indicator Assessment(HIA)	2016 (TAIS) - approx. 4 Million USD 2021 (TAIS) - approx. 4 Million USD	Ongoing discussion about requirements for TAIS which may impact cost. Major goal is to assess district level prevalence.
Malaria Survey (MIS)	2017	Identified as the NMCP programme priority to assess the LLIN mass campaign this would have been assessed through the THMIS It is also in the M & E plan
TB Prevalence Survey	2016	***Check with Lilian Ishengoma? Confirm timing and cost?***
National Panel Survey (NPS) Health modules (service utilization and expenditures)	2017 (every 2 years), 2019, 2021, 2023, 2025. Year 1 costs are 2.4 Billion TSH and year 2 costs are 0.8 Billion TSH (for total survey, not health only portion).	
Tanzania Service Provision Assessment	2014 - 2 Million USD 2019 - 2 Million USD 2024 - 2 Million USD	All hospitals, 50 % of all health centers and a representative sample of dispensaries
Annual QoC / Data Verification Facility Service Availability and Readiness Assessment and Data Verification	Every Year 200 - 250 facilities random sample = 250 000 USD (2012 SARA was 1300 facilities)	Currently in GF R9 II for 2015 but discussion underway about timing based on TSPA (drugs, HR, data, lab…) Proposed SARA is 250K USD
Household Budget Survey	2015 2018	Ministry of Labor and NBS. Not funded through HSSP IV

Activities, Outputs and Budget Estimate

	Objective			
	Activity	**Measurable Output**	**Sustain, HSSP IV Priority, Development Priority**	**Other Info to inform costing**
1	Finalize the 10 year survey plan	10 year plan approved	Priority	See above cost estimates
2	For each survey, ensure kickoff includes PMORALG, NBS, MOHSW, Ministry of Land (maps/demarcation)	Detailed Survey Implementation plan	Sustain	Include in Survey costs – not in MESI budget other than SARA
3	Group meeting to finalize the approach to annual facility assessments and continue to update the methodology for integrated facility assessments across health sector	Finalized plan integrated into 10 year Survey plan	Priority	Budget included in MESI for workshop every two years
4	Yearly review meeting of survey plan at M&E TWG	M&E TWG meeting minutes and revised plan	Priority	Included in M&E TWG budget
5	Group meeting to harmonize definition and dis-aggregation across surveys	Common definitions for data and indicators to allow for correlation	Priority	Included in M&E TWG budget? Not in MESI budget
6	Implement each survey per plan	Survey report disseminated	Sustain	Included in survey costs;
7	MOHSW and health sector stakeholders, in cooperation with PMORALG and NBS, to coordinate annual data collection and verification of health facility service area population data sets with all District Medical Officers and District Planning Officers.	Revised service area population data sets entered in DHIS2 and the HFR	Sustain	In MESI Budget
8	Create a working group with PMORALG, NBS and other stakeholders to develop requirements for a single	Geographic Administration Registry Information	Priority	Estimate costs about 500, 000, 00 to 900,000,000 TSH (based on estimates

	Geographic Administration Authority and identify how to implement this system	System operational		from integrated eHealth costed action plan for other registries). Not in MESI budget currently

10. Surveillance

The Ministry of Health and Social Welfare through Monitoring and Evaluation Section, National Sentinel Surveillance System Unit is responsible for coordination of community based data collection systems for the health sector.

Situational Analysis

The two areas of focus for Surveillance systems are the Demographic Surveillance (HDSS, SAVVY) and disease surveillance. The HDSS is a process of monitoring births, deaths, cause of deaths and migration of population overtime and HDSS provide important information about Burden of Disease (BOD). To ensure national representation and cost efficiency, Health sector stakeholders led by the MOHSW have setup the Sentinel Panel of Districts (SPD), which include the 23 SAVVY districts along with the IHI HDSS sites.

HDSS sites under Ministry of Health and Social Welfare include Ilala, Temeke, Hai, Igunga, Morogoro Rural and Morogoro Municipal whereas those under the Ifakara Health Institute (IHI) are Rufiji, Ulanga, Kilombero and Kigoma Urban, and under NIMR are Korogwe and Magu districts. There are also 23 SAVVY sites under IHI Temeke,Ilala,Kinondoni,Kilosa, Bagamoyo,Moshi,,Babati,Kondoa,Singida,Geita,Uyui,Musoma,Kasulu,Sumbawanga,Muleba,Mbozi, Songea,Kahama, Mtwara-Mikindani, Tanga, Arusha, Iringa and Ruangwa. SAVVY generates annual all cause, cause-specific and age-specific mortality estimates as well as other demographic indicators. These estimates can further be disaggregated by zone and residence (rural-urban).
The panel has two "arms". The population-based arm (SAVVY1) tracks vital events in a total population of around 800,000 people. This will produce annual estimates of age- and cause-specific mortality as well as other key demographic variables. The facility-based information system (FBIS) arm collects health service statistics from all facilities in the sample districts (~ 1,500 in totals, ~20% of all health facilities in the country).

New guidelines (led by NSS) for Community based data management systems have been developed and reviewed.

Five Year Vision

The health sector continuously improves demographic and disease surveillance (SAVVY, DSS, HIV/AIDS, malaria)) based data collection to provide community based health data.

HSSP IV

Priority issue/area of work	Key Programmatic Interventions (Refer reader to specific section of M&E 5 year strategy)	Indicators and targets and M&E systems needed
Coordinated approach to demographic and HDSS surveillance and timely dissemination of surveillance results and sharing of survey data sets.	Surveillance activities implemented and reports released according to five year surveillance plan.	Surveillance Reports Disseminated within 12 months of data collection

Table: HSSP IV Surveillance Priorities

Objectives and Outcomes

Objective	Outcome Indicator	2014 Baseline	2020 Target
Surveillance activities implemented and reports released according to five year surveillance plan.	Surveillance Reports Disseminated within 12 months of data collection	TBD	How many reports for DSS? How many reports for Disease Surveillance

Activities, Outputs and Budgets

	Objective Surveillance activities implemented and reports released according to five year surveillance plan.			
	Activity	**Measurable Output**	**Sustain, HSSP IV Priority, Development Priority**	**Other Info to inform costing**
	Health and Demographic Surveilance Systems (HDSS & SAVVY)	Annual analytical report/document	Sustain	IHI budget for HDSS/SPD sites Do we include in MESI budget?
	Integrated Disease Surveillance and	Reporting rate	Sustain	

	Response (IDSR)	Weekly and Annual Reports Disseminated		
	Transition from ANC Surveillance to use of PMTCT data to provide annual information on HIV prevalence among pregnant women.	NACP publishes trends in HIV infection among pregnant women every year within 6 months of year end.	HSSP IV Priority	Initially need to 350 000 for comparison study, and 100 000 per year in subsequent years. (URT and PEPFAR) (in NACP budget)
	NACP conducts drug resistance study every two years, including transmitted drug resistance and acquired drug resistance and publishes drug resistance report.	Drug resistance reports published in 2016, 2018 and 2020.		Rough estimate of 600 000 USD per study with limited sample size. (URT and PEPFAR) (in NACP budget)
	Hot Spot Surveillance for HIV	Population HIV surveillance results are used for incidence modeling, and platform is used for validating recent HIV infection assays		
	HIV Key populations Size Estimations			
	HIV Incidence Surveillance			
	Malaria Surveillance	• Disease surveillance: HMIS monthly reports and DHIS weekly reports associated to epidemic early detection system • Programmatic surveillance: Therapeutically	Monitoring disease trends and control implication Through HMIS/DHIS2 PW are tested to determine availability of parasites during first attendance. Output	

		Efficacy and Insecticide resistance testing, community malaria control monitoring • Parasite and vector surveillance: includes parasitaermia survey in sentinel population (school and RCH), entomological surveillance in sentinel sites • School malaria Prevalence Survey	provide a longitudinal proxy estimate of the risk of malaria transmission in a given population	
	Integrated disease surveillance	Weekly data reported in DHIS2	Sustain and Expand	EIDSR training included under other programs so not in MESI budget
	TB and leprosy surveillance system: Develop case-based TB and leprosy electronic system (Under DHIS2) *Routine data quarterly districts reports submitted to national level*	Previous quarter report available at national level through DHIS	HSSP IV Priority	Budget for estimated at development of case-based TB and leprosy electronic system
	NTLP conducts TB drug resistance Survey every 5 years.	TB drug resistance survey reports published in 2018	HSSP IV Priority	Estimated budget at US $ 250,000
	PST and DRS	Most source understanding TB burden in the country (Prevalence, Incidence)		
	East Africa Surveillance? need to check if routine or surveillance			

	EPI surveillance			

11. Civil Registration and Vital Statistics (CRVS), SAVVY

Situational Analysis

The best source for tracking causes of death and new births is data collected in civil registration of vital events, which includes the events of births and deaths, but this source of information is incomplete in Tanzania. Currently Sample Vital Registration and Verbal Autopsy (SAVVY) is used in the Health Sector to provide nationally representative birth and death data.

Sep 2014, a multisectoral comprehensive assessment on the status of CRVS in Tanzania was conducted, report is out, and strategic plan is available. The annual health sector performance profile, used within the annual health sector review process makes use of cause of data from SAVVY. Currently 23 districts of DHSS/SAVVY sites are reporting on registered births and causes of death at community level.

One of the current limitations of SAVVY and DHSS systems is the limited access of health sector stakeholders to raw data sets for secondary analysis. Implementing partners are proactively sharing completed reports but in line with wider government of Tanzania and health sector efforts to embrace open data principles the implementing organizations should make data sets available to all health sector stakeholders with appropriate use agreements. The sector may investigate if data sets can be uploaded to DHIS to facilitate improved access.

Further background information describing the SAVVY and DHSS in details is provided in ***Appendix C***.

To strengthen data on deaths across health facilities, the MOHSW M&E section introduced a new register for deaths within health facilities and established a line by line reporting mechanism so facilities could report every death along with ICD-10 actual and underlying cause of death codes. This reporting mechanism only covers facility based deaths. Initial results for death reporting in 2014 show a significant decrease in facility deaths when compared to previous reporting methods but stakeholders have not yet been able to determine if decrease is a result of low reporting using the new system or double counting within the previous reporting mechanism.

There is a need to train HCW and registrars, WEO on ICD10, improve access to datasets, move to reducing paper data collection to electronic data collection, partner with RITA and build their capacity, integrate into other systems.

Five Year Vision

The health sector continuously improves sample based data collection (SAVVY and DSS) to provide estimates for community data including births, deaths and causes of death while strengthening collaboration with RITA to ensure that at least 50% of all births and deaths are registered with civil authorities by 2020.

HSSP IV

Priority issue/area of work	**Key Programmatic Interventions (Refer reader to specific section of M&E 5 year strategy)**	**Indicators and targets and M&E systems needed**
Improve registration of births and deaths in Tanzania	Continue SAVVY surveillance data available to all stakeholders with full data element definition and data assumptions. PMORALG, RITA, NSS and SAVVY meet regularly	60% of all births registered 50% Of all deaths registered

Objectives and Outcomes

Objective	**Outcome Indicator**	**2014 Baseline**	**2020 Target**
Continue SAVVY surveillance data available to all stakeholders with full data element definition and data assumptions.	Raw data sets made available to stakeholders via MOHSW data web-portal at least every 6 months proportion of births which are registered proportion of deaths which are certified	TBD	60% of all births registered 50% OF all deaths registered
Collaboration between RITA, MOHSW and PMORALG results in over 60% of all births being registered by 2020.	TBD	TBD	TBD

Activities, Outputs and Budget

	Objective: Continue SAVVY and make all de-identified surveillance data available to all stakeholders with full data element definition and data assumptions.			
	Activity	**Measurable Output**	**Sustain, HSSP IV Priority, Development Priority**	**Other Info to inform costing**
1	RITA, MOHSW and POPSM collaborate to leverage presence and capacity of all three MDAs to increase percentage of registered births.	% of births and deaths that are registered	HSSP IV Priority	Workshop every 2 years in MESI budget
2	SAVVY and HDSS results for cause of death and other health statistics included in health sector performance profile and data sets available to all in line with open data principles.	HSPPR produced annually	Sustain	Part of the HSPPR budget (it this in MESI?)
3	ICD 10 training for registrars and WEO	Death information includes ICD10 codes	HSSP IV Priority	Not in MESI budget
4	Prepare Policy Brief based on CRVS report	Policy Brief	Development Priority	We have some policy brief costs in MESI budget under DDU
5	RITA and PMORALG participate in M&E TWG meetings	Revised M&E TWG distribution list	Sustain	No budget impact
6	Support RITA to expand birth registration systems to rural areas			Is this covered under RITA budget?
7	Vital Registration Workshop every two years		Development Priority	included in MESI budget
8	Accelerate the under five children birth registration in Tanzania through the Under Five Birth Registration Initiative (U5BRI)	Roll out the under five children registration based on experiences gained from Temeke Municipal Council and Mbeya Region	Development Priority	Included in One Plan II strategic plan

12. Data Quality

Situational Analysis

Having well defined Data Quality definitions that all health sector actors involved in health sector data collection, management, analysis, review, dissemination, accountability and use of data are trained on and using is critical to ensuring that the data can be used reliably for decision making. Encouraging a culture of information use, where all levels of the health sector are using data improves data quality and health care workers collecting and reporting information are more accountable for data quality. With the rollout of the revised MTUHA tools, and the use of DHIS2 with monthly reporting, this makes the facility data available in a timely manner (one quality attribute) and allows for more stakeholders to have access to review the data quality. Also, as part of M&E SI, HMIS Supportive Supervision tool was piloted and tested (in DHIS2/MTUHA), and the first 8 regions used these tools during July-August 2014. At the core of this tool is a focus on data quality, and checking whether data entered into DHIS2 matches the facility based paper records.

Use of different Data Quality Assessment (DQA) instruments across projects and donors so there is no consistency across different stakeholders conducting a DQA leads to a lot of parallel assessments that could be combined together, with better sharing of results. There is a lack of defined data audit trails for particular data review activities, and follow up (such as to make sure data quality issues are addressed. The health sector needs to better define the combination of internal (i.e. Supportive Supervision) and external DQA that are conducted and how the results are used

Refer to **Appendix E** for more details.

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Five Year Vision

Vision: By 2020, the Health Sector has a consistent approach to data quality, identifying how data quality is assessed, interpolated and used in all data analysis, synthesis, dissemination and use with a standard measurement of data quality in use at all levels of the health sector.

HSSP IV

Priority issue/area of work	Key Programmatic Interventions (Refer reader to specific section of M&E 5 year strategy)	Indicators and targets and M&E systems needed
HMIS Data	Data Quality Checks integrated into	# and % of HMIS reports received

Quality: Strengthen accuracy, of data.	supportive supervision, routine monitoring of data accuracy indicators including validation and outliers, automated interpolation for missing data.	that have 0 validation errors and 0 unconfirmed outliers (Disaggregated by form, service area or disease program) Data Quality Verification Measures assessed during either the supportive supervision visit or within the BRN star rating still to be defined. % of sampled facilities passing external data quality audit.

Objectives and Outcomes

Objective	Outcome Indicator	2014 Baseline	2020 Target
Proceduralize/institutionalize HMIS Data Quality: Strengthen accuracy, completeness, and timeliness of data in the complete health data lifecycle.	# and % of HMIS reports received that have 0 unconfirmed validation errors and 0 unconfirmed outliers. Data Quality Verification Measures assessed during either the supportive supervision visit or within the BRN star rating still to be defined. % of sampled facilities passing external data quality audit.	Overall: RCH: PMTCT: HIV: TB: Malaria:	Overall: 98% RCH: 98% PMTCT: HIV: 98% TB: 98% Malaria: 98%
Strengthen the M&E framework that promotes, assesses and tracks data quality in the health sector, including data quality definition, DQA methodology, tools and use that meets the M&E TWG requirements (internal and external stakeholders)	Comprehensive DQA assessment tool developed and DQA data entered into DHIS	0	80% of all DQA entered and reviewed in DHIS2 Disaggregated by form, service area or disease program)

Activities, Outputs and Budget

	Objective: HMIS Data Quality: Strengthen accuracy, completeness, and timeliness of data.			
	Activity	**Measurable Output**	**Sustain, HSSP IV Priority, Development Priority**	**Other Info to inform costing**
1	Routine Monitoring, feedback, follow up and publication of indicators for completion, timeliness, validation and outliers.	Evidence of follow up with low performing districts. Quarterly dissemination of summary of performance disseminated to all districts, regions, MDAs, M&E TWG.	HSSP IV Priority	Workshops to develop standardized DQA tools and annual DQ review meetings. MESI budget includes one DQA workshop
2	Supportive supervision includes comparison of reported data to facility level registers and results of comparison recorded on supportive supervision forms and entered into DHIS.	Reports from Supportive Supervision carried out by Districts, Regions and National level recorded in DHIS.	Sustain	In MESI budget under GF R9 PII
3	External Data Quality Audit	Number of sites assessed by external data quality audit and % of sampled facilities passing external data quality audit	Development Priority	Not in MESI budget
4	Measure of Data quality incorporated into BRN star Rating and Results Based Financing		Development Priority	Not in MESI budget
5	Integration of surveillance or survey data into DHIS to support triangulation and data		Development Priority	Not in MESI budget

	quality review			
6	Data Triangulation		Development Priority	Not in MESI budget
7	MOHSW introduces penalties or punitive measures for intentional false reporting and false reporting related to gross negligence (linked to pay for performance?)			Not in MESI budget
8	Harmonization partners efforts on data quality	DQA guideline developed A comprehensive DQA assessment tool developed	Sustain	See DQA above
9	Strengthen mechanism for data validation(DQA and SS)	Rollout of the revised supportive supervision checklist to the remains regions data quality checks integrated into routine supportive supervision Data quality checks done as a routine activity DQA and SS results are shared and used	Sustain	See earlier Supportive Supervisions
10	Use the existing meeting/workshop to share the quality of data collected by facilities	Data dissemination at levels of the health sector conducted	Sustain	Districts quarterly meetings with the in charge of facilities Regional and districts M&E workshops No additional costs
11	Strengthen the collaboration between private facilities and DMOS office on Data issues	Increase the report accuracy and completeness rate by private facilities	Development Priority	Not in MESI budget

12	Work with UDSM-HMIS to integrate the DQA and Use into DHIS2 and ensure separation of roles of data entry and data review, and the ability to lock data (with supervisor ability to override) along with full data life cycle audit trail		Development Priority	Some UDSM development costs included in MESI budget
13	Host a competition that rewards good examples of how improving data quality has had an impact on health service delivery at facilities or on programming of health funds at the district or regional level		Development Priority	In MESI budget
14	Include data quality measurement in Facility Health Profiles, District Health Profiles and Regional Health Profiles		Sustain	Include one workshop or meeting to define the measure and how to roll out to participants; Not in MESI budget
15	Include data quality accountability in roles and responsibilities for health sector workers		Development Priority	Not in MESI budget
14	Complete a calendar for all internal and external DQA over the next 5 years		Development Priority	Part of M&E TWG meetings

13. Data Dissemination, Use & Evidence Based Decision Making

Situational Analysis

The basic premise of Data Dissemination and Use (DD&U) and evidence based decision making is that health data and information lack value unless they are actually used at all levels of the health system to inform decisions. As such, interventions that increase local demand for reliable health information and promote/facilitate its use (Data Dissemination and Use or 'DD&U' interventions) are critical to improving the effectiveness and sustainability of the health system.

There is a need to develop a culture of information use that demands quality information for evidence based decision making at every level: at facilities to improve quality of care; at districts to monitoring service delivery and higher levels for policy and planning.

Progress has been made

1. The government recognizes the value of sound health information system and is backing this up with appropriate financial and staff investment.
2. Existence of an established structure that allows for the efficient flow of data from service delivery sites through the districts and regions to the national level.
3. MOHSW and PMORALG collaborate with multiple development partners under the SWAp structure and the M&E TWG and build capacity at the sub-national level (e.g. District Health Profiles)
4. M&E SI focus on data dissemination and use at every level of health services delivery
5. The DDU team has created a draft DDU Strategy.

Refer to **Appendix F** for more details.

Five Year Vision and Approach

Vision

By 2020, the Health Sector has a culture that demands evidence based decision making to continuously improve provision of quality services to achieve better health outcomes.

A **data use and dissemination strategy** is nearly finalized, and uses the following Logic Model to illustrate the causal pathway to improved routine decision making, advocacy and policy development and program review and planning.

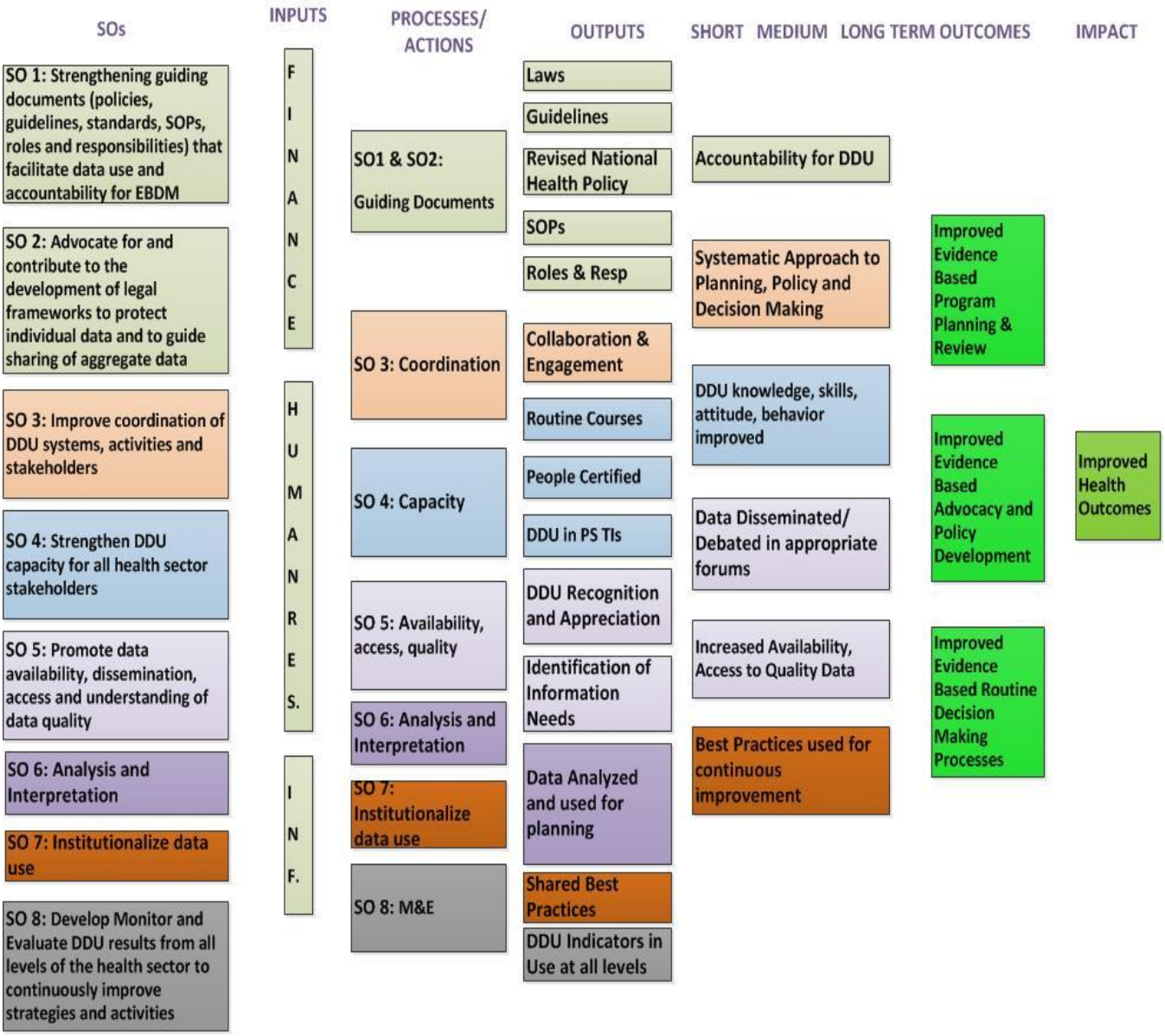

Figure Y: DDU Logic Model

The data use and dissemination strategy will work with vertical and administrative programmes throughout the MOHSW, PMORALG and other organizations within the health sector to review existing procedures and business processes so that a formal step requiring references to appropriate data can be suggested or required.

HSSP IV

Priority issue/area of work	**Key Programmatic Interventions (Refer reader to specific section of M&E 5 year strategy)**	**Indicators and targets and M&E systems needed**
Analysis, Synthesis, Dissemination and Use of Data for Evidence Based Decision Making and Citizen Engagement	Strengthen Guiding Documents that facilitate data use and accountability for Evidence Based Decision Making (EBDM). Contribute to legal frameworks to protect individual data and guide sharing of aggregate data. Routine courses and certifications for data use capacity. Data Analyzed and used for planning. DDU Indicators in use at all levels.	Annual Health Sector Performance Profile that responds to National Indicator Data Set (NIDS) priority indicators and HSSPIV M&E requirements disseminated at JAHSR. % LGAs achieving desired level of Data Use using MOHSW DDU monitoring tool % Regions, LGAs, and Vertical Programmes with evidence of providing feedback to lower levels as part of the Supportive Supervision documentation and follow up Number/Percentage of sampled facilities that can provide an example of a change in service delivery practice as a result of data review (within BRN star rating or Supportive Supervision Visit) Regional/District/Facility level data electronically disseminated on a quarterly basis via MOHSW public portal within 3 months of a quarter end. (evidence) MOHSW website has dissemination documents for all levels (national, regional and District) to citizens or external stakeholders (minute of stakeholder (citizen) dissemination meetings)

Objectives and Outcomes

Objective	Outcome Indicator	2014 Baseline	2020 Target
1. Strengthening ***policy, guidelines, legal frameworks*** **and** roles and responsibilities to facilitate data use and accountability for EBDM by all stakeholders.	• DDU guiding documents available and disseminated at all levels	0	
2. Improved **co-ordination of DDU** systems, activities and stakeholders and Strengthen **DDU capacity** for all health sector stakeholders	DDU issues discussed during 50% of M&E TWG meetings Annual national DDU champions workshop Number of people certified to be competent in data interpretation and use (disaggregated by National, CHMT, and IP etc.)	0 0 0	50% 1/year
4. Ensure regular detailed **analysis and interpretation** including estimate and projections, interpolation for missing data, in-depth studies, assessment of progress, performance and efficiency of health systems using existing data and international best practice.	Number of Policy decisions made using policy briefs and interpreted health information %RHMT and CHMT showing evidence of using data for decision making		
5. Proceduralize / Institutionalize data use and evidence based decision-making within routine work practices, standard processes and work culture throughout the health sector	LGAs achieving desired level of Data Use using MOHSW DDU monitoring tool % Regions, LGAs, and Vertical Programmes with evidence of providing feedback to lower levels as part of the Supportive Supervision documentation and follow up Number/Percentage of facilities that can provide an example of a change in		

	service delivery practice as a result of data review (reference in the data reviewed and used for this activity will need to be specified)		

M&E Outcomes

1) Annual Health Sector Performance Profile (includes NIDS indicators analysis) and Annual Statistical Abstract created, reviewed, disseminated at JAHSR and used annually
2) % LGAs achieving desired level of Data Use using MOHSW DDU monitoring tool
3) % Regions, LGAs, and Vertical Programmes with evidence of providing feedback to lower levels as part of the Supportive Supervision documentation and follow up

Activities, Outputs and Budget

	Objective	Strengthening ***policy, guidelines, legal frameworks*** **and** roles and responsibilities to facilitate data use and accountability for EBDM by all stakeholders.		
	Activity	**Measurable Output**	**Sustain, HSSP IV Priority, Development Priority**	**Other Info to inform costing**
1	Develop national policy on data ownership, flow, dissemination and information use	DHIS is used as only source of information Reduce the number of parallel system or multiple reporting Reduce burden to the health care workers	Development Priority	In MESI budget (legal consultant and workshops)
2	Rollout District Health Profiles to the remaining 130 districts		Development Priority	Included in MESI budget (GF R9 PII)
3	Work with the first 36	90% of districts	Development	CCHP team, HMIS

	districts who created 2012 DHPs to create 2014 DHPs	developed their DHPs yearly	Priority	and Partners support is needed to assist with the ongoing DHP production
4	Work with all regions to create their RHP	100% of regions develop their RHP annually	Development Priority	Need to add RHP workshops to MESI budget
5	Capacity building with MOHSW central M&E/HMIS staff	Attended and using training	Sustain	Included in MESI budget under GF R9 PII
6	Publish Issue briefs and Annual Statistical Abstract on lessons learned from data		Development Priority	Included in MESI budget
7	Monitoring team develops draft data monitoring tool and circulates to stakeholders for comments	Finalized DDU monitoring Tool	Development Priority	Included in MESI budget
8	Disseminate DDU strategy	Published DDU strategy	Sustain	Included in MESI budget
9	Document and share internationally on the good practice of Tanzania Monitoring and Evaluation Strengthening Initiatives (M&E SI) 2010 – 2014	MESI documentation	Sustain	Included in MESI budget under CDC TA
10	Analysis of Hospital Mortality Prevalence and Trend	Mortality data to share with WHO		Included in MESI budget
11	DDU training	# people trained		Need to review in MESI budget

14. Information Systems Integration and ICT Infrastructure to Support M&E

Situational Analysis

A dramatic expansion in Internet Bandwidth in the country was major enabler of M&E SI success to date. This allowed M&E SI to change from a distributed model that required a separate DHIS

installation in every district to a single web based model, with centralized DHIS instance that all users access. DHIS is just available to LGA, regional and central MOHSW staff currently, with data entered and reviewed at the LGA level, with regional and central level staff able to view aggregated reports. ICT is an enabler for data management and use, and facilities, districts, region and central level continue to invest in improving their ICT infrastructure to support access and use.

The MOHSW continued work on the draft eHealth Strategy, through a participatory process and launched the National 2013-2018 eHealth Strategy on 30 September, 2014. The National eHealth Steering Committee was also launched at this time, and has been meeting to review eHealth priorities.

The MOHSW under M&E SI has strengthened the central level infrastructure and services, and improved infrastructure at 29 districts. The MOHSW ICT Unit is part of the DHIS2, eLMIS, eIDSR, HRHIS and TIIS training and is also working on DHIS2 and PlanRep integration, and supporting DHIS2 software updates. The ICT Unit has also redeveloped the MOHSW website. The MOHSW has implemented the Tanzanian Health Facility Registry and provided training to district level staff, and is in the process of data cleaning. mHealth activities have progressed and eIDSR is now operational in 4 regions, implemented in DHIS2 and hosted at Vodacom. Negotiations are underway on USSD pricing across operators.
Refer to ***Appendix G*** for more details.

Five Year Vision

The Tanzania health sector has cost-effective, flexible, reliable, scalable, sustainable, and integrated e-health infrastructures that support integrated M&E;

HSSP IV

Priority issue/area of work	**Key Programmatic Interventions (Refer reader to specific section of M&E 5 year strategy)**	**Indicators and targets and M&E systems needed**
Integrate more programs in the health sector in DHIS2 and introduce multiple modes for data entry based on emerging technology trends		TBD

Objectives and Outcomes

Objective	***Outcome Indicator***	***2014***	***2020***

		Baseline	***Target***
To continue to expand and maintain the decentralized and flexible HMIS data warehouse that is integrated with other data sources and related systems	# priority HIS systems integrated successfully with DHIS2	0	PROMIS, HFR, eLMIS, etc
To expand use of mobile technologies and Internet-based information systems to: contribute to remote data collection, automated collation of data, and feedback to users, and assist in the integration of health data with the DHIS	# facilities reporting using the mobile based application disaggregated by eIDSR, and other new mHealth applications	Take from current 1/4ly reort	7000 facilities

Activities, Outputs and Budget

	Objective To continue to expand and maintain the decentralized and flexible HMIS data warehouse that is integrated with other data sources and related systems			
	Activity	**Measurable Output**	**Sustain, HSSP IV Priority, Development Priority**	**Other Info to inform costing**
1	Ongoing DHIS2 training	# HCW using DHIS2	Sustain	Included some yearly trainings in MESI budget
2	Ongoing DHIS2 feature expansion, maintenance and support and new revisions	Work plan approved and milestones met	Sustain	Included some funds; Need estimate from UDSM to update MESI budget
3	Workshops with Vertical programs and other programs (e.g. DSW, WASH)		Sustain	Included in MESI budget
4	Integration of HIS with DHIS2 from vertical programs		Development Priority	Some funds included in MESI
5	Integrate the RMNCH scorecard into HMIS/DHIS 2 and thus facilitate an	RMNCH scorecard integrated into HMIS/DHIS	Initiate	Included in One Plan II Strategic

	active participation of CHMTs, RHMTs and Central Level Actors to update the score card action lines	2 that includes an action points interactive interface		Plan
	Integrate Maternal and Perinatal Death Surveillance and Reporting (MPDSR) data into the HMIS/DHIS 2 electronic data base at Council level	Maternal and Perinatal Death Surveillance and Reporting (MPDSR) data integrated into the HMIS/DHIS 2 electronic data base at Council level	Initiate	Included in One Plan II Strategic Plan
	Pilot and roll out an electronic data collection system for Reproductive, Maternal, Newborn and Child Health at all Tertiary and Secondary level facilities to replace the paper based system for services data collection.	Electronic data collection system for Reproductive, Maternal, Newborn and Child Health at all Tertiary and Secondary level facilities rolled out	Initiate	Included in One Plan II Strategic Plan
	Objective: To expand use of mobile technologies and Internet-based information systems to: contribute to remote data collection, automated collation of data, and feedback to users, and assist in the integration of health data with the DHIS			
5	Development of mHealth reporting for HMIS		Development Priority	Some funds included in MESI budget; No GF support

15. Systematic and Continuous Professional Development (CPD) for M&E

Situational Analysis

HSSP III included a brief reference to 'appropriate training programmes on data collection and use including in-service and pre-service training to strengthen health worker's capacity'. M&E SI built on this concept envisioning a pre-service and in-service training and support system that ensured all health workers have the skills and knowledge to collect and use health information to improve health services delivery. Despite the recognition of systematic capacity building there has been limited progress. There was some orientation for training institution lecturers and zonal training centres who then played an active role in the training of over 30 000 HCW and district officials.

One of the main constraints to implementing Health Management Information System (HIMS) is a shortage of skilled health care workers (HCW). The MOHSW through M&E SI has trained over 24,000 HCWs (facilities, regions and districts) in the paper HMIS tools, along with over 700 in DHIS2 (regions and districts). Despite this progress there are still concerns about whether new graduates have requisite HMIS skills for either the paper based or computerized HMIS systems.

In 2013/2014, M&E SI together with 61 tutors from various training institutions incorporated HMIS training materials into a Facilitator Guide and Students Manual. A limited number of copies of the

Facilitator Guide and Student Manual were printed for these training institutions, but more are needed.

The current Human resource management process for HMIS is weak in terms of staffing patterns, job descriptions and established training modalities for HMIS. UDSM has introduced a Master's degree in Health Information Systems and Mzumbe has introduced a Health M&E Masters and the second batch starts in September 2014.

Five Year Vision

The Health Sector has systematic Continuous Professional Development (CPD) including pre-service and in-service training programs that ensures all health workers have the skills and knowledge to collect and use health information to improve health services delivery.

HSSP IV

Priority issue/area of work	**Key Programmatic Interventions (Refer reader to specific section of M&E 5 year strategy)**	**Indicators and targets and M&E systems needed**
Pre-service training programs include the MTUHA, DHIS and DDU curriculum	Health Sector continues to advocate for and support the **inclusion of M&E competencies within Health pre-service training programs** to ensure all new graduates are able to collect, analyze and use health information to improve health services delivery.	
In-Service training programs respond to HMIS/DDU needs	Through a systemic in-service training programme, **Zonal training centres provide certification based M&E short-term** training in data collection, analysis, interpretation and use of health information to improve health services delivery.	

Objectives and Outcomes

Objective	Outcome Indicator	2014 Baseline	2020 Target
Health Sector continues to advocate for and support the **inclusion of M&E competencies within Health pre-service training programs** to ensure all new graduates are able to collect, analyze and use health information to improve health services delivery.	% training centres and schools with HMIS-trained tutors (dis-aggregated zone, private, region, district) % of health management		

	training courses with HMIS integrated into the curriculum		
Through a systemic in-service training programme, **Zonal training centres provide certification based M&E short-term** training in data collection, analysis, interpretation and use of health information to improve health services delivery.	Number of HCW that receive certifications for M&E skills from zonal training centres.		

Activities, Outputs and Budget

	Objective: Health Sector continues to advocate for and support the **inclusion of M&E competencies within Health pre-service training programs** to ensure all new graduates are able to collect, analyse and use health information to improve health services delivery.			
	Activity	**Measurable Output**	**Sustain, HSSP IV Priority, Development Priority**	**Other Info to inform costing**
1	Catalog courses available in country and online (course must include examination) and build capacity to develop micro training videos			Not in MESI budget
2	Develop publicly available and routinely offered courses to improve data analysis, interpretation and use as well as constructive feedback measure			Not in MESI budget
3	Take the pilot test results of the Facilitator Guide and Student Manual and expand to all health training institutions			Not in MESI budget
7	Develop certification standards for these training programmes			Not in MESI budget

8	Develop the Learning Management System			Not in MESI budget
9	Develop workbooks for specific HMIS topics to assist users with self-paced learning		Sustain	Some funds included under CDC TA ivor this work
10	Develop digital training materials to be used both off and on line			Not in MESI budget
11	Create specific tailored workshop/courses for CSO, CBO's, Faith Based Organization (FBO), Media, Schools managers/teachers			Not in MESI budget
	Create standard qualification for each position on M&E and DDU (continuous professional capacity development)			Not in MESI budget
	Develop training courses on how to take results and reports and synthesize into policy briefs			Not in MESI budget
	M&E masters for central staff with Technical Assistance (TA) replacement			Already included in MESI budget under GF R9 PII