NATIONAL HEALTH SECTOR MONITORING AND EVALUATION STRATEGY 2021 - 2025

Towards Universal Health Coverage and Health Security

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FOREWORD

I am delighted to present the Monitoring and Evaluation Strategy 2021–2025 that provides the strategic framework to measure progress towards achieving the objectives of the National Health Sector Strategic Plan (2021 -2025 NHSSP), a strategy that will deliver universal health coverage in Sierra Leone and ensure that all people are able to enjoy a healthy and productive life. This plan has also been prepared to help the MoHS improve the quality of monitoring and evaluation within the health sector.

It focuses on how monitoring and evaluation can support health services management and engage stakeholders in understanding progress in health programmes implementation, learning from constraints and achievements, and collectively agreeing on how to improve both strategy and operations.

Through the development of the strategy, we have had the opportunity to look at the successes within the previous strategy, 2011-2016. This has allowed us to determine a clear vision and agree on the future goals that will be achieved through the implementation of the M&E strategy. This plan will ensure that effective and well-functioning data sources are in place to monitor the NHSSP; ensuring that high-quality data is available and used in decision making and policy development; ensuring that MOHS has the managerial capacity and leadership to plan, coordinate and implement a well-functioning and Health Information System with adequate inputs (HR, ICT, and financing) to implement the system.

The M&E strategy provides the roadmap for measuring the progress of the National Health Policy and Strategic Plan and the Essential Package of Health Services (EHSP). The strategy defines data collection, management and dissemination processes. It also document means by which the health sector will be monitored, reviewed and evaluated. The strategy includes important milestones, process, output, outcome and impact indicators.

The full implementation of this strategy will help identify gaps in the health care delivery system, permitting necessary adjustments to be made to improve service delivery, data collection and management processes and procedures to facilitate the delivery of quality health services to all in an equitable manner.

This M&E strategy represents the concerted efforts of all stakeholders, whose valued inputs have been incorporated in this document. We are grateful to all those who committed their efforts, time and resources to the preparation of national M&E Strategy. We are confident that the implementation of the national M&E Strategy is both critical and achievable. We encourage all actors and programmes to join us in this drive towards the transformation and development of the health sector.

Austin Demby

Dr Austin Demby
Minister of Health and Sanitation

ACKNOWLEDGMENTS

The Monitoring and Evaluation Strategy is a result of a fruitful process of internal and external consultations, drafting, and reviews involving departments and programmes within Ministry of Health and Sanitation(MoHS), health development partners and other government ministries, departments, and institutions.

The MoHS expresses its profound gratitude to all departments and programmes who contributed technical inputs leading to the successful completion of this document; who, with overall guidance from the Directorate of Policy, Planning and Information ensured that the objectives of the strategy are aligned to the priorities of the National Health Sector Strategic Plan covering the period 2021–2025.

We also would like to acknowledge and thank all development partners that provided funds and technical support towards this process. Specifically, we wish to thank the United Nations Children's Fund (UNICEF) for funding the process of developing this stratergy.

The Ministry of Health and Sanitation (MOHS) expresses its appreciation to all programmes, organizations and individuals that assisted and supported the development of this new M&E Strategic (2021-2025). For the formulation of this document, we owe the following departments, programmes, institutions special thanks and appreciation; DHMTs, National Malaria Control Programme, National TB Control Programmes, Directorate of Nutrition, National HIV/AIDS Control Programme, Directorate of Health Security and Emergency, WHO, National Civil Registration Authority (NCRA), National Monitoring and Evaluation Department (NaMED), Montrose and Focus 1000.

Once more, I am pleased to recognize and appreciate the dedicated sacrifices and commitments of partners and individuals who have contributed immensely to the finalization of the National M&E Strategy. It is my fervent hope that this document is implemented to its fullest and that the M&E Unit of the Directorate of Policy, Planning and Information, continues to work with these individuals, programmes, and organizations as we work together towards reforming and improving the health and social welfare system in Sierra Leone.

Dr. Sartie M. Kenneh
Ag. Chief Medical Officer

List of Abbreviations

Abbvrevaitions	Meaning
AMREF	African Medical and Research Foundation
BDR	Births and Deaths Registration
CBOs	Community-based Organization
CHC	Community Health Center
CHIS	Community Health Care Information System
CHO	Community Health Officer
CHP	Child Health Post
CHWs	Community Health Workers
CMO	Chief Medical Officer
COMAHS	College of Medicine and Allied Health Sciences
COMSA	Comprehensive Mortality Surveillance for Action
DHIS	District Health Information System
DHMTs	District Health Management Teams
DHS	Demographic and Health Survey
DPPI	Directorate of Policy Planning and Information
DQA	Data Quality Assessment
FBOs	Faith-based organizations
FCDO	Foreign, Commonwealth and Development Office
FMCs	Facility Management Committees
GFTAM	Global Fund for TB, HIV/AIDs and Malaria
GoSL	Government of Sierra Leone
HDPs	Health Development Partners
HIS	Health Information Systems
HMIS	Health Management Information System
HRIS	Human Resource Information System
ICD	International Classification of Diseases
ICT	Information Communication Technology
IDSR	Integrated Disease Surveillance and Response
IFMIS	Integrated Financial Management Information System
IHP	International Health Partnership
KPIs	Key Performance Indicators
LGs	Local Governments
M&E	Monitoring and Evaluation
MCHP	Maternal Child Health Post
MDSR	Maternal Death Surveillance and Response
MICS	Multiple Indicator and Cluster Survey
MoHS	Ministry of Health and Sanitation
MTEs	Mid Term Evaluations
MTNDP	Medium-Term National Development Plan
NAMED	National Monitoring and Evaluation Directorate

NCRA	National Civil Registration Authority
NGOs	Non-Govermental Organisations
NHA	National Health Account
NHA	National Health Accounts
NHSSP	National Health Sector Strategic Plan
NHSSP	National Health Sector Strategic Plan
NTDs	Neglected Tropical Diseases
PHUs	Peripheral Health Units
SDGs	Sustainable Development Goals
SECHN	State Enrolled Community Health Nurses
SLIHS	Sierra Leone integrated household survey
SMART	Standardised Monitoring and Assessment of Relief and Transitions.
Stats SL	Statistics Sierra Leone
TWG	Technical Working Group
UHC	Universal Health Coverage
UiO	University of Oslo
WB	World Bank

CHAPTER 1: Introduction

1.0 Background and Context

1.1 Introduction

The Government of Sierra Leone (GoSL) as a member of the United Nations is keen to make quality and affordable health care accessible to everyone everywhere in the country in a bid to join the global drive to achieve Universal Health Coverage (UHC).

Universal Health Coverage is prioritized by GoSL in its Medium-Term National Development Plan (MTNDP) 2019-2023 to contribute to Human Capital Development. The inclusion of UHC in the SDGs presents an opportunity to promote a comprehensive and coherent approach to health, beyond the control of specific diseases, to focus on how the health system delivers integrated, equity-based and people-centered health services.

The National Health Sector Strategic Plan (NHSSP) envisions to provide the people of Sierra Leone full complement of promotive, preventive, curative, rehabilitative, and palliative health services of sufficient quality that ensures the population is not exposed to financial hardship.

In light of the above, the Health Sector Monitoring and Evaluation (M&E) Strategy is a fundamental document that holds the health sector and its stakeholders mutually accountable to ensure the successful implementation of the MTNDP, UHC Road Map and the health sector strategic plan through a more transparent and well-coordinated process and to preserve institutional memory. The document will also depict the broader objectives and strategies for improvement of the health sector monitoring and evaluation functions. It is in this regard, that the development of this M&E straqtegy was undertaken by key stakeholders including development partners, program implementers, and districts teams through a consultative and participatory process.

The document will therefore guide all investments in the collection, processing, interpretation and use of heath data from the year 2021 to 2025, with a review proposed thereafter.

This M&E Strategy has been organised in 8 chapters. Chapter 1 describes the background, policy environment and process of developing the strategy. Chapter 2 describes the current national health sector M&E situation. Chapter 3 focuses on strengthening coordinate of M&E functions within the sector, while Chapter 4 describes plans to improve human resources capacity for M&E in the sector. Chapter 5 describes the Monitoring and Evaluation Framework with the list of core indicators, targets and data sources. Chapter 6 describes the routine data collection, reporting and data quality, while Chapter 7 describes the plan for evaluation and programme reviews. The Chapter 8 describes the plan for improving data use and dissemination.

1.2 Purpose, goal, objectives, outputs and outcomes of the M&E Strategy

1.2.1 Goal

The goal of the Monitoring and Evaluation (M&E) Strategy (2021 -2025) is to provide a functional M&E system that delivers improved decision making, transparency, and accountability in the health sector.

1.2.2 Purpose of the M&E Strategy

The purpose of this Monitoring and Evaluation (M&E) Strategy is to outline a roadmap and the intervention necessary to monitor progress progress towards achieving Universal Health Coverage (UHC) and articulate the vision and outcomes of health sector M&E through 2025. It builds on existing health sector policies and guidelines and provides an operational framework to strengthen and integrate M & E systems across the sector.

1.2.3. Objectives

The specific objectives of the 2021 -2025 M&E Strategy are to:

1. Deliver an Integrated and strengthened health M&E system that is robust, holistic, coordinated, and cohesive,and includes the implementation of a regular and coordinated program of population-based surveys and facility assessments
2. Strengthen institutional programme and human resources capacity in all aspects of monitoring and evaluation (M&E) in the health sector
3. Provide a health sector-wide framework for tracking progress and demonstrating the result on the basis for mutual accountability and transparency
4. Enhance the use of data in planning and decision-making, including policy development and corrective action
5. Improve compliance with government policies on M&E, through constructive engagement with stakeholders.

1.2.4. Outcomes

The MoHS will need data to plan and to report on results achieved. Results from the M&E Framework will be used by central level agencies such as the Ministry of Health and Sanitation (MoHS) and the Ministry of Finance and Economic Development to mobilize resources for the health sector. Multilateral and bilateral development partners will also need health information to plan their annual reporting. In addition, these organizations will use this data to report the results to their headquarters. International and local Non-Govermental Organisations (NGOs) will use M&E data for developing areas of assistance, planning on-going programs, and reporting results. Local (city and district) councils will also use the M&E Framework to monitor and evaluate their Comprehensive District Health Plans, while communities and civil society groups will use M&E data to advocate for neglected service areas, neglected groups and to assist communities to request services from local governments.

Specifically, the M&E Strategy should result in:

i. Improved institutionalized,better, resourced, and coherent health sector M&E System

ii. Strengthened leadership, structure, planning, coordination, and management of health sector performance-based M&E.
iii. Strengthened systems for health surveillance, research, and data management
iv. Strengthened inter-departmental coordination in M&E: M&E, Health Information Systems (HIS), Information Communication Technology (ICT), and all other departments within MoHS.
v. Systematic, and quality reporting to and by government, Development Partners (DPs), International Partners and UN (including on the Sustainable Development Goals (SDGs)).
vi. An integrated health sector-wide M&E system that can provide timely information to all stakeholders through:
    - Improved relations between M&E and research through the integration of data sources.
    - Improved birth and death reporting in the entire country.
    - A functional surveillance and response system.

1.3 Policy Environment and Guiding principles for the M&E strategy

1.3.1 Policy Environment

From a global perspective, the development of the M&E Strategy has taken into consideration the relevant Systainable Development (SDGs) Goals and indicator, and the WHO 100 Core indicators

The M&E strategy was developed in line with key national policies and programs, and Sierra Leonean and international standards. At the national level, the following documents were taken into consideration: The Medium-Term National Development Strategy Year to Year, which sets the vision for government services in the next five years; the National Statistics Act (year) which mandates the Statistics Sierra Leone (Stats SL) to coordinate and monitor statistical activities in all government ministries and the National Civil Registration Authirity Act (NCRA Act, year) which provides guidance for collecting data on vital statistics.

Within the health sector, the M&E Strategy has taken into consideration the following documents: The Health Information Systems (HIS) Strategic Plan 2019–2023; the Sierra Leone National Health Policy 2021 (Draft), which presents a framework that articulates the development of health services in Sierra Leone to achieve UHC and the National Health Sector Strategic Plan 2021- 2025. The UHC roadmap is the key document that has guided the development of the M&E Strategy and provides a vision for the delivery of health services in Sierra Leone for the next five years.

From a global perspective, the development of the M&E Strategy has taken into consideration the following Sustainable Development (SDGs) Goals and indicators, as well as the WHO 100 core indicators.

The goal for the Sierra Leone UHC Roadmap (2021 to 2030) is "*All people in Sierra Leone have equitable access to quality and affordable health services whether public or private at all times without any undue financial hardship by 2030"*. The goal, when achieved, shall ensure that Sierra Leonean residents have access to affordable quality health care services and health security without suffering financial hardship.

To achieve this goal, the health sector shall focus on achieving universal coverage with quality health, and health-related services through addressing the following objectives.

1. To prioritise UHC as a commitment at all levels of Government and as a whole-of-government and whole-of-society action to improve health outcomes by 2030
2. To attain minimum health worker density and sustain a high performing workforce that is equitably distributed and delivering high quality care services.
3. Redesign the health service delivery environment to optimize functionality, effectiveness and performance for service delivery, especially in deprived and challenged communities
4. To expand service coverage and increase equitable access to improve uptake in quality healthcare services at all levels, with a special focus on community participation and ownership in service delivery
5. Build and strengthen community systems to effectively shape and influence health service design, provision and outcomes at all levels by 2030
6. To foster effective, efficient and sustainable pharmaceutical management system that meets priority health needs by 2030.
7. To establish a robust, digitally-savvy, comprehensive, fully integrated, harmonized and well-coordinated M&E system that effectively guides sector monitoring and impact evaluation
8. Support provision of healthcare services at all levels that is safe, efficient, timely, equitable, accessible, respectful, responsive and people-centred using evidence-based interventions that results in the best possible outcomes, and provided by competent and compassionate workforce in an enabling environment in accordance with national standards by 2030
9. Establish innovative and sustainable health financing that supports resilient quality health care with special focus on the most vulnerable and disadvantaged population by the year 2030.
10. Establish and maintain technologically appropriate disease surveillance mechanisms, robust epidemic outbreak warning systems capable to prevent, detect and adequately respond to public health threats and hazards by 2030

1.3.2 Guiding Principles

The Monitoring and Evaluation (M&E) Strategy will be guided by the following core principles:

- **Managing for Results:** In line with the GoSL policy of Results-Based Management that focuses on results, all interventions and operations shall clearly define the results or benefits for the people of Sierra Leone. Interventions will ensure the committed use of performance target setting and tracking. The results are targeted at improving the quality of life of the citizenry.
- **Value for Money:** M&E shall provide a mechanism that informs on whether resources allocated achieve the intended results in the most economic, efficient, and effective manner.
- **Ownership and Inclusivity:** M&E will contribute to the public identification of the NHSSP towards UHC programs and provide platforms to demonstrate the extent to which related programs deliver equity and benefit for all Sierra Leoneans
- **Utility:** M&E shall provide information that is readily available and usable by all stakeholders.
- **Integrity and Credibility**: M&E shall be based on reliable, evidence-based data. At project and program levels, M&E shall use realistic and practical techniques and indicators for measurement of results and progress.
- **Transparency**: Information about M&E shall be easily accessible to the general public, and clear communication on the availability and use of resources shall be provided.

- **Accountability**: Individuals and institutions shall be required to report on how allocated resources for M&E intervention are used for implementing agreed outputs and outcomes. Accountability mechanisms shall be aligned to those of the government and partners.
- **Ethical service delivery and data management**: M&E shall provide due regard for the welfare, beliefs, and customs of those involved or affected, upholding a strict moral code.
- **Confidentiality**: Institutions and individuals shall be assured of their right to provide information to monitors and evaluators without their identity being publicized.
- **Gender equality and equity**: M&E shall ensure the availability and use of data dissagregated by gender, age, geographic area and disability status in decision making.

1.3.3. Target Audience

This M&E Strategy is intended to assist actors in the health sector to gather, synthesize, and analyse data and use this information for improved health sector performance.

The actors at the national level include state actors such as the national MoHS directorates, programs and units, referral and teaching hospitals, and parastatals, as well as non-state actors from non-governmental organizations (NGOs), Community-based Organization (CBOs), faith-based organizations (FBOs), the private sector and health development partners including UN.

District and community level actors will include District Health Management Teams (DHMTs), Local (city and district) Councils, Implementing partners, Hospitals, and Peripheral Health Units (PHUs), including Community Health Workers (CHWs), Facility Management Committees (FMCs) and Non-state actors. The non-state actors at this level include development and implementing partners and private health organizations that are involved in the design, support, and implementation of M&E and other projects and programs being implemented across the various tiers/levels of care.

These guidelines will serve as a reference for different department ts within MoHS. See the table 1 below.

Table 1.1: Target groups for Institutionalization of M&E

Entities	Description
Ministry of Health & Sanitation	Office of the Chief Medical Officer (CMO), directorates, programs and various units of the MoHS, referral and teaching hospitals, regulatory boards, and parastatals within the Ministry of Health
District Level	District Health Management Teams (DHMTs), referral and district hospitals, implementing partners, primary care facilities (dispensaries and health centres/facilities)
Non-state actors	Development partners, civil society organizations, implementing partners, faith-based organizations (FBOs), Community-Based Organization (CBOs), Civil Society Organizations (CSOs), private health providers, non- governmental organizations (NGOs)
Communities	All community units and community-based organizations (CBOs)

1.4 Process of Developing the Strategy (Methodology)

The development of the M&E Strategy was led by the Directorate of Policy, Planning, and Information (DPPI) of the MoHS with extensive technical input and consultation from other departments and offices within MoHS, across the Government of Sierra Leone (GoSL), and external partners. The development of the ME Strategy was aligned with the UHC Road Map 2021 - 2030. The process considered the, existing policies, MTNDPand international reporting commitments.

DPPI led the drafting and coordination of the strategy. The process started with an M&E assessment in September 2020 based on the 12 components of a functional M&E systems (See figure 1 below). The objective of the M&E Systems assessment was to identify the strengths and weaknesses of the existing M&E systems for the Health Sector. This assessment served as a prelude to developing the strategic and costing it.

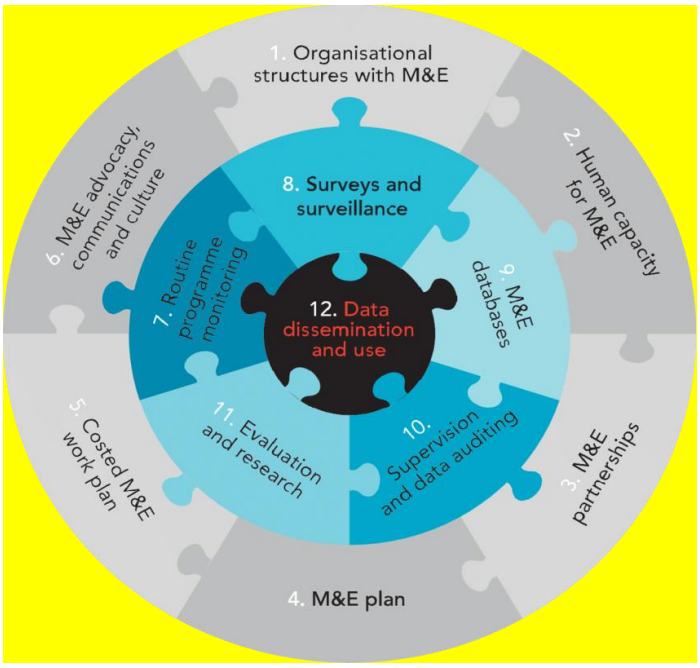


Figure 1.1 The 12 components of a functional M&E system

1.5 Implication for Sector Monitoring and Evaluation

Investments in human resources, health infrastructure, commodities, and management support (including planning, supervision, and M&E) will primarily aim at achieving better results through increasing demand and access to a package of essential health services in the light of UHC. It is hoped that this will ultimately accelerate improvement in the level and equity of the health status of the people of Sierra Leone.

For more sustained and accelerated improvement in the health impact, it is important for the sector to strategically focus on a comprehensive knowledge management approach. This should guide a comprehensive look at information needs, analysis, and use to better guide decision making for health. This requires establishing a comprehensive performance monitoring approach for the sector

M&E strategy, which uses input, output, outcome, and impacts indicators to generate information for analysis and use.

The health sector M&E component should have a supportive institutional environment, with defined roles and responsibilities for the different stakeholders. There is a need for sufficient funding and human resources with the adequate technical capacity to manage the various components of an effective M&E system in support of progress and performance reviews.

Chapter 2. Monitoring and Evaluation in the Health Sector

2.1 Overview of Key M&E Achievements and challenges

The M&E Plan for NHSSP 2010- 2015 was developed and disseminated aiming at establishing an M&E system that is robust, comprehensive, fully integrated, harmonized, and well-coordinated to guide monitoring of the implementation of the NHSSP and evaluate impact. This resulted in a Country-led M&E Platform especially in the use of harmonized data collection tools and reporting systems, and transitioning to the District Health Information System (DHIS)-2, an electronic web-based reporting mechanism. The sector has made progress towards aligning the previously fragmented information systems within the health sector to ensure contribution to ONE (1) integrated M&E system.

Data collection tools have been revised several times to deepen data integration and data disaggregation. Surveys and facility assessments for sector performance impact assessment and state of readiness for service delivery were planned and conducted. During the period, the timeliness of DHIS monthly reporting by the districts increased from 50% in 2011 to 88% in 2020; and completeness of PHU reporting increased from 85% in 2011 to 96% in 2020. Data Quality Assessment (DQA) show that data agreement between source documents (mostly paper-based registers and reports) and the DHIS are highly variable.

With support from the Global Fund for TB, HIV/AIDs and Malaria (GFTAM), Foreign, Commonwealth and Development Office (FCDO), World Bank (WB), UNICEF and other partners reporting tools have been routinely printed, and capacity for M&E has been strengthened at all levels. Several Annual Health Sector Performance Reports have been compiled and disseminated. Quarterly performance reviews were conducted at district and program levels. Regular annual reviews have been conducted for specific programs, including Malaria Program, TB program, HIV/AIDS program, Neglected Tropical Diseases (NTD), and nutrition.

2.2. M&E Gaps and challenges

M&E in the health sector still faces serious challenges these include inadequate number of staff, and weak skills and competencies for M&E programming. There is currently no nationally endorsed M&E training curriculum appropriate for M&E personnel, and as a result most M&E staff learn on the job. Also, most of the staff providing M&E functions entered into the civil service in other capacities but were later co-opted to serve in the M&E units of programs and districts with little or no formal M&E training.

While inadequate understanding of indicators/data elements by data collection staff has been highlighted in almost all DQAs, follow-up training, and mentorship to correct the situation havebeen limited. There is also a need to develop a systematic approach to data quality assessment.

The M&E Structure for the MoHS is yet to be streamlined to match M&E functions at the national and subnational level. There are no standards guiding the placement of M&E officers/ staff to Directorates, Programs, DHMTs, Hospitals and PHUs. Consequently, Directorates and

Programmes recruit their own M&E officers to address their M&E needs. This creates additional challenges for coordination and capacity building of the M&E cadre in the sector.

There are stills critical challenges in the generation, compilation, and submission of programmatic and departmental reports that are expected to feed into the overall health sector performance reports. There are still irregular program and sub-national performance reviews due to inadequate funds. The low reporting rates from hospitals and private health facilities limit the ability to appropriately monitor overall sector outcome performance. Evaluations for most programs are not conducted due to inadequate funding and as a result impact of interventions is not well documented.

A recent national assessment of births and deaths registration (BDR) revealed that whereas people are knowledgeable about birth and death registration, they seldom register births and deaths, except when a birth or death certificate is needed as a requirement to access a certain service. It was further established that the majority of the duty bearers who are charged with the registration of births and deaths do not consider making birth and death registration returns as an important issue. The Country lacks a policy on BDR which makes it difficult to enforce the NCRA Act.

The utilization of data for decision-making is still minimal as the data collected is often not used as part of decision-making and planning. This is due to multiple factors, including a lack of regular information products or other documents that make data readily available, limited systems to make incorporating data into decision-making easy, and finally, a lack of trust in the data available. Some potential users of the data do not know how to retrieve the data in DHIS 2 and use them.

The health sector has started holding periodic reviews, but these have not yet been institutionalized to ensure that it is routinely implemented at various levels.

At the Facility level, most staff have limited capacity to interpret the graph and charts they produce at the health facility and as a result data is not used for decision making on service improvement.

A recent assessment of the M&E situation for implementation of the UHC Roadmap was undertaken to identify the strengths and weaknesses in the country M&E system, including identification of the major actions required to address the gaps and needs.

The key gaps identified are outlined below:

1. The main Human Resource (HR) challenge is the absence of an HR structure for M&E at the MoHS even though M&E Positions have been included in the Scheme of Service for health workers. So far there are scattered uncoordinated efforts that have nevertheless enabled the recruitment of a few staff. There is still a need for skills development for M&E.
2. The local capacity for the configuration of DHIS 2, the backbone to the HMIS, is still low. There is an over-reliance on external experts to support DHIS configuration.
3. There is a TWG on HMIS and M&E, but its composition does not include some critical stakeholders such a Statistics SL, Universities and other Research Institutions, NCRA, and relevant Private Sector partners.
4. International Classification of Diseases (ICD 11) is not in use in the country to classify deaths.

CHAPTER 3: M&E Organizational Structure, Coordination, and Partnerships

3.1 Organizational structure

There is a National Monitoring and Evaluation Directorate (NAMED) existing within the Office of the President with the mandate to monitor and coordinate the M&E activities of all Ministries, Departments and Agencies (MDAs). Within MoHS, the Directorate for Policy, Planning, and Information (DPPI) has the mandate to lead the coordination of M&E activities across the Directorates, Programs, units, DHMTs, and health facilities ofthe MoHS. At district level, there are M&E Officers who, under the guidance of DPPI, coordinate M&E activities. At hospital level, there are designated staff responsible for performing M&E duties. At PHU level there are no dedicated M&E officers, but all staff are expected to be involved in carrying out M&E functions as an integral part of their work.

Sierra Leone currently has no legislation providing the framework for M&E. However, there is a National Civil Registration Act (add year) that gives mandate to the NCRA (National Civil Registration Authority) to register births and deaths and report on them. The public health ordinance is outdated and is currently under review, to develop a public health act. This ordinance provides direction for the data collection on specific health-related issues.

There are also no formally established M&E positions at the various levels of the health care delivery system, as there is no document indicating the different M&E positions required within the different MoHS Directorates, Programs, Units, DHMTs, and Health facilities. Each DHMT and Program has at least one M&E person who is dedicated full-time to data management and other functions. Job descriptions for M&E staff within various Directorates, Programs, Units, DHMTs, and health facilities are not properly articulated and, in some cases, non-existent. The current M&E staffs are not designated civil servants. DPPI has an M&E unit, but Program M&Es owe allegiance to their programs and not to DPPI. There is no national M&E organogram.

There is a shortage of technical staff in the M&E unit of DPPI, for example epidemiologists, statisticians etcetera. (for detail see the chapter 4 on M&E Human capacity)

A recent M&E situational analysis (September 2020) identified the following as critical activities for improving the organizational structure of the M&E within the health sector:

- Develop a legal framework for M&E, that gives a mandate to DPPI for monitoring, evaluation, and documenting compliance to health policies
- Design and implement the M&E structure for the health sector, including the development of a national M&E organogram

3.2 M&E Coordination

A health sector-wide M&E system for effective tracking, evaluation, and feedback on UHC Roadmap implementation will be adopted. This implies that the GoSL, MoHS, Local Government (LGs), Health Development Partners (HDPs), Non-govertnmentyal Organisations (NGOs), Private Sector, Civil Society Organiswations (CSOs), and other stakeholders will be involved directly or indirectly in the M&E activities. A participatory approach that entails the involvement of all key actors and primary stakeholders is already in progress. This will enable all key actors to fully internalize and own the system as well as use the results to inform their actions.

Better coordination of service delivery is a key element required to maximize the outputs of the health sector. Coordination of M&E activities in the health sector will be through the existing organizational structures of the health sector.

DPPI has established an **M&E / HMIS Technical Working Group (M&E/HMIS TWG)** that includes M&E Personnel at the central level within Directorates, Programs, Units and developmentpartner organisations. The M&E/HMIS TWG was established following the formulation of Monitoring and Evaluation as one of the nine pillars of the National Health Sector Strategic Plan (year to year). The M&E/HMIS TWG meets once every month or when the need arises to discuss and communicate critical monitoring and evaluation issues including routine HMIS integration, data quality, the publication of health information bulletin, health sector indicators, integration of tools, review of the Health Sector Strategic plan monitoring, evaluation framework and M&E capacity and other challenges and opportunities for health Sector M&E development.

The role of the M&E/HMIS TWG is to:

a. advise and support the MOHS/DPPI with coordination and improvement of the health management information systems and support the MoHS/DPPI initiatives in the country.
b. work in collaboration with Policy, Planning, and Health Financing TWG to support and manage participatory processes that lead to development or revision, evaluation of MOHS policies and strategic plans, and inform evidence-based policy decision-making and
c. strengthen the capacity of DPPI to monitor, evaluate, and provide quality health information for decision making by MOHS and partners. (source TOR February 2019)

A recent M&E situational analysis (September 2020) identified the following as critical activities for improving the coordination of the M&E within the health sector:

- Focus more on the monitoring aspects of M&E in the M&E / HMIS TWG.
- Improve attendance to TWG meetings through the development of an M&E contact inventory and regular follow-up.
- Expand on membership and improve active participation of M&E personnel in M&E/HMIS TWG meetings by having program/directorate/unit/district/hospital M&E officers and implementing partners present on a specific topic / indicator, and ensuring the right technical persons are attending for the different organizations.
- Review M&E/HMIS TWG TOR based on lessons learned.

3.3 Partnerships

Primary and secondary health care is devolved to **Local (city and district) councils**, however, roles and responsibilities of MoHS and local councils are not clearly defined, which is affecting M&E functions.

Statistics Sierra Leone (Stats SL) carries out household and facility surveys, and also provides technical support to surveys conducted by other organizations and share population data and other information with MoHS and other M&E stakeholders.

Universities in Sierra Leone do not provide stand-alone health M&E training, although they have collaborated with African Medical and Research Foundation (AMREF) for such training in the past. Research is taking place in the universities, however, collaboration and information sharing with the MoHS on this are not formalized.

As part of the health sector, the **private sector** should feed into the national HMIS (including DHIS-2) by providing service-related and financial data, to contribute to the national picture of health service provision in the country. However, private organizations are mostly not providing this data at the moment.

Currently, **Faith-based organizations** (FBOs) **and NGOs** contribute significantly to the health sector, so their data contributions and M&E/HMIS TWG membership are important. The existing health M&E system does not currently capture much of the data generated by these institutions.

Civil Society Organizations (CSOs) are currently playing a critical role in the monitoring of health care services. They have been involved in advocacy for additional support for the sector, ensuring that drugs and other health commodities reach their intended targets as well as helping communities to set up structures for monitoring health services delivery. They have also been working on setting up social accountability structures at the community level.

Development partners and Donors provide both technical and financial support for setting up the national M&E system and sustaining it.

A recent M&E situational analysis (September 2020) identified the following as critical activities for improving M&E partnerships within the health sector:

- The local council M&E officers to work closely with the DHMT and hospital M&E officers/staff.
- Local councils to be part of district-level health reviews and district level health planning.
- CSOs to share monitoring findings with DHMTs and national level
- CSOs to be included on district / national level M&E groups like the M&E/HMIS TWG
- Improve the submission of HMIS/DHIS-2 data from private, faith-based, and NGO health facilities
- Institutionalizing M&E training at Sierra Leone universities
- Establishing an M&E stakeholder organization contact inventory at DPPI (DPPI, Other Directorate/program/unit/district/hospital M&E personnel, partners, others) with at least 2 contact persons per organization (head of organization & M&E officer).

CHAPTER 4: Human Capacity for Monitoring and Evaluation

4.1 Recruitment and postings of M&E staff

The positions for M&E were not established in the MoHS scheme of services before. However, the new draft scheme of service (add date/year) now contains those positions with clear job specifications, requirements, and career pathways at all levels. At the moment (2020) most of the personnel serving in M&E related functions were either contracted through donor funding or co-opted from other, mostly clinical, positions for example Community Health Officers (CHOs), Environmental Health Officers, State Enrolled Community Health Nurses (SECHNs), Public Health graduates, etc.

DPPI is working with the Directorate of Human Resources in the MoHS to incorporate all contract staff working on M&E functions into the GoSL payroll. Going forward, all recruitment for the positions for M&E will be done through the civil services with strict adherence to the revised MoHS scheme of services (add date, year) .

Re-posting of M&E staff is expected to be done between every 3-5 years. This timeline applies to all MoHS Directorates, Programs, Units, DHMTs, and Hospitals.

A recent M&E situational analysis (September 2020) identified the following as critical activities for improving the Recruitment and postings of M&E staff within the health sector:

- Integrate and work with NAMED and the Ministry of Local Government (incl. local (city and district) councils) on recruitment and postings of M&E staff, while maintaining staff trained specifically on health M&E in the health sector
- Recruit staff for M&E according to the scheme of service.
- Develop job descriptions based on the MoHS Scheme of Service and Primary Health Care Handbook as applicable.
- To develop generic M&E organograms that can be further developed at national and district levels.

4.2 M&E core competencies

Monitoring and evaluation are critical to the success of an organization. Therefore, staff serving in this capacity need to be regularly assessed to ascertain whether their competencies match the evolving M&E needs. A preliminary skills and competencies assessment for M&E took place in July 2019, and the report contained several recommendations including the development of a training plan.

A recent M&E situational analysis (September 2020) identified the following as critical activities for improving the assessment of M&E staff within the health sector:

- Develop a M&E core competencies assessment framework
- M&E Core competencies assessed at least every 3-5 years in relation to re-posting, promotion, and training.

Table 4.1: M&E and related staff within the Ministry of Health and Sanitation - current number and planned additional staff *(all levels combined)*

Designation	**Current Number Of Staff**	**Planned Additional Number**
M&E Specialist	1	2
ICT Specialist	1	2
DHIS Backend Adminstrators	0	4
HMIS Specialists	0	3
Demographer	0	1
Epidemiologist	1	1
Statistician	0	2
Data Manager	2	6
Data-base developers	0	4
M&E Officers	32	120
HMIS Officers	2	58
Assistant M&E Officers	9	312
Data Entry Operators	13	0
Web Administrator	0	3
Information and Communication Technology Staff	1	5

4.3 Training

Improvements in the M&E system cannot be achieved unless attention is paid to the training of human resources at all levels. At the national level, skilled epidemiologists, statisticians, and demographers are needed to oversee data quality and ensure appropriate analysis. At district and health facility levels, M&E staff should be accountable for supportive supervision, data validation, data quality checks, data analysis, and data use, reporting, and feedback. In 2017 a mix of 120 M&E staff and health professionals engaged in M&E tasks were trained in a 2 weeks' in-service course by AMREF / World Bank/UNICEF, while 2018, a similar course was done by College of Medicine and Allied Health Sciences (COMAHS) / Global Fund for 60 mixed staff. Thirty 30

M&E staff recently completed an online M&E training supported by UNICEF. Despite this training, the M&E human capacity building offered is not coordinated. Also, there is no database on staff trained on M&E. There is no nationwide capacity development plan for M&E. There are no M&E training courses in universities, polytechnics, and other training institutions in Sierra Leone.

A recent M&E situational analysis (September 2020) identified the following as critical activities for improving the training/ capacity building of M&E staff within the health sector:

- include a basic M&E module in the pre-service curricula of all health professionals
- develop an in-service training plan and related materials/tools for M&E staff based on the M&E core competencies assessment results
- develop an in-service training plan and related materials/tools for health professionals involved in M&E tasks based on supportive supervision findings.
- develop an M&E training database in close collaboration with the Directorate of Human Resources
- For the short-term: support M&E staff on Master /Ph.D. courses on M&E topics
- For the mid/long term: to develop capacity within Sierra Leone universities to provide health M&E Bachelor, Masters, and Ph.D. courses.
- Work with local institutions to develop short and long-term training programmes for M&E professionals.

4.4 Coaching and mentoring

There is no structured mentoring and coaching arrangement for M&E staff, however a mentoring and coaching programme has commence for M&E Staff within DPPI. The purpose of this exercise is to improve the competency of staff performing the M&E Functions.

A recent M&E situational analysis (September 2020) identified the following as critical activities for improving mentoring and coaching of M&E staff within the health sector:

- develop standards and materials/tools for mentoring/coaching of M&E staff in the health sector
- develop a mentoring / coaching plan for M&E staff in the health sector

CHAPTER 5 Monitoring and Evaluation Framework

Over the course of the health programmmeimplementation, data will be collected to monitor trends towards achievement of the targets of the Key Performance Indicators of the UHC Roadmap and the NHSSP.
Two levels of monitoring and evaluation will be undertaken, namely: (a) inputs and output, and (b) outcomes and impact.

5.1 Implementation Monitoring

Implementation monitoring will monitor financial, physical and organisational issues affecting progress towards UHC as described in the UHC Roadmap and implementation of the NHSSP. Physical monitoring will track delivery of inputs to all health facilities, districts, units, programmes and directorates. These inputs include construction and rehabilitation of PHUs, supply of drugs, postings of health staff and provision of training among others. The District Health Information System (DHIS) is one of the major tools used for physical monitoring, which will be implemented by various Supervision Missions. It is proposed that findings from physical monitoring will be reported through the Annual Health Statistics Report and Quarterly Health Sector Reports. Staff across the health sector shall be responsible for physical monitoring.

The common International Health Partnership (IHP+) M&E framework (see Figure 2) will be used to guide the monitoring, evaluation and review work, including the selection of indicators, the identification of critical data gaps, and the identification of needs in analysis, data quality assessment, synthesis, reporting, communication and use. The core indicators and targets will be aligned with the NHSSP (2021 to 2025).

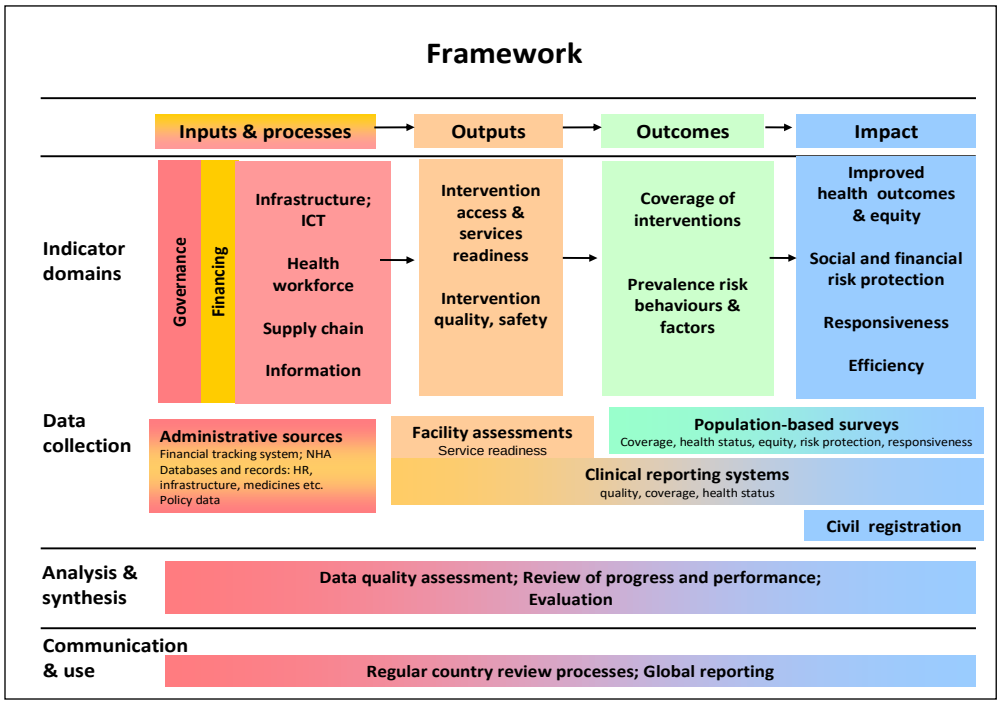


Figure 5.1: The IHP+ M&E framework

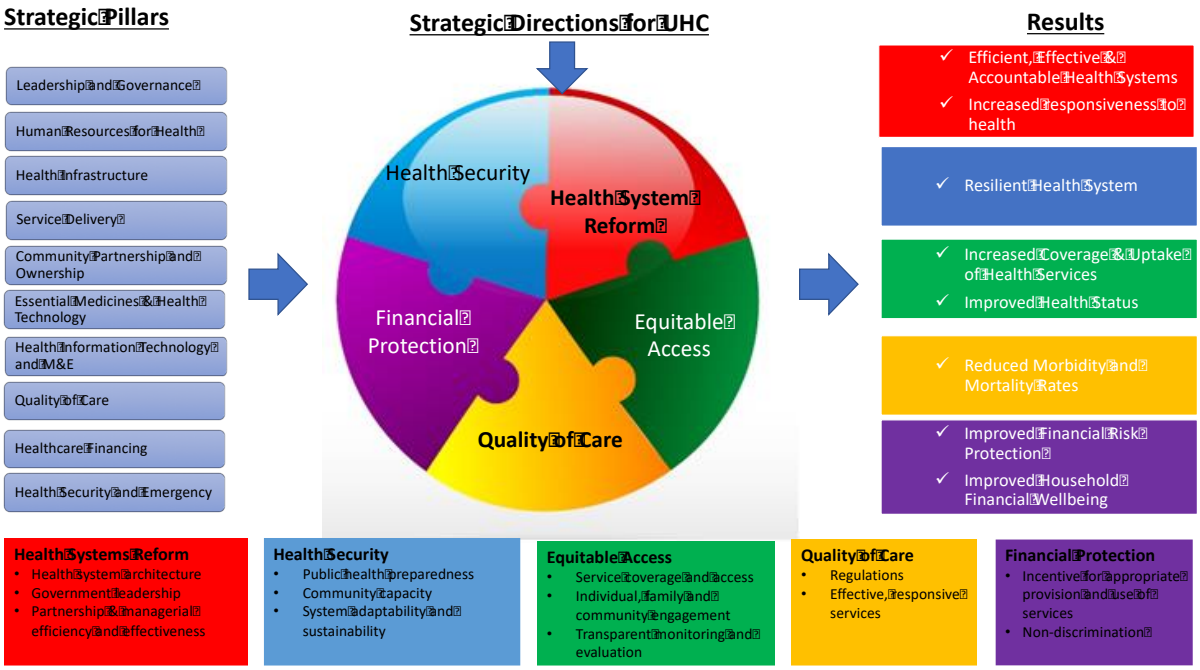


Figure 5.2: Theory of Change - Achieving UHC through Health System Strengthening in Sierra Leone (Roadmap for achieving UHC in Sierra Leone (2020)

5.4 Core Indicators for monitoring progress and performance of the NHSSPsimplementation

Needs some narrative. Are these the final indicators – or draft to be further developed for example?

Table 5.1: Core Health Sector Indicators and Targets

Indicator	Strategic Document to which indicator is aligned	IndicatorSource	Level of Disaggr.	Baseline (National)	2025 Target	Frequency
Health Strategy Objectives: Indicators and Targets						
1. Coverage of essential health services [SDG 3.8.1]		HFS	National, District	39% (2918)	60%	Every 2 years
2. Large household expenditure on health as a share of total household consumption or income [SDG 3.8.2][1]		SLIHS	National, District	9.92 (2018)	8	Every 5 years
3. Average life expectancy (in years)		Census	National	54 (2019)	64	Every 5 years
4. Maternal mortality ratio (per 100,000 live births) [SDG 3.1.1]		DHS	National	717 (2019)	538	Every 5 years

Indicator	Strategic Document to which indicator is aligned	IndicatorSource	Level of Disaggr.	Baseline (National)	2025 Target	Frequency
5. Under-five mortality rate (per 1,000 live births) [SDG 3.2.1]		DHS	National	105 (2018)	80	Every 5 years
6. Neonatal mortality rate (per 1,000 live births) [SDG 3.2.2]		DHS, MICS	National	31 (2019)	25	Every 5 years
7. Adolescent birth rate (births per 1,000 15-19 year olds) [SDG 3.7.2]		DHS, MICS, HMIS	National, District	102 (2019)	60	Every 5 years
8. Prevalence of HIV among female and males (% ages 15-24)		WDI, DHS, Sentinel surveillance	National, District	1.0 (2019)	0.6	Every 5 years
	Health Financing Indicators and Targets					
9. Out-of-pocket health spending as percentage of total health expenditure		NHA	National	64.6	30.0	Every 2 years
10. Percent of national budget		NHA	National	11 (2020)	15	Every 2 years

Indicator	Strategic Document to which indicator is aligned	IndicatorSource	Level of Disaggr.	Baseline (National)	2025 Target	Frequency
allocated to the health sector						
11. Coverage of Health Care Insurance		DHS, MICS	National, District	4 (2019)	40	Every 2 years
12. Proportion of the population with impoverishing health expenditure[1]		WDI, DHS, MICS	National, District	15.6 (2011)	10	Every 2 years
13. Expenditure for primary health care as percentage of national government financing		SL Health PER	National	3 (2015-2019)	4.5	Every 2 years
14. Government expenditure on health as percentage of total recurrent national budget (percentage)	E.g MTNDP	MoF Annual Budget	National	11	15	Anually
	Service Delivery Indicators and Targets					
15. Key Health professionals by cadre per 10,000	HRH Strategy (xx)	HRIS[1]	National, District	a. Physicians per 1,000 pop: 0.025 (2011)	a. 0.040 b+c. 0.440	Annually

Indicator	Strategic Document to which indicator is aligned	IndicatorSource	Level of Disaggr.	Baseline (National)	2025 Target	Frequency
population 15a. Doctors 15b. Midwives 15c. Nurses 15d. Allied Health Workers				b+c. Nurses and midwives per 1,000 pop: 0.224 (2016)		
16. Population living within 5Km of a health facility (percentage)	xx	HFS	National, District	76%	85%	Every 2 years
17. Access to a core set of relevant essential medicines [SDG 3.b.3] (percentage)		SARA	National, District	31% (2017)	70%	Every 2 years
18. Births attended by skilled health personnel [SDG 3.1.2] (percentage)		DHS, MICS, HMIS	National, District	87 (2019)	92	Annually
19. Antenatal care coverage (4+ visits) (percentage)		DHS, MICS, HMIS	National, District	79 (2019)	85	Annually
20. Postpartum care coverage within 2		HMIS	National, District	86 (2019)	90	Annually

Indicator	Strategic Document to which indicator is aligned	IndicatorSource	Level of Disaggr.	Baseline (National)	2025 Target	Frequency
days of birth – women (percentage)						
21. Postnatal care coverage within 2 days of birth – newborn (percentage)		DHS, MICS, HMIS	National, District	83 (2019)	86	Annually
22. Antiretroviral therapy (ART) coverage among people living with HIV (percentage)		HMIS	National, District	41.0	48	Annually
23. Intermittent preventive therapy for malaria during pregnancy (IPTp) 3+ doses (percentage)		DHS, MICS, HMIS, MIS	National, District	36 (2019)	70	Annually
24. Children receiving Penta-3 before 12 months of age (percentage) (percentage)		DHS, MICS, HMIS,	National, District	76.2 (2019)	85	Annually

Indicator	Strategic Document to which indicator is aligned	IndicatorSource	Level of Disaggr.	Baseline (National)	2025 Target	Frequency
25. Incidence of low birth weight among newborns (percentage)		DHS, MICS, HMIS	National, District	5 (2019)	3	Annually
26. Children under 5 years who are stunted [SDG 2.2.1] (percentage)		DHS, MICS, HMIS	National, District	30 (2019)	22	Annually
27. Children under 5 years who are wasted [SDG 2.2.2] (percentage)		DHS, MICS, HMIS	National, District	5 (2019)	3	Annually
28. Population with access to at least basic sanitation service		DHS, MICS	National, District	16 (2019)	45	Annually
29. Percent of those 20-49 years not married by age 18 years		DHS, MICS	National	63.5 (2019)	80	Annually
30. Raised blood pressure among adults (percentage)		STEP	National, District	(TBC)	(TBC)	Every 2 years

Indicator	Strategic Document to which indicator is aligned	IndicatorSource	Level of Disaggr.	Baseline (National)	2025 Target	Frequency
31. Raised blood glucose/diabetes among adults (percentage)		STEP	National, District	(TBC)	(TBC)	Every 2 years
	Performance Accountability Indicators and Targets					
32. Percentage of health facilities publicly reporting performance data		HFIS	National, District	(TBC)	(TBC)	Annually
33. Maternal death reviews completed		Record review	National, District	20% (2020)	80%	Annually

5.2 Expanded set of program indicators

The core indicators listed above will be used to monitor progress of UHC Roadmap and implementation of the NHSSP 2021-2025. Programmes and district teams will however require an expanded set of indicators to help them assess various aspects of their programme or district activities. An additional set of Key Performance Indicators (KPIs) will be reported on once a quarter at community,district and national level. Most of these indicators will be routinely tracked and presented ondashboards and performance monitoring. Additional indicators will be used by individual programs to assess progress within their directorates and programs. Directorate and programs should incorporate the relevant core national indicators into their M&E plans while expanding their indicator frameworks to incorporate program/directorate-specific indicators.

5.3 Data sources

The specific sources of data required for monitoring of the UHC Roadmap and implementation of the NHSSP 2021 – 2025 are:

- DHIS2
- Health facility surveys (HFS, censuses and samples)
- Population-based surveys (Demographic Health Survey (DHS), Multiple Indicator and Cluster Survey (MICS), Malaria Indicator Survey (MIS), Severvice Delivery Indicator (SDI) Survey – Health Nutrition Standardised Monitoring and Assessment of Relief and Transitions (SMART) Survey
- Logistics Management Information Systems (LMIS)
- National Health Accounts (NHA)
- Human Resource Management Information System (HRIS)
- Civil Registration
- Integrated Disease surveillance system (IDSR)
- Sector and Programme Evaluations
- Research

5.3.1 DHIS 2

The routine health management information is built on the DHIS 2 as the data repository for the HMIS. The District Health Information System (DHIS 2) is an open source software developed by the University of Oslo (UiO). The Ministry of Health and Sanitation (MOHS) has been using this web-based software for health information management throughout the country since 2008, for collecting information, analysis of data and contributing to the real time health information dashboard. The DHIS2 software is uniquely suited to meet the information needs of Sierra Leone's district health system.

Sierra Leone has extensive experience in implementation of DHIS2 over the past years. However, there is still room for improving its technical and organisational capacity for better use and operationalization. There is a need for expansion of DHIS2 into additional programmatic areas and into new use cases. There is also the need for a unified HMIS integration roadmap to guide MOHS in its planned health programs integration activities and general HMIS strengthening.

Finally, there is a need to improve local technical capacity to manage DHIS as well as to epand the storage capacity to serve as the warehouse for HMIS data in Sierra Leone.

There are problems with timeliness, completeness, and general quality of data from routine HMIS. There are significant data quality capacity issues at the PHU and hospital level which are compounded by fragmentation and the burden of parallel reporting systems (HIV, TB, malaria).

Problems with quality of routine HMIS data will be addressed by fully implementing the data quality improvement plan developed by DPPI and by digitalising the registers used at health facility level, so that summary data are automatically generated and not manually tallied. Additional computers and tablets will be procured for data capture at hospitals and PHUs.

5.3.2 Health facility surveys

Health facility surveys (HFSs) will be conducted biannually to assess the availability and geographic distribution of health services nationwide. All private sector facilities (private-for-profit as well as private-not-for-profit) will be covered by these censuses. Maps of the health infrastructure in each district will thus be updated biannually. Service Availability Readiness Assessment (SARA) survey will be conducted every 2 years from a representative sample of health facilities to assess service readiness in conjunction with a data quality assessment and record review. Quality of care assessment will be conducted every 2 years in conjunction with SARA.

5.3.3 Population surveys

The Demographic and Health Survey (DHS) and Multi-indicator cluster surveys (MICS) will form the main population-based surveys for health statistics. A DHS will be conducted every 5 years, and MICS surveys will be conducted in between successive DHS surveys toget population-based survey report every 2.5 years. In this way, these two surveys will complement each other especially in assessing service coverages.

In addition to these surveys small-scale surveys, such as the Malaria Indicator, Non-Communicable Diseases risk factors STEP survey, SMART, SDI Health and Client satisfaction surveys will be conducted periodically. It is expected that, where possible, the questions in these surveys will be expanded to capture information on other key health indicators.

Table 5.2 List of population-based surveys

Survey	Methodology	Implementation Dates	Responsible Institution
Demographic and Health Survey (DHS)	National Household surveys	5 years	Statistics Sierra Leone (SSL)
Multiple Indicator Cluster Survey (MICS)	National Household surveys	5 years	Statistics Sierra Leone (SSL)
Sierra Leone integrated household survey (SLIHS)	National Household surveys	5 Years	Statistics Sierra Leone (SSL)
Standardised Monitoring and Assessment of Relief and Transitions (SMART)	District level household survey	2 years	MoHS
Service Availability and Readiness Assessment (SARA)	Health Facility Level	2 years	MoHS
Malaria Indicator Survey (MIS)	District level household survey	2 years	Statistics Sierra Leone (SSL)
Client Satisfaction Survey	District level household survey	2 years	MoHS
National Health Accounts (NHA)	National level	2 years	MoHS
NCD STEPS		?? years	MoHS / WHO
SLIHS?			
Nutrition?			

5.3.4 Resource tracking and institutionalization of NHA and sub-accounts

The MoHS put in place a system for tracking government budget and expenditure called the Integrated Financial Management Information System (IFMIS). The IFMIS however only tracks government expenditure. It does not track donor, FBO, or NGOs expenditure. A National Health Accounts (NHA) survey will be conducted every two years to capture government, partner and individual health expenditure. As funding for NHA (two-year cycle) has not been regularly available, there are plans to institutionalise most of the NHA data collection process to cut down data collection cost.

5.3.5 Logistics Management Information System

As part of the process of strengthening the Logistics Management Information System (LMIS), the Ministry of Health and Sanitation, in collaboration with its partners has developed standards for recording the essential data items. These include:

- Stock keeping records such as stock (or bin) cards,
- Transaction records such as requisition and issue vouchers, and,
- Consumption records such as a daily activity record that tallies the amount of each product used or dispensed to patients each day.
- Report, Request and Issue Voucher (RRIV) summary forms for reporting on stock acquisition and levels at individual health facilities. The RRIV data has recently (year) been incorporated into the DHIS 2 platform and reporting rate is already pretty impressive, even through not yet optimal.

There is a national LMIS platform for health logistics and commodities management. Three application systems making up the LMIS are mSupply, Pharmaceutical Dashboard, and CHANNEL. The RRIV forms have been fully integrated into DHIS2 and all districts are now entering data into DHIS2. In addition, there is a computerized form of Inventory Control mechanism (CHANNEL), which has been installed in the District and Hospital Medical Stores. However, the system is yet to be used effectively to get consumption data. The RRIV reporting completeness and timeliness are still low and the following measures will be implewmented to improve these rates:

- Additional training will be provided for all health workers that handle drugs and other supplies, to efficiently perform their respective roles in the LMIS chain.
- Supervision will be heightened to strengthen the capacity of health workers to use the paper-based LMIS.
- The RRIV registers will be digitalized to permit electronic reporting by health facilities using tablets. This system will be designed to take advantage of the supply distribution process and operate throughout the varying levels of telecommunication available in remote and rural areas.

5.3.6 Human Resources Management Information System

An open-source Human Resource Information System (HRIS) platform is the main source of health workforce data deployed throughout the country in public health facilities, and also including data from censuses and other national surveys. The system has been decentralized to all districts and there are now district HR officers managing the system. The system for updating human resources information is however currently weak and prone to delays in updating staff information. The scope of functionalities of the HRIS are enormous but the country is yet to tap and utilize all its functionalities for HR management partly due to the low capacity of staff managing the HRIS. There is also currently no national database to track the annual numbers graduating from all health training institutions. The HRIS has not yet been integrated into the DHIS due to concerns over disclosure of HR personel data.

To further improve the functionality of HRIS

- additional qualified staff will be deployed to support the management of the HRIS platform so that an increasing number of its functionalities can be used to improve HRH management, decision making and planning within the sector.

5.3.7 Community Health Care Information System (CHIS)

The MoHS currently has a network of 14,000 Community Health Workers (CHWs) providing health care services in communities throughout the country. Community data is collected daily by the CHWs in registers and is compiled by the Peer Supervisors into a monthly summary register. Data from this summary register is transferred onto the HF4 form by the PHU, which is then submitted to the DHMT for entry into the DHIS2. Data entry has traditionally been done at district level, but this will in future be done at health facility level (PHU level).

Once data is in the DHIS2, all approved users have access to perform quality checks and make relevant information products. M&E officers will use standard dashboards to disseminate data to all CHW program stakeholders within the MoHS and outside it in order to stimulate discussion about the data at routine meetings and to get expert analysis and interpretation by relevant program managers, community organisations and CHW supervisors.

Feedback mechanisms will be developed for all levels using DHIS2 to inform lower levels on their performance. In all cases, data will be used to calculate standard indicators which will be used in turn to measure progress towards locally set targets developed as part of a CHW plan. Also, each CHW will be given a specified identification number to enable tracking of individual CHW contribution to service delivery every month, to justify payment of their monthly incentives.

The Directorate of primary health care (DPHC) is currently designing a community service integrated Human Resource information System (IHRIS) that will serve as a database for community services, human resource management and performance monitoring, collaborative partners between line, Directorates will ensure interoperational between this and related information systems.

5.3.8 Vital Statistics

By Act of Parliament, the Registration of births and deaths is now the responsibility of a separate legal entity, the National Civil registration Authority (NCRA). The MoHS however supports the process by providing notification of births and deaths and medically certifying the cause of death. The system for International Classification of Diseases (ICD) is not yet used in the country, even though training of a core set of staff has commenced. Currently, statistics from civil registration are not representative as most community deaths as well as some births are not reported, and hence not registered. An organization, Comprehensive Mortality Surveillance for Action (COMSA), is working with government to improve civil registration by piloting the combination of hospital mortality data with data from a representative sample of demographic surveillance sites to assess mortality by causes in one district.

To address this situation, the following activities will be conducted:

i. Physicians and clinical officers will receive training in the classification of deaths based upon the system for International Classification of Diseases (ICD)

ii. Expand the pilot currently conducted by COMSA to the whole country by 2023

iii. Collaboration with local authorities to pass bye-laws in support of mandatory reporting of births and deaths events to health facilities.

5.3.9 Maternal Death Surveillance and Response (MDSR)

There is a system of Maternal Death Surveillance and Reponse (MDSR) including investigations at facility/community levels and review by a district MDSR committee that started in xxx (add year). Facility level investigations are taking place but there have been only a few investigations in communities. Hospital reporting with accurate causes of maternal deaths is nearly complete. However, the MDSR system is not regularly reviewed, and the results are not always used for advocacy and community mobilization. The system as a whole is not yet well established

5.3.10 Integrated Disease Surveillance and Response (IDSR)

In 2019, Sierra Leone became the first country in the WHO Africa region to fully transform its national Integrated Disease Surveillance and Response (IDSR) system from paper-based to web-based electronic platform. The disease surveillance is based on the electronic IDSR reporting platform, where disease surveillance data is active in all public health facilities. Each health facility sends out weekly electronic reports using tablets to the district from where it is sent to the national system for immediate analysis and action. Reporting rate is about 90% and continues to improve. To improve reporting rate additional tablets will be provided for facilities currently without tablets and periodic feedback will be given to health facilities.

5.3.11 Research

Various types of research will be supported over the course of the period covering the UHC Roadmap and implementation of the NHSSP year-year. The Directorate of Post Graduate Training and Research will coordinate with MoHS Directorates, programmes and implementing partners to develop a Health Research Strategic Plan. This will guide research to fill knowledge gaps in the provision of health facilities in Sierra Leone. Research results will be used to improve programming and service delivery.Various programmes and partners working in the sector embark on various researchs. There is however currently no central hub that houses these products from these researches. During the period the Directorate of policy, planning and information will serve as a hub and provide a repository for researches conducted within the sectorCHAPTER 6: Routine Data Collection, reporting and data quality.

6: ROUTINE DATA COLLECTION, REPORTING AND DATA QUALITY

6.1 Routine Data Collection and reporting

Routine data is collected through a network of about 1,350 Peripheral Health Units (PHUs): government, NGOs, faith-based, clinics and private health facilities, and about 52 hospitals that are distributed across 16 health districts. The PHUs and hospitals gather data from client/patient registration forms, using facility registers. These are collated unto paper-based integrated summary reporting forms that are sent to the district office. Data from the community is included in the PHU's reporting forms. DHMT captures this data into an online electronic District Health Information System (DHIS) against the 15th of every month. The electronic DHIS database also allows the integration of key Electronic Medical Records (EMR) Systems such as the OpenMRS (explain abbreviation) software that will permit the development of a Hospital Information System. This electronic medical recording process using OpenMRS has started with data for HIV-positive patients on anti-retroviral medication being recorded at the nation's teaching hospital (which one? Please specify) and will be scaled up to all hospitals as a second step. The DHIS database will progressively be extended to capture data from other sources such as specific surveys, civil registration (births and deaths), research, supervision, private sector, civil society, resources, and administrative records to give a broad picture of the country. Data and reports on key indicators and reports of national reviews will be stored in a national data repository/observatory.

The current Health Management Information Systems (HMIS) uses both paper and software to report healthcare services and interventions. Even though the directorate is poised to completely phase out the use of paper in its reporting system, the facility and DHMT still uses this system to record healthcare services.

The Ministry set itself a target of two (2) years' timeframe starting from 2021 to digitize all reporting tools to enable data collection at all health facility level in the country. As part of the process of digitalizing data collection at health facility level, laptops have been provided to 215 Community Health Centres (CHCs) nationwide for data inputting and analysis at chiefdom level. over 700 tablets have been procured for inputting monthly summary data at individual PHU level this will complete the current other data collection efforts using tablets at health facility. The following is a list of current tools (Table 6)

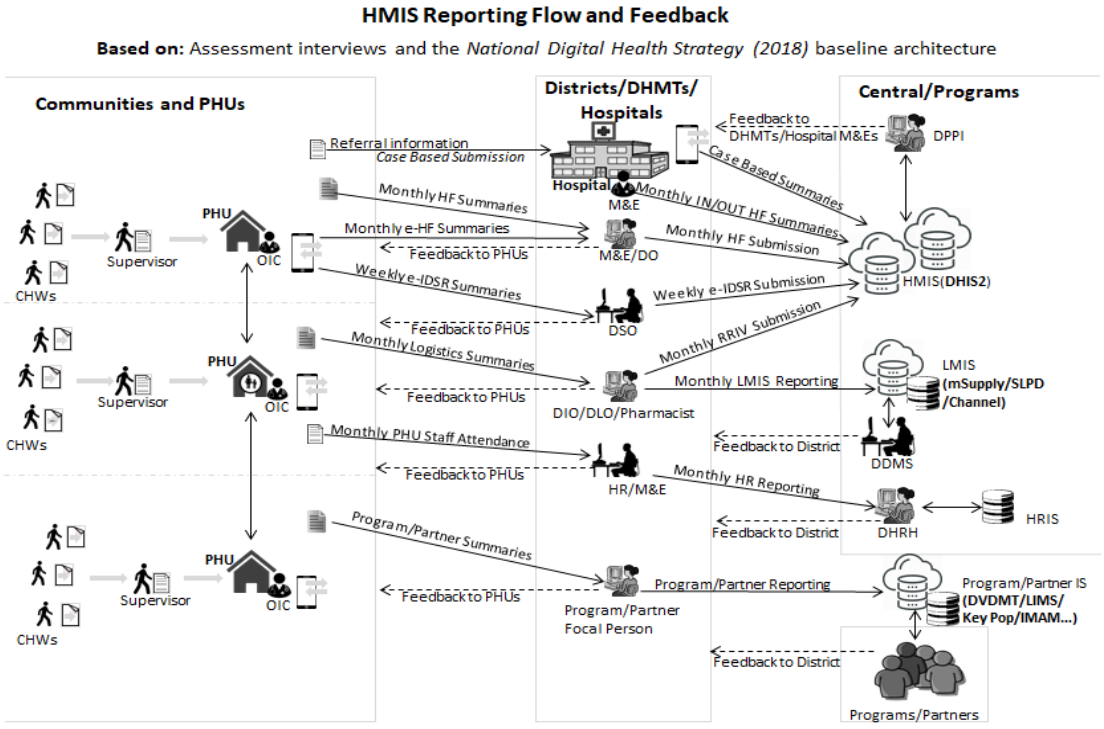
Table 6.1: List of current Tools

No	Name of Form
1	Monthly Summary Out-Patient Morbidity Forms HF1
2	Monthly Summary of Child Preventive Services - HF2
3	Monthly Summary Form For Reproductive Health Services -HF 3
4	Monthly Summary Form For Community Interventions- HF 4

No	Name of Form
5	Hospital Monthly In-Patient HF 5
6	Hospital Monthly Out-Patient HF 6
7	Epi / Under 2 Register
8	Under Five Register For PHUs- Age Up To 2 Months
9	2 Months To -Five Years Treatment Register - PHUs
10	Above-Five (General) Treatment Register - Hospital
11	Family planning register
12	Maternity and Delivery Register
13	Mother And Neonate Health Register
14	Epi Tetanus Diphtheria (TD) And Hpv Register
15	Above-Five (General) Treatment Register - Phu
16	Under Five Register For Phus: Age 2 Month-5 Years
17	NACP – Adult ART
18	NACP-HCT/TB Screening
19	NACP – Paediatric HIV
20	NACP - PMTCT
21	TB-Case registration - Monthyly
22	TB-Treatment Outcome - Monthly
23	RR/MDR – TB Case registration - Quarterly
24	RR/MDR – TB Treatment Outcome - Quarterly
25	RR/MDR – TB Case Detection and Treatment (WHO)
26	RRIV – Consummables (CHC, Hospitals, CHP/MCHP)
27	RRIV- Essential Medicines (CHC, Hospitals, CHP/MCHP)

No	Name of Form
28	RRIV - HIV/AIDS (CHC, Hospitals, CHP/MCHP)
29	RRIV- Malaria (CHC, Hospitals, CHP/MCHP)
30	RRIV – Most Essdential Medicines and consumables (CHC, Hospitals, CHP/MCHP)
31	RRIV – Nutrition (CHC, Hospitals, CHP/MCHP)
32	RRIV – Reproductive Health (CHC, Hospitals, CHP/MCHP)
33	RRIV – TB/Leprosy (CHC, Hospitals, CHP/MCHP)
34	RRIV – Vaccines (CHC, Hospitals, CHP/MCHP)
35	IDSR – Emergencvy IDSR Daily disease report
36	IDSR – Emergencvy IDSR Weekly disease report
37	CBDS – Weekly report

Figure 6.1: HMIS Reporting Flow and Feedback loop



6.2 Data quality audit

A critical challenge in collecting routine HMIS data is the quality of the collected data. Errors may happen at each stage of data collection and transmission. Periodic Data quality assessment (DQA)will be conducted to determine the quality of the data interms of: internal consistency, external comparisons and external consistency of population data. The objective of data quality assessment is to measure the extent to which the information in the source documents has been transmitted accurately to the next level of reporting. This will allow systematic errors that occur in the reporting of data to be identified and, for specific indicators, provide an estimate of the degree of over-reporting or under-reporting in the system at national level.

This will originate fromtwo levels: District to PHUs,hospitals and community (CHWs), and National (including program) to DHMTs, Hospitals, and PHUs (both government and non-government facilities), and community (CHW)

DQA at each level will be preceded by data quality checks at the facilities with more data quality issues. District personnel will plan to visit at least half of their health facilities each year to assess the quality of the data they are submitting to the DHMT. The district personnel will conduct on-the-job training for all staff, during the visit, based on the inefficiencies identified. District will develop yearly data quality improvement implementation plan.

Additional data quality improvement exercises will include:

- revising the current data quality improvement plan to reflect the changing challenges and bottleneck, especially when changing from paper-based to electronic reporting.
- involvement of independent groups (SSL, Universities) for data quality ascertainment
- documenting processes for data adjustment including assessment of completeness of reporting, assessment of denominators, comparison/analysis of results from facility data with data from population surveys and use of well documented methods for adjustment .
- conducting an bi-annual system of verification through bi-annual facility surveys (combined with the service readiness surveys - as described above)
- development of data quality report cards
- sharing of data inconsistency reports in the public domain,
- training and supervision of data collectors

6.3 Supportive supervision

Supportive supervision in the health sector is a process of helping health workers to continuously improve their work performance, with a focus on using supervisory visits as an opportunity to improve the knowledge and skills of health staff. The M&E Specialist at DPPI will champion these activities that will promote data use and emphasizing mentorship, joint problem -solving, and two-way communication between supervisors and supervisees.

Just like the data quality audit, supportive supervision will be conducted from two levels: From District (DHMT) to PHUs,hospitals (government and private) and community (CHWs), National (DPPI) to DHMTs, Hospitals, and PHUs (both government and non-government and community

(CHWs)). This activity will be jointly conducted with other directorates and program staff. District will develop yearly and quarterly supportive supervision plans.

6.4 Data analysis

Analysis of data will be done at various levels of the health sector. Data will be analysed and presented in the form of tables, charts, and graphs. Data from routine HMIS will be disaggregated by district/local (city and district) councils and when required by chiefdom, health facility, and Community (CHW). Data from surveys will further be disaggregated by sex, urban/rural, education and wealth quintiles, and other aspects of interest (e.g. PWD). The main focus of analysis will be for tracking progress and trends based on measurement of baselines and targets for core indicators (as in the progress and performance report), equity analysis (main disaggregation: region, district, level of income, sex, age, disability status etc.), efficiency (value for resources / value for money). Training will be provided to staff at various levels in data analysis and presentation to facilitate data use to inform practice and policy.

CHAPTER 7: Evaluation and Reviews

7.0 Evaluation

Evaluation will be carried out periodically to assess the health status of Sierra Leoneans as a result of implementing the NHSSP for UHC (year to year) and the health component of the MTNDP (Medium Term National Development Plan 2019-2023).

The major evaluations will be (i) Annual Health Sector Performance Review; (ii) NHSSP for UHC Mid- Term Evaluation in year 202xx(iii) MTNDP midterm evaluation; (iv) NHSSP for UHC End of Term Evaluation in year 202xx and (v) MTDNP end term evaluation (2023/2024?); Tracking UHC – National Evaluation (XXXX)

The evaluations will be used for accountability, and thus a review of efficiency, economy, effectiveness, equity and sustainability (value for money). Evaluation will have 3 phases: planning, implementation and dissemination, with various stakeholders needed at the different phases.

7.1 District and program reviews and evaluations

District health reviews are district health activity evaluations conducted every 3 months based on the current district health Annual Work Plan (AWP), led by the DHMT (including program focal persons), together with district/regional/national hospitals in the district, local (city and district) councils and district health partners. At the moment this does not happen in every district.

Separate **Program quarterly reviews** are organized by national programs like TB, HIV, Malaria, EPI, surveillance and RCH for district level M&E and program focal point staff every quarter..

Half-yearly data review is led by DPPI with as participants M&E of DHMTs, hospitals, programs and directorates and selected partners. The participants review progress on program indicators and data quality of those indicators.

District, program and data reviews feed into the annual health sector performance review.

Action points:

- To develop and disseminate comprehensive reports of the 6-months district reviews, program quarterly reviews and the half-yearly reviews**.**
- Integration of separate program quarterly reviews into one quarterly activity review led by DPPI.
- To develop and agree indicator list for the half-year data review meetings.

7.2 National level reviews and evaluations

The **Annual Health Sector Performance Review** is a process evaluation (focused on inputs, activities and outputs) done by the MoHS together with partners, with a focus on the progress

against indicators in the respective plans, using mostly routine data and already available research and surveys. There is no additional data collection specifically for this review. This review will inform decisions including corrective action, planning, budgeting etc. Beneficiaries are included in this review.

The **Mid Term Evaluations** (MTEs) will be used as outcome level evaluations to inform mid-implementation adjustments to improve programming and delivery in the remaining half of the five-year period. The MTEs will assess programme performance and management capacities at central and district level and amongst major partners. The Mid Term evaluations will be internal. The MTEs will use the same data as the annual health sector performance review with additional data collection as needed.

The **End Term Evaluations (ETEs)** will be impact level evaluation used to inform decision making, learn lessons for the next plan, feedback to the donor and resource mobilization for the next phase. The ETEs will assess programme performance and management capacities at central and district level and amongst major partners. The End Term evaluations will be external. The ETEs will use, next to routine and other already available data, specially collected data for the ETE – usually in the form of document reviews, surveys and other quantitative and qualitative data collection.

7.3 Annual Performance Reviews

Every year (except the year for the mid-term review and final evaluation) a Joint Annual Performance Review will be undertaken that includes stakeholders namely, cooperating partners and other non-state actors, to review progress made in selected indicators of interest. The reviews will be guided by particular themes of interest and will be premised on the evidence of performance in the HMIS and available survey data

7.4 Mid-term Reviews

Mid way into the implementation of the 5-year National Health Sector Strategic (NHSSP) for UHC (2021 - 2025), so in 2023 a national review of the plan will be undertaken to assess progress made towards goals, document success and identify areas for modification. Data on implementation progress will be gathered from a representative sample of implementing entities, covering all key areas of the M&E Framework with a focus on *inputs*, *outputs* and *outcomes*. Some dimensions in the outcome domain may not be included in the review but shall be left to the end line (final) evaluation in 2025.

Table 7.1. Timelines for Reviews and Evaluations

Milestone	Timeframe
Joint Annual Performance Reviews	June
Health Sector Review Summit	July
District Reviews	March June, September, December
Programme Reviews	March, June, September, December
National level Mid-Year Review of AWP Implementation	August
Mid-term review of NHSSP	September 2023
End term Evaluation of NHSSP	December 2025

CHAPTER 8: Data Dissemination and use

8.1 Data dissemination for action

An effective M&E system ensures the optimum use of system wide data and information. This requires that data generated from different sources are translated into information that is relevant for utilization at different levels of decision making. Existing routine and non-routine data are disseminated to data users and decision makers across all levels of the health system, while moderate progress has been made in improving data collection and analysis, data use remain at its infancy in Sierra Leone.

Data need to be translated into information that is relevant for decision-making. Data needs to be packaged and disseminated in formats that are determined by management at the various levels. Service delivery data shall be packaged and displayed at the various health facilities using the HMIS formats already provided. The timing of information dissemination should fit in the planning cycles and needs of the users.

The MoHS will ensure timely dissemination and use of quality data in the following decision making structures at national Level:

- Executive management meeting chaired by the Honorable Minister of Health and Sanitation, attended by Deputy Ministers, Permanaet secretary, CMO to make policy decisions. This meeting is held weekly.
- CMO Management meeting with Directors and Managers frequency? What is shared?
- To use the National M&E /HMISTechnical Working Group as a forum to disseminate performance of key HMIS indicators on a monthly basis
- Technical programmes to assess progress in programme implementation.
- NGO and Donor partners – to assess progress in implementation of planned projects

8.2 Knowledge management

Knowing that good knowledge management practices enhance the work process of organizations. Specific intervention to improve knowledge management are described below:

- Virtual discussion forums: groups will be created both users and collectors of health data with the purpose of making quick discussions. This will include WhatsApp groups and periodic virtual meetings. The memberships of the existing Whatsapp groups and purpose of the groups will be reviewed to focus on knowledge management. This is particularly useful when any or all member (s) of the group are not physically close and need to take some questions or even share something interesting.

- Mentoring and coaching: this practice offers support and encouragement to the novice in order to improve their performance. The practice is known to be extremely rich, and will sharpen the skills and performance of the mentee through on the job skill-building.
- Best practices: sharing involves sharing successful activities that produced great results for the ministry. This is considered a very important practice, as it improves performance and avoids reinventing the wheel, helping to improve productivity and reduce costs.

- Benchmarking: this practice consists of sharing best practices with other department or organisation, be it a technology, a system or a know-how that can improve performance. It consists of a continuous process of understanding the best practices used by the health area and incorporating transformations.
- Peer review: Feedback and safer diagnosis and treatment are the two greatest benefits perceived by health professionals who perform this practice, according to the interviewees:
- Lessons learned: this practice consists of meetings aimed specifically at the exchange of knowledge aimed at facilitating open discourse and promoting an environment of trust, which helps to promote and sustain an organizational culture. For successful lesson learnt practice it is important for the MoHS to have a way of storing new knowledge so that it can be applied in the future for the benefit of the sector.
- Organizational memory: this practice is supported through the database. This knowledge can then be reused at any time. importance of organizational memory in health organizations and recognizes that memory allows recognizing valuable knowledge and also understanding how it is interpreted. The new knowledge, as interpreted, is added to the organization's memory (Walsh, Ungson, 1991).
- Map of knowledge: this practice consists of identifying the knowledge of each professional, his subspecialty. The map created through the identification of knowledge allows the MoHS to know its key knowledge, act with coordinated actions.

8.3 District Level

At district level information is shared at various fora including:

- DHMT meeting : At district level, the District M&E officer shares monthnly data relevant to each programme focal person to assess data consistency and identify issues relating to the integrity of the data for the programme. Each focal person reviews the data for the month and provide feedback on credibity and consistency.
- Partners coordination meetings: Each district conducts a partner coordination meeting each month, to share information on planned and ongoing activities to report progress and explore areas of synergy with planned or ongoing activities by other partners. At these meeting key indicators are discuss to recommendations made to improve or maintain the gains.
- In-charges meeting : Each district holds a m onthly PHUp-in-charges meetings at the beginning of every month. The purpose of bthe in-charges m eeting isto provide feedback to PHU-in-charges on progress made or challenges identifies in the previous months. Feedback is also provided on individual PHU performance and suggestions provided to improve service delivery.
- Stakeholders meeting at community level: DHMT also hold quarterly meetings with community stakeholders inc luding Param ount chiefs, local chiefs, Councillors and other stakeholderts to provide feedback on service delivery coverages and identify solutions to challenges encountered.
- Community Monthly Chalkboard: Each health facility is expected to have Facility Management Committee (FMC) that serve a liaison between the health workers and the community. The FMC are expected to hold monthly meetings with opinion leaders to communicate key public health events arising from the community health teams' interactions or service provision during the month and also create a forum to share community experience with service delivery at the facility.

In order to facilitate this process, a simplified performance framework, with indicators of public health priorities, will be introduced to provide guidance and this will be update yearly. Guidance on how to use and interpret community indicators will be released as part of the package for the Data Handling and use. T

- CHW and Community Services Monthly Meetings.

8.4 Analytical Products

8.4.1. Annual Statistical Bulletin

The Annual Statistical Bulletin applies to the district level only. It is a summary of performance (on selected key performance indicators)of the district health system in charts, simple tables and maps. The presentation of the data should be simple enough as the targeted audience shall be the general public in the catchment area. At the end of the year, each district will produce this report indicating how each facility (under them) performed on preselected set of indicators. These bulletins will be sent to all facilities. Individual facilities will in turn pin this report, in strategic areas of the facility for public view. Besides pinning these reports for public view, each facility will be expected to develop a package of messages based on the performance for communication to their clients during health talks. The outline of the bulletin will be circulated at the beginning of each reporting period.

8.4.2. Facility level Self-Assessment Reports

Performance monitoring frameworks specific to facility level of care will be introduced at Maternal and Community Health Posts (MCHP), Community Health Post (CHP), Community Health Centres (CHC) and Hospital (by service area/ department) and district. Data generated from the HMIS will be reviewed monthly and each of these levels of care will be expected to undertake self-assessments against set targets, complete performance improvement templates and plans if targets are not met. At the district level, this will provide input in the preparation of quarterly review reports. The list of indicators to be reported on will be released every year. Instructions on how to complete this will be included in the Data Management Procedures Manuals for the various level and guidance on the interpretation of indicators will be published in the Indicators Definitions Manual.

8.4.3. Quarterly bulletins:

Quarterly bulletins showing progress in service delivery coverage both nationally and at district level will be developed and distributed. These bulletins should give programmes and opportunity to identify gaps in service delivery and take apprproaite

These products will report on; i) achievements/progress relative to planned targets, ii) assess development impact; and iii) performance of sector, districts and agencies. These will be shared with stakeholders to facilitate use during the course of planning and implementing their support to health care. Dissemination of M&E products are in Table 8.1 below.

Table 8.1 : Dissemination of M&E Products

M&E Product	Reporting Frequency	Responsibility
✓ National Quarterly Health information Bulletin	Quarterly	Director, DPPI
✓ Annual Reports **(Summary of completed outputs (target, achievement in the year and cumulative total from KPIs)**	Annually	Principal M&E Specialist , DPPI
✓ Supportive Supervision reports	Quarterly	Principal M&E Specialist , DPPI
✓ Briefs	On demand	Principal M&E Specialist , DPPI
✓ Evaluation Report	On Demand	Principal M&E Specialist , DPPI
✓ **Newsletters**	On Demand	Principal M&E Specialist DPPI
✓ **Dashboard**	Monthly	Principal M&E Specialist DPPI
✓ Feedback meetings reports with stakeholders	After meetings	Principal M&E Specialist , DPPI
✓ Performance of management bodies in the health sector	Half Yearly	Director, DPPI
✓ Beneficiary Report – **satisfaction with services from community score cards**	Yearly	Principal M&E Specialist , DPPI

In order to facilitate use of information for decision-making among the different stakeholders, a number of communication and feedback mechanisms will be instituted as part of the M&E system. Table xxx shows the stakeholders and the M&E products that they will require. M&E products will be disseminated as appropriate through:

- Official email
- Web pages and portal
- Post
- Courier
- Delivered by hand

- Presentations

Table 8.2: Health sector M&E lines of communication and feedback mechanisms

Stakeholder	M&E information requirements and Use	Communication and Feedback mechanism
District Councils	Performance of the district to assess progress, experiences, challenges and how they have been resolved	National Quarterly Health Information Bulletin, Annual Reports; Briefs, Quarterly District Stakeholder meetings; MoHS Portal
DHMTs	Performance of the project to assess progress, experiences, challenges and how they have been resolved	Quarterly Bulletin, Annual Reports; Briefs, Quarterly Review meetings; MoHS Portal
PHUs	Performance of the facilities/PHUs to assess progress, experiences, challenges and how they have been resolved	Monthly In-charges meetings, Quarterly and Annual District Review meetings;
HSCC, HSSG	Compliance with the NHSSP, rules and regulations. Challenges impacting project implementation	National Quarterly Bulletin, Quarterly and Annual Reports; Briefs, Quarterly Review meetings; MoHS Portal
MoHS	Contribution in progress towards MDG indicators 4, 5 and 6. Compliance with rules and regulations. Challenges impacting project implementation	National Quarterly Bulletin, Quarterly and Annual Reports; Briefs, Quarterly and annual Sector meetings, MoHS Portal
Funding development partners	Tracking progress towards global and national development goals and objectives . programme development and objective setting. Tracking risks and challenges impacting programme/project implementation	National Quarterly Bulletin, Project supervision missions, Quarterly and Annual Reports; Briefs, Quarterly and annual meetings, MoHS Portal
Non funding development partners (e.g., NGOs, CBOs, FBOs)	Tracking progress towards global and national development goals and objectives. Programme development and objective setting. Tracking risks and challenges impacting programme/project implementation.	National Quarterly Bulletin, Quarterly and Annual Reports; Briefs, Quarterly and annual Review meetings, MoHS Portal

The health sector with leadership from the DPI will actively seek to create knowledge products from experiences, lessons learned, and best practices observed during project/program implementation. This will position the health sector as a "*Learning*" sector.

8.5 Data access:

- At the district level, the integrated data warehouse will automatically generate user-friendly bulletins, other reports and maps to feedback to health facilities and inform DHMTs and local councils. These will show comparisons between facilities and districts through indicators on coverage and efficiency (e.g., outpatient attendances per health professional).

- Multiple agencies, partners and other information consumers (researchers, the media, civil society organizations) will have web-based access to routine and survey statistics via the portal of the integrated warehouse

- Government health service statistics data collected by public agencies will, in principle, be regarded as being in the public domain once the data has been rendered anonymous. Public access to this data should be guaranteed by law.

Table 8.3; List of Information dissemination platforms including organizer, distribution and frequency

Platforms	Participants	Frequency	Organizer
Health facility In-charges meeting	All in-charges of health facilities in the district	Monthly	DHMT
National Review meetings	All Directors, Programme Managers, DMOs, MS, NGOs, DP	Quarterly	DPPI
District Review Meetings	All DHMT Focal persons, Zonal Supervisors, Partners, LC, Chiefs	Quarterly	DHMT
National HSSG committee meetings	All Directors, Programme Managers, NGOs, DP	Monthly	Donor Liaison Unit
District Health coordination meetings	All DHMT Focal persons, Partners, LC,	Monthly	DHMT
Health information bulletin	All Directors, Programme Managers, DMOs, MS, NGOs, DP	Quarterly	DPPI

Platforms	Participants	Frequency	Organizer
MoHS portal (data/ document repository)	All Stakeholders	Regularly	Publication Unit
MoHS website	All Stakeholders	Regularly	Publication Unit
Media houses	Press	As and When required	MoHS PRO

ANNEX 1: NATIONAL MONITORING AND EVALUATION Activity PLAN

Activities Plan

Sub-heading	Activities	Frequency	2021	2022	2023	2024	2025
Institutionalising Monitoring and Evaluation	Conduct biannual M&E capacity assessment wold	Every two years	X		X		X
	Development of training materials for the health sector M&E framework	Every four years	X				X
	Develop M&E Framework	Every five years	X				
	Recruitment of M&Es, HMIS Officers and other technical HIS staff into the Civil service	Yearly	X				
	Provide internet for data entry.	Monthly	X	X	X	X	X
	Provision of office equipment for M&E work (Computers and accessories, etc)	Yearly	X	X	X	X	X
	Carryout Training and Capacity Building Assesment and develop in-service training plan for M&E Professional	5 YEARS	X				
	Conduct In-service training, coaching and mentoring for M&Es	Yearly	X	X	X	X	X
	Support training of M&E Staff at master's level	Yearly	X	X	X	X	X
	Support training of M&E Staff at Masters PHD level		x		x		x
	Advocacy with local universities to develop capacity in M&E training		x	x			
	Support training of 100 MoHS Staff in M&E			x	x	x	x
	Monitor the implementation of General Health programmes	Half-yearly	X	X	X	X	X
	Demographer	2 yearly	X		X		X
	Epidemiologist	2 yearly	X		X		X
	Statistician	2 yearly	X		X		X
	Data Manager	2 yearly	X		X		X

Sub-heading	Activities	Frequency	2021	2022	2023	2024	2025
	Data-base developers	2 yearly	X		X		X
	M&E Officers	2 yearly	X		X		X
	Assistant M&E Officers	2 yearly	X		X		X
	Data Entry Clerks	2 yearly	X		X		X
	Information Technology staff	2 yearly	X		X		X
	Web Administrator	2 yearly	X	X	X	X	X
Enhancing data sharing and promoting use of information	Build human resources capacity of DHMT Focal persons and other key personnel within DHMTs and hospitals on the effective use of DHIS2	Every two years	X		X		X
	Develop/update DQA protocol.	Every two years	X		X		X
	Production of district and national quarterly health bulletin and other materials that enhance data use.	Quarterly	X	X	X	X	X
	Support effective data analysis and use during in-charges meetings	Monthly	x	x	x	x	x
Compilation and submission of performance reports	Produce national Health sector performance report	Yearly	X	X	X	X	X
Data Quality Assurance	Support the development and updating of HMIS, CHIS, SOPs for data quality improvement.	Yearly	X	X	X	X	X
	Quarterly Health Facility Data Quality Audit	Quarterly	X	X	X	X	X
	Monthly data cleaning and approval meeting for PHUs and Hospitals data	Monthly	X	X	X	X	X
	Monthly In-charges meeting	Monthly	X	X	X	X	X
	Conduct supportive Supervision	Quarterly	X	X	X	X	X
	Joint review mission by Health Sector Steering Committee	Yearly	X	X	X	X	X
	Health Sector Review Summit and National Health sector M&E forum.	Yearly	X	X	X	X	X

Sub-heading	Activities	Frequency	2021	2022	2023	2024	2025
Performance Reviews	Conduct half-yearly performance review meeting at national level	Half-yearly	X	X	X	X	X
	Conduct quarterly review meeting at district level	Quarterly	X	X	X	X	X
	Conduct programme review meetings	Quarterly	X	X	X	X	X
	Give annual award best performing PHU, Hospital and DHMT	Yearly	X	X	X	X	X
	Monthly Health Sector Coordinating Committee review meetings	Monthly	X	X	X	X	X
	Conduct monthly technical working group meeting	Monthly	X	X	X	X	X
Surveys	Conduct SARA survey	Yearly	X	X	X	X	X
Surveys	Demographic and Health Survey (DHS)	5 years				X	
	MICS	5 years	X				
	SMART	2 years	X		X		X
	SARA	2 years	X		X		X
	Malaria Indicator Survey	2 years	X		X		X
	Client Satisfaction Survey	2 years		X		X	
	NHA	2 years	X		X		X
Improve data dissemination and use Dissemination	prepare and distribute district performance report with stakeholders	Quarterly	x	x	x	x	x
	Produce quarterly bulletins at National level	Quarterly	x	x	x	x	x
	Produce quarterly district statistical reports	Quarterly	x	x	x	x	x
	Support Health Portal	Annually	x	x	x	x	x
	Support MoHS Website	Annually	x	x	x	x	x
Improved birth and death reporting in the entire country.	Train health workers in ICD Classification	Annually	x	x	x	x	x

Sub-heading	Activities	Frequency	2021	2022	2023	2024	2025
	Support community sensitisation in births and deaths reporting	Annually	x	x	x	x	x
	Conduct pilot death registration in one district	Annually	x	x	x	x	x
	Expand death reporting nationwide	Annually	x	x	x	x	x

Annex II: Indicator Definitions/Meta Data

No.	Results Level	Indicator	Indicator Definition	Numarator	Denominator	Source
1	Input- Health financing	Government expenditure on health as % of total recurrent national budget	Current expenditure on health publically funded as a share of total current expenditure on health (expressed as a % of total current expenditure on health). This is the sum of current health outlays funded from domestic public funds such as taxes, social contributions, compulsory private insurance contributions or other government revenues.	Sum of all public domestic sources of current spending on health (12-month period).	Total current expenditure on health.	MoF Annual Budget
4	Input- Health workforce	Key Health professionals by cadre per 10,000 population	Density of health workers per 10 000 population.	Number of health workers.	Total population	HRIS / Health worker registry
		Doctor				
		Midwives				
		Nurses				
		Allied Health Workers				
5	Inputs- Health infrastructure	% of the population living within 5Km of a health facility				HFS
6	Inputs - Health Information / Governance	Birth registration [SDG 16.9.1]	Proportion of children under 5 years of age whose births have been registered with a civil authority.	Number of children under age of five whose births are reported as being registered with the relevant national civil authorities.	Total number of children under the age of five.	DHS, MICS
7	Inputs - Health Information / Governance	Death registration [SDG 17.19.2]	Percentage of deaths that are registered (with age and sex).	Number of deaths registered.	Total number of deaths.	DHS, MICS
8	Inputs - Health Information / Governance	A) HMIS B) LMIS completed reports rate	Percentage of facilities that submit reports within the required deadline	Number of reports received.	Total number of expected reports	DHIS 2
	Inputs – Supply Chain	Stock out rate(s)	A measure of product availability, this indicator measures the percentage of facilities (e.g., service delivery points [SDP], warehouses) that experienced a stockout of a	Number of facilities that experienced a stockout of specific product(s)	Total number of facilities that are expected to offer the specific product(s)	DHIS2/LMIS

No.	Results Level	Indicator	Indicator Definition	Numarator	Denominator	Source
			specific product that the site is expected to provide, at any point, within a defined period (e.g., the past six or 12 months). Stockout rates can be calculated for a single product across facilities or aggregated for all products carried by a certain type of facility, or with a certain region.			
	Inputs – Supply Chain	On-Time Delivery	Measures the percentage of all orders delivered by the requested delivery date, as indicated in the PO/contract during a defined period.	Number of orders delivered by requested date	Number of orders delivered by requested date	LMIS
9	Inputs - Health Information / Governance	Existence of national health sector policy/strategy/plan	Existence of a comprehensive national health sector policy/ strategy/ plan with goals and targets, updated within the last 5 years.	N/A	N/A	Annual reports
10	Out-put-Service access and availability	Outpatient service utilization	Number of outpatient department visits per person per year.	Total number of outpatient department visits per y	Total population.	HMIS
11	Out-put-Service access and availability	Service-specific availability and readiness	Number of health facilities offering specific services per 10 000 population and meeting minimum service standards on the basis of a set of tracer criteria for specific services, etc.	Number of facilities that offer and meet tracer criteria for specific services:	Total number of health facilities and total number of facilities offering specific services.	HFS
12	Out-put-Service access and availability	Access to a core set of relevant essential medicines [SDG 3.b.3]	Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis. Availability: will be calculated based on currently existing data on average proportion of medicines available in health facilities per country. Affordability: methodology is still under discussion. Data available on lowest price per drugs at facility level	Number of surveyed health facilities with the core set of relevant essential medicines available per country.	Total number of surveyed facilities per country.	DHIS 2
	Out-put-Service access and availability	Chilren with pneumonia treated with antibiotics in community	Proportion of children 0-59 months with pneumonia treated with antibiotics in community	Number of children 0-59 months with pneumonia treated with antibiotics in community	Number of children 0-59 months with pneumonia in community	HMIS

No.	Results Level	Indicator	Indicator Definition	Numarator	Denominator	Source
13	Output-Service quality and safety	Perioperative mortality rate	All-cause death rate prior to discharge among patients having one or more procedures in an operating theatre during the relevant admission.	Number of deaths among patients having one or more procedures in an operating theatre during the relevant admission.	Total number of surgical procedures	Record review
14	Output-Service quality and safety	Institutional maternal mortality ratio	Number of maternal deaths among 100 000 deliveries in health facilities/institutions	Number of maternal deaths in institutions.	Total number of deliveries (all deliveries that include live and stillbirths) in institutions.	HMIS
15	Output-Service quality and safety	Maternal death reviews	Percentage of maternal deaths occurring in the health facility that were audited and reviewed	Number of maternal deaths occurring in the health facility that were audited and reviewed.	All maternal deaths in facilities.	Record review
16	Output-Service quality and safety	ART retention rate	Percentage of adults and children with HIV alive and on ART at 12 months (or 24, 36, 48 and 60 months) after initiating treatment among patients initiating ART during a specified time period.	Number of people on ART at 12 months (or 24, 36, 48 and 60 months)	Total number of people who initiated treatment and should have completed 12, 24, 36 (etc.) months.	HMIS
17	Output-Service quality and safety	HIV test results for TB patients	Number of new and relapse TB patients who had an HIV test result recorded in the TB register, expressed as a percentage of the number registered in a specified time period.	Number of new and relapse TB patients registered during a specified time period (usually one year) who had an HIV test result recorded in the TB register.	Total number of TB patients registered during the reporting period	HMIS
18	Output-Service quality and safety	TB notification rate	Number of new and relapse TB cases notified in a given year, per 100 000 population.	Number of new and relapse cases of TB notified in a specified time period, usually one year.	Total number of new and relapse TB patients registered in the TB register during the specified time period.	HMIS / Facility Rgister/ TB district register
19	Output-Service quality and safety	TB treatment success rate	Percentage of TB cases successfully treated (cured plus treatment completed) among TB cases notified to national health authorities during a specified period, usually one year.	Number of TB cases registered in a specified time period that were successfully treated.	Total number of TB cases registered in the same period.	HMIS / Facility Rgister/ TB district register
20	Output-Health security	International Health Regulations (IHR) core capacity index [SDG 3.d.1]	Percentage of attributes of 13 core capacities that have been attained at a specific point in time.	Number of attributes attained.	Total number of attributes.	Programme Report

No.	Results Level	Indicator	Indicator Definition	Numarator	Denominator	Source
21	Outcome-Coverage of interventions	Demand for family planning satisfied with modern methods [SDG 3.7.1]	The percentage of women of reproductive age (15–49 years) who desire either to have no (additional) children or to postpone the next child and who are currently using a modern contraceptive method.	Number of women of reproductive age (15–49 years old) who are currently using, or whose sexual partner is currently using, at least one modern contraceptive method.	Total demand for family planning (the sum of contraceptive prevalence (any method) and the unmet need for family planning).	DHS, MICS
22	Outcome-Coverage of interventions	Contraceptive prevalence rate	Percentage of women aged 15−49 years, married or in union, who are currently using, or whose sexual partner is using, at least one method of contraception, regardless of the method used.	Number of women using or partner using a contraceptive method.	Number of women married or in a union.	DHS, MICS
23	Outcome-Coverage of interventions	Antenatal care coverage	Percentage of women aged 15−49 years with a live birth in a given time period who received antenatal care, four times or more times from any provider.	Number of women aged 15−49 years with a live birth in a given time period who received antenatal care four or more times.	Total number of women aged 15−49 years with a live birth in the same period.	DHS, MICS, HMIS
24	Outcome-Coverage of interventions	Births attended by skilled health personnel [SDG 3.1.2]	Percentage of live births attended by skilled health personnel during a specified time period.	Number of births attended by skilled health personnel (doctors, nurses or midwives) trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, childbirth and the postpartum period, to conduct deliveries on their own, and to care for newborns.	The total number of live births in the same period.	DHS, MICS, HMIS
25	Outcome-Coverage of interventions	Postpartum care coverage – women	Proportion of women who have postpartum contact with a health provider within 2 days of delivery.	Number of women who received postpartum care within two days of childbirth.	Total number of women aged 15−49 years with a live birth in the specified time period	HMIS
26	Outcome-Coverage of interventions	Postnatal care coverage – newborn	Proportion of newborns who have a postnatal contact with a health provider within 2 days of delivery	Number of newborns who received postnatal care within two days of childbirth.	Total number of last live births in the specified time period.	DHS, MICS, HMIS
27	Outcome-Coverage of interventions	Care-seeking for symptoms of pneumonia	Percentage of children under 5 years of age with suspected pneumonia (cough and difficult breathing NOT due to a problem from a blocked nose) in the two weeks preceding the survey taken to an appropriate health facility or provider.	Number of children with suspected pneumonia in the two weeks preceding the survey taken to an appropriate health facility or provider	Number of children with suspected pneumonia in the two weeks preceding the survey	DHS, MICS, HMIS

No.	Results Level	Indicator	Indicator Definition	Numarator	Denominator	Source
28	Outcome-Coverage of interventions	Coverage of diarrhoea treatment	Percentage of children under 5 years of age with diarrhoea in the last two weeks receiving ORS (fluids made from ORS packets or pre-packaged ORS fluids) and zinc supplement.	Number of children under 5 years of age with diarrhoea in the two weeks preceding the survey given fluid from ORS packets or pre-packaged ORS fluids and zinc supplement.	Number of children with diarrhoea in the two weeks preceding the survey	DHS, MICS, HMIS
29	Outcome-Coverage of interventions	% of children receiving Penta-3 before 12 months of age	Percentage of the target population that has received the last recommended dose of the basic series for each vaccine recommended in the national schedule by vaccine	The number of individuals in the target group for each vaccine that has received the last recommended dose in the basic series. For vaccines in the infant immunization schedule, if coverage is measured by administrative system it would be the birth cohort for BCG and Hepatitis B birth dose and surviving infants for the other antigens, in countries where measles is administered at first year of life will be children 12–23 months old. In case of coverage measured by survey this would be the number of children aged 12–23 months in the sample who have received the specified vaccinations before their first birthday.	The total number of individuals in the target group for each vaccine. For vaccines in the infant immunization schedule, this would be the total number of infants surviving to age one. In case coverage is measured m by survey it would be the total number of 12–23 months of infants in the sample	DHS, MICS, HMIS,
30	Outcome-Coverage of interventions	Antiretroviral therapy (ART) coverage	Percentage of people living with HIV currently receiving ART among the estimated number of adults and children living with HIV.	Number of adults and children who are currently receiving ART at the end of the reporting period.	Estimated number of adults and children living with HIV.	HMIS
31	Outcome-Coverage of interventions	TB treatment coverage	Number of new and relapse cases that were notified and treated in a given year, divided by the estimated number of incident TB cases in the same year, expressed as a percentage.	Number of new and relapse cases notified and treated in a given year.	Number of estimated incident cases in the same year.	HMIS
32	Outcome-Coverage of interventions	Intermittent preventive therapy for malaria during pregnancy (IPTp)	Percentage of women who received three or more doses of intermittent preventive treatment during antenatal care visits during their last pregnancy	Number of women receiving three or more doses of recommended treatment.	Total number of pregnant women/surveyed with a live birth in the last 2 years.	DHS, MICS, HMIS, MIS

No.	Results Level	Indicator	Indicator Definition	Numarator	Denominator	Source
33	Outcome-Coverage of interventions	Treatment of confirmed malaria cases	Percentage of confirmed malaria cases that receive first-line antimalarial treatment.	Number of confirmed malaria cases that receive first line antimalarial treatment.	Number of confirmed malaria cases.	HMIS, MIS
34	Outcome-Coverage of interventions	Coverage of preventive chemotherapy for selected neglected tropical diseases	Proportion of the population living in endemic areas requiring preventive chemotherapy that received treatment for at least one of the selected neglected tropical diseases (schistosomiasis, soil-transmitted helminthiases, lymphatic filariasis, onchocerciasis).	Number of people requiring and receiving preventive chemotherapy for at least one of the selected neglected tropical diseases (schistosomiasis, soil-transmitted helminthiases, lymphatic filariasis, onchocerciasis).	Number of people requiring preventive chemotherapy for at least one of the selected neglected tropical diseases (schistosomiasis, soil-transmitted helminthiases, lymphatic filariasis, onchocerciasis).	HMIS
35	Outcome-Coverage of interventions	Coverage of essential health services [SDG 3.8.1]				HFS
36	Outcome-Risk factors and behaviours	Incidence of low birth weight among newborns	Percentage of live births that weigh less than 2500 g	Number of live-born neonates with weight less than 2500 g at birth.	Number of live births.	DHS, MICS, HMIS
37	Outcome-Risk factors and behaviours	Children under 5 years who are stunted [SDG 2.2.1]	Percentage of stunted (moderate and severe) children aged 0–59 months (moderate = height-for-age below -2 standard deviations from the WHO Child Growth Standards median; severe = height-for-age below -3 standard deviations from the WHO Child Growth Standards median).	Number of children aged 0–59 months who are stunted.	Total number of children aged 0–59 months who were measured.	DHS, MICS, HMIS
38	Outcome-Risk factors and behaviours	Children under 5 years who are wasted [SDG 2.2.2]	Percentage of wasted (moderate and severe) children aged 0–59 months (moderate = weight-for-height below -2 standard deviations of the WHO Child Growth Standards median; severe = weight-for-height below -3 standard deviations of the WHO Child Growth Standards median).	Number of children aged 0–59 months who are wasted.	Total number of children aged 0–59 months	DHS, MICS, HMIS

No.	Results Level	Indicator	Indicator Definition	Numarator	Denominator	Source
39	Outcome-Risk factors and behaviours	Population using safely managed drinking-water services [SDG 6.1.1]	Population using an improved drinking water source (piped water into dwelling, yard or plot; public taps or standpipes; boreholes or tube wells; protected dug wells; protected springs, rainwater, packaged or delivered water) which is located on premises, available when needed, and free of faecal and priority chemical contamination.	Population using safely managed drinking-water services.	Total population.	DHS, MICS, HMIS
40	Outcome-Risk factors and behaviours	Population using safely managed sanitation services [SDG 6.2.1a/6.2.1b	Population using an improved sanitation facility (flush or pour flush toilets to sewer systems, septic tanks or pit latrines, ventilated improved pit latrines, pit latrines with a slab, and composting toilets) that is not shared with other households and where excreta are safely disposed of in situ or treated off site	Population using safely managed sanitation services	Total population.	DHS, MICS, HMIS
41	Outcome-Risk factors and behaviours	Raised blood pressure among adults	Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg), and mean systolic blood pressure.	Number of respondents with systolic blood pressure ≥ 140mmHg or diastolic blood pressure ≥ 90mmHg.	All survey respondents with a valid measurement.	STEP
42	Outcome-Risk factors and behaviours	Raised blood glucose/diabetes among adults	Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years or on medication for raised blood glucose (defined as fasting plasma glucose value ≥ 7.0 mmol/L (126 mg/dL) or on medication for raised blood glucose among adults aged 18+ years).	Number of respondents aged 18+ years with fasting plasma glucose value ≥7.0 mmol/L (126 mg/dL) or on medication for raised blood glucose. Fasting blood glucose must be measured, not self-reported, and measurements must be taken after the person has fasted for at least eight hours.	All survey respondents with a valid fasting plasma glucose measurement.	STEP
43	Impact-Health status	Life expectancy at birth	The average number of years that a newborn could expect to live if he or she were to pass through life exposed to the sex- and age-specific death rates prevailing at the time of his or her birth, for a specific year, in a given country, territory or geographical area.			Census

No.	Results Level	Indicator	Indicator Definition	Numarator	Denominator	Source
44	Impact-Health status	Under-five mortality rate [SDG 3.2.1]	The probability of a child born in a specific year or period dying before reaching the age of 5 years, if subject to age-specific mortality rates of that period, expressed per 1000 live births.	Number of deaths among children aged 0–4 years (0–59 months of age), broken down by age groups.	Number of live births.	DHS, MICS
45	Impact-Health status	Infant mortality rate	The probability that a child born in a specific year or period will die before reaching the age of 1 year, if subject to age-specific mortality rates of that period, expressed as a rate per 1000 live births	Number of children who died before their first birthday (0−11 months of age).	Number of live births.	DHS, MICS
46	Impact-Health status	Neonatal mortality rate [SDG 3.2.2]	Probability that a child born in a specific year or period will die in the first 28 days of life (0–27 days) if subject to age-specific mortality rates of that period, expressed per 1000 live births.	Number of children who died during the first 28 days of life.	Number of live births.	DHS, MICS
47	Impact-Health status	Stillbirth rate	Number of stillbirths per 1000 total births. Stillbirths can occur antepartum or intrapartum. In many cases, stillbirths reflect inadequacies in antenatal care coverage or in intrapartum care. For purposes of international comparison, stillbirths are defined as third trimester fetal deaths (≥ 1000 g or ≥28 weeks).	Number of fetuses and infants born per year with no sign of life and born after 28 weeks gestation, or weighing ≥ 1000g	Total births	HMIS
48	Impact-Health status	Maternal mortality ratio [SDG 3.1.1]	The annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100 000 live births, for a specified time period	Number of maternal deaths.	Number of live births.	DHS, MICS
49	Impact-Health status	Adolescent birth rate [SDG 3.7.2]	Annual number of births to females aged 10–14 or 15–19 years per 1000 females in the respective age group.	Number of live births to women aged 10–14 years or 15−19 years.	Exposure to childbearing by women aged 10–14 years or 15−19 years.	DHS, MICS, HMIS

No.	Results Level	Indicator	Indicator Definition	Numarator	Denominator	Source
50	Impact-Health status	Total fertility rate	Mean number of children a woman would have by age 50 if she survived to age 50 and was subject, throughout her life, to the age-specific fertility rates observed in a given year. The total fertility is expressed as the number of children per woman. Total fertility is computed as the sum of agespecific fertility rates divided by 1000			DHS, MICS
51	Impact-Health status	New cases of IHR-notifiable diseases and other notifiable diseases	Number of new confirmed cases of IHR-notifiable diseases (immediately notifiable diseases) and other notifiable diseases (diseases that could cause serious public health impact and could spread rapidly internationally) per year	Number of new cases.		HMIS
52	Impact-Health status	HIV prevalence rate	Percentage of people living with HIV. Prevalence measures the frequency of existing disease in a defined population at a specific time	Total number of people living with HIV.	Total population.	DHS, Sentinel surveillance
	Impact – Health status	UHC Service coverage Index [SDG 3.8.1]	The indicator is an index reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage. The tracer indicators are as follows, organized by four components of service coverage: 1. Reproductive, maternal, newborn and child health 2. Infectious diseases 3. Noncommunicable diseases 4. Service capacity and access			
	Impact – Financial risk protection	Incidence of catastrophic health expenditure	Out-of-pocket expenditures exceeding 10% of household total consumption or income. This de-nition with this threshold also corresponds to SDG indicator 3.8.2, defined as “the proportion of population with large household expenditures on health as a share of total household expenditure or income”.			

No.	Results Level	Indicator	Indicator Definition	Numarator	Denominator	Source
53	Impact - Finanical risk protection	Proportion of the population with impoverishing health expenditure	Proportion of the population where a household's total consumption expenditure or income including household expenditure on health is greater than the poverty line but the household's total consumption expenditure or income excluding household expenditure on health is below the poverty line.	Total number of people whose household's total consumption expenditure or income including household expenditure on health is greater than the poverty line but the household's total consumption expenditure or income excluding household expenditure on health is below the poverty line.	Total number of people.	DHS, MICS
54	Impact - Finanical risk protection	large household expenditure on health as a share of total household consumption or income [SDG 3.8.2]	Proportion of the population the population with large household expenditure on health as a share of total household expenditure or income.	Total number of people with large household expenditure on health as a share of total household expenditure or income (i.e. greater than 10% and 25%).	Total number of people.	DHS, MICS
55	Input- Health financing	Coverage of Health Care Insurance				DHS, MICS

Annex 3: M&E Budget

Sub-heading	Activities	Frequency	2021	2022	2023	2024	2025	Total
Institutionalising Monitoring and Evaluation	Conduct biannual M&E capacity assessment wold	Every two years	6,000		6,000		6,000	18,000
	Development of training materials for the health sector M&E framework	Every four years	3,000				3,000	6,000
	Develop M&E Framework	Every five years	10,000					10,000
	Recruitment of M&Es, HMIS Officers and other technical HIS staff into the Civil service	Yearly	180,000	200,000	220,000	240,000	260,000	1,100,000
	Provide internet for data entering	Monthly	86,800	86,800	86,800	86,800	86,800	434,000
	Provision of office equipment for M&E work (Computers and accessories, etc)	Yearly	100,000	50,000		50,000	500,000	700,000
	Develop in-service training plan for M&E Professional	5 YEARS	4,000					4,000
	Conduct In-service training for M&Es	Yearly	40,000		30,000		40,000	110,000
	Support training of M&E Staff at master's level	Yearly	40,000	40,000	40,000	40,000		160,000
	Support training of M&E Staff at Masters PHD level		60,000		60,000		60,000	180,000
	Advocacy with local universities to develop capacity in M&E training		500	500				1,000
	Support training of 100 MoHS Staff in M&E			20,000	20,000	20,000	50,000	110,000
	Monitor the implementation of NGO activities	Half-yearly	10,000	10,000	10,000	10,000	10,000	50,000
	Demographer	2 yearly	12,000	12,000	24,000	24,000	36,000	108,000
	Epidemiologist	2 yearly	12,000	12,000	24,000	24,000	36,000	108,000
	Statistician	2 yearly	12,000	12,000	24,000	24,000	36,000	108,000

Sub-heading	Activities	Frequency	2021	2022	2023	2024	2025	Total
	Data Manager	2 yearly	12,000	12,000	24,000	24,000	36,000	108,000
	Data-base developers	2 yearly	12,000	12,000	24,000	24,000	36,000	108,000
	Information Technology staff	2 yearly	12,000	12,000	24,000	24,000	36,000	108,000
	Web Administrator	2 yearly	12,000	12,000	24,000	24,000	36,000	108,000
Enhancing data sharing and promoting use of information	Train DHMT Focal persons and other key personnel within DHMTs and hospitals on the effective use of DHIS2	Every two years	12,000		12,000		10,000	34,000
	Develop DQA protocol.	Every two years	20,000		2,000		2,000	24,000
	Production of district and national quarterly health bulletin	Quarterly	10,000	10,000	10,000	10,000	10,000	50,000
	Support in-charges meetings	Monthly	192,000	192,000	192,000	192,000	192,000	960,000
Compilation and submission of performance reports	Produce national Health sector performance report	Yearly	25,000	25,000	25,000	25,000	25,000	125,000
Data Quality Assurance	Quarterly Health Facility Data Quality Audit	Quarterly	50,000	50,000	50,000	50,000	50,000	250,000
	Conduct supportive Supervision	Quarterly	80,000	80,000	80,000	80,000	80,000	400,000
	Joint review mission by Health Sector Steering Committee	Yearly	30,000	35,000	35,000	35,000	35,000	170,000
	Health Sector Review Summit	Yearly	80,000	80,000	80,000	80,000	80,000	400,000
Performance Reviews	Conduct half-yearly performance review meeting at national level	Half-yearly	80,000	80,000	80,000	80,000	80,000	400,000
	Conduct quarterly review meeting at district level	Quarterly	32,000	32,000	32,000	32,000	32,000	160,000
	Conduct programme review meetings	Quarterly	60,000	60,000	60,000	60,000	60,000	300,000
	Give annual award best performing PHU, Hospital and DHMT	Yearly	25,000	25,000	25,000	25,000	25,000	125,000
	Monthly Health Sector Coordinating	Monthly	3,200	3,200	3,200	3,200	3,200	16,000

Sub-heading	Activities	Frequency	2021	2022	2023	2024	2025	Total
	Committee review meetings							
	Conduct monthly technical working group meeting	Monthly	48,000	48,000	48,000	48,000	48,000	240,000
Surveys	Conduct SARA survey	Yearly	250,000	250,000	250,000	250,000	250,000	1,250,000
Surveys	Demographic and Health Survey (DHS)	5 years				3,000,000		3,000,000
	MICS	5 years	1,200,000					1,200,000
	SMART	2 years	250,000		250,000		250,000	750,000
	SARA	2 years	250,000		250,000		250,000	750,000
	Malaria Indicator Survey	2 years	400,000		400,000		400,000	1,200,000
	Client Satisfaction Survey	2 years		120,000		120,000		240,000
	NHA	2 years	120,000		120,000		120,000	360,000
Improve data dissemination and use Dissemination	prepare and distribute district performance report with stakeholders	Quarterly	1,000	1,000	1,000	1,000	1,000	5,000
	Produce quarterly bulletins at National level	Quarterly	3,000	3,000	3,000	3,000	3,000	15,000
	Support Health Portal	Annually	20,000	20,000	20,000	20,000	20,000	100,000
	Support MoHS Website	Annually	2,000	2,000	2,000	2,000	2,000	10,000
Improved birth and death reporting in the entire country.	Train health workers in ICD Classification	Annually		250,000	250,000	250,000	120,000	870,000
	Support community sensitisation in births and deaths reporting	Annually	56,000	120,000	100,000	56,000	56,000	388,000
	Conduct pilot death registration in one district	Annually	80,000					80,000
	Expand death reporting nationwide	Annually		120,000	180,000	200,000	200,000	700,000
	Total		**4,003,500**	**2,097,500**	**3,201,000**	**5,237,000**	**3,672,000**	**18,211,000**