The Gambia, Ministry of Health and Social Welfare

The National Monitoring and Evaluation Plan for the National Health Strategic Plan (NHSP), 2014-2020

April, 2015

Acknowledgements

This monitoring and evaluation (M&E) plan was formulated through a highly participatory and consultative process spearheaded by the Ministry of Health and Social Welfare (MoH &SW). Relevant stakeholders at national and regional level were engaged. Funding for the formulation of this M & E plan was made available by The Gambia Government and the kind support of the World Health Organization (WHO) Regional Office for Africa and The Gambia WHO Country Office (WCO).

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Technical assistance to develop this plan was provided by Dr Ambrose O Talisuna through a WHO consultancy. Dr Talisuna is a physician and epidemiologist who has worked in communicable disease control, surveillance, monitoring and evaluation for over 20 years both at country and international level. He obtained a bachelor's degree in medicine and surgery (MBchB) from Makerere University (Uganda), a master's degree (MSc.) in epidemiology from the University of London-London School of Hygiene and Tropical Medicine, and a PhD, in medical sciences from the University of Antwerp and Institute of Tropical Medicine, Antwerp, Belgium. Dr Talisuna also has the requisite expertise in public sector management and advanced monitoring and evaluation of health systems.

Finally, I would like to state that the development of this M & E plan for The Gambia MoH & SW NHSP has been inclusive and participatory, involving several stakeholders from the different sectors of government, civil society, academia/research, development partners, the private sector and sub-national levels. Therefore, I would like to call upon all stakeholders to support and implement this M & E plan.

Thank you all

Dr. Samba Ceesay
Director of Health Services

Foreword

The Ministry of Health and Social Welfare (MoH & SW), The Gambia has formulated the national health sector strategic plan (NHSP), 2014-2020 and this accompanying monitoring and evaluation (M & E) plan. The aim is to align the NHSP and the M & E plan with the International Health partnerships Plus (IHP+) principles: **One NHSP, One overall M & E plan and one coordination mechanism.** The "three ones" will ensure that limited resources are harnessed to support the implementation, monitoring and evaluation of the NHSP. In line with IHP+, the development of this M & E plan was preceded by a rapid assessment of the monitoring, evaluation and review systems in The Gambia. Consequently, this M & E plan is not only anchored on the vision, mission, objectives and targets of the NHSP, but also on the findings of a rapid assessment conducted in December, 2014 and previous assessments of the health information systems (HIS). This M & E plan is comprehensive and in line with the national and international goals and targets. The integration of the data sources for the selected indicators from the Health Management Information System (HMIS), health facility and population-based surveys will allow for tracking quarterly and annual progress, as well as monitoring progress over a long period of time at the population level.

Core values

The core values that this M & E plan will imbue in all health workers, health managers and health sector stakeholders are: Accountability for outputs, excellence, technical empowerment, efficiency, effectiveness, value for money (VfM), multi-stakeholder involvement, and responsiveness.

Priorities

The following will be the priorities:

1. Strengthening the capacity for management and coordination to ensure a harmonized monitoring, evaluation and review system in the health sector.

2. Developing the capacities and capabilities for M & E at all levels of the health care delivery system.

3. Ensuring robust monitoring and evaluation of the accelerated and synchronized scale up of health interventions to achieve universal coverage of the basic package in all the parts of the country.

4. Strengthening the integration of the NHSP efforts with non health sector actors.

5. Ensuring that there is capacity, resources and preparedness to track and respond in a timely and effective manner, to communicable disease epidemics, especially extremely dangerous pathogens.

6. Strengthening the capacities and capabilities of the MoH & SW to coordinate and conduct operational research to generate evidence and translate it into effective action at all levels of health care.

7. Strengthening surveillance, monitoring, and evaluation at all levels so that key indicators are routinely monitored and used for decision making.

Goal

By 2018, to have established a monitoring, evaluation and review system that is robust, comprehensive, harmonized and well-coordinated to generate information in real time for tracking the implementation of the NHSP.

Strategic objectives

There are six strategic objectives, namely, by 2018, to have:

1. Strengthened the capacity and capability for monitoring and evaluation & review in the MoH & SW;
2. Strengthened the coordination and harmonization of performance measurement/assessment at all levels of the heath care delivery system;

3. Strengthened the health information system (HIS) at all levels to improve evidence-led programming and decision making;

4. Strengthened operational research to generate evidence and translate evidence into policy and practice;

5. Strengthened the system for pharmacovilance and post marketing surveillance of medicines, vaccines and other health commodities;

6. Improved the quality of information, in terms of validity, consistency, reliability, accuracy, timeliness and completeness.

Conclusion and perspectives for the future

This plan is based on the principles intended to institutionalize the use of M&E as a tool for better health sector management, transparency and accountability, so as to support

the overall direction of the NHSP and the achievement of the results. The underpinning principles include; a) simplicity; b) flexibility; c) progressiveness; d) harmonization; e) alignment; and f) enhancement of country ownership. The M&E plan describes the processes, methods and tools that the sector will use to collect, compile, report, analyse and use data, as well as provide feed-back as part of the national health sector performance measurement and management system. It translates these processes into annualized and costed activities, and assigns responsibilities for implementation. However, as the MoH & SW assumes its stewardship role with respect to other sectors with regard to other health determinants which are part of their contribution, the M&E plan also describes how key-information will be obtained from these non health sectors.

This M&E plan has been developed in a participatory manner and shall guide all NHSP M&E activities. Moreover, it specifies the type of monitoring, reporting, timing of evaluations and reviews. Further, it stipulates the roles and responsibilities of the MoH & SW and the different stakeholders and emphasizes the importance of timely reporting for each implementer to facilitate robust performance measurement. It also clearly states the data collection platforms and the roles and responsibilities with respect to data gathering and reporting. The main M&E activities are clearly stated and are aligned with the existing national and international structures and frameworks.

It is my appeal to all the MoH and SW programmes, the hospitals, the regional health management teams and other implementers to adhere to this M & E plan so as to support the establishment of systems that are robust, comprehensive, fully integrated, harmonized and well coordinated to guide monitoring and evaluation of the NHSP. I urge all health sector partners to subscribe to this comprehensive M&E plan as the basis for improving the quality of health information systems (HIS) in The Gambia and to institutionalize mechanisms for measuring the quality of both health facility and community-based services. All levels of the health care delivery system will be supported to strengthen the dissemination and use of information for evidence-led programming and decision making.

Finally, I would like to express my appreciation to all of you who worked tirelessly to develop this M&E Plan. I look forward to the accelerated implementation of this plan.

HON OMAR SEY

MINISTER OF HEALTH AND SOCIAL WELFARE

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AHSPR	Annual Health Sector Performance Report
BHCP	Basic Health Care Package
CHN	Community Health Nurse
CNO	Chief Nursing Officer
DDHS	Deputy Director of Health Services
DHIS-2	District Health Information System-2
DHS	Demographic Health Survey
DPI	Director of Planning and Information
DPM	Deputy Programme Manager
EDC	Epidemiology and Disease control
EPI	Expanded Programme of Immunization
GBoS	The Gambia Bureau of Statistics
GDHS	The Gambia Demographic and Health Survey
GIS	Geographic Information Systems
HIS	Health Information Systems
HIV/AIDs	Human Immuno-deficiency Virus/Acquired Immuno-deficiency Syndrome
HMIS	Health Information Systems
HMN	Health Metrics Network
HPR	Health Sector Performance Report
HR	Human Resources
HRH	Human Resources for Health
ICD	International Classification of Diseases
ICT	Information, Communication Technology
IDSR	Integrated Disease Surveillance and Response
IHP+	International Health partnerships Plus
IHR	International Health Regulations
JANs	Joint Assessment of National Strategies
JARs	Joint Annual Reviews
KAP	Knowledge Attitudes and Practices
LAB	Laboratory
PMUs	Project Management Units
M & E	Monitoring and Evaluation
M, E & R	Monitoring, Evaluation and Review
MIS	Malaria Indicator Survey
MNCH	Maternal Neonatal and Child Health
MoH & SW	Ministry of Health and Social Welfare
MTR	Midterm Review

NA	National Assembly
NAS	National AIDs Secretariat
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHP	National Health Policy
NHSP	National Health Sector Strategic Plan
NPO	National Professional Officer
NTLP	National Tuberculosis and Leprosy Programme
PAGE	Program for accelerated growth and employment
PHC	Primary Health Care
PHCVs	Primary Health Care Villages
PIUs	Project Implementation Units
PM	Programme Manager
QA	Quality Assurance
QC	Quality Control
RFH	Riders for Health
RHD	Regional Health Director
RHMTs	Regional Health Management Teams
RHT	Regional Health Teams
SMART	Specific Measurable Accurate Reliable and Timely
TB	Tuberculosis
ToRs	Terms of Reference
TWGs	Technical Working Groups
URR	Upper River Region
WCO	World Health Organization Country Office
WHO	World Health Organization
WHO-IST	World Health Organization Inter-country Support Team
WR	World Health Organization Representative

Operational definitions

Civil Society Organization (CSO): Any organization except the government and the UN system.

Data Management: All processes related to data collection, collation, analysis, synthesis and dissemination.

Data Quality Assurance: The process of profiling data to discover inconsistencies, and other anomalies in the data cleansing activities (e.g. removing outliers, missing data interpolation) to improve the data quality.

Evaluation: The rigorous, science-based collection of information about program activities, characteristics, outcomes and impact that determines the merit or worth of a specific program or intervention.

Impact: Fundamental intended or unintended changes in the conditions of the target group, population, system or organization.

Knowledge Management: A set of principles, tools and practices that enable people to create knowledge, and to share, translate and apply what they know to create value and improve effectiveness.

Monitoring: The routine tracking and reporting of priority information about a program and its intended outputs and outcomes.

Monitoring & Evaluation Plan: An integral part/component of a national health or disease strategy that addresses all the monitoring and evaluation activities of the strategy.

Monitoring & Evaluation Framework: Refers to the performance based framework for monitoring and evaluation of health systems strengthening.

Outcome: Actual or intended changes in use, satisfaction levels or behaviour that a planned intervention seeks to support.

Performance: The extent to which relevance, effectiveness, efficiency, economy, sustainability and impact (expected and unexpected) are achieved by an initiative, programme or policy.

Performance measurement: The ongoing monitoring and evaluation of the results of an initiative, programme or policy, and in particular, progress towards pre-established goals.

Performance management: Reflects the extent to which the implementing institution has control, or manageable interest, over a particular initiative, programme or policy.

Review: Is an assessment of performance or progress of a policy, sector, institution, programme or project, periodically or on an ad hoc basis. Reviews tend to emphasize operational aspects, and are therefore closely linked to the monitoring function.

1.0 Background and Rationale

The Gambia National Health Strategic Plan (NHSP) 2014-2020 monitoring and evaluation (M&E) plan has been developed to operationalize the strategic orientations needed for the comprehensive M&E of the NHSP. This M&E plan aims at informing policy makers about progress toward achieving the targets set in the NHSP. Further, it focuses on the efforts of all stakeholders and the direct efforts of the MoH & SW towards the vision of**:** *Provision of quality and affordable health services for all by 2020, the mission to: promote and protect the health of the population through the equitable provision of quality health care and the goal to: Reduce morbidity and mortality to contribute significantly to quality of life in the population***.** In order to do so, the M&E plan will provide strategic information to decision-makers, who will combine this information with other strategic information to make evidence-led decisions. This is relevant to both national and sub-national levels. At national level, strategic information will be used by the management and partnership/governance structures described in the NHSP for improved management and service delivery. In addition, selected information will be provided in the context of PAGE, the Health Development Partners (HDPs) in line with government procedures and partnership commitments and to meet reporting obligations toward international institutions such as the World Health Organization (WHO) and IHP+. This plan is based on principles intended to institutionalize the use of M&E as a tool for better public sector management, transparency and accountability, so as to support the overall direction of the NHSP and the achievement of the results.

This M&E plan has been developed in a participatory manner and shall guide all NHSP M&E activities. The M&E plan specifies the type of monitoring, reporting, timing of evaluations, roles and responsibilities for the overall process and how they interact with the reporting each implementer is required to perform (clear roles and responsibilities with respect to data gathering and reporting). It focuses on the main M&E activities and aligns them to the existing national and international structures and frameworks.

2.0 Situational Analysis

2.1 Key strengths

The Gambia NHSP stipulates the core impact/health status level indicators that are SMART-specific, measurable, attainable, relevant and time-bound with bold targets for 2020. A monitoring and evaluation indicator matrix is available and is aligned to The Gambia NHSP 2014-2020, the NHP 2012-2020 and the Vision 2020-PAGE. Most of the baseline data are based on very recent data sources such as: the Gambia Demographic and Health Survey (GDHS, 2013), a 2013 TB prevalence survey and KAP study, HMIS service statistics for 2013 and the national health accounts-NHA 2013, which provides reliable bench marking of the NHSP.

Multiple data platforms exists including: the census every 10 years, the GDHS every five years, programme specific surveys such as the malaria indicator survey-the MIS, the EPI coverage surveys, as well as, routine HMIS/IDSR, and sentinel surveillance at 6 sites. There is a well-established HMIS and IDSR system, and the DHIS-2 system for data management has been adopted and is being scaled up. HMIS is disaggregated by gender and by age (below 5 and above 5) and the health status indicators are disaggregated by region, gender and socioeconomic status. HMIS and IDSR data analysis is being conducted and data quality issues are anticipated and are being addressed. For example there is quarterly HMIS data verification and the DHIS 2 has an in built data quality system. Moreover, the DHIS 2 captures the timeliness and completeness of data at regional and national level and facilitates quick remedial action. The HMIS Unit at central level and regional level data managers and health facility data entry clerks endeavor to conduct data analysis.

There is long standing experience with births and deaths registration and there are plans to make this system electronic so as to improve coverage. Moreover, critical gaps and weaknesses for M & E implementation have been identified and mainly have to do with un-timely and incomplete HMIS data, inadequate data quality, and inadequate infrastructure (Energy supply, Finances, HR, ICT and logistics) for timely reporting, inadequate HR capacity and the challenges with ICT.

There are mechanisms for effective and regular data dissemination and communication. There is experience of having a resource Centre in the past and a MOH & SW website. There are plans to produce the HMIS quarterly bulletin to be made available to both central and at regional levels but for 2014 only one bulletin was produced.

2.2 Key weaknesses/gaps

The HR capacity analysis for HIS done 2006 by the WHO Health Metrics Network, the sector capacity gap analysis done in 2010 and the HIS assessment done in 2013 specifically addressing ICT are out of date and contemporary assessments are needed.

While the selected impact indicators are broadly valid and measureable, the annual and interim milestones had not been clearly indicated for many of the basic health care package (BHCP) service delivery areas. Moreover, some critical core indicators such as non-communicable disease risk factors, financial risk protection and responsiveness of the health system were missing. In addition, programmatic indicators for quarterly and annual performance assessment were limited. For example, critical input and process indicators on human resource capacity development, health commodity procurement and distribution, resource mobilization (domestic and external), and financial disbursements had not articulated. Further, some of the BHCP programme indicators were not aligned with the NHSP indicators.

Some critical indicators do not have baselines or the sources of data are not clear or ambiguous. Consequently, assessment of the feasibility of achievement for some targets will be challenging, unless this is resolved. Delays in the processes to update or include baselines are attributed to inadequate funding.

There are parallel data management reporting systems (IDSR, LAB, and EPI). In addition indicators for monitoring the performance of the surveillance systems, the HMIS and community based systems are not clearly stipulated. The MoH&SW cannot guarantee that all partners will sign MoUs for the common arrangements.

The roles, responsibilities and coordination mechanism are not very clear. Moreover, there are inadequate resources (human, material and financial) to support M & E. In addition, the creation of parallel project management units (PMUs) or project implementation units (PIUs) weakens the capacity of the MoH & SW planning, monitoring and evaluation unit.

There is minimal coordination between the different technical units, the directorates, the broader health sector stakeholders and the sub-national levels, especially the regions. There is no reporting from the teaching hospital and the general hospitals unless the central team goes to actively collect data, which is often late. The general hospitals are autonomous and report directly to the Minister for Health which creates challenges in the hierarchy for reporting and technical supervision.

There are no streamlined roles and responsibilities in data collection, analysis and dissemination. Use of DHIS2 for births and deaths was recommended during the assessment of 2013 but at the time of the 2014 rapid assessment no action had been undertaken. The system for quality assurance of the of health services is not well articulated nor is the strategy for pharmacovigilance and post marketing surveillance of medicines indicated.

The implementation of any M & E plan is critically anchored on the functionality and quality of HMIS (timeliness, completeness and accessibility to all stakeholders). However, monthly reporting is not complete and not timely. Weekly reporting is needed for Notifiable or reportable disease to facilitate the early detection and response to events with outbreak potential. The Gambia needs to draw lessons from the Ebola outbreak in West Africa and future M &E plans need to describe how core capacities for the rapid response to epidemics and diseases of outbreak potential will be strengthened and monitored at portals of entry, national, sub-national and community levels in line with the international health regulations 2005.

There are major gaps in terms of resources (energy supply, work environment, financial, HR, logistics and ICT-systems and limited band width) that impede effective implementation and monitoring of the NHSP. Only one DHS has been conducted in The Gambia. Surveys (population and health facility) have in the past not been conducted regularly) and quality of care assessments are rare. The scheme for data flow presented in previous assessment has not been adopted, besides it has critical gaps; including lack of linkages to the different implementing partners and research institutes.
The births and deaths registration system is still paper based and its coverage is not adequate.

There are major challenges in monitoring and evaluation of the performance of the teaching hospital and the general hospitals, largely because of miss alignment in reporting hierarchies. The international classification of diseases-ICD is not used, despite previous recommendations and accessibility to hospital data for analysis is limited. There is no community based information system, yet community health workers are a key component in the NHSP.

The QA/ QC system for laboratory services and its linkage to a reference laboratory at national level needs further strengthening. Feedback and dissemination is not regular, largely because of inadequate skills for analysis and synthesis for data. For example, there is no consolidated annual sector performance report and no independent verification of service delivery quality and service availability.

There is no resource centre or national data repository and the website is not regularly updated. There is inadequate funding to produce and distribute quarterly and annual bulletins. Prospective evaluations and reviews have in the past not been conducted and there is no system of joint periodic progress and performance reviews.

There is no multi-partner review mechanism that inputs systematically and regularly into assessing sector or programme performance against annual and long-term goals, including national joint annual sector reviews (JARs) at which the whole sector performance is reviewed; annual progress evaluation/review of annual plans by multiple stakeholders, midterm review, and end of term review. In addition periodic internal performance assessments at national and regional levels are not regularly conducted.
Joint processes by which corrective measures can be taken and translated into action are lacking. The lack of institutional memory at the MoH & SW creates challenges to recall what previously worked such as the joint sector working group, technical working groups, sector undertakings etc.

3.0 General approach and process

The development of this M&E plan was in conjunction with the development of the NHSP 2014-2020 and took into consideration the National Health Policy, 2012-2020, PAGE, the changing epidemiology of communicable and non communicable diseases, the changing dynamics and issues in international health. The process also took into consideration the international treaties and conventions to which The Gambia is a signatory such as: the Millennium Development Goals (MDGs) and the International Health Partnerships and related Initiatives (IHP+) which seek to achieve better health results and provide a framework for increased aid effectiveness. The aim is to harmonize and ensure alignment of this M & E plan with the other existing sector and inter sectoral M&E plans. A review of a wide range of national and health sector documents and stakeholder consultations were conducted as part of the rapid assessment and the key strengths and challenges/gaps noted in the situational analysis above have been taken into consideration in developing a technically sound M&E plan that will be fundamental to the effective tracking of the progress in the implementation of the NHSP. A Task Force (TF) led by the MoH & SW was formed which worked in consultation with technical assistance provided by the World Health Organization and all other relevant stakeholders to develop this M & E plan. The involvement of the different stakeholders was important in order to ensure Government ownership and buy in from stakeholders of the plan. Consequently, this M & E plan is anchored on the three IHP+ principles of one strategy, one monitoring & evaluation framework and one coordinating mechanism. It will be the guiding document to: develop, update, assemble, and harmonize relevant M&E strategic documents (tools, job-aids,and allied training materials); strengthen the national M & E system through regular (monthly/quarterly) tracking, logistics-commodity monitoring and feedback to national and sub-national levels; monitor in-puts (human resources, financing, supplies), processes (procurements and training), outputs (services delivered), outcomes (intervention coverage) and programme impact (changes in disease incidence, prevalence, and mortality rates) and strengthen linkages with national, regional and global levels stakeholders for standardized metrics for performance assessment.

4.0 The NHSP M & E Plan

This M & E plan is anchored on the vision, mission, objectives and targets of the NHSP. The latter have been formulated during a highly consultative process with major stakeholders. The plan also takes into consideration the findings of a rapid assessment conducted in 2014 using the IHP+ guidance document and previous assessments of the health information system (HIS) in the Gambia, which have all informed the development of the core values, priorities, goals and strategic objectives of this plan. The strategic plan builds on lessons learned during the previous periods at different levels of care and seeks to consolidate these gains to ensure future program impact. The M & E plan integrates indicators from population-based national surveys and the Health Management Information System (HMIS) will allow for tracking annual progress, as well as progress over a long time at the population level.

4.1 core values

Accountability for outputs, Excellence, Technical empowerment, Efficiency, Effectiveness, Value for money (VfM), Multi-stakeholder involvement, Responsiveness

4.2 Priorities

The following will be the priorities for the period 2015-2020:

1. Strengthening management and coordination to ensure a harmonized monitoring, evaluation and review system in the health sector.

2. Developing the capacities and capabilities for M & E within the directorate of planning and information (DPI), the technical programmes and the regional health management teams (RHMTs).

3. Ensuring robust monitoring and evaluation of the accelerated and synchronized scale up of interventions to achieve universal coverage of the basic package in all the regions of the country.

4. Strengthening monitoring and evaluation of the integration of the NHSP efforts with non health sector actors such as: Education, Agriculture, Environment, the Army, the Police, Prisons, Local and Urban Authorities, meteorology, the Private sector, Research/Academia and Civil Society.

5. Ensuring that there is capacity, resources and preparedness to track and respond in a timely and effective manner, to communicable disease epidemics, especially extremely dangerous pathogens
6. Strengthening the capacities and capabilities of the directorate of research to coordinate and conduct operational research to generate evidence and translate it into effective action at all levels of health care, including the tracking of the increase in the population's awareness and knowledge about health interventions to improve uptake and correct use of interventions by providers and the community.

7. Strengthen surveillance, monitoring, and evaluation at all levels so that key indicators are routinely monitored and used for decision making.

4.3 Goal, strategic objectives, milestones and targets

4.3.1 Goal

To establish a monitoring, evaluation and review system that is robust, comprehensive, harmonized and well-coordinated to generate information in real time for tracking the implementation of the NHSP.

4.3.2 Strategic objectives

<u>Strategic objective 1:</u> To strengthen the capacity and capability for monitoring and evaluation & review within the directorate of planning and information (DPI)

Milestones

1. By 2016, to establish a fully functional planning, monitoring and evaluation unit within the directorate of planning and information (DPI) with clear terms of reference (ToRs), clear alignment and linkages with sector partners and other national institutions.
2. By 2016, to have provided adequate infrastructure and logistic support for the DPI to perform the M & E functions..

3. By 2016, to have built the technical and information and communication system capacity to facilitate the DPI to regularly and systematically track progress of implementation of the NHSP.
4. By 2016, with technical assistance from technical and development partners, the DPI to have designed on the job training courses and short courses in M & E for national and sub-national level managers.

Targets

1. By 2018, the DPI will have adequate staff (numbers and quality) xxx epidemiologists, xxx monitoring and evaluation specialists, xxx statisticians, xxx ICT, xxx Health Economists, Health planners, Quality Assurance and xxx GIS staff.
2. By 2018 the DPI in collaboration with technical and development partners will have trained xxx RHTMs and xx HFs teams in M & E

<u>Strategic Objective 2:</u> To institutionalize and coordinated and harmonized strengthen performance measurement/assessment at national, regional and health facility level

Milestones:

1. By 2015, to have launched and disseminated the NHSP and accompanying M & E plan to national and sub-national levels.
2. By 2015, to have developed and disseminated to national and sub-national levels the M & E and data analysis user hand book.
3. By 2015, to have reviewed the health management information system (HMIS) to tailor it to the requirements of the NHSP, including tracking changes in referral functions.
4. By 2016, to have supported all RHMTs and programmes to develop M & E plans as part of their comprehensive annual operational plans.
5. By 2016, to have introduced performance league tables for the RHMTs, hospitals, major and minor health centres.
6. By 2016, to start producing quarterly performance assessment reports.

Targets:

1) By 2020, train all programmes at national level and all RHMTs in performance measurement/assessment so as to inform evidence-led policy formulation and decision-making.
2) By 2020, produce and disseminate to national and sub-national level, at least 16 quarterly performance assessment reports.
3) By 2020, produce and disseminate to national and sub-national levels, 6 annual health sector performance reports (AHSPR).
4) By 2020, have conducted 6 annual joint review meetings (AJRMs)
5) Conduct a midterm review of the NHSP in 2017/2018.
6) Conduct an end term evaluation of the NHSP in 2020.

Strategic Objective 3: To strengthen the health information system (HIS) at community, health facility, regional and national level to improve evidence-led programming and decision making.

Milestones:

1) By 2015, all RHMTs and HFs are capable of timely reporting using the weekly IDSR and monthly HMIS reporting formats.
2) By 2016, all hospitals are able to report on a quarterly basis key hospital performance indicators
3) By 2016, 3 hospitals (pilot program) are able to report on a monthly/quarterly basis outpatient and inpatient disease statistics using the international classification of diseases (ICD) (standard or modified
4) By 2016, to have developed tools to monitor the quality of health service delivery at national, regional, health facility and community level.
5) By 2016, all PHC villages will have to introduce a community based information system that is linked to HMIS

Targets:

1) By 2016 achieve and sustain 80 % timeliness of IDSR weekly and HMIS monthly reporting, respectively
2) By 2016, achieve and sustain 90 % completeness of IDSR weekly and HMIS monthly reporting, respectively
3) By 2016, achieve and sustain 80 % of HFs and RHMTs displaying trend analyses for key NHSP indicators

4) By 2016 achieve and sustain 100 % quarterly performance assessment reporting from RHMTs for key sector indicators
5) By 2020 75% of all villages will have a community functional registers link to the national HMIS.
6) By 2020, all core capacities for international health regulations have been built at national, regional , HF, and community level
7) By 2016, achieve and sustain 100% of diseases of outbreak potential are investigated and responded to in 24-48 hours
8) By 2016 all Hospital health workers have been trained in the ICD classification and performance indicators for hospitals
9) By 2018 have trained all relevant national programmes, all RHMTs and all HF teams in IDSR, HMIS and DHIS-2.
10) By 2020 to have conducted at least 2 facility based surveys to assess the quality of care of health services (these surveys will include service availability and readiness assessment (SARA)
11) By 2020, all (approximately 50) Birth and Death registration centres will be computerized and linked electronically
12) By 2020, to achieve and sustain Birth and Death registration coverage of 80%
13) By 2020, to have conducted 2 client satisfaction surveys to assess the community satisfaction with health services.
14) By 2020, to have conducted 2-3 programme specific population based surveys (malaria, HIV/AIDs etc)
15) By 2020, to have conducted 3 expenditure tracking studies and national health accounts

Strategic objective 4: To strengthen operations research to generate evidence and translate evidence into policy and practice

Milestones

1) By 2016 to have established the national research council to address issues of standards and bioethics (to be moved to the strategic orientation)
2) By 2016, to have set up a sectoral technical working group for operations research with clear ToRs.

3) By 2016, to have formulated a priority research agenda.

Targets

1) By 2020, to have held 10-15 operations research TWG meetings to discuss progress
2) By 2020, to have conducted 1-2 studies to evaluate the impact, effectiveness and cost-effectiveness of health service delivery to facilitate continuous learning (document and share the challenges and lessons learnt) with in the health sector
3) By 2020, to have conducted 2 mixed international and national research conferences to discuss key issues for research in West Africa and the Gambia

Strategic objective 5: Strengthen the system for pharmacovilance and post marketing surveillance of medicines, vaccines and other health commodities

Milestone

1. By 2016, in collaboration with the national pharmacy agency the MOH & SW will have integrated pharmacovilance tools into the HMIS
2. By 2016, in collaboration with the national pharmacy agency the MOH & SW will have integrated pharmacovilance trainings into the HMIS
3. By 2017, 50% of regions will have established functional systems for pharmacovilance

Targets

1) By 2020, to have conduct 2 surveys to monitor the quality of essential medicines on the market (public, private and at community level).
2) By 2020, to have conducted 2 surveys to assess the availability and use of inappropriate medicines in the public and private sector. (move to strategic orientation)
3) By 2020, to have established drug information centres in all regions

Strategic objective 6: To improve the quality of information, in terms of validity, consistency, reliability, accuracy, timeliness and completeness

Milestones:

1. By 2016 to have introduced a system for quarterly external quality assurance-EQA (internal) and annual EQA (external) for all laboratories

2. By 2016, to have developed standard operating procedures, guidelines and manuals for HMIS/IDSR and quality assurance for all levels
3. By 2016, to introduce and sustain a system for quarterly and annual data quality audits
4. By 2016, to have trained all HWS in the reviewed HMIS at all levels
5. By 2016, to have trained all PHC villages in the integrated village registers
6. By 2016, all RHMTs will conduct quarterly supervisory visits to PHC villages

Targets

1. By 2016, Train all RHTs in HMIS
2. By 2016, Train all HWs in HMIS
3. By 2016, Train at least all VHW in each PHC village in the revised integrated resisters
4. By 2017, Conduct evaluation of the surveillance system (HMIS/IDSR)
5. By 2020, have conducted (12 x 5) quarterly supervisory visits to PHC villages
6. By 2020, have conducted (4 x 5) EQA (internal) and annual EQA (external) for laboratory data

4.4 The performance measurement/assessment system

4.4.1 Indicators for performance assessment

Tracking progress will be based on robust indicators that have been agreed upon by all major stakeholders. The indicators will be used to measure achievement of targets; assess changes/trends; compare level of achievement between different groups and identify under-served areas/populations.

4.4.1.1 Indicator categorization

Indicators have been categorized according to the logical framework approach into: Input/process, output, outcome and impact (**Figures 1 and 2**).

Figure 1 IHP+ framework used to formulate indicators for the GNHSP

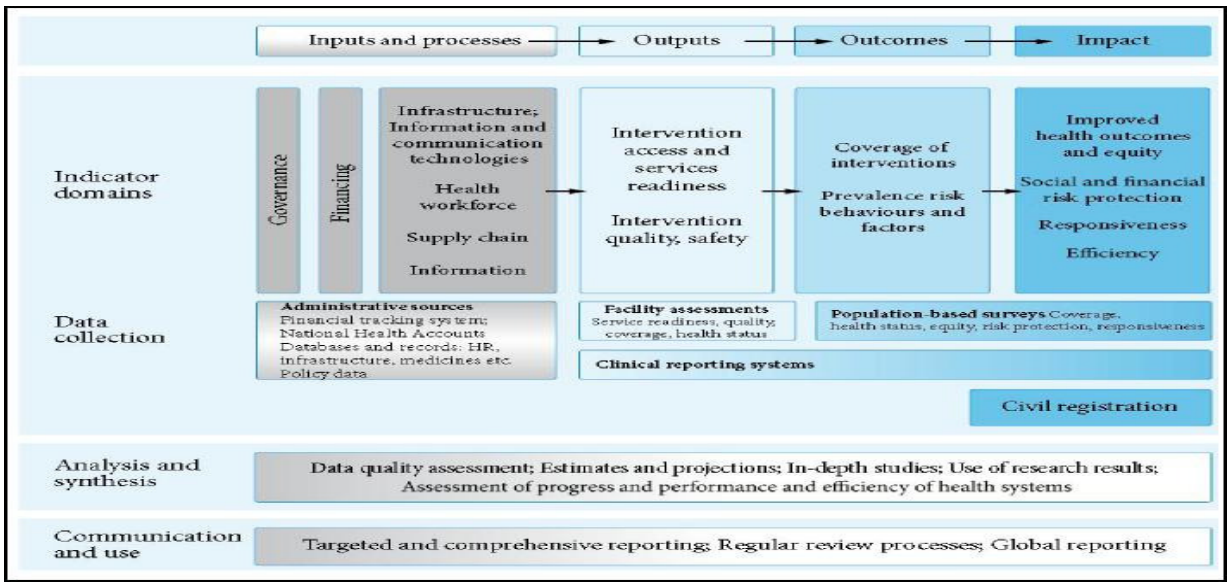


Figure 2 NHSP goal, objectives and targets

GOAL

To reduce morbidity and mortality to contribute significantly to quality of life in the population

IMPACT INDICATORS AND TARGETS

Reduce Neonatal Mortality Rate (NMR) from 22/1000 live births in 2013 to 15/1000 live births by 2020

Reduce Infant Mortality Rate (IMR) from 34/1000 live births in 2013 to 24/1000 live births by 2020,

Reduce under five Mortality Rate (U5MR) from 54/1000 in 2013to 44/1000 by 2020,

Reduce the Maternal Mortality Ratio r(MMR) from 433/100000 live births in 2013 to 315/100000 live births by 2020,

Reduce Malaria incidence by 50% by 2015

Reduce overall HIV/AIDS prevalence from 1.9% to 1% by 2020.

Reduce the percentage of young people aged 15–24 who are living with HIV/AIDs from 0.3% in 2015 to 0.2% by 2018.

Reduce morbidity due to other communicable diseases by over 50% by 2020

Reduce the burden of NCD risk factors from 24% in 2010 to 20% by 2020

Reduce the incidence of cancers by 50% by 2020 (disaggregated by gender

Reduce the death rate due to road traffic accidents per 10 000 population by 50% % by 2020

Reduce the death rate due to heart diseases per 10 000 population by 50% by 2020

STRATEGIC OBJECTIVES

1. To provide high quality basic health care services that is affordable, available and accessible to all Gambian populace.
2. To reduce the burden of communicable and non-communicable diseases to a level that they cease to be a public health problem
3. To ensure the availability and retention of highly skilled and well-motivated HR for Gambian populace based on the health demands
4. To increase access to quality pharmaceutical, laboratory, radiology and blood transfusion services to all by 2020
5. To improve infrastructure and logistics requirements of the public health system for quality health care delivery
6. To establish an effective, efficient, equitable and sustainable health sector financing mechanism by 2020
7. To improve the effectiveness and efficiency of Health Information System for Planning and decision making to yield improved service delivery
8. To ensure effective and efficient health service provision through the development of effective regulatory framework and Promoting effective coordination and partnership with all partners

OUTCOME INDICATORS AND TARGETS

Increase the contraceptive prevalence rate from 9% to 25% by 2018
Prevalence of hypertension (among 25 years and over)
Prevalence of smoking among adult population (among 25 years and over)
Prevalence of overweight/obesity among adults (among 25 years and over)
Prevalence of diabetes (among 25 years and over)
Prevalence of mental illness

OUTPUT INDICATORS AND TARGETS

Increase case detection rate of new smear positive cases from 64% in 2012 (MOH&SW 2012) to 70% by 2017

Increase the percentage of TB patients who have HIV test from 83% in 2012 to 95% in 2017

Per capita outpatient utilization rate

Bed Occupancy rate

Percentage of HF without stock outs for a week of 14 tracer medicines

Percentage of minor and major HFs with functioning theatre for EMOC

% of pregnant women attending 4 ANC visits

% deliveries in HFs

% deliveries by skilled health workers

% of children fully immunized with 3rd dose of pentavalent vaccine

% of one year old children immunized against measles

% of pregnant women with two or more doses of SP (IPTp)

% of children exposed to HIV from their mothers accessing HIV testing within 12 months

% U5s with fever receiving malaria treatment within 24 hours

% eligible persons receiving ARV therapy
% . % households with safe sanitation (flush/pit/toilet latrine)
% U 5s with height/age above lower normal

% U 5s with weight/age above lower normal

% of clients expressing satisfaction with health services

INPUT/PROCESS INDICATORS AND TARGETS

Ratio of health workers (Nurses, Midwives, Doctors, Public health Officers and Nurse Anesthetics) per population

Distribution (%) of health care professionals in urban and rural areas

Percentage of approved vacancies that are filled

Annual absenteeism rate

Annual staff attrition rate

Percentage of PHC villages with functional VHWs

4.4.1.2 Formulation of the long list of indicators

We have reviewed the National Health Policy, 2012-2020, the objectives of the NHSP, 2014-2020; the indicators available for each strategic objective of the GNHSP, technical programme documents, other MoH documents and international initiatives to generate a long list of indicators using the following robust criteria:

1. Measurability-are the indicators measurable/quantifiable?
2. Representative- how representative is the indicator?
3. Reliability- is the indicator consistent on repeat measurement?
4. Feasibility of measurement- how easy is it to collect the source data for the indicator?
5. Validity-does the indictor measure what it is intended to measure?
6. Precision- does the indicator have a precise definition of the numerator and denominator?
7. Comparability- can the indicator be comparable in different settings or different time periods?

For each of these criteria a score of 1 was given and the indicators with a score above 3.5 (50 % cut off) were retained. The long list of indicators will be used for comprehensive monitoring and evaluation (**See annex 2).** However, for quarterly or annual monitoring a shorter list is needed (see **annex 1**).

4.4.1.3 Formulation of the short list

We used the following criteria to select the priority indicators which will be reported on regularly in the context of quarterly and annual performance measurement.

1. Simplicity- is the indicator simple i.e. not composite/complex
2. Relevance-does it fit in the policy context for the Gambia
3. Validity- does it measure what it is intended to measure
4. Sensitivity- does the indicator capture small changes in performance
5. Reliability-are t\he estimates replicable with repeat measurement

Each criterion was given a score of 2 and indicators with a score above 6 (60 % cut off) were short listed. Finally, we consulted the technical programmes and national stakeholders about the short list of indicators to get their concurrence on the selected indicators. These indicators are presented in **annex 1 and 2**.

4.4.1.4 Indicators for monitoring health sector undertakings and strategic re-orientations

Some activities are critical, catalytic, undertakings, policy shifts or represent strategic re-orientations. Many of them are important for the success of the NHSP but they are one off. We

have captured these in the table 1 below and stipulated the latest date when they should be actualized if the NHSP is to be implemented successfully.

Table 1 Indicators for monitoring health sector undertakings and strategic re-orientations

Policy shift or Strategic re-orientation	Year of measurement of progress
Redefine and implement the health care package for all levels	2015
Establish a M & E coordinating unit in the DPI	2015
Strengthen sector coordination capacity Establish a joint high level sector steering committee/sector policy advisory committee along with technical working groups (TWGs) for: 1) Health Sector Budget WG 2) Human Resources WG 3) Health Infrastructure WG 4) Medicines and Health Commodities Management & Procurement WG 5) Supervision, Monitoring & Evaluation and Operations Research WG 6) Public Private Partnership for Health WG 7) Maternal neonatal and child health WG 8) Environmental and Nutrition Health WG 9) Health Education and Promotion WG 10) Communicable Diseases WG 11) Non communicable Diseases WG	2015
In an effort to reduce maternal deaths, every maternal deaths shall be audited and shall be under case based reporting.	2015
Presence of robust appraisal system	2016
Increase the number of non health sector players involved in health service processes	2016
Involve corporate private sector	2016
Strengthen cross border initiatives	2016
Establish a National Research Council	2016
Introduce performance based Financing	2016
Presence of human resource data system	2016
Establish a functional Laboratory Network	2017
Ensure availability of relevant, accurate, accessible and timely health care data for planning, coordination, monitoring and evaluation of the health care services	2017

Presence of comprehensive incentive package for all health workers	2018
Fully functional laboratory services in all hospitals and all major health centres by 2020	2018
Fully functional radiology services in all hospitals and all major health centres by 2020	2018
Expand and strengthen Blood transfusion services to all hospitals and major health facilities by 2020	2018
Provide sustainable infrastructure and logistics conducive for the delivery of health services at all levels of the health care system by 2020	2018

4.4.2 Data collection systems

The performance measurement/assessment system will use several data platforms. The main source of data will be the Health Management Information System (HMIS), the principal health care monitoring system for collecting routine information. The HMIS provides weekly, monthly, quarterly and annual reporting from health facilities to the regional level where it is consolidated and transmitted electronically to the national level. However, data are often not received in a timely manner or they are incomplete. Further, programmes have expressed experiencing difficulties in accessing the routine HMIS data on a consistent basis and in a standardized format ready for analysis and decision making. This M & E plan 2014-2020 will address these setbacks by strengthening capacities at national, regional and health facility levels. Further, the MoH & SW will introduce the use a standardized performance assessment formats which will provide useful summaries at national and regional level to quickly identify performance and progress. The routine data collection system will be complemented by household population based surveys –The Gambia Demographic and Health Surveys (GDHS) and other community/population based surveys, which will provide primary information on population based indicators. These sources will be complimented by: standard reports from programmes and other government line ministries. This M & E plan wil strive for the establishment of a unified, country-led data platform and procedures for collecting, analyzing and sharing data.The key information sources will be:

1. The Health management Information Systems and District Health Information System Version 2 (DHIS2),
2. Demographic and Health Survey (DHS),
3. Health Facility Surveys
4. Household Surveys (MIS, MICS, IBBS and the BSS),
5. Sentinel Surveillance
6. Epidemiology and Disease Surveillance

Based upon the national sector performance indicators (**M&E Framework ANNEX 2**) a total of **83 indicators** have been selected for comprehensive assessment and their data sources are summarized in **Table 2** below. Most of these sources are already well established within national priority health programmes of the Ministry of Health & Social Welfare.

Table 2 National sector indicators

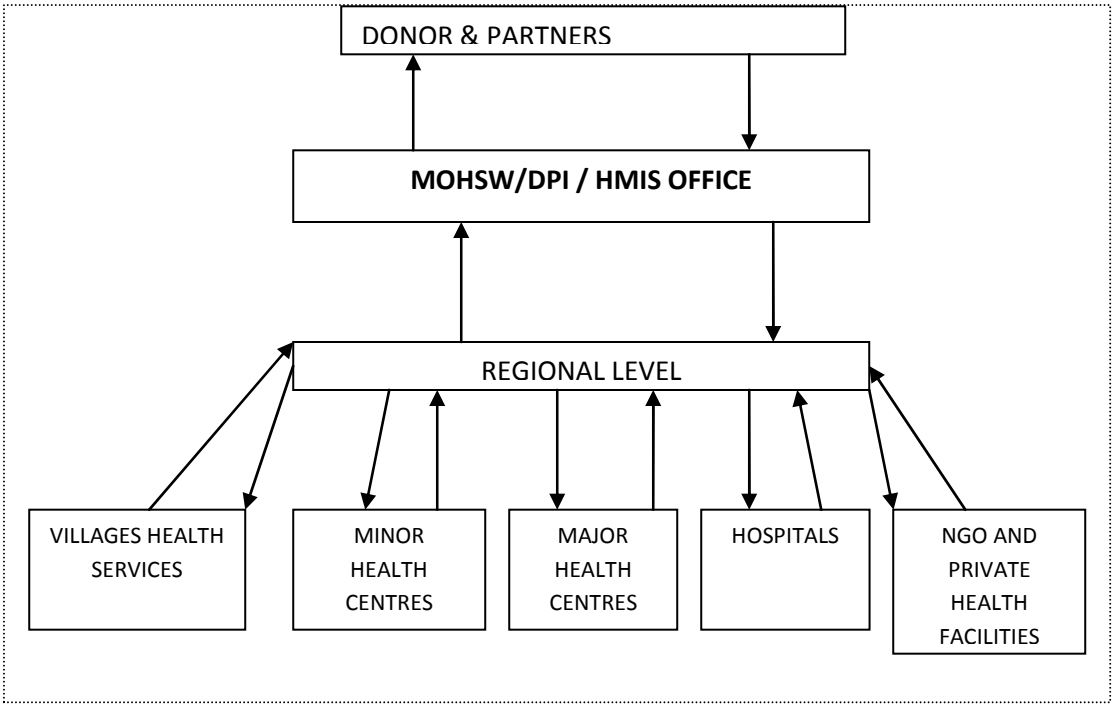
Type	Data Source	Number of Indicators
Routine Data	HMIS/DHIS2	6
	LMIS/M supply	1
	CHANNEL	0
	iHRIS	24
	IFMIS	1
	IDSR	1
	LabMIS	2
	QA database	0
	Inventory Control System	14
Health Facility Survey	Health facility survey	3
	NHA	1
Household Survey	DHS	8
	HH Survey	2
MOH & SW Reports	MOH Reports	20
Grand Total		**83**

4.4.2.1 The Health Management Information System (HMIS)

The primary clinical services monitoring system for the MoH & SW is the Health Management Information System (HMIS). The Gambia HMIS is part of the monitoring and evaluation framework for the public health sector. The HMIS was initiated in 2006 and has undergone several assessments. The role of HMIS fits within the larger context of health sector monitoring and evaluation efforts and in the Gambia. Health information collected as part of the HMIS includes disease cases and deaths for children less than five years of age and above. This information is reported weekly (IDSR) and monthly (for the other diseases). Cases include both laboratory-confirmed cases and those that are clinically diagnosed cases based on the reported presence of illness with no other obvious cause. Many challenges exist with the current HMIS stemming from changes in the human resource capacity and data demand for specific programs. However, improvements in quality and completeness of data have resulted from the sustained effort to strengthen the HMIS. The extent to which reporting completeness and data quality are reflected in routine reporting remain problematic in the ability for the end user to understand from the health information generated through HMIS. Further strengthening of capacity within health facilities and the RHMTs, the focal point for ensuring timely and complete information is reported at the local level, is needed. This M & E 2014-2020 plan will strengthen capacities and capabilities at national and provincial level.

Figure 3 HMIS data flow Chart

HMIS NATIONAL DATA FLOW CHART



Furthermore, the MoH & SW will initiate the use a standardized leagues tables which will provide useful summaries at national and provincial level to quickly identify performance and progress for each province. As part of the SME plan a series of trainings for RHMTs and Health facility teams will be conducted. The HMIS system will be used to populate a standard dashboard to report on key indicators on a monthly basis.

HMIS data quality assurance system

There are three main systems through which data will be assessed for quality and completeness:

1. Quarterly Data Audits by the HMIS unit and RHMTs – The HMIS unit and the RHMTs will review HMIS data from each facility on a quarterly basis and individual facilities will be visited to verify the data, and provide feedback as to the quality and completeness of reports.
2. Annual Data Review by the HMIS unit – The HMIS unit will annually review and verify with each facility all available health service delivery data, general health data and the DHIS data.

3. Project related Data Quality Audits – Will be performed according to requirements of specific donors (Global Fund, PMI, World Bank and others). These will typically focus on selected indicators ranging from national to peripheral level.

Where problems are indentified with data quality and completeness, corrective measures will be proposed and implemented by the RHMTs. These measures will include: local visits, supervision, and additional training to improve the timeliness, completeness, and quality of the data. The results of quarterly and annual data quality audit reports will be published on the MOH website and discussed during Joint Health Sector Reviews in order to maintain progress already made in this area.

4.4.2.2 The Human Resource Information System (HRIS)

This was re-launched at the end of 2011, and the data are now maintained in a decentralized manner by hospital HR managers with support from the central level HR team. It now has active records of over 16,000 health professionals. This system is managed by the Department.

4.4.2.3 Logistics Management Information System (LMIS)

A Logistics Management Information System was established under the National Pharmaceutical Services (NPS) and is funded under the Capacity Building Strengthening Plan of the Global Fund as per approved plan in 2011. This system was to strengthen the previously existing inventory control system of the NPS to further track supplies to the furthest level of the supply chain. Data generated at the field level is collected, compiled and sent to the RHT for verification and punching into the system. The electronic format of the data which is sent to the NPS always needs to be verified. This is done on a quarterly basis during our monitoring.

The consumption data is collected from the public, private; NGO and community managed/ owned health facilities by the primary data collectors. At the facility levels, registers are provided by the Ministry of Health to record all services that are being provided by the health workers.

4.4.2.4 CHANNEL

Since 2010 UNFPA through the Reproductive Health Commodity Security (RHCS) program have been instrumental in the provision of training and tools to improve the LMIS system in the Gambia. This has led to the need for training of staff in the use of CHANNEL as 22 computers procured by UNFPA have been deployed to the health centres and regional stores immediately after the training. The development of CHANNEL was undertaken in direct response for health supply management software that would be easy enough to use at warehouses and locations where computer usage is minimal and therefore capacity is not strong. It was developed to provide useful management reporting and also to be flexible and easily adaptable in a variety of country settings. The use of CHANNEL has proven to be useful and easy to use health supplies management software. The software is meant to automate the data collection and reporting requirements of the facilities at which it is used, and it is also meant to instruct and encourage good practices in logistics and supply management.

4.4.2.5 The National Health Account (NHA)

An internationally recognized methodology for comprehensively tracking spending within the health sector, will institutionalized to track the health spending within the health sector. The 2013 NHA study has been finalized and will be presented to the National Steering Committee on NHAs before being published.

Approaches to improve timelines and completeness of reporting

PBF incentives for timely reporting have dramatically improved reporting rates and completeness, while the recent exercise to harmonize health facility registers and recording tools is expected to improve data accuracy. In addition, the implementation of Results Based Financing (RBF), a World Bank (WB) Project by the MOH and NaNA which started off as a pilot in 2012 in the North Bank West Region is scaled up in three other health Regions such as North Bank East Region, Central River Region and Upper River Region in 2014. In 2012, the Ministry of Health conducted and published the report on an investment case for the Health Sector using the **Marginal Budgeting Bottlenecks (MBB)** as an evidence-based planning and budgeting tool with support from UNICEF and partners.

The Gambia investment case as being proposed is ultimately intended to support preparation of the 2012-2015 National & Regional health sector investment case plan with its budget, inform Government as well as donor funding, and help national and regional leaders to make informed choices or important decisions about adoption of new health strategies and resources allocation. Information derived from the invest case based on the different scenarios could effectively be used to inform the MTEF (2015-2017) in terms of cost projections. The purpose of the investment case is primarily to support us and partners to improve the use of evidence in developing national and regional health plans, and enhance the allocation efficiencies of health budgets through evidence-based costing and budgeting. A secondary goal, given the broad inter agency involvement in this effort, is to promote coordinated donor support towards the health- related MDGs.

4.4.2.6 Periodic population and health facility based surveys

Surveys provide useful measures of population and facility-based coverage indicators for gauging progress in scale up efforts at national and provincial level. Methods for conducting surveys vary greatly, but rigorous sampling methods and household surveys based on representative samples of the population or facility surveys based on the most recent national facility inventory are desirable. These provide greater reliability and comparability with other survey efforts and allow for monitoring trends over time. At the household level, international stakeholders have developed a standardized survey package and guidelines for assessing the coverage of core indicators at the household level. The survey package contains standard methods and questions for measuring household level possession and usage of key interventions. Household surveys also provide a reliable method for understanding trends in

all-cause child mortality. These indicators and methods are incorporated in large-scale survey mechanisms such as the Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS) for standardized cross country comparability and global monitoring efforts.

4.4.2.6 Health facility surveys

Health facility surveys are useful for determining the quality of care delivered by health professionals for outpatient and inpatient; stock outs and levels of health commodities and laboratory equipment; as well as capacity at health facilities for delivering adequate care and diagnosis. The MoH & SW has developed several guidelines and training curricula have been developed and health workers trained. However, the availability and the proper use of these guidelines at peripheral facilities countrywide remain challenging.

4.4.2.7 Service Availability and Readiness Assessment (SARA)

Service availability and readiness assessments (SARA) shall be conducted every 2 years, to assess/monitor readiness of facilities to deliver services (i.e. to assess if the necessary medicines, supplies, equipment, trained staff, diagnostic capacity, infection control precautions etc. are available. In addition these surveys will assess the availability of services such as family planning, MNCH, HIV, TB, malaria, NCDS. The readiness assessment is conducted using a standard instrument that has been jointly developed by WHO, USAID and other partners. A record review will also be conducted during the facility assessment to allow for verification of the quality of routinely reported facility data (RDQA). The approach will serve to: Fill the data gaps in terms of service delivery, generating standard tracer indicators that are required to plan and monitor scale-up of interventions for key health services and assess /measure progress in health system strengthening within the broader context of M&E of the national strategy; and to systematically assess and verify the quality of routinely reported facility information that goes into progress and performance reports. The facility readiness assessment shall be conducted every 2 years to inform the analytical reviews. The methodology is based on a random sample of facilities that is nationally representative and stratified by region, facility type and managing authority. A complete list of public and private list of facilities is required for the sampling frame.

4.4.2.8 Availability of 21 tracer medicines study

Availability/stock outs of 21 tracer essential medicines are one of the core indicators of the NHSP to be monitored at facility level monthly through the HMIS. At national level the availability of the 21tracer medicines will be monitored quarterly. As the MoH and SW endeavors to increase access and availability of the essential medicines and health supplies it is important to use innovative approaches such as mobile phone SMS based tracking of essential medicine stock outs.

4.4.2.9 The Gambia Demographic and Health Survey (GDHS)

The first conducted Gambia Demographic and Health Survey **2013** is to provide current and reliable information on demographic and health indicators on the general population, adolescents, youth and the elderly by gender for use in Government policy, planning, programming and decision-making. The GNHSSP planning process has greatly been informed by data derived from GDHS 2013. Several large-scale, nationally representative household surveys have been conducted in the Gambia that are useful for monitoring and evaluation. The majority of these are carried out with the assistance of the Gambia Bureau of statistic (GBOS) for design of representative samples based on the most recent census information. Demographic and Health Surveys (DHS) are nationally representative household surveys that focus on reproductive and child health issues. Typically, DHS consist of interviews with between 4000 and 50,000 women aged 15-49 years living in households that are sampled in a multiple-stage cluster design. Because the questionnaires are standardized and structured and change little between surveys, DHS results are comparable between countries and over time. DHS are a primary source of information on all-cause under-5 mortality rates, obtained by the direct estimation technique , e.g., from birth histories. Recent DHS also measure the prevalence of anaemia by haemoglobin measurement in children under 5 years old. DHS are organized by ORC MACRO, Calverton, MD, USA and are funded by the United States Agency for International Development (USAID) and other partners. Questionnaires and survey results are usually publicly available on the internet approximately one year after completion of field work. In the Gambia, a Demographic and Health Surveys was conducted in 2013 and another is planned in 2018. These are facilitated through the GBOS, with additional financial support from the MoH & SW and other stakeholders such as the NAS.

4.4.2.10 Periodic programmatic evaluation surveys

Specific technical programmes such as malaria, HIV/AIDS, TB also conduct population based surveys. The results of such surveys will provide critical data for decision making. However the lack of longitudinal data has made evaluation of progress in the scale up of programme interventions challenging.

4.4.2.11 Client Satisfaction Surveys

Two types of client satisfaction surveys are needed to measure client satisfaction:

a) Client satisfaction surveys among uses of health services that are carried out at all levels of service delivery to determine the quality of services offered in the client perspective. A client satisfaction survey tool will be developed by the Quality Assurance Unit for incorporation into the HMIS. Facility client satisfaction surveys will be carried out annually and findings utilized for quality improvement.

b) A population based client satisfaction surveys is be needed to provide the client satisfaction indicators. Two national surveys will be conducted during the NHSP period 2014-2020. The

MoH & SW will collaborate with the GBOS and other stakeholders to identify modalities of conducting population based client satisfaction surveys.

4.4.2.12 Non-Communicable Diseases (NCD) Survey

During the life span of this NHSP, the MoH & SW will conduct 2 national NCD surveys on risk factors and magnitude of non-communicable diseases in the country. The NCD survey will use the WHO recommended STEP approach on the prevalence of NCDs and their risk factors.

4.4.2.13 Health research and evidence generation

A lot of research is conducted in the Gambia but presently it is not used to guide policy. Research is intended to inform decision making hence contribute to improving delivery of and access to health care and nutrition services. Operational research will be carried out and findings disseminated through the existing structures. Operational research shall encompass a wide range of problem-solving techniques and methods applied in the pursuit of improved decision-making and efficiency. The Directorate of Research (DR) shall be responsible for coordinating all the health related research in the Gambia and will mobilize resources, set the research agenda, update and disseminate health research, commission and organize health research in collaboration with other research and academic institutions and NGOs. The DR shall coordinate the sharing of research findings in the MoH & SW by liaising with research institutions, universities and research agencies such as the MRC which should become a member of the SMEOR TWG.

4.4.2.14 The National Census

The 2013 will provide much-needed data for updating the denominators for calculating key service coverage indicators and better understanding the impact of certain equity and public health initiatives. Several of the disease control programs have scheduled surveys to collect data more frequently, particularly among high-risk populations and in highly endemic areas. These include the Malaria Indicator Survey, AIDS Indicator Survey, an HIV incidence survey and the Behavioral Surveillance Study (BSS) and IBBSS (Integrated Bio-Behavioral Surveillance Study).

4.4.2.15 Financial monitoring and audit

Financial monitoring will be carried out on a quarterly basis at all levels of implementation, including in each region and for central level initiatives. Financial monitoring will be carried out for the following purposes:

- To ensure that funds are spent in accordance with the approved work plan;

- To ensure that financial management guidelines are being followed;
- To ensure that adequate and acceptable financial records are in place, maintained properly and are up to date.
- To give support to RHMT in maintaining of financial records as well as timely gathering and consolidation of financial reports;
- To ensure that accountabilities are made on time; and
- To track the flow of financial resources and deal with constraints that may hinder smooth and regular flow of the resources.

There will be internal audits carried out under the guidance of the National Audit Office and also external audits carried out by Independent Audit Firms. Financial monitoring will be carried out in close collaboration with the monitoring of the NHSP performance to ensure that the two are linked to facilitate accountability of successes or failures. The tools to be used in financial monitoring will include financial records (cashbooks, bank statements etc) and supervision visit reports.

4.4.3 Information dissemination and feedback mechanisms

Formal mechanisms for periodically sharing performance results and revising targets and interventions will be through (Quarterly review meetings, SMOER TWG Review meting AJRMs, and National Health Research Conference). All the data that are collected will be translated into information that is relevant for decision-making. Data will be packaged and disseminated in formats that are suitable for each management level. Service delivery statistics shall be packaged and displayed at the various health facilities using the revised HMIS formats. The timing of information dissemination will fit in the planning cycles and the needs of the users.

4.4.3.1 Quarterly Performance Review Reports (QPRRs)

Quarterly sector performance review reports (QPRRs) will be produced and presented by each sector technical programme, projects and central level institutions during the sector quarterly review meetings. In addition, Quarterly regional performance review reports (Quarterly Regional League Table) will also be produced by the HMIS unit and disseminated and discussed at this forum. At sub-national level (RHMTs, Hospitals, Major and Minor Health centres and projects), quarterly assessment reports will be presented and discussed at the quarterly review meetings attended by the key implementers.

4.4.3.2 Annual Health Statistical Report

This report will be compiled from the periodic statistical reports submitted through the Health Information System (HMIS). The annual health statistical report will provide ample attention to data quality issues, including timeliness, completeness and accuracy of reporting, as well as

adjustments and their rationale. The HMIS unit will be responsible for compiling and disseminating this report. These reports will also be available on the MoH & SW website.

4.4.3.3 Annual Health Sector Performance Report (AHSPR)

The AHSPR is useful in highlighting areas of progress and challenges in the health sector. The report will assess progress on the annual work plan and an overall assessment of sector performance against the targets set in the NHSP. It will also review progress against the sector priorities set during the preceding Annual Joint Review Mission (AJRM) with stakeholders. The different levels of health care delivery are expected to compile their reports every quarter and use them for performance review. The annual regional performance reports will then be forwarded to the national level for compilation of the AHSPR in the fourth quarter. The AHSPR will bring together all data from different sources, including the facility reporting system, household surveys, administrative data (minutes, supervision reports, financial reports, hospital reports, HRIS reports, etc) and research studies, to answer the key questions on progress and performance using the NHSP core indicators and health goals. The AHSPR will present a detailed account of annual performance against the core and programmatic indicators of the sector strategic plan, comparing current results with results of previous years, and formulate challenges and recommendations by sector and technical programmes. The AHSPR will provide the background and in-depth information for annual reviews and disease specific reports. It will be presented by MoH & SW to health stakeholders and discussed at the A**JRM held in the month of February every year.** The AHSPR will include an assessment of performance at and within the different levels using league tables. Similar to the analysis of progress in programmes, the report shall presents an analysis of the sectors support systems (health financing, human resources, health infrastructure, essential medicines and health supplies, diagnostic and blood transfusion services, information management & research) against set targets. A sample AHSPR format is presented in IHP+ guidance document (reference 7). The AHSPR shall also be able to reflect attribution of outputs and inputs to the public and private sectors. The aide memoire will summarize the findings and agreed actions of the AJRM based on the review of the Pre-JRM field visits and review of the AHSPR and will provide input in subsequent planning. The compilation of the AHSPR shall be coordinated by the Director planning and Information. The budget of collating annual sector performance data and report writing will be provided for under the sector monitoring budget. Annual sub-national performance reports shall be presented and discussed at the relevant annual stakeholders' fora.

4.5 Evaluation of the Gambia NHSP

The following will be used to evaluate the NHSP in a joint collaborative approach by the MoH & SW and Cooperating Partners;

- National Joint Annual Reviews
- Mid-Term Review to be conducted in 2016/2017

- End-term NHSP Evaluation in 2019

The NHSP will be evaluated based on the indicators for strategic re-orientations presented in Table 1 and the detailed indicators for performance assessment presented in Annexes 2 and 3.

4.5.1NHSP Evaluation

Evaluation is a process of measuring the outcomes, impacts and effectiveness of programmes /projects as well as documenting experiences and lessons learnt. Evaluations are separately scheduled activities performed at specific intervals (for example baseline, midterm or at the end of a programme / project). The can be internal, mixed or external,

4.5.2 Programme / Project Evaluation

A number of health sector programmes/projects will be undertaken during the NHSP period 2014-2020. All programmes/projects will be subjected to rigorous evaluation. The type of evaluation to be planned for and conducted should reflect the nature and scope of the public investment. For example, pilot projects that are being conducted amongst a random group of participants shall be selected for impact evaluation to determine whether or not the investment should be scaled up. As a minimum requirement, each project in this category will be required to conduct the following:

1) A Baseline study during the preparatory design phase of the project
2) A Mid-term review at the mid-point in the project to assess progress against objectives and provide recommendations for corrective measures
3) A Final evaluation or value-for-money (VFM) audit at the end of the project. A VFM audit will be carried out for key front-line service delivery projects where value for money is identified as a primary criterion. All other projects will be subjected to standard rigorous final evaluation.

The MoH & SW through specific programme /project managers will be responsible for the design, management and follow-up of the programme and project evaluations (including baseline and mid-term reviews). All projects will be required to budget for periodic project evaluations. All project evaluations will be mixed (internal and external) evaluators to ensure independence. Programme /Project evaluation reports shall be disseminated during the sector quarterly and annual review meetings.

4.5.3 Mid Term Review

A Mid-Term review of the NHSP 2014-2020 will be done after two and half years of the launch of the NHSP implementation and the report will be presented to the JRM. The purpose of the MTR will be to review the progress of implementation; identify and propose adjustments to the NHSP and other government policies as required. The specific objectives of the MTR will be to:

1. Assess progress in meeting the NHSP targets and to make recommendations for their adjustment if found necessary;
2. Review the appropriateness of the outputs relative to inputs, processes and desired outcomes;
3. Review the costing and financing mechanisms of the NHSP

The MTR shall entail extensive review of documents including routine reports and recent studies in the sector; special in-depth studies may also be commissioned as part of the MTR; and interviews with selected key stakeholders. The MTR will be undertaken in a participatory manner involving government line ministries (MoH & SW and related line ministries), national level institutions, service delivery levels, DPs, civil society, private sector and academia. The analysis will focus on progress of the entire sector against planned impact, but will also include an assessment of inputs, processes, outputs and outcomes, using the NHSP core indicators. The main result will be a list of recommendations for the remaining NHSP years. This will be an internal, joint exercise involving all stakeholders. The overall responsibility of the process will be with the Directorate of planning and information. A secretariat shall be constituted to support and co-ordinate the MTR process. The secretariat shall be located in the DPI and will work closely with the Directorate of Research. Technical Assistance (lead facilitator) will be required to support the MTR secretariat. The review shall be carried out by the Technical Working Groups. Each TWG will be responsible to undertake a review according their specific Terms of Reference. Issues not covered by any specific working group will be a responsibility of the MTR Secretariat. External support may be required to address critical issues identified by the Working Groups. The outputs of the Working Groups shall be presented to the Health Sector Review Committee. Specific Terms of Reference will be developed for the Lead Facilitator, TWGs and MTR Task Force.

4.5.4 NHSP End Term Evaluation

The End Term evaluation will be conducted in 2019 in order to enable the sector to make use of its findings and recommendations for the formulation of the next strategic plan. Like the mid-term review, the analysis will focus on progress of the entire sector against planned impact, but will also include an assessment of inputs, processes, outputs and outcomes, using the NHSP core indicators. It will focus on expected and achieved accomplishments, examining the results chain, processes, contextual factors and causality, in order to understand achievements or the lack thereof. The evaluation will have to answer questions of attribution (what made the difference?) and counterfactual (what would have happened if certain interventions had not been implemented and will take into account contextual changes (economic growth, social changes, environmental factors etc.), as well as policies and resource flows. The end term evaluation will provide answers (but will not be limited to) the following questions:

a) **Relevance:** Did the NHSP address priority problems faced by the target areas and population? Was the NHSP consistent with policies of the government and the Health Development Partners (HDP)?

b) **Economy:** Have the NHSP inputs (financial, human, Assets etc) been applied optimally in the implementation process?

c) **Efficiency:** Were inputs (staff, time, money, equipment) used in the best possible way to maximize the ratio of input/outputs in the NHSP implementation and achieve outcomes; or could implementation have been improved / was there a better way of doing things?

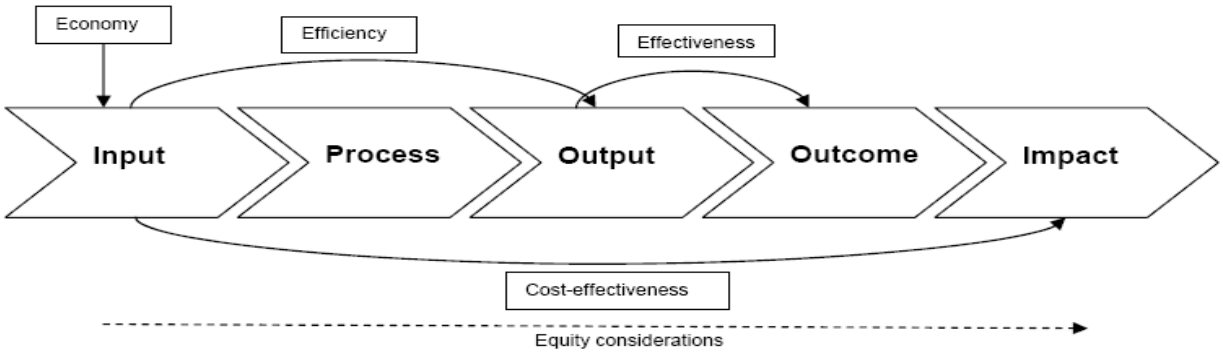
d) **Effectiveness:** Have planned NHSP outputs lead to desired outcomes?

e) **Efficacy:** To what extent have the achievements of the NHSP objectives and goal been achieved?

f) **Impact:** What has been the contribution of the NHSP to the higher level development goals, in respect of national development goals; did the NHSP have any negative or unforeseen consequences?

Trends in performance will be based on the NHSP baseline indicators. The regions shall be the primary units of statistical analysis for the national evaluation platform approach. A dose–response analysis that examines the association between funding levels and service coverage shall be carried out to further contribute to the evaluation. The evaluation will be conducted by a team of independent in-country institutions in close collaboration with international consultants. The purpose of conducting the evaluation prior to the conclusion of the NHSP is to generate lessons and recommendations to inform the next NHSP.

Figure 4 Framework that summarizes what the end term evaluation should answer



5.0 Accountability, coordination and implementation mechanisms

5.1 Accountability

All central level technical programmes and departments, institutions and the RHMTs will be held accountable for the achievement of targets set and agreed upon annually as documented in policy statements and framework papers. These will, where appropriate, include targets linked to client charters and service delivery standards. Performance for central departments, institutions and the RHMTs against set targets will be scored, and institutions will be benchmarked. Success and failure to achieve set targets, upon review, will impact upon the resources provided to the accountable institution in future budget rounds.

All accounting officers (central and regional) will be held accountable for the use of resources set out in their Performance Contracts with the Ministry of Finance and HDPs. Failure to account adequately for such resources will result in sanctions in accordance with established regulations and laws.

All Hospital Executive Directors will be held accountable for the achievement of targets set and agreed upon in their Performance Contracts. These contracts will pertain to targets reflecting adherence to Public Service Code of Conduct and Ethics, and to the contribution to institutional results linked where appropriate to Client Charters and service delivery standards. Success and failure to achieve set targets, upon performance appraisal, will impact upon the individual through the reward and recognition scheme, and in professional career advancement.

5.2 Translating knowledge into policy and action

The sector coordinating group will be responsible for discussing health policy and advise on the implementation of the NHSP. At national level policy issues / problems will be raised through reports presented by the sector coordinating group which will meet every two months. At sub-national level technical committees will be responsible for generating policy issues / problems for discussion during the relevant technical programme meetings and forwarding to the respective regional structures. The regional committees will be responsible for analyzing and making policy recommendations to the RHMTs. The MoH & SW will develop a comprehensive approach for translating knowledge into policy and action.

5.3 M & E, supervision and Operation Research working group (MEORS-WG)

This M&E plan has been aligned with the NHSP in order to monitor its implementation. The sector M&E and supervision WG will play an important coordinating role in monitoring the implementation of the NHSP by advising and giving strategic direction to the sector coordinating committee. The M&E and supervision Working Group will report to sector coordinating committee and will be accountable to the MoH & SW and sector development partners. The M&E Working Group will also coordinate the monitoring of the implementation of the NHSP. The

Working Group is cross cutting to all basic package programmes. The M&E Working Group responsibilities are to:

- Develop M&E guidelines for use at all levels
- Develop and implement the annual M&E action plans
- Monitor and evaluate the NHSP performance as outlined in this M & E plan.
- Mobilize and coordinate all resources for monitoring and evaluation activities
- Advise/provide input into the Annual Health Sector Reviews and quarterly M&E bulletins
- Facilitate the build-up of robust frameworks for data collection and health information management
- Co-ordinate M&E activities being implemented by the MoH & SW.

Coordination of all M&E activities within the Gambia must occur within the MOH & SW and partner agencies. The M&E TWG will play an important role by understanding ministry and partner activities and ensuring integration of data collection systems especially focused on the HMIS. To ensure strong collaboration and integration, the M&E TWG will work closely with the following all the other working groups:

5.4 Key indicators for monitoring the implementation of the M & E plan

The following indicators will be used for monitoring implementation of the M&E Plan for NHSP.

1) A comprehensive M&E plan for NHSP developed and launched.
2) Number of copies of the M&E plan disseminated to the public and private health sector at national and sub-national level.
3) Proportion of health managers and workers trained in M&E.
4) Number/proportion of implementing partners (Technical programmes, NGOs and Private sector) contributing to periodic reports (Target= 90% by 2016).
5) Proportion of planned M&E support supervision visits carried out.
6) Proportion of planned data quality audits conducted.
7) Proportion of departments, programmes, semi-autonomous institutions, CSOs and health facilities submitting timely and complete reports.
8) Proportion of planned periodic reviews that are carried out increased to 100% by 2015.
9) Proportion of planned performance review reports compiled and disseminated.
10) Proportion of planned surveys carried out.
11) Proportion of planned survey reports compiled and disseminated.
12) Number of policy / decision makers oriented in knowledge management methods.
13) Number of performance improvement, planning and resource allocation decisions made based on the M&E results
14) Number of evidence based policy dialogues or briefs made.

5.5 The Key NHSP M&E Plan Implementation Tasks

The key M&E plan implementation tasks will include;

1) Producing annual results oriented Ministerial Policy Statements (MPSs), linked to the corresponding sector budget framework papers and the NHSP.
2) Ensuring that DPI and the DR have adequate capacity for monitoring and evaluation.
3) Ensuring that HMIS and other data collection systems and tools are in place and functioning
4) Training of health workers and managers in M&E.
5) Planning and budgeting for monitoring and evaluation annually. A minimum of 3% of the non-wage recurrent budget and 2% of each project budget should be allocated to monitoring.
6) Holding quarterly performance review meetings to determine progress towards output targets.
7) Providing, on a quarterly basis, data and explanatory information on progress against performance indicators to all relevant stakeholders.
8) Ensuring proper coordination and oversight (monitoring and supervision) of M&E activities in the sector, in relation to the National Policy on Sector M&E policy, related strategies, norms and guidance higher level coordinating institutions.
9) Planning and budgeting for evaluations of all projects and programmes. At least 3% of each project budget will be allocated to evaluation.
10) Utilizing M&E findings to inform programme, policy, and resource allocation decisions.
11) Maintaining a Recommendation Implementation Tracking Plan which will keep track of review and evaluation recommendations, agreed follow-up actions, and status of these actions.
12) Ensuring that complete and approved M&E reports and health statistical data are made easily available to the public in a timely manner and on the website.

5.6 Monitoring the Implementation of the NHSP M&E Plan

Existing sector M&E structures will be strengthened and used for monitoring the implementation of the NHSP M &E plan. Support supervision, meetings and periodic reports will be used for monitoring at the various levels as outlined below.

5.6.1 National Level:

1) Monthly M&E Unit meetings to track progress of the implementation of the M&E Plan.
2) Quarterly integrated supervision to institutions and RHMTs.
3) Quarterly M&E progress reports to be presented at the sector review meetings.
4) Mid-term and end evaluation of the NHSP M&E plan

5.6.2 RHMT Level:

1) Monthly RHMT meetings to track progress on implementation of the regional M&E plan.
2) Monthly supervision to HFs

3) Quarterly RHMT M&E progress reports to be presented at RHMT performance review meetings.

5.6.3 Health Facility level:

1) Monthly meetings to track progress on implementation of the HF M&E plan.
2) Monthly supervision to PHC villages.
3) Quarterly M&E progress reports to be presented at HU management committee performance review meetings.

5.7 Key Stakeholders

There shall be a transparent and documented process to ensure input of a broad range of stakeholders in the NHSP monitoring and evaluation. Operationalization of the M&E plan will involve institutions at various levels of the health sector as outlined below.

a) Central Level: This level includes: The legislature, cabinet, MoH & SW directorates, semi-autonomous institutions, Hospitals, Development Partners, (i.e. Donors, international development agencies), Private Sector, NGOs and private not for profit (PNFPs) operating at national level.

b) Regional Level: This level includes the RHMTs, Regional hospitals etc.

c) Community level: This level includes the PHC village health workers etc.

5.8 Roles and Responsibilities for the NHSP M&E Plan Implementation

The sector-wide M&E system for effective tracking, evaluation and feedback of the NHSP implementation and results will be followed. This implies all relevant stakeholders. Consequently, a participatory approach that entails the involvement of all key actors and primary stakeholders will be adopted. This will enable all key actors to fully internalize and own the system as well as use the results to inform their actions. All other monitoring plans in the sector will be aligned this overall M&E plan for the NHSP at national and regional level. In order to avoid over-laps, role conflicts, and uncertainty in the M&E function during the implementation of the NHSP roles and responsibilities of key actors are specified below.

5.8.1Cabinet/Parliament

The Sector shall work closely with the relevant committees of parliament and cabinet for;

a) Overall political, and policy oversight.
b) Review of sector progress in the past year (based on the AHSPR), against the policy imperatives set out in contribution towards the second NHP and NDP.

c) The health sector shall interface with parliament and cabinet whenever necessary and during the JRM of the Health Sector.

5.8.2 Top Management

The sector top management will be responsible for;

a) Overall political, and policy oversight in the sector.
b) Providing governance and partnership oversight to the sector.
c) Reviewing of sector progress in the past year (based on the AHSPR), against the policy imperatives set out in the NHP2012-2020 and PAGE.
d) Articulating the policy direction for the sector, taking broader Government objectives into consideration.
e) Monitoring adherence to the policy direction of the sector.
f) Mobilizing resources for achievement of the sector policy direction

5.8.3 DPI

The DPI will be responsible for guiding technical direction, including to:

a) Ensure that Units assign adequate staff for statistical production, monitoring and evaluation.
b) Monitoring health sector performance
c) Establishing the results framework for the NHSP and for ensuring that relevant departments (and relevant non-state actors) develop results indicators that are consistent with the NHSP
d) Ensure proper coordination and oversight (monitoring and supervision) of M&E activities in the sector, in relation to the National Policy on Sector M&E policy, related strategies, norms and guidance from other coordinating institutions.
e) Ensure training of health workers and managers in M&E.
f) Quality assurance of the statistical and other performance monitoring reports; and surveys.
g) Organizing regular NHSP sector review meetings.
h) Support RHMTs to organize regular performance review meetings;
i) Producing the quarterly and annual health sector performance reports,
j) Providing on a quarterly basis, data and explanatory information on progress against performance indicators
k) Maintaining a Recommendation Implementation Tracking Plan which will keep track of review and evaluation recommendations, agreed follow-up actions, and status of these actions.
l) Coordinating focused evaluation on emerging concerns and impact assessment studies.
m) Utilizing M&E findings to inform programme, policy, and resource allocation decisions;

The proposed Monitoring and Evaluation Unit will be responsible for overall coordination and implementation of the NHSP M&E plan. The program M&E Focal persons/ Specialists will work under the overall stewardship of the M & E unit. They will be responsible for analyzing data and assembling monitoring reports that will be reviewed and verified by Heads of Departments before submission to the M&E Unit. The M&E unit will use the statistical information generated by HMIS, administrative reports, integrated supervision Technical supervision reports to generate and disseminate relevant sector reports.

5.8.4 MoH and SW programmes, Departments and Semi-autonomous Institutions

Central level bodies will be centers for performance monitoring as well as reporting on progress against Ministerial Policy Statements, including against the targets and actions set out in the PAGE. They will also be the direct consumers of the outputs and outcomes of this M&E strategy. The focus of the central level M&E activities will be on service delivery, compliance with national standards, outputs and outcomes, including to:

a) Produce results orientated annual operational plans.
b) Ensure proper coordination of monitoring activities at departmental / institutional levels.
c) Provide timely and quality data on relevant performance indicators to the M & E unit.
d) Assign one or more positions responsible for statistical production, monitoring and evaluation.
e) Train health workers and managers in M&E.
f) Maintain a recommendations implementation tracking plan which will keep track of review and evaluation recommendations agreed follow-up actions, and status of these actions.
g) Utilize M&E findings to inform programme, policy, and resource allocation decisions.

5.8.5 Technical Working Groups and (sub) Committees

Actual technical coordination will be through the technical working groups, each focused on specific technical areas. This will be the forum through which technical issues are debated and agreed and specific recommendations and actions are implemented. All the technical working groups and committees will be managed through the Senior Management Committee (SMC) and the sector working group. Technical Working Groups will be as follows:

1) Health Sector Budget WG;
2) Human Resources WG;
3) Health Infrastructure WG;
4) Medicines and Health Commodities Management & Procurement WG;
5) Supervision, Monitoring & Evaluation WG;
6) Public Private Partnership for Health WG;
7) Maternal, Neonatal and Child Health WG;
8) Environmental Health and Nutrition WG
9) Health Education and Promotion WG;

10) Communicable Disease Control WG;
11) Nutrition WG;
12) Non Communicable Diseases Control WG.

The TWGs will be responsible for;

1) Tracking and coordinating the implementation of the M&E plan and promoting joint monitoring and evaluation of the NHSP for the respective program areas.
2) Participating in the JRM and preparation of the AHSPR
3) Submitting reports for discussion during the monthly SMC meetings and policy issues submitted for discussion in the quarterly sector coordinating committee meetings.
4) Meeting regularly with partners to track progress of achievement of intended NHSP results
5) Conducting joint field monitoring to measure achievements and constraints that impede the realization of the NHSP targets
6) Identifying and document lessons learnt
7) Identifying capacity development needs, particularly in areas of monitoring and evaluation.

5.8.6 The Monitoring and Evaluation unit/Resource Center

The M & E unit/RC will have the primary responsibility of;

1) Coordinating and operationalizing the Health Sector M & E system at all levels.
2) Strengthening capacity for collection, validation, analysis, dissemination and utilization of health information at all levels;
3) Generating health statistical data on quarterly and annual basis.
4) Ensure that complete and approved M&E reports and health statistical data are made easily available to the public in a timely manner.

The M & E unit/Resource Centers will serve as repository for health data and information at the national level.

5.8.7 Regional levels

Will be responsible for;

i) Producing results orientated annual operational plans
ii) Ensuring proper coordination of monitoring activities at regional levels and the HFs
iii) Training of health workers and managers in M&E.
iv) Providing timely and quality data on relevant performance indicators to the MoH & SW M & E unit
v) Assigning one or more positions responsible for health statistical production, monitoring and evaluation.

vi) Maintaining a Recommendation Implementation Tracking Plan which will keep track of review and evaluation recommendations, agreed follow-up actions, and status of these actions.
vii) Utilizing M&E findings to inform programme, policy, and resource allocation decisions.

5.8.8 Development Partners

Will be responsible for;
i) Providing an external perspective on the health sector performance and results.
ii) Participation in the refinement of indicators tools and processes.
iii) Integration of development partners" monitoring frameworks into Government systems
iv) Providing feedback to domestic and international constituencies on health sector performance and results
v) Assisting the health sector through financial, technical and other forms of assistance to strengthen M&E performance.
vi) Utilizing M&E findings to inform programme, policy, and resource allocation decisions.

5.8.9 Other executing agencies (NGOs and Private sector)

The role of the private sector in the implementation of the NHSP M&E strategy will be; Contribution in the development of and adherence to the necessary M&E standards.
i) Participating in public sector planning processes at regional and sector level.
ii) Providing quarterly performance reports and quality data to the relevant programme managers / focal persons at national and regional level. These will be compiled as part of departmental reports to be reviewed by relevant working groups for onward transmission to SMC or regional Technical Planning Committee (TPC).
iii) Participating in discussion and decision-making committees at programme, sector and national level that review and comment on public sector performance.
iv) Maintaining a Recommendation Implementation Tracking Plan which will keep track of review and evaluation recommendations, agreed follow-up actions, and status of these actions.
v) Utilizing M&E findings to inform programme, policy, and resource allocation decisions.

The NGO umbrella body will play a coordination role in monitoring all NGOs to ensure alignment with national priorities.

5.8.10 Health Facilities

Will be responsible for;
i) Overseeing monitoring activities at HF and PHC village level.
ii) Ensuring that the HF and PHC villages adhere to the M&E plan.
iii) Maintaining a Recommendation Implementation Tracking Plan which will keep track of review and evaluation recommendations, agreed follow-up actions, and status of these actions.
iv) Utilizing M&E findings to inform programme, policy, and resource allocation decisions.

5.8.11PHC village's responsibilities will be to:

i) Provide information on; i) delivery of various services, ii) transparency and accountability of resources accorded; and iii) challenges and gaps experienced in delivery of various services.

ii) Validate outcomes of implementation of the NHSP in their respective areas.

iii) Support communities to be engaged in the review process using participatory appraisal mechanisms like focus group discussions and community meetings.

5.8.12 Households Actors

These comprise individual citizens and constitute the primary beneficiaries of the NHSP strategies and initiatives. The role of the citizens within the M&E strategy is to provide information on the NHSP implementation and delivery of target outputs as well as validate results thereof. **Village Health Team (VHT)** The VHT is defined for each village in the country, to guide discussion on health and health related issues affecting their community. The VHT shall use data from the Community HMIS to discuss performance within the community, and agree on priorities to focus on. A standard planning, and reporting format, tools and process will be provided to the VHT, to guide them in their deliberations.

5.8.13 Bureau of Statistics (GBOS)

Will be responsible for;

i) Coordinating, supporting, validating and designating as official any statistics produced by GBOS

ii) Coordinating and clearing all censuses and nationally representative household economic surveys.

iii) Ensuring production, harmonization and dissemination of statistical information.

iv) Strengthening statistical capacity of planning units in MoH and LGs for data production and use.

v) Ensuring best practice and adherence to standards, classifications, and procedures for statistical collection, analysis and dissemination in MoH and LGs.

vi) Ensuring that complete and approved M&E reports and health statistical data are made easily available to the public in a timely manner.

5.8.14 Research institutions

Research activities by academic institutions that are related to the M&E will also contribute in this regard and will periodically present their finding to the MoH & SW.

6 References/bibliography

1. Guidance for Monitoring and Evaluation of National Health Strategies, WHO 2010.

2. The Gambia National Health Sector Strategic Plan (NHSP) 2014-2020

3. The Gambia National Health Policy, 2012

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7. Monitoring, evaluation and review of national health strategies. A Country-led Platform for Information and Accountability. International Health Partnership+ and WHO, November, 2011

8. Ministry of Health and Social Welfare, The Gambia, rapid assessment of the monitoring, evaluation and review system for the Gambia National Health Strategic Plan (NHSP), December, 2014

Annex 1 Indicators for quarterly and annual performance measurement

Broad categories

- I. UTILISATION (OUTPATIENT AND INPATIENT)
- II. DISEASE SPECIFIC INDICATORS
- III. REPRODUCTIVE HEALTH
- IV. CHILD HEALTH AND IMMUNIZATION
- V. OUTREACH TO THE COMMUNITY AND POPULATION COVERAGE
- VI. MANAGEMENT
- VII. OTHERS-FINANCIAL (ONLY APPLY AT NATIONAL LEVEL)

UTILISATION AND DISEASE-SPECIFIC INDICATORS

1) OPD utilization rate
2) Bed occupancy rate
3) Malaria incidence
4) Malaria-case fatality rate in children under 5
5) ARI-pneumonia case fatality rate in children under five years
6) Diarrhoea case fatality rate in children under five years of age
7) Age-sex urban/rural specific HIV sero-prevalence rates
8) HIV sero-prevalence among mothers attending antenatal care
9) Number of new cases of acute flaccid paralysis (AFP)
10) Cumulative incidence of sexually transmitted infections
11) Percentage of new TB smear positive cases detected under DOTs
12) Percentage of TB patients who have HIV test and results given
13) Number of TB cases notified per 100, 000 population per year
14) Percentage of new smear positive TB patients successfully treated
15) Incidence and 5 year survival rate of common cancers (breast, liver, prostate, lung and lymphoma)
16) Percentage of those with cataract who have been managed and regained

II. REPRODUCTIVE HEALTH INDICATORS

17) Proportion of women who register in the first trimester of pregnancy

18) Tetanus Toxoid Coverage
19) Coverage of pregnant women with 2 or more intermittent preventive treatment for malaria using SP
20) Percentage of deliveries taking place in a health facility
21) Percentage of deliveries attended by a skilled health worker
22) Caesarean section rate (number of caesarean section sections per 1,000
23) Family planning new acceptors
24) Contraceptive prevalence rate
25) Percentage of pregnant women who received antenatal care services(at least four visits)
26) Percentage of women screened for cervical cancer
27) Percentage of women screened that are managed for cervical cancer
28) Proportion of family planning users issued with the barrier method
29) Proportion of pregnant women screened for syphilis
30) Proportion of pregnant women reactive to syphilis
31) Proportion of pregnant women treated for syphilis
32) Proportion of pregnant women screened for other STIs
33) Proportion of pregnant women treated for other STIs
34) Proportion of pregnant women reactive to syphilis who had their partners treated
35) Number of persons aged 15-49 sensitized on Sexual and Reproductive Health
36) Number of people screened for STIs
37) Number of people treated for STIs
38) Number of communities sensitized on SRH issues

III. CHILD HEALTH AND IMMUNISATION INDICATORS

29) BCG immunization coverage
30) DPT 3 immunization coverage
31) Measles immunization coverage
32) Percentage of fully immunized children (PENTA-3)
33) Percentage of under five children registered
34) Underweight prevalence at measles immunization

IV. OUTREACH TO THE COMMUNITY AND POPULATION COVERAGE INDICATORS

35) Access to basic health care package

36) Percentage of population satisfied with health services
37) Percentage of villages with village health committees
38) Percentage of households with access to safe water
39) Percentage of planned outreach activities conducted
40) Number of trained active community health workers per village

V. MANAGEMENT INDICATORS

41) Percentage of facilities without any stock-outs (for a week) for 14 tracer essential medicines
42) Proportion of health centres with at least the minimum staffing norms
43) Daily staff workload
44) Average number of supervision visits
45) Percentage of agreed funding allocation received at provincial level
46) Display of current user charge rates
47) Proportion of PHC villages with VSGs trained on management
48) Proportion of PHC villages with VDCs trained on management (define what mgt constitutes)
49) Proportion of health facilities (secondary and tertiary) with fully functional ambulance services
50) Proportion of facilities with a stock out of fuel when ambulance services are needed
51) Proportion of facilities with a stock out of fuel when trekking services are needed
52) Number of health facility refurbished with power supply (generator, solar)
53) Proportion of facilities that have timely HMIS reporting
54) Proportion of facilities that have timely IDSR reporting
55) Proportion of facilities that have complete HMIS reporting
56) Proportion of facilities that have complete IDSR reporting
57) Proportion of planned data quality audits that are conducted
58) Proportion of planned quarterly HMIS bulletins that are produced
59) Percentage of approved vacancies that are filled by level
60) Proportion of healthcare providers in rural and urban areas
61) No. of health workers per 10 000 population

62) No. of doctors per 10 000 population
63) No. of nurses per 10 000 population
64) No. of midwives per 100 000 population
65) Doctor-patient ratio
66) Nurse-patient ratio
67) Proportion of approved posts that are filled at the level of the Ministry of Health
68) Proportion of health workers benefiting from incentives
69) Attrition rate by cadre
70) Proportion of hospitals, major and minor health centres with functional laboratory services
71) Proportion of hospitals, major and minor health centres with functional radiology services
72) Number of activities held for the dissemination and utilization of health research findings
73) Proportion/number of registration centres computerized and networked
74) Number of service providers trained on database and data collection tools
75) Proportion of health facilities connected to the internet
76) Implementation rate of the training plan

VI. OTHERS INDICATORS (ONLY APPLY AT NATIONAL LEVEL)

77) General government expenditure on health as % of GDP
78) Total expenditure on health as % of GDP
79) General government expenditure on health as % of total expenditure budget
80) Percentage of total budget released on time to the health sector
81) Total public (Government and donor) allocation to health per capita
82) Percentage of un-earmarked donor funds to the health sector
83) Percentage of co-operating partners using a single set of procurement procedures
84) Private expenditure on health as % of total expenditure on health
85) Prepaid and pre-pooling funds as % private sector expenditure on health
86) Out of pocket expenditure as a % of private expenditure on health
87) External resources on health as % of total expenditure on health
88) Total expenditure on health per capita (at PPP international dollar rate)

89) Total government expenditure on health per capita (at PPP international dollar rate)
90) % of public social health insurance to total health expenditure
91) % of private health insurance to total health expenditure
92) % expenditure of primary and secondary level health care services over total government health expenditure
93) Proportion of population covered by community health financing mechanisms or social health insurance.

Annex 2 Comprehensive indicator matrix

Key: Red= Impact, White=Outcome, Green =Output, Blue =Process, Grey=Input

No	Indicators	Baseline	Target	Data Source	Frequency	MOV	Critical Assumptions	Responsible Party
1	Number of neonatal deaths per 1000 Live Births	22/1000 LB (2013)	15/1000 LB by 2020	Health facility registers	Annual	HMIS annual report, RCH reports	skilled attendants at deliveries are increased Increase demand for service utilisation	RCH, DPI,DHPE,RHTs
2	Maternal mortality ratio per 100,000 live births	433/100,000 in 2013	315/100,000 by 2020,	DHS, Other Surveys	3-5 years	Survey reports	skilled attendants at deliveries are increased Increase demand for service utilisation	RCH, DPI,DHPE,RHTs
3	Proportion of women who register in the first trimester of pregnancy	13.30%	80%	HMIS	Annual	HMIS annual report, RCH reports		RCH, DPI,DHPE,RHTs
4	Indicator for (promote and enhance infection-free sexual and reproductive health) is needed							
5	Birth attended by skilled health personnel	57.20%	80%	Surveys				
6	Percentage of deliveries taking place in health facilities			HMIS	Annual	HMIS annual report, RCH reports		
7	Percentage of pregnant women who received antenatal care services(at least four visits)	72% in 2010 (Baseline DHS 2013 and HMIS 2014)	80% by 2020	ANC Registers	Annually	Annual Reports	Antenatal coverage improved	RCH, HMIS,RHTs
8	Infant mortality rate per1,000 live births	34/1000 LB in 2013	24/1000 by 2020	Registers, surveys	3-5 years	Survey reports	maintained High immunisation coverage, Strengthened IMNCI and C-IMNCI	RCH, IMNCI,EPI, DHPE,
9	Under five Mortality rate per 1000 Live Births	54/1000 in 2013	44/1000 by 2020	Registers, surveys	3-5 years	Survey reports	maintained High immunisation coverage, Strengthened IMNCI and C-IMNCI	RCH,EPI,IMNCI,DHPE,RHTs
10	Contraceptive prevalence rate (CPR)	9% in 2013	25% in 2018	DHS	Every five years	Survey reports	Contraceptives available, accessible, affordable and acceptable	RCH,DHPE, RHTs
10	Percentage of women screened for cervical cancer	NA	50% by 2018	Health Facility Registers	quarterly and annually	RCH annual Reports	women voluntarily go in for cervical cancer screening	RCH,EPI,DHPE,RHTs
11	Percentage of women managed for cervical cancer							
12	Proportion of PHC Villages with VSG's							

	trained on management							
13	Proportion of PHC Villages with VDC's trained on management	None	200 VDC's, 200VSG's	Minutes	quarterly	Reports	Availability of funds	DHS/DPI/PHC Coordinator
14	Proportion of facilities with no stock out for one week	None	1	Invoices,	Bi annually	NPS registers	Availability of funds	NPS
15	Percentage of fully immunized children (Penta 3)	97 % in 2013	97% by 2020	EPI Cluster survey/ HMIS	Annually	EPI cluster survey report	maintained immunisation coverage	EPI, RCH, EDC, RHTs
16	Malaria incidence	103/1000 in 2013	Reduced by50% by 2015	HMIS	Monthly, Quaartely	Reports	Increse funding for malaria	NMCP,NPHL,NPS, RHTs
17	Prevalence of HIV and AIDS in the general population	1.8% (GBoS 2013)	0.5% by 2020	DHS	5-10 years	reports	Uptake of VCT increased among the sexually active population	NACP, NPHL, NAS, GBoS and RHTs
18	HIV Zero prevalent among Mother attending antenatal care			Sentinal Surveillance	Annual			
19	Prevalence of of HIV1 and HIV 2 in the general population	HIV1-1.57 and HIV2 - 0.26	HIV1-0.5 and HIV2-0.1 by 2020	NSS	Annually	reports	Uptake of VCT increased among the sexually active population	NACP, NPHL, NAS, GBoS and RHTs,
20	OPD utilization per capita							
21	Percentage of new smear positive cases detected under DOTS	70% (2013)	90% by 2020	Registers	Annually	TB prevalence surveys and annual reports	early case detectiion of TB within 1 to 2 weeks onset of symptoms	NLTP, NPHL, NPS, RHTs
22	Percentage of TB patients who had HIV test and results given	83% in 2012	95% by 2020	TB/VCT registers	Monthly, Quarterly, Annually	TB annual reports, TB case notification reports	95% of TB patients tested for HIV/AIDS by 2020	NLTP, NACP,NAS, NPHL, NPS, RHTs
23	Number of TB cases notified per 100, 000 population per year	57/100,000						
24	Percentage of new smear positive TB patients successfully treated	88% in 2013	95% by 2020	TB registers	Quarterly, Annually	TB case notification reports	TB patients will successfully complete treatment by 2020	NLTP, NACP,NAS, NPHL, NPS, RHTs
25	Prevalence of NCD risk factors	24% in 2010	20% by 2020	NCD stepwise survey	3-5 years	Survey report	Improved healthy lifestyles	DHPE/NCD,DSW,RHTs
26	Incidence and 5 year survival rate of common cancers (breast, liver, prostate, lung and lymphoma)							
27	Prevalence of cataract							

28	Percentage of those with cataract who have been managed and regained							
29	% of straight forward cataract having surgery and regain visual acuity		no less than 6/18 with best correctio n by 2015					
30	Proportion of health facilities (secondary and tertiary) with fully functional ambulance services	9	45	RfH database	Annual	Report Fleet inventory	Availability of funds	RfH/MOH&SW/MOFEA
31	Proportion of facilities with a stock out of fuel when ambulance services are needed							
32	Proportion of facilities with a stock out of fuel when trekking services are needed							
33	Percentage of programs with adequate functional transport and logistics	NA	100%	RfH database	Annual	Report fleet inventory	Availability of funds All units with functional transports	RfH/MOH&SW/MOFEA
34	% of health facility refurbished with power supply (generator, solar)	7	35	PCU	Annual	Reports	Availability of funds	PCU, MOHSW
35	Number of biomedical engineer and technicians equipped with tools and spare parts	NA	8	MOHSW	Annual	Reports	Availability of funds	MOHSW
	Proportion health facilities submitting annual biomedical equipment							
36	Proportion of planned trainings of biomedical engineers and technicians actually conducted	0	20	DHR	Annual	Nominal roll	Availability of finds	MOHSW
37	Timeliness HMIS reporting							
38	Completeness of HMIS reporting							
39	Timeliness of IDSR reporting							
40	Completeness of IDSR reporting							
41	% of planned data quality audits							

	conducted							
42	% of quarterly HMIS bulletins per year							
43	Conduct training at all level on DHIS2							
44	Proportion of data sources integrated to DHIS2	80.0%	100%	HMIS Database	once	DHIS2	Commitment and funding	DPI
45	Proportion of HFs with at least one member trained on HMIS	375	900	HMIS Database	Annual	certificates and training reports	Availability of funds	DPI
46	Proportion of HFs displaying key NHSP indicators every quarter							
47	Proportion of diseases of outbreak potentials that are investigated and responded within 24 hours	70.0%	100%	HMIS Database	Monthly	monitoring report	Availability of funds	DPI
48	% of total health budget spent on health % of total external project aid made available to health research	0	2% of total health budget and 5% of total external project aid to be made available to health research	National Budget	Annual	Budget estimate of health	Availability of funds	DPI
49	Availability of priority setting mechanisms for health research	NA	availability of an annual agenda for health research	Health research policy and strategic plan	Annual	priority setting agenda	Availability of the research priority setting agenda	DPI
50	% of planned activities held for the dissemination and utilization of health research findings	2	bi-annual National Health Research Conferences	Research Unit	bi-annual	Conference reports	Availability of funds, abstracts & researches. Utilization of research findings to inform policy and decision-making	DPI
51	Percentage of under five children registered	52.5%	80.0%	DHIS	Annual	Records, birth certificate	Availability of funds	BR, H4, LGA
52	Proportion/number of registration centres computerized and networked	None	All registration centres	ICT Unit	Annual	IT Records	Funding, administrative commitment	BR, H4
53	% of communities sensitized on birth and deaths	NA	All communities	Sensitization reports	Quarterly	Sensitization schedules, reports	Funding	BR, Health Promotion, UNICEF, LGA

	registration at least once a year							
54	% of service providers trained on database and data collection tools	NA	All registration officers	HRIS	Annual	Training reports	Funding, trainers, manuals	DHR, BR, H4
55	% of computers licensed and protected	20 computers	100%	ICT records	Annual	Licenses	Availability of funds	DPI
56	Proportion of health facilities connected to the internet	33.0%	100%	ICT records	Annual	VPN	Funding, availability59 of electricity supply	DPI/ISPs
57	Number of computers available		100%	ICT inventory	Quarterly	monitoring report	Availability of funds, ICT tools	DPI
58	Number of ICT staff trained	Zero (specialized training)	4	Certificates	Annual	Certificates	Availability of funds	DPI/DHR
59	Prevalence rate of communicable diseases	NA	70% by 2020	Survey	bi-annual	Survey reports	Enhanced and case based surveillance, appropriate case management	EDC, NMCP, NTLP, NACP, NECP, RHTs
60	% of health facilities with at least one staff trained		75% health care providers trained	iHRIS	Annual	Training reports	Availability of funds & administrative commitment	DHR, PMO
61	Percentage of approved vacancies that are field with qualified staff	NA	100%	Budget estimate, staffing norm, personal files	Annual	iHRIS	Availability of funds, availability of the required staff	DHR, PMO
62	Proportion of healthcare providers in rural and urban areas		1.5/1000	iHRIS, staffing norms, posting and redeployment reports, HMIS Database	Annual	Staff profile	Availability and willingness of the staff to accept postings, Availability a functional postings committee,	DHR, PMO
63	Health worker population ratio	0.9/1000	1.5/1000	iHRIS, staffing norms, posting and redeployment reports, HMIS Database	Annual	Staff profile	Availability a functional postings committee, availability of funds for training, availability of candidates	DHR, PMO
64	Proportion of health workers benefiting from incentives		100%	IFMIS	Annual	Salary slip, salary vouchers, IFMIS	Availability of funds	MOFEA
65	Attrition rate for health workers		Reduce attrition by 50% by 2020	iHRIS, PMO HR Database, HMIS Database	Annual	iHRIS, monitoring reports, quarterly reports from regions	Availability of funds, commitment from the regions	DHR, RHTs
66	Proportion of staff appraised annually	NA	All categories of healthcare providers	Appraisal reports	Annual	Appraisal reports, completed appraisal forms	Commitment at all levels, availability of appraisals tools, availability of tools	DHR, Directors, Program/Unit Heads
67	Proportion of data	80.0%	100%	HMIS	once	DHIS2	Commitment and	DPI

	sources integrated to DHIS2			Database			funding	
68	% of HF with at least one staff trained on HMIS	375	900	HMIS Database	Annual	certificates and training reports	Availability of funds	DPI
69	Availability of a fully functional National Health Research Council	NA	1	Act of parliament	To be determined	meeting reports &financial records	Availability of personnel and funding to make it functional	DPI
70	Availability of priority setting mechanisms for health research	NA	availability of an annual agenda for health research	Health research policy and strategic plan	Annual	priority setting agenda	Availability of the research priority setting agenda	DPI
71	Availability of ICT policy and strategic plan	NA	One					
72	Number of computers licensed and protected	20 computers	100%	ICT records	Annual	Licenses	Availability of funds	DPI
73	Proportion of health facilities connected to the internet	33.0%	100%	ICT records	Annual	VPN	Funding, availability of electricity supply	DPI/ISPs
74	Number of computers available		100%	ICT inventory	Quarterly	monitoring report	Availability of funds, ICT tools	DPI
75	Number of ICT staff trained	Zero (specialized training)	4	Certificates	Annual	Certificates	Availability of funds	DPI/DHR
76	Implementation rate of the Training Plan		100%	Training reports	Annual	Training reports	Availability of funds	DHR, PMO
77	Number of staff trained		75% health care providers trained	iHRIS	Annual	Training reports	Availability of funds & administrative commitment	DHR, PMO
78	Proportion of healthcare providers in rural and urban areas		1.5/1000	iHRIS, staffing norms, posting and redeployment reports, HMIS Database	Annual	Staff profile	Availability and willingness of the staff to accept postings, Availability a functional postings committee,	DHR, PMO
79	Availability of health financing policy	Draft stage	Finalize the report by 2015	MOH&SW/DPI	Every five years	Final health financing policy	Availability of funds	MOH&SW/DPI
80	Percentage of National budget to health	10.5% in 2013	15% by 2018	Budget Estimates	Annual	Reports	Adequate funding from government	Budget Committee

81	Availability of revenue pooling scheme	N/A	Revenue pooling scheme established by 2015	MOH&SW/MOFEA	Every five years	Health financing policy, NHA and other Reports	Strong MoH&SW SMT will and commitment	MOH&SW/DPI
82	Allocate Resource and purchase based on needs assessment and priority	N/A	Resource allocation and purchase criteria in place by 2016	MOH&SW/DPI	Annually	Need assessment and procurement reports	Management (SMT) will and commitment	Budget Committee
83	Increase budgetary allocation to enhance access and availability of quality essential medicines	40 (GMD) million in 2014	200 million (GMD) by 2015	MOH&SW/NPS	Annual	Reports and budget estimates	Adequate budget allocation	MOH&SW/NPS
84	% of hospitals, major and minor health centres with functional laboratory services	38 fully functional laboratory services in minor health centres	All hospitals, major, and minor health centres (53) by 2020	MOH&SW/NPHL	Annual	Supervisory reports	Availability of functional laboratory services in all hospitals, major and minor health centres	MOH&SW/NPHL
85	% of hospitals and major health centres with functional radiology services	19 Radiographic Assistants and 10 Radiographic technicians	Provide a Radiographer for each unit, 5 Assistants , and 38 Technicians by 2020	HRH	Annual	Supervisory reports	Adequate and accessible radiology services	MOH&SW/Radiology
		4 (29%) fully functional radiographic units across the country	Increase fully functional radiographic units to 100% by 2020			Annual reports /reviews		
86	% of facilities with functional Blood transfusion Centres and services	11 functional blood transfusion facilities	Increase blood transfusion facilities to 13 by 2016	NBTS	Annual	Reports and reviews	Adequate funding for blood transfusion services	MoH&SW/NBTS

			Establish 1 national and 3 regional blood transfusion centres	NBTS		NBTS Strategic plan		MoH&SW/NBTS
87	Availability of updated Acts and Regulations	5 Acts and Regulations	7 Acts and Regulations	MOH&SW	Ad hoc	Review existing Acts and Regulations	Appropriate Acts and Regulations	MOH&SW/Attorney General Chambers
88	PCU strengthen to provide Sector Coordination and partnership	Non	PCU to provide Health Sector Coordination and partnership	PCU	Quarterly	Minutes and Quarterly reports	Commitment of SMT	MoH&SW/PCU

Annex 3 Detailed activities and budget by strategic objective (SO)

	2015	2016	2017	2018	2019	2020
Activities by strategic objective (SO)						
SO 1						
Capacity Need Assessment for DPI and Research	2500					
Recruit one M&E specialist and two M&E officers to the DPI						
Provide office space for the DPI and Research	36000					
Develop Quality audit tools for supervision and monitoring		5500				
Develop Quality Assurance guidelines/Policy for service delivery standards	8000					
Procure hardware and software for the DPI						
24" TFT Monitors		10,000				
Dock able Laptop		30,000				
Printers		1,350				
Tablet Computer		2,400				
Heavy Duty Photocopiers/Printer/Scanner		20,000				
LCD	1600			3000		
HP Docking Station		20000				
Wireless Key Boards and Mousses		15000				
HP ProLiant Server		10000				
VPN						
TB Portable Hard Drive		1800				
Software Licensing (Antivirus)	1800	600	1800	1800	1800	1800
Back-up UPS		8000				
Router		600				
Internet Service Provider Fee	136000	136000	136000	136000	136000	136000
Switch		400			200	
network trunks		19500				
Network Cables (Cat6 cable)		1350				

Office support (stationery, and other supplies)					
A4 Papers					
Arch Files					
Filing Cabinets (Fire Proof)					
Transport and logistics		50000			
Fuel and Lubricants					
Maintenance/Spare Parts					
Conduct masters level training					
- Public Health x					
-Health services management x					
-Epidemiology x		20000	20000		
-Biostatistics x		20000	20000		
Health Care Financing/Health Economics		20000	20000		
Health System Planning					
Geographical information systems-GIS					
- Quality assurance and control x					
-Human Resource for Health x					
- ICT					
- Health/Medical Informatics		20000	20000		
- Health System Research					
Conduct short course training for programmes and RHMTs					
- Health services management	6000	6000	3000	3000	
- Monitoring and evaluation	6000	6000	3000		
Health Economics/Financing		3000	3000		
- Quality assurance and control	3000	3000			
- Public Sector Management	3000	3000		3000	
- Disease prevention and control	6000	3000	6000	6000	
- Health/Medical Informatics	6000	3000	3000	3000	3000
- Technical Programmatic Areas	3000	6000	3000		
- Epidemiology/Biostatistics	6000		3000		
- Health Management Information System	6000	3000	3000	3000	
- Community Health and Health Promotion		3000	6000	3000	
- ICT	6000	3000	3000	3000	
Health Planning Policy and Financing	3000		3000	3000	
- Project Planning and Management	3000	3000			
In collaboration with the School of Medicine and Allied Health Sciences, develop fellowship		50000			

programme for programme managers and RHMTs						
In collaboration with the School of Medicine and Allied Health Sciences, develop Field Epidemiology Laboratory Training Programme (FLETP) for programme managers and RHMTs		50000				
Exchange visits / Study Tour / International Conferences		6000				
Energy Backup	30000					
Maintenance						
SO2						
Launch NHSP and M & E Plan	2000					
Produce and disseminate NHSP	10000					
Produce and disseminate M & E Plan	10000					
Produce and disseminate M & E indicator handbook and data analysis guide	10000					
Conduct comprehensive review of the HMIS to tailor it to the requirements of the NHSP (TA and Workshop)	50000					
Develop planning guidelines for all levels	7000					
Train technical programmes and RHMTs in planning and M & E	50000					
Support technical programmes and RHMTs to develop AOPBs and M & E plans	800	800	800	800	800	800
Develop check list for integrated support supervision and mentoring (Workshop)	4000					
Conduct quarterly M & E WG meetings among M&E stakeholders	2000	2000	2000	2000	2000	2000
Conduct quarterly integrated support supervision	400	400	400	400	400	400
Conduct quarterly technical programme planning and review meetings	1200	1200	1200	1200	1200	1200
Conduct bi-annual regional planning and review meetings	10000	20000	20000	20000	20000	20000
Conduct Annual Health Sector review meetings	15000	15000	15000	15000	15000	15000
Produce and disseminate quarterly performance assessment reports	2000	4000	4000	4000	4000	4000
Produce and disseminate annual health sector performance reports (AHSPR)	2250	2250	2250	2250	2250	2250
Conduct midterm review (MTR) of the NHSP			20000			

Conduct end term evaluation of the NHSP						20000
Establish the resource center and data repository			100000			
Digital Camera	300					
Maintain the MoH and SW website	1000	1000	1000	1000	1000	1000
Establish a website committee to meet quarterly	1000	1000	1000	1000	1000	1000
SO3						
Review and integrate PHC village registers	9000					
Produce and distribute PHC village registers	14000	6000	4000	4000	6000	6000
Tally Books	56000	56000	56000	56000	56000	56000
Produce and distribute HMIS and IDSR tools for all levels	29200					
Develop training manuals (trainers and trainees) for all levels	81800					
Train trainers of trainees at National and Regional levels	6000					
Train all relevant HF/regional staff in M&E, HMIS/IDSR (procedures, data management and use-DHIS-2)	81800					
Train relevant hospital staff in M&E, HMIS/IDSR (procedures, data management and use-DHIS-2), including ICD	5000					
Tools and Data base development						
Conduct pilot programme for monthly and quarterly reporting using ICD in 3 pilot hospitals	90000					
Develop tools to monitor the quality of health care services provided at all levels	7000					
Conduct quarterly laboratory service quality assurance and control- Internal Reference Lab	3592	3592	3592	3592	3592	3592
Conduct annual laboratory service quality assurance and control – External Reference Lab	861	861	861	861	861	861
Conduct 2 quality of care surveys and service availability and readiness assessments (SARA)			150000		150000	
Procure 50 computers to ensure electronic		75000				

data capture and networking of the Births and Death registration						
Conduct 2 client satisfaction surveys			200000		200000	
Conduct 3 expenditure tracking studies and National health accounts		50000	0	50000	0	50000
Implement M health technology to track key health sector indicators (disease of epidemic potentials, essential medicines and diagnostic)			40000			
Implement Electronic medical record				50000		
SO4						
Conduct stakeholder consultations to formulate bill to establish national health research and ethic council	6000					
Establish operations research WG with clear terms of reference and membership	3200	3200				
Conduct research stakeholders consultations to set priority research agenda	6000					
Conduct quarterly operations research WG meetings	3200	3200	3200	3200	3200	3200
conducted 2 studies to evaluate the impact, effectiveness and cost-effectiveness of health service delivery to facilitate continuous learning, document challenges and lessons learnt)			150000			150000
Conduct 2 international meetings for researchers and policy makers to disseminate and share research findings to facilitate research to policy uptake			50000		50000	
Quarterly research dissemination seminar	2000	2000	2000	2000	2000	2000
SO5						
Collaborate with the national medicine control agency to develop tools for pharmacovigilance	8000					
Integrate all HMIS training to include pharmacovigilance HMIS						
Integrate pharmacovigilance information into routine performance feedback HMIS						
Strategic Objective 6						
Develop standard operating procedures	7000					
Data management						
Develop training manuals (Trainers and trainees) and procedures	7000					
Conduct quarterly data quality audits (DQAs)	6400	6400	6400	6400	6400	6400
Conduct an evaluation of the SM&E					25,000	
GRAND TOTAL PER YEAR	**84903**	**821,403.00**	**1,090,503**	**391,503**	**691, 703**	**483,503**
TOTAL OVER 5 YEARS						**3,880,015**

Annex 4 Major Health Centre Performance Assessment indicators for functionality

Indicator	Baseline (2015)	2016	2017	2018	2019	2020
Proportion of major health centres with a functional theatre						
% of Caesarean Sections done out of the total deliveries in the major HCs						
Proportion of qualified/trained health workers staying at the health facility						
% of major HCs providing the recommended minimum health care package*						
Average length of stay						
Daily Average Occupancy at major HC						
Bed Occupancy Rate						
Proportion of major HC with a functional surgical ward						
Proportion of major HCs with at least 1 Medical Officer						
Death Rate (Deaths out of the total patients admitted)						
Maternal deaths						
Percentage of major HCs providing ART services						

*** Minimum health care package is defined in NHP, 2012**

Annex 5 Minor health centres performance assessment indicators for functionality

Indicator	Baseline (2015)	2016	2017	2018	2019	2020
% of qualified/trained health workers staying at the minor health centres						
% of minor HCs providing the recommended minimum care package*						
Proportion of minor HCs with the recommended staffing						
Average length of stay						
Bed Occupancy at major HC						
Death Rate (Deaths out of the total patients admitted)						
Maternal deaths						
Percentage of minor HCs providing ART services						

*** Minimum health care package is defined in NHP, 2012**

Annex 6 Hospital performance assessment

	Beds	Inpatients	Inpatient Days	Outpatients	Deliveries	Major Operations	ANC	C/S	Immunization	others
Total										
Average										
Minimum										
Maximum										
Average (2015)										

Annex 7 Regional performance assessment indicators (The League Table)

Indicator domain	Indicator	Bottom two	Top two (to receive awards during JRMs)
Health services coverage			
	% pregnant women attending 4 ANC sessions		
	% deliveries in health facilities		
	% deliveries by skilled attendants		
	% children under one year immunized with 3rd dose Pentavalent vaccine		
	% one year old children immunized against measles (m/f)		
	% pregnant women who have completed IPT2		
	% of children exposed to HIV from their mothers accessing HIV testing within 12 months		
	% U5s with fever receiving malaria treatment within 24 hours from VHT		
	% eligible persons receiving ARV therapy		
	% of new TB smear + cases notified compared to expected (TB case detection rate)		
Coverage for other health determinants	% HH with latrine		
	U5 children with height /age below lower line (stunting)		
	% U5 children with weight /age below lower line (wasting) (m/f)		
Prevalence of risk factors	**CPR**		
Health system outputs (availability, access, quality and safety	Per capita OPD utilization rate		
	% of health facilities without stock outs of any of the 14 tracer medicines in previous 3 months		
	% of villages/ wards with trained VHTs, by district		
	% of functional Health Centre IVs (providing EMOC)		
	% Annual reduction in absenteeism rate		
Health investments	Absorption rates of funds provided		