



Health Metrics Network

[Afghanistan] Health Information System: Review and Assessment

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By:

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Acronyms

ANDS	Afghanistan National Development Strategy
APHI	Afghanistan Public Health Institute
BPHS	Basic Package of Health Services
DEWS	Disease Early Warning System
EC	European Commission
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
FFSDP	Fully Functional Service Delivery Point
GD	General Directorate
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
I-ANDS	Interim Afghanistan National Development Strategy
JHU	Johns Hopkins University
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MOPH	Ministry of Public Health
MSH	Management Sciences for Health
NGO's	Non-governmental organizations
NRVA	National Risk and Vulnerability Assessment
NTP	National Tuberculosis Program
PPH	Provincial Public Health
PPHDs	Provincial Public Health Directorates
PPHO	Provincial Public Health Office
Tech-Serve	Technical Support to the Central and Provincial Ministry of Public Health
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization

1. Background

In 2002 the Ministry of Public Health began a process to determine the major issues in the re-development of the national health system. This process resulted in a number of key policy initiatives including the Interim National Health Policy and Interim National Health Strategy 2002-2004, setting priorities and the development of evidence based interventions such as the Basic Package of Health Services (BPHS). These and other issues are also reflected in the new National Health Policy 2005-2009 and National Health Strategy 2005-2006. According to the policy and strategy, stewardship, including leadership, of the health system in Afghanistan is one of the Ministry's main responsibilities. The MOPH fulfils this responsibility in a number of ways, including looking at trends in health priorities and resource generation and their implications, information needs, and generating appropriate data for decision making.

Planning, monitoring and evaluation are key functions of the Ministry. Relevant, accurate, timely and accessible evidence and information on performance of the health system (and its component parts) is key for the Ministry to effectively fulfill its stewardship responsibility. A focus on health outcomes and a results-based culture can only be achieved when relevant information is available. Accountability and transparency within the Ministry and among its NGO partners can only be achieved and maintained if well-founded information is generated and used systematically. Effectiveness of policies, strategies and program implementation cannot be evaluated without sound evidence.

2. Context

After 23 years of war, December 2001 found Afghanistan facing extreme poverty, insecurity, political instability, an appalling infrastructure and large gender disparities. Though it is still early in the post-conflict phase, Afghanistan is addressing these contextual issues. However, the challenges to success are enormous, especially in light of the lack of social and human capital, the absence of government income through taxation or natural resources, the transitional status of the political system and the receipt of relatively little international aid. All these challenges are adding to the complexity of health sector development.

In 2002 the Ministry of Public Health began a process to determine the major issues in the re-development of the national health system. This process resulted in a number of key policy initiatives including the Interim National Health Policy and Interim National Health Strategy 2002-2004, setting priorities and the development of evidence based interventions such as the Basic Package of Health Services (BPHS). These and other issues are also reflected in the new National Health Policy 2005-2009 and National Health Strategy 2005-2006.

According to the policy and strategy stewardship, including leadership, of the health system in Afghanistan is one of the Ministry's main roles. The MOPH carries out this role in a number of ways including looking at trends in health priorities and resource generation and their implications, information needs, and generating appropriate data for policy making. Planning, monitoring and evaluation are also key functions of the Ministry which aim at assessing progress on health outcomes and other results.

2.1. Contracting out.

In 2003 the MOPH had decided to contract out the implementation of basic health services to non-state providers in order to fully concentrate on its role as steward of the sector whilst non-state service providers are contracted to implement services through performance based grant and service contracts in 31 out of 34 provinces. The exceptions are the 3 provinces in which the Ministry, under a special program, strengthening mechanism (MOPH-SM), implements the basic package of health services (BPHS). Two important sets of interventions, for primary health care, the BPHS, and at hospital level, the essential package of hospital services (EPHS) have been formulated. The BPHS involves a defined set of cost-effective interventions with particular attention on women and children, and a strong focus on reaching the rural population and on ensuring equity. The BPHS is the foundation of the Afghan health system and has considerably contributed to the development of the health sector. It is complemented by the EPHS which defines all elements of hospital services and promotes a referral system in synergy with the BPHS.

2.2. ANDS and MDGs

The Interim-Afghan National Development Strategy (I-ANDS) was presented to the international community January 2006. After more development and consultation a final ANDS will be published mid 2008. The strategy lays out the strategic priorities and mechanisms for achieving the Government's development vision. It builds on previous initiatives and incorporates commitments made in the Afghan Millennium Development Goals Report.

Due to the long years of conflict the Afghan government adopted 2003 (instead of 1990) as the baseline year for its Millennium Development Goals (MDGs). Intermediate targets have been set for 2010 in line with the Afghanistan Development Strategy and 2020 has been designated as the year when the full MDG benchmarks will be achieved. Table 1 gives the targets, baselines and indicators as determined by a UN MDG Working Group.

Table 1 - MDGs in Afghanistan

1.1.1.1 Goal #4	Reduce child mortality	Baseline adopted	Numerical target:
Target #5	Reduce by 50%, between 2003 and 2015, the under-five mortality rate, and further reduce the U5MR to 1/3 of the 2003 U5MR by 2020		
Indicator #13	Under-five mortality rate	230/1,000 live births (2003)	115/1,000 live births by 2015 77/1,000 live births by 2020
Indicator #14	Infant mortality rate	140/1,000 live births (2003)	70/1,000 live births by 2015 47/1,000 live births by 2020
Indicator #15	Proportion of 1-year-old children immunized against measles	60% (2004)	90% by 2015
1.1.1.2 Goal #5	Improve maternal health	Baseline adopted	Numerical target:
Target #6	Reduce by 50%, between 2002 and 2015, the maternal mortality ratio, and further reduce the MMR to 25%		

	of the 2003 MMR by 2020		
Indicator #16	Maternal mortality ratio	1,600/100,000 live births (2002)	800/100,000 live births in 2015 400/100,000 live births in 2020
Indicator #17	Proportion of births attended by skilled health personnel	14.3% (2003)	50% by 2015 75% by 2020
1.1.1.3 Goal #6	Combat HIV/AIDS, Malaria and other diseases	Baseline adopted	1.1.1.3.1 Numerical target
Target #7	Have halted by 2015, and begun to reverse, the spread of HIV/AIDS		< 0.5% of population aged 15-49 are HIV positive by 2015
Indicator #18	HIV prevalence among all blood donors		
Indicator #19	Condom use rate of the contraceptive prevalence rate		
Indicator #19(a)	Condom use at last high-risk sex	1.1.1.3.1.1 Indicator deleted	
Indicator #19(b)	Percentage of population aged 15-49 with comprehensive correct knowledge of HIV/AIDS		>= 50% of population aged 15-49 have a correct and comprehensive knowledge of HIV/AIDS by 2015
Indicator #19(c)	Contraceptive prevalence rate	10% of married women < age 50	
ADDED Indicator under Target #7	Proportion of blood samples screened for HIV/AIDS and STDs		100% of blood is screened for HIV/AIDS and STDs by 2015
ADDED Indicator under Target #7	Proportion of women's need for family planning met		50% of the need for family planning of women is met by 2015
ADDED Indicator under Target #7	Proportion of IV drug users treated for their addiction		60% of known IV drug users will be under treatment by 2015
1.1.1.3.2 Target #8	Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases		
Indicator #21	Prevalence and death rates associated with malaria		
Indicator #22	Proportion of population malaria risk areas using effective malaria prevention and treatment measures	≈ 18% of population in high-risk areas use bed nets (2004)	60% by 2010 80% by 2015
Indicator #23	Prevalence and death rates associated with tuberculosis		
Indicator #24	Proportion of TB cases detected and cured under DOTS (Directly Observed Treatment Short Course)		70% of TB will be detected and 85% treated successfully under DOTS by 2015

As part of the process of monitoring progress towards achieving the MDGs, ANDS has set some benchmarks for the relevant entities in Government. The benchmarks for the health sector are that by end 2010:

- The BPHS will be extended to cover at least 90% of the population
- Maternal mortality will be reduced by 15%
- Full immunization coverage for infants under-5 for vaccine preventable diseases will be achieved and their mortality rates reduced by 20%.

3. Resources

The following listing of resources contributing to the Health Information System in Afghanistan clearly indicates that the HMN assessment covers a much larger scope than what is the mandate of the HMIS Unit within the MOPH. Several of the key aspects of HIS are situated outside the MOPH (e.g. within CSO for population-based data). Interpretation of the results should bear in mind that the HMN assessment has evaluated the total picture of HIS in Afghanistan, not only the more narrow activities of the HMIS unit.

3.1. Health Management Information System

The HMIS unit is headed by a national consultant and has four PRRed positions. Its tasks involve collecting routine information on (i) key BPHS services, (ii) CHW activities; (iii) reports on the facility status from the majority of BPHS facilities (85%). Since mid-2006 a routine reporting system for the hospital sector has been introduced. The unit works closely with key departments involved in using information collected by this system such as the Grant Contract Management Unit but the level of involvement of other important units for monitoring service delivery such as EPI and Reproductive Health requires further streamlining and strengthening.

The HMIS Unit provides also Management Information Systems (MIS) support to other MOPH units. It maintains the reference files on administrative units and population data and the inventory of all health facilities registered with the MOPH. It also provides assistance to the HRD for the maintenance of the Human Resources Database, and to the GCMU for the maintenance of the Grants&Contracts database, which tracks the BPHS and EPHS contracted out services. The HMIS unit is strongly coordinating all its activities with the M&E unit. It collaborates closely with the NGOs and UN agencies through an active HMIS TaskForce. It received substantial technical support from USAID through the REACH Project, and recently through the TechServe program, both implemented by Management Sciences for Health (MSH).

3.2. Monitoring & Evaluation

The Monitoring & Evaluation (M&E) unit, likewise the HMIS unit, is headed by a national consultant and has 8 PRRed positions. It aims to coordinate, guide and compare all M&E activities among different departments, NGOs and Provincial Public Health Directorates. Similar to the HMIS unit it closely works with the Grant Contract and Management Unit but its capacities should be more utilized by other departments who on their end should ensure that all M&E activities are in line with the national system. A major activity is supported by Johns Hopkins University / Indian Institute for Health Management Research (JHU/IIHMR) who are contracted by the MoPH as a Third Party Evaluation Team. Within this contract a province-wise National Health System Performance Assessment (NHSPA) is carried out annually and, in a selected number of provinces, biannually to measure progress achieved

in BPHS health facilities. This activity at the same time follows a handover schedule to the MoPH as part of the contract, along with more specific capacity building requirements.

The M&E unit hosts an M&E Board composed by M&E and HMIS staff, technical experts from the EC, MSH and the JHU/IIHMR. The mentioned partners provide important support to the M&E unit in overseeing M&E activities and providing support for developing national tools and guidelines, and preparing and disseminating information analysis. Recently, a National Monitoring Checklist for use by national and provincial MOPH monitoring missions has been put in use, and the M&E unit manages a database with the results of the checklist by facility.

3.3. Provincial Public Health Directorates

The provincial level plays an important role in collecting, processing and analyzing information on health related issues in their respective provinces. The General Directorate for Provincial Public Health at the central MoPH levels oversees 34 Provincial Public Health Directorates (PPHD), each of which has undergone the PRR process. Provincial Teams now consist of nine officers, among them one technical officer for HMIS. The Provincial Public Health Coordination Committee (PPHCC) that involves key partners in health, as outlined in its terms of reference, should provide support to monitoring and evaluation activities of the PPHD and even facilitate joint missions in this regard. However, there is an urgent need not only to build capacities at provincial level in order to ensure ownership of service implementation and strengthen the MoPH's stewardship role but also to examine the scope of information that are required for assessing the health system at provincial level.

3.4. The Afghan Public Health Institute

In order to make long term policies and synthesize all the information coming to the Ministry and making it relevant to the policies and plans, the MOPH recently revived the Afghanistan Institute of Public Health. The APHI has a mandate to serve as a think tank and provide management inputs to the ministries programs. It also leads efforts in stewardship functions of the ministry. The core stewardship functions are establishing the institutional network, generating appropriate information for policy making, setting priorities, and determining trends in health priorities, generating resources and coordination. It has six departments, surveillance and Research, Policy and Strategy department, Public Health Training Management department, Information, Education and Communication department, Public Health laboratories department and Food and Drug control department in its fold. In addition, it has also been mandated to work on Disease Early Warning System (DEWS), Surveillance for maternal and child health, Research, in-depth analysis of HMIS and Monitoring and Evaluation data. Some of its functions are presently shared with other directorates and departments in the MOPH, and future restructuring should clarify roles and responsibilities.

3.5. Central Statistics Office

The Central Statistics Office (CSO) is a government body, reporting directly to the first vice-president. It is in charge of the official tracking of population data in Afghanistan, and of performing population-based surveys. It is presently undergoing the PRR process. Its effective functioning has been hampered greatly by the past decades of war and political instability. In fact, since 1978, no central government has effectively controlled the whole of the Afghan national territory, which made data collection a difficult, if not dangerous undertaking for government officials.

Population data have been projections, based on the (incomplete) census of 1979, understandably with a large margin of error given the population movement inside and outside the country. Several estimates by UN and other agencies have been proposed. However, consensus between the MOPH and its partners is to use the CSO official data as basis for calculating target groups and coverage rates.

A recent challenge has been to adequately reflect population by civil division, since districts have increased from 329 to 398, with necessarily indicating the population distribution.

CSO has been invited to participate in the HMIS Task Force and the M&E board, but lack of adequate staffing has prevented routine participation. UNFPA is the main agency providing technical assistance to the CSO.

3.6. Donors, technical agencies and programs

Apart from the units and departments directly involved in monitoring the BPHS/EPHS performance, there are several other partners that contribute to performance monitoring of the health system in general. They include the Global Fund Management Unit which aims at combating HIV/AIDS, Tuberculosis and Malaria, the department for nutrition, EPI, reproductive health and others. The National Malaria and Leishmania Control Program (NMLCP) has revised new data collection forms to be used by NGOs implementing BPHS services, and to be compiled by provincial and national NMLCP managers. Similarly, the National Tuberculosis Program (NTP) collects data on case finding and treatment results to be compiled by NTP managers and coordinators. Since integration of both disease control programs into the BPHS/EPHS is still in progress, some important information is either not adequately collected or not used by relevant decision makers such as type of anti-malarial treatment, drug stocks and quality of malaria microscopy.

The NMLCP receives data from some 38 malaria control centers, while the HMIS regularly receives reports from more than 900 the BPHS facilities that are integrated in the routine reporting system. The EPI program and reproductive health department receive support from UNICEF on data collection and processing.

The World Bank supports national consultants as heads of the HMIS and M&E unit but also three national M&E consultants based in the GCMU. Similarly, USAID through MSH/TechServe, and the EC have placed national consultants and international consultants to support donor specific contract management and its monitoring in the GCMU. International and national experts funded by USAID/MSH/TechServe, EC, JHU/IIHMR, USCDC, UNICEF, WHO and Global Fund contribute through the HMIS TaskForce and the M&E Advisory Board to coordinating the management of health information.

Table 2 - Assessment Results on HIS Resources

Summary	Result
Policy and Planning	Present but not adequate
HIS institutions, human resources and financing	Present but not adequate

HIS Infrastructure	Present but not adequate
Overall	Present but not adequate

4. HIS infrastructure

The Afghanistan National Health Resources Assessment (ANHRA), conducted in the summer of 2003, found that about 2/3 of all functioning facilities had copies of the MOH HIS forms available. However, few of the reports found their way to the central HIS unit in the MoH, and many of the entries were not used by the majority of the facilities. The data collected were inconsistently used for action at the local level and focused primarily on disease and morbidity reporting, rather than information about services and resources that might be helpful in improving health services management.

The MoH formulated its priorities in the Basic Package for Health Services (BPHS) early 2002, and this was the starting point for a re-assessment of the HIS by the revived HMIS Task Force. The planned rapid expansion of health services under different grants programs to NGOs (Private Partnership Agreements, REACH Access to Quality Services) called for an HMIS that allowed following progress in implementation of the BPHS. It also obliged the HMIS Task Force to produce an improved system within a very short time frame.

Given that there was no functioning uniform data collection and processing system, the Task Force decided to take the following approach:

- a. Define indicators for each of the components of the BPHS;
- b. Review existing data collection and report forms for appropriateness;
- c. Draft new reporting forms;
- d. Draft new data collection forms, where necessary.

4.1. Essential Health Indicators and data sources

The indicators to monitor progress of the Basic Package of Health Services and Essential Package of Hospital Services were developed early 2003. Part of these indicators are suitably followed through routine reporting systems. Others need data collected through health facility assessments and household surveys, although for many of these, proxy indicators that can be calculated based on routine reporting systems have been defined as well.

Table 3 - Assessment results of Indicators

Summary	Result
Indicators	Adequate

Data sources are multiple, and as mentioned before, CSO plays a central role in defining the denominator for many of the indicators. The total population is presently estimated at 24,100,000.

However, without vital registration, these estimates are based on projections, corrected with data from a recent pre-census household count.

Population-based surveys at national level have been undertaken by CSO, with the assistance of UNICEF for the Multi Indicator Cluster Survey (MICS), or UNDP for the National Risk and Vulnerability Assessment (NRVA). However, the representativeness of the results of these surveys have been challenged because of problems with sampling (parts of the country are inaccessible for the data collectors) and data integrity (quality control of the data collection process).

The MOPH, with assistance from WHO and UNICEF, has a functioning polio surveillance system, and recently the DEWS has been implemented in sentinel sites.

Routine services statistics are available from the large majority of health facilities run or contracted out by the MOPH, including data from community health workers, supervised by the facilities.

Administrative records are kept on paper, and difficult to retrieve. Since 2002, the MOPH has been registering active facilities, and a computerized database keeps track of all active health facilities registered with the MOPH. A unique code is given by the MoPH to each facility. Likewise, since 2005, the MOPH has started making an inventory of all available health personnel in Afghanistan, including MOPH staff (civil servants) and staff of contracted NGOs. Presently, a computerized database contains basic identification of about 17,000 health personnel, who also have received a unique ID card, carrying a unique code and certifying registration with the MOPH. A computerized payroll system exists within the central MOPH.

Table 4 - Assessment results on Data Sources

Data Source	Contents	Capacity & Practices	Dissemination	Integration and use	Total
Census	Not functional	Not adequate	Not adequate	Present but not adequate	Not adequate
Vital statistics	Not functional				
Population-based surveys	Present but not adequate	Present but not adequate	Present but not adequate	Not adequate	Present but not adequate
Health and disease records (incl. disease surveillance sys.)	Present but not adequate	Not adequate	Not adequate	Adequate	Present but not adequate
Health service records	Present but not adequate	Present but not adequate	Present but not adequate	Adequate	Present but not adequate

Administrative records	Present but not adequate	Present but not adequate	Not adequate	Not adequate	Not adequate
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4.2. Data Management

4.2.1. The HMIS

The HMIS should not be seen only as a mechanism for collecting information and passing it to successively higher levels. Information should be used at the level at which it is collected. The HMIS involves the following processes: collection of data, processing it for conversion into useful information, analyzing and discussing it assess the current status of services and using it to set appropriate strategies and targets for improvement. The flowchart in Figure 1 shows the different steps in data collection and transmission, as well as analysis and feedback.

1. At the level of Health Posts, male and female CHWs keep a record of activities and the BHC/CHC/DH collects monthly summary reports. Pictorial data recording and reporting forms have been developed, taking into account that many of the health workers at this level may be functionally illiterate. A standard Monthly Activity Report (MAR) summarizes the data on the activity in the Health Post, and is transmitted to the CHC/BHC/DH, where the MARs of all Health Posts in the catchments area are aggregated into the Monthly Aggregated Activity Report (MAAR).
2. The Health Posts, with the cooperation of the BHC/CHC, will collect data on the communities served by their activities through the Catchment Area Annual Census (CAAC). This census will help measure progress towards population-based objectives. The BHC/CHC will assist the Health Posts in analysis and interpretation of this data. This part of the HMIS has been tested by some of the REACH grantees and proven very useful to help establish the Community Mapping for Health Posts.
3. Health workers in BHC/CHC/Hospitals record encounters in registers and cards (OPD, TB, EPI, ANC-Delivery-Neonatal, and FP). Hospitals will use records for both OPD and IPD.
4. To complete the picture obtained from aggregating the mini-surveys of the Health Posts, the BHC/CHC/Hospitals will also collect data on the communities directly served by their activities through a CAAC,.
5. For notifiable diseases, health workers investigate locally and immediately report to PPHO. An Immediate Report on notifiable Diseases has been developed, as well as a (limited) list of notifiable diseases.

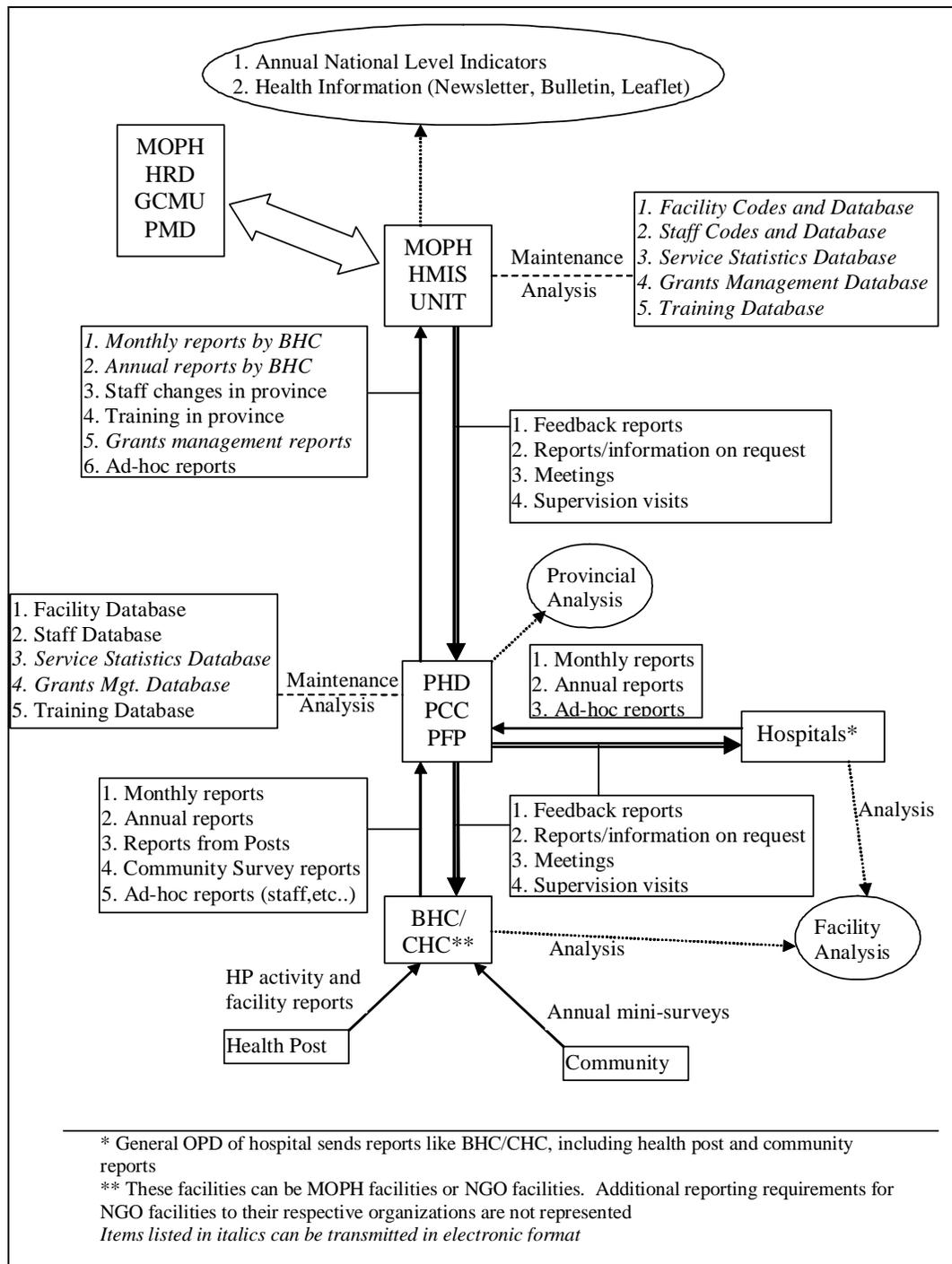


Figure 1 - HMIS Data Flow

- At the end of each month, BHC/CHC/Hospitals tally their data from registers and other records and transfer the information to monthly reporting forms. One Monthly Integrated Activity Report (MIAR) form combines the tallies from different outpatient registers and cards. One Monthly Hospital Inpatient Report (HMIR) combines the information on inpatients. Health Post monthly

reports are aggregated by the BHC/CHC to complete the picture of the BCH/CHC catchments area. The aggregated report is sent on to the PPHO before the 7th day of each month. The reports facilitate the use of data at the facility level.

7. Special reports for vertical programs (TB, EPI and others) are sent to corresponding program officers in the MOPH.
8. At least once a year, a Facility Status Report (Hospital Status Report for hospitals) on health services, infrastructure, equipment, staffing, etc... is compiled by the in-charge of each facility and sent to the PPHO. During the period of rapid expansion of health services, it is recommended that the report be compiled and sent quarterly or six-monthly.
9. At the provincial level, reports are received and registered to allow for monitoring of completeness. A register is kept for this purpose. Health facilities are contacted for missing reports and errors in the reports. Using the same MIAR form, individual reports are aggregated by type of facility.
10. At the provincial level, several databases are maintained. Databases can be in paper or electronic format, but most PPHCCs will have access to the necessary electronic resources. Data is consolidated at this level and consolidated monthly reports are forwarded to the central HMIS Unit of the MOPH. If computerization is available, data will be entered in the computer at provincial level and data can be forwarded electronically.
11. At the provincial level, quarterly or at least twice a year, data is analyzed by facility and written feedback is sent to each facility. With computerization, the content of many of these reports can be produced automatically. Before each supervisory visit, the HMIS data of the concerned facility should be reviewed to facilitate performance assessment and customize the supervisory visit. The information should be discussed with the staff. The final responsibility for the process lies with the Provincial Public Health Director; technical implementation lies with the Provincial HMIS or Nutrition Office, or the focal NGO for that province.
12. At the provincial level, grants data is recorded and quarterly reports are sent to the central level.
13. At least once a year, all facility in-charges should meet at the provincial level for the planning meeting. This meeting should include analysis of data, interpretation of trends, and prioritization of activities and setting of targets for the next year. National level indicators, as well as indicators specific for each province, are monitored and discussed at this level.
14. Database. At this level, facility and staff databases are also maintained, as well as a grants management database. One important function of the national HMIS Unit is giving unique facility codes and staff codes that facilitate maintenance of the databases. Facility codes are void of any meaning, other than being a unique identifier: facility types change, province and district boundaries change. The HMIS Unit coordinates closely with the HRD to maintain unique staff ID numbers for all MOPH and NGO health personnel working in Afghanistan.. The HMIS Unit maintains close coordination with the Human Resources Department, Personnel Management Department, and the Grants and Contract Management Unit, to ensure unique coding of staff, grants, etc...
15. Every six months, or at least once a year, reports are sent to each province. Once a year, a report on the trends of the national level indicators is produced. Other information material can be produced as well. The HMIS unit prepares material for the Annual National Health Planning meeting, where

PPHD and NGOs from each province convene. The National meeting will take place after a similar meeting in each province. Necessary budget for this meeting should be secured at the national level.

16. Computerization allows the MOPH to ensure that all implementing agencies, PPHOs and NGOs, have the most recent data available. Whenever NGOs submit electronic data to the PPHO, they will receive a new analysis copy of the data base that contains their own data as well as all other data in the province. Whenever PPHOs submit electronic data to the MOPH, they will receive a new analysis copy of the data base that contains their own data as well as all other data in the country. The routine reports included in the analysis database facilitate the interpretation and use of data at the PPHO and NGO level.

4.2.2. Other data management

Data collected intermittently is managed in different ways.

NHSPA tracks results in a database at national level, and analysis takes place at the national level.

Data management procedures of the NMC are still being worked out.

The DEWS is still working out its data management and coordinating with the HMIS Unit to avoid duplication of efforts and disruption of the functioning routine reporting system.

Table 5 - Assessment results on Data Management

Summary	Result
Data management	Adequate

4.3. Information products

The HMIS database contains pivot tables in Excel that adequately reflect several of the key BPHS/EPHS indicators. The database and pivot tables are distributed on a quarterly basis to all MOPH departments, PPHDs and contracted NGOs. The most updated version is also available upon request from the HMIS Unit. Indicators can be reflected from national, to province, district, NGO all the way down to facility level.

The NHSPA publishes results under the form of a annual “balanced scorecard”, reflecting compound indicators of performance, aggregated by national average, province and contracting scheme.

Other data available from the NMC, DEWs etc... are still too new for their information products to be evaluated.

Table 6 - Assessment results on Information Products

Marking Indicators <i>Elements for assessing selected indicators</i>	Health status			Health system indicators	Risk factors indicators	Overall health indicators quality
	Mortality	Morbidity	Overall			
Data collection method	not adequate	not adequate	not adequate	present but not adequate	not adequate	Not adequate
Timeliness	present but not adequate	not adequate	Not adequate			
Periodicity	not adequate	not adequate	not adequate	not adequate	not functioning	Not adequate
Consistency / completeness	not adequate	not functioning	not functioning	not adequate	not functioning	Not adequate
Representativeness / appropriateness	not adequate	not adequate	not adequate	not adequate	not adequate	Not adequate
Disaggregation	present but not adequate	Not functioning	not adequate	not adequate	not functioning	Not adequate
Estimation method / transparency	not functioning		not functioning	not functioning		Not functioning
Overall assessment of results	not adequate	Not adequate	not adequate	not adequate	not functioning	Not adequate

4.4. Dissemination and Use

Both the HMIS and NHSPA data seem adequately distributed and used. The analysis of the data is done and used at different levels for planning, prioritization, implementation and corrective actions. Their overall use for policy and advocacy may be improved, and likewise the resource allocation within the MOPH may be improved.

As indicated before, the population-based data has its flaws, but it is still extensively used by the MOPH and its partners.

Table 7 - Assessment results on Dissemination and Use

Summary	Result
Analysis and Use of Information	Adequate
Policy and Advocacy	Present but not adequate
Planning & Priority Setting	Adequate
Resource allocation	Present but not adequate
Implementation/action	Adequate
Overall	Adequate

5. Summary of the HIS assessment and policy implications

5.1. Summary of scoring

Table 8 -Summary of the Assessment

Topic	Score	Qualification
<u>Overall HIS</u>		
Dissemination & use	60%	
Information products	30%	
Data management	64%	
Data sources	36%	
Indicators	72%	
Resources	50%	
<u>Data Sources</u>		
Administrative records	37%	
Health service records	53%	
Health & diseases records	45%	
Population-based surveys	46%	
Vital statistics	3%	
Census	31%	
<u>Information Products</u>		
Estimation method / transparency	15%	
Disaggregation	32%	
Representativeness / appropriateness	32%	
Consistency / completeness	26%	

Periodicity	30%
Timeliness	39%
Data collection method	39%

Quality of Health Information

Overall health indicators quality	30%
Risk factors	19%
Health system	34%
Health status – morbidity	26%
Health status – mortality	31%

5.2. Analysis of Strengths, Weaknesses, Opportunities and Threats

Strengths

- Three years of experience in HMIS
- Two+ years of experience in M&E
- Presence of cadre of people in both departments with skills and experience
- Presence of active HMIS Task Force and active M&E Advisory Board
- Presence of technical assistance from other sources: TechServe/MSH, JHU/IIHMR, Consultants, others
- Capacity of the staff has grown many fold in the last two-three years

Opportunities

- With MOPH adopting stewardship role, there is widespread agreement that MOPH needs strong M&E/HMIS systems
- Leadership and donors would like to see stronger system
- Strong system will lead to improved performance
- Evidence produced may attract more donor support
- HSPA may contribute to government legitimacy
- Increased involvement of and decentralization of decision making to provincial level

Weaknesses

- Sub-optimal coordination with other departments
- No clear scope of work for M&E Dept.
- Limited capacity for in-depth analysis in HMIS/M&E
- Under-utilisation of available data reflecting lack of data culture
- Lack of operational budget
- Low capacity especially in data analysis
- High staff turnover
- Conflicting demands on time
- Limited capacities and lack of ownership at provincial level

Threats

- Unclear what donor investment in Afghan health sector over next five years will be
- Frequent changes within MOPH: organogram/departmental relations/staff turnover
- Deteriorating security
- Tendency for donor driven initiatives
- Conflicting information from outside MOPH, especially regarding size and distribution of the population and administrative divisions of the country

5.3. Potential areas for development with existing resources

The BPHS and EPHS require more support to make services available to the entire population.

Validity, accessibility, quality and utilization of data is important for decision making at different levels (health post, BHC, CHC, District hospital, provincial hospital and central MoPH). Based on the assessment findings, the following recommendations can be made:

- At all levels:
 - Improvement and development of capacity building of all staff to explain HIS and its importance for decision making and planning;
 - Improve routine information sharing and accessibility of data
- At MOPH central level:
 - Improve coordination between all stakeholders and sectors, including CSO;
 - Formulate a clear national HIS policy
 - Develop a national HIS strategy
 - Improve supervision and monitoring of the existing HIS
 - Improve utilization of data for policy decisions
- At MOPH provincial level:
 - Strengthen HMIS committees
 - Promote use of HIS data for provincial planning
- At hospital level:
 - To implement central hospitals MIS system.
 - Arrangement and renovation of medical records at hospitals levels.

5.4. Opportunities for donor coordination

Additional resources will be required for the following:

- HMIS training workshops for new staff and HMIS updates
- Expand the hospital HMIS to all hospitals
- Explore introducing HMIS to private health facilities and practitioners
- Integrations of DEWS and HMIS
- Publication and dissemination of HMIS statistics

5.5. Critical next steps

The existent BPHS is active in more than 80% of the districts of Afghanistan, and 30% of provincial hospitals are implementing the EPHS. Shortage of funding and security considerations have delayed to implementation of the strategy throughout the whole country.

Some critical pieces of the HIS need urgent attention:

- Census: without more reliable population figures, all population-based indicators will remain shaky;
- Vital statistics: a system should be developed to routinely collect vital statistics, which will help to fine-tune population projections in-between census;
- Clarity on functions, roles, responsibilities within then MOPH: a clear definition of the roles between HMIS, M&E and APHI , but also between those three departments and the different

vertical programs (DEWS, HIV/AIDS, TB, malaria, EPI) will enhance adequate collection and use of data;

- Roll out of EPHS HMIS implementation beyond the 10 provincial hospitals presently involved;

Annex 1 - HMN Assessment tool: scoring

I. Resources

A. Policy and Planning

Items		Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average
		3	2	1	0	
I.A.1	The country has up-to-date legislation providing the framework for health information covering the following specific components: vital registration, notifiable diseases, private sector data including social insurance, confidentiality, and fundamental pri	Legislation covering all aspects exists and is enforced	Legislation covering some aspects exists and is enforced	Legislation exists but is not enforced	There is no such legislation	0.8
I.A.2	There is a written HIS strategic plan in active use addressing all HIS components as in the HMN Framework that is being implemented at the national level	Yes, it exists and is being implemented	The strategic plan exists, but the resources to implement it are not available	The strategic plan exists, but it is not used or does not emphasize integration	There is no written HIS strategic plan	0.5
I.A.3	There is a written HIS strategic plan addressing all HIS components as in the HMN Framework that is being implemented at sub-national level	Yes, it exists and is being implemented at sub-national level	The strategic plan exists, but the resources to implement it at sub-national level are not available	The strategic plan exists, but it is not used or does not emphasize integration	There is no written HIS strategic plan	0.5
I.A.4	There is a representative national committee in charge of coordination of HIS	Yes, a functional committee exists	There is a functional national HIS committee, but without resources	There is a national HIS committee, but it is not functional	No national HIS committee exists	2.4
I.A.5	Country Statistical Office and Ministry of Health have established coordination mechanisms (e.g. task force on health statistics; this mechanism may be multi-sectoral)	Yes, fully operational, meets regularly and meets needs for coordination	Yes, but meets only occasionally on an <i>ad hoc</i> basis or agenda is too full	Yes in theory, but these mechanisms are not operational	No	1.4
I.A.6	Is there a regular system in place for monitoring the performance of the HIS and its various sub-systems?	Yes, it exists and is used regularly	Yes, but it is seldom applied	Yes, but never used	No	2.0
I.A.7	There is a written policy (part of the HIS strategic plan) to promote a culture of information use throughout the health system. Senior managers act as role models for use of information	Yes, both the HIS strategic plan and senior management do promote an information culture	Yes, the HIS strategic plan promotes information culture but it is not implemented	No policy exists on promoting culture but discussion is ongoing	No policy exists or discussion on promoting culture of information	0.8
I.A.8	It is an official policy to conduct regular meetings at facility, district and other levels to review HIS information and take action based upon such information	Yes, the policy exists and is being implemented	The policy exists, but there is no regularity of meetings	The policy exists, but is not implemented	No policy exists	2.3

B. HIS institutions, human resources and financing

Items		Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average
		3	2	1	0	
I.B.1	There is national capacity in core health information sciences to meet health information needs (epidemiology, demography, statistics, health planning)	Highly adequate	Adequate	Partially adequate	Not adequate	0.6
I.B.2	There is a functional central HIS administrative unit in the Ministry of Health for design, development and support of health information collection, management, analysis, dissemination and use for planning and management	HIS central unit is effective at coordinating, strengthening and maintaining the national HIS	HIS central unit is functional but lacking adequate resources	HIS unit has very limited functional capacity and undertakes few HIS strengthening activities	There is no functioning central HIS administrative unit in the Ministry of Health	2.3
I.B.3	At sub-national levels (e.g. regions / provinces, districts) there are designated full-time health information officer positions and they are filled	Yes, 100% of health offices at sub-national level have a designated, filled full time health information officer	Yes, more than 50% half of health offices at sub-national level have a filled designated full-time health information officer position	Less than 50% of health offices at sub-national level have a designated full-time health information officer position	No positions	2.3
I.B.4	HIS capacity building activities have occurred over the past year <i>for HIS staff</i> (statistics, software and database maintenance, and/or epidemiology)	Significant capacity building occurred as part of a long-term government-driven human resources development plan	Significant capacity building, but largely depending on external (e.g. donor) support and input	Limited capacity building	No	2.1
I.B.5	HIS capacity building activities have occurred over the past year <i>for health facility staff</i> (data collection, self-assessment, analysis, presentation)	Significant capacity building occurred as part of a long-term government-driven human resources development plan	Significant capacity building, but largely depending on external (e.g. donor) support and input	Limited capacity building	No	1.5
I.B.6	Availability of IT and database support to health and HIS staff at national and sub-national levels	Excellent	Adequate, usually available for occasional assistance and back-up	Limited, does not meet needs of staff for assistance and support	Not available	1.2
I.B.9	Are there specific budget line items within the national budgets for various sectors to provide adequately for a functioning HIS for all data sources (the HMN HIS sub-systems)?	Yes, there are specific budget line items within the national budgets to provide adequately for a functioning HIS for all data sources	National HIS budget line items are limited but allow for adequate functioning of all data sources	National HIS budget line items are limited and do not allow for adequate function of all data sources	There are no National HIS budget line items and there is inadequate function of most data sources	0.8

C. HIS Infrastructure

Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average
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		3	2	1	0	
I.C.1	A complete list of public sector health facilities exists and is up-dated every year	Yes, at least 90% of public sector health facilities are listed. The list is updated annually	The listing covers 50-89% of public sector health facilities and the listing is up to date	Listing is out of date or covers less than 50% of facilities	Not available	2.5
I.C.2	A complete list of private sector health facilities exists, and is up-dated every year	Yes, at least 80% of private sector health facilities are listed. The list is updated annually	The listing covers 50-79% of private sector health facilities and the listing is up to date	Listing is out of date or covers less than 50% of facilities	Not available	0.2
I.C.3	Is there availability of paper forms, paper, pencils, and supplies that are needed for recording of health information?	Yes, paper recording forms, paper and supplies are always available for recording required health information	There are occasional "stock-outs" of recording forms, paper, pencils and supplies but it does not affect our ability to record required information	There are "stock-outs" of recording forms, paper, pencils and supplies and it affects our ability to record required information	Health service is not able to meet reporting requirements due to lack of recording forms, paper and pencils	2.0
I.C.4	Are computers available at the relevant offices at national, regional, and district levels to permit rapid compilation of sub-national data?	Yes, all managers at district, regional and national levels have access to computers	Some managers at district level and nearly all managers at regional and national levels have access to computers	Managers at regional/provincial level and majority of managers at national level have access to computers	No, only managers at national level have access to computers	1.3
I.C.5	Is the basic communication technology infrastructure (telephones, internet access, e-mail) in place at national, regional and district levels to ensure rapid compilation of sub-national data?	Yes, the basic communication technology infrastructure is in place at national, regional and district levels to ensure rapid compilation of sub-national data	No the basic communication technology is not in place at all levels but we are able to ensure compilation of national and sub-national data as needed	The basic communication technology is not in place at the national and all sub-national levels and it affects our ability to ensure compilation of national and sub-national data as needed	The basic communication technology is not in place at national and sub-national levels and we are not able to compile data as needed	1.4
I.C.6	Is there IT equipment maintenance support available at national and sub-national levels to ensure data and information reporting requirements are met and on time?	Yes, there is IT equipment maintenance support at national and sub-national levels that makes possible meeting data and information reporting requirements	There is not always IT equipment maintenance support available but we are able to meet data and information reporting requirements	There is not always IT equipment maintenance support available and it prevents us from meeting data and information reporting requirements	There is no IT equipment maintenance support and it affects meeting data and information reporting requirements	1.5
Summary of Result		Maximum	Score	%		

A	Policy and Planning	24	11	45%
B	HIS institutions, human resources and financing	27	15	55%
C	HIS Infrastructure	18	9	50%
	Overall Results	69	34	50%

II. INDICATORS

Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all	Rationale/ comments	
	3	2	1	0		
II.A.1	National minimum core indicators have been identified for national and sub-national levels covering all categories of health indicators (determinants of health; health system inputs, outputs, outcomes; health status)	Yes, minimum core indicators are identified at national and sub-national levels and covering all categories	Minimum core indicators are identified at national and sub-national levels but they do not cover all categories	Discussions under way to identify essential indicators	No, minimum indicators or data set identified	
II.A.2	There is a clear and explicit official strategy for measuring each of the country relevant health-related MDG-indicators	Yes, all of the appropriate health-related MDG indicators are included in the minimum core indicator set	Not all, but at least half of the health-related MDG indicators are included in the minimum core indicator set	At least one but less than half of the appropriate MDG indicators are included in the minimum core indicator set	None of the MDG health related indicators are included in the minimum core indicator set	
II.A.3	Are core indicators defined in collaboration with all key stakeholders, e.g., Ministry of Health (MoH), National Statistics Office (NSO), other relevant ministries, professional organizations, sub-national experts, major disease-focused programs?	Yes, all the relevant stakeholders collaborated in the selection of the core indicators	Relevant ministries and the NSO are involved but more external participation would be desirable	Collaboration across the MoH, sub-national, some disease programmes but no involvement of the NSO	No, each programme demands data as they see fit.	

II.A.4	Have the core indicators been selected according to explicit criteria including usefulness, scientific soundness, reliability, representativeness, feasibility, accessibility	Yes, the core indicators have been selected according to explicit criteria including usefulness, scientific soundness, reliability, representativeness, feasibility, accessibility	Mostly, but not all criteria for selection were clear and explicit	There are guidelines but they do not include explicit criteria for selection of indicators	There are not guidelines or explicit criteria for selection of indicators
II.A.5	Reporting on the minimum set of core indicators occurs on a regular basis	Regular reporting (e.g. annual, bi-annual)		Reporting is irregular and incomplete	Reporting is very limited

A. Census

Core dimensions	Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all
		3	2	1	0
III.A.1 Contents	1.1 Mortality questions on the last census Note: This question is not applicable if vital registration covers at least 90% of deaths	Questions on recent household deaths as well as questions for indirectly estimating both child mortality and adult mortality	Questions on recent household deaths as well as questions for indirectly estimating either child mortality or adult mortality	Questions on recent household death or questions for indirect estimating either child mortality or adult mortality	No recent mortality questions
III.A.2 Capacity & practices	2.1 The country has adequate capacity to (1) implement data collection, (2) process the data and (3) analyze the data	Adequate capacity for all 3	Adequate capacity for 2 of the 3	Adequate capacity for only 1 of the 3	Adequate capacity for none of the 3
	2.2 A census was carried out in the last ten years and results have been published or are likely to be published in the next 5 years	Yes			No
	2.3 Census sample re-interview has been completed and a written report is available and widely distributed	Re-interview undertaken and report is available on the web	Re-interview undertaken and printed report is available	Re-interview undertaken but no report available	No re-interview under taken
III.A.3 Dissemination	3.1 Report including descriptive statistics (age, sex, residence by smallest administrative level) from the most recent census are available and widely distributed (on line or with paper copy)	All districts have immediate access	All provinces have immediate access	Central health officials have immediate access	Not available

	3.2 Lag between the time that descriptive statistics (age, sex, residence by enumeration area) were last published and the time that the data were collected	Less than 2 years	2 or 3 years	4 or 5	No census results available for at least 10 years (if so, skip all subsequent questions on the census)
	3.3 Accurate population projections by age and sex are available for small areas (districts or below) for the current year	Accurate projections are available for the smallest administrative level	Accurate projections are available for districts	Accurate projections are available for provinces/regions	No projections for current year or projections are not felt to be accurate
	3.4 Microdata are available for public access	Available on request	Available on request with restrictions		Not available
III.A.4 Integration and use	4.1 Census projections are used for the estimation of coverage and planning of health services	Projections used by most sub-districts	Projections used by most districts	Projections used at national +/- provincial levels	Population projections are not used for health

B. Vital statistics

Core dimensions	Items	Highly adequate	Adequate	present but not adequate	not adequate at all	Average Score
		3	2	1	0	
III.B.1 Contents	1.1 Is there a reliable source of nationwide vital statistics: civil registration vs. sample registration system (SRS) vs. demographic surveillance systems (DSS)?	Civil registration	Sample registration system	Demographic surveillance systems	There is no reliable source	0.1
	1.2 Coverage of vital registration of deaths (in percent)	90% or more	70 - 89%	50 - 69%	<50%	0.0
	1.3 Cause of death information is recorded on the death registration form	Always - compulsory by law		Sometimes	Never	0.5
III.B.2 Capacity & practices	2.1 The country has adequate capacity to (1) implement data collection, (2) process the data and (3) analyze the data from vital registration or SRS or DSS	Adequate capacity for all 3	Adequate capacity for 2 of the 3	Adequate capacity for only 1 of the 3	Adequate capacity for none of the 3	0.7
	2.2 Frequency of the assessment of completeness of vital registration	Every year	Every 2-4 years	Every 5 years	Never	0.2
	2.3 International Statistical Classification of Diseases and Related Health Problems (ICD) is currently in use Note: not applicable if there is no cause of death registration	ICD-10 detailed	Tabulation List ICD10	ICD-9	No ICD used or ICD 8 or earlier	0.0

	2.4 Proportion of all deaths coded to ill defined causes (garbage codes) - in percent Note: this question is not applicable if there is no cause of death registration	<5%	5-10%	11-19%	20% or more or no cause of death registration	0.0
	2.5 Published statistics from vital statistics (VR) or SRS are disaggregated by (1) sex, (2) age, and (3) geographic region (or urban / rural) Note: not applicable if no VR or SRS	All 3	2 of 3	1 of 3	None of 3 or no cause of death registration	0.8
	2.6 Sample registration system (SRS) developed and generating timely and accurate data Note: not applicable if no SRS	Nationally representative		Partially representative	None	0.0
	2.7 Demographic surveillance system (DSS) sites developed and generating timely and accurate data Note: not applicable if no DSS		Partially representative (at least 1 urban and 2 rural sites)	Non-representative	None	0.0
	2.8 Verbal autopsy (VA) tool Note: not applicable if no DSS or SRS	VA tool validated; questionnaire publicly available and consistent with intl stds	VA tool validated	VA not validated	No verbal autopsy used by SRS and/or DSS	0.0
III.B.3 Dissemination	3.1 Lag between the time that statistics from VR / SRS / DSS were last published and the time that the data were collected Note: not applicable if no VR or SRS or DSS	Less than 3 years	3 years	4 or 5 years	More than 5 years or statistics not published or no VR and no SRS and no DSS	0.0
III.B.4 Integration and Use	4.1 Information from VR / SRS / DSS on (1) mortality rates and (2) causes of death is used for national and sub-national analyses Note: not applicable if no VR or SRS or DSS	Both mortality rates and cause of death information are used	1 of 2 used		Not used or statistics not published or no VR and no SRS and no DSS	0.0

C. Population-based surveys

Core dimensions	Items	Highly adequate	Adequate	present but not adequate	not adequate at all	Average Score
		3	2	1	0	

III.C.1 Contents	1.1 In the last five years, a nationally representative survey has measured the percentage of the relevant population receiving key maternal and child health services (family planning, antenatal care, professionally attended deliveries, immunization)	Yes			No	2.4
	1.2 In the last five years, a nationally representative survey has provided sufficiently precise and accurate estimates of infant and under-five mortality.	Yes			No	1.3
	1.3 In the last five years, nationally representative population-based survey(s) have measured the prevalence of some priority non-communicable diseases/health problems (e.g. disability, mental illness, hypertension, diabetes, accidents, violence) and le	Yes, nationally representative surveys have measured biomarkers and at least three priority non-communicable diseases/health conditions or risk factors	Surveys have not measured any additional biomarkers but have measured the prevalence of at least one priority non-communicable disease/health problem or risk factor	In the last five years, population-based surveys have not measured the prevalence of any priority non-communicable disease/health problem or risk factor	No population-based surveys have been organized in the past five years	1.4
III.C.2 Capacity & practices	2.1 The country has adequate capacity to (1) conduct household surveys (including sample design and field work), (2) process the data and (3) analyze the data	Adequate capacity for all 3	Adequate capacity for 2 of the 3	Adequate capacity for only 1 of the 3	Adequate capacity for none of the 3	1.6
	2.2 Surveys follow international standards for consent, confidentiality and access to personal data (see OECD Guidelines on the Protection of Privacy)	Yes			No	1.5
	2.3 The data allow disaggregation by age, sex and geographical regions (urban/rural, first administrative level)	All three	Two	One	None	1.9
	2.4 The data allow disaggregation by socio-economic status: a) wealth and b) education	Yes, both		Only by education	No	0.4
III.C.3 Dissemination	3.1 Metadata (design, sample implementation, questionnaires) are available for recent surveys	Publicly available			Not available	1.3
	3.2 Microdata are available from recent surveys	Available on request	Available on request with restrictions		Not available	1.4

III.C.4 Integration and use	4.1 There are meetings and a multi-year plan to coordinate the timing, key variables measured and funding of nationally representative population-based surveys which measure health indicators	Yes, coordination mechanism and plan coordinates all nationally representative surveys	Coordination group and long-term plan coordinate > 75% of nationally representative household surveys	Plan exists but is incomplete and/or coordination group is unable to effectively coordinate surveys	Neither a coordination group nor a long-term plan exist	1.0
	4.2 The health and statistical constituencies in the country work together closely on survey design, implementation and data analysis and use	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	1.2

Core dimensions	Items	Highly adequate	Adequate	present but not adequate	not adequate at all	Average Score
		3	2	1	0	
III.D.1 Contents	1.1 For each of the key epidemic prone diseases and diseases targeted for eradication / elimination (see text) appropriate case definitions have been established and cases can be reported on the current reporting format	True for all key epidemic prone diseases and diseases targeted for eradication / elimination	True for all except one or two key epidemic prone diseases and diseases targeted for eradication / elimination	There are 3 or more key diseases for which case definitions remain to be established or for which the reporting form is not adequate	No system for notification or a system which fails to report on most of the key diseases	2.2
	1.2 For health conditions of substantial importance other than in 1.1 above, a measurement / assessment strategy exists and is reflected in appropriate plans, tools, supporting structures, and assignments of responsibility	True for all leading causes of morbidity, mortality, and disability	True for several major conditions of public health importance; plans exist for extending coverage	True for one to several prototypes, and plans exist to discuss how to extend to at least one more public health problem	No good prototype currently exists	1.6
	1.3 Mapping of public health risks, populations at risk and health resources (facilities, labs, health workers)	Maps are up-to-date and comprehensive and capacity exists to promptly add new features	Maps are up-to-date and reasonably comprehensive	Mapping of only a few public health risks or resources	No mapping of public health risks or services	1.2
III.D.2 Capacity & practices	2.1 The country has adequate capacity to (1) diagnose and record cases of notifiable diseases, (2) report and transmit timely and complete data on these disease (3) analyze and act upon the data for outbreak response and planning of public health intervene	Adequate capacity for all 3	Adequate capacity for 2 of the 3	Adequate capacity for only 1 of the 3	Adequate capacity for none of the 3	1.8
	2.2 Percentage of health workers making primary diagnoses who can correctly cite the case definitions of the majority of notifiable diseases	90% or more	75% to 89%	25% to 74%	< 25%	1.2

	2.3 Percentage of health facilities submitting weekly or monthly surveillance reports on time to the district level	90% or more	75% to 89%	25% to 74%	< 25%	1.2
	2.4 Percentage of districts submitting weekly or monthly surveillance reports on time to the next higher level	90% or more	75% to 89%	25% to 74%	< 25%	1.5
	2.5 Proportion of investigated outbreaks with laboratory results	90% or more	75% to 89%	25% to 74%	< 25%	1.0
	2.6 Individual patient records (patient charts or patient-retained "health passports") support quality and continuity of care	Patient records are almost always completed adequately and can be retrieved for almost all patients	Records are usually completed adequately and can be retrieved for the majority of patients in time to promptly inform clinical decision making	Essential patient information is often not recorded and/or records cannot be retrieved for most patients	No system of patient charts or health passports in most health facilities	1.4
	2.7 International Statistical Classification of Diseases and Related Health Problems (ICD) is currently used for reporting hospital discharge diagnoses Note: not applicable if No ICD coding of discharge diagnoses	ICD-10 detailed	Tabulation List ICD10	ICD-9	No ICD used or ICD 8 or earlier	0.1
III.D.3 Dissemination	3.1 Surveillance data are disseminated and fed back through regularly published weekly, monthly or quarterly bulletins	Bulletin produced regularly during last year and available at all district health offices		Bulletin not produced regularly during the last year or not distributed to districts	No bulletin produced	0.8
III.D.4 Integration & use	4.1 Integration of reporting for disease surveillance and other focused public health programs (e.g. maternal care, family planning, growth monitoring,...)	A single form is used for notification of key diseases. Reporting of other public health programs is also well integrated	Although there are a number of reporting forms, there is good coordination and efforts to integrate the reporting requirements of public health programs		Health workers and managers face a heavy burden completing and reviewing separate reports for numerous public health programs	2.3
	4.2 Proportion of epidemics detected at regional or national levels through analysis of surveillance data from districts and that were missed by the district level	At least 90% of epidemics noted at regional or national levels are first detected at district level	At least 75% of epidemics noted at regional or national levels are first detected at district level		More than 25%	1.4

E. Health service records

Core dimensions	Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average Score
		3	2	1	0	
III.E.1 Contents	1.1 There is a health services based information system that brings together data from all public and private facilities	Yes, it covers both public and private facilities	Integrated but covers few private facilities	Covers few private facilities (e.g. only not-for-profit)	No data from private facilities	1.0
	1.2 There is a systematic approach to evaluating the quality of services provided by health facilities. This includes both a) systematic standardized supervision with reporting of findings to district and national levels; and b) a health facility survey	There is both systematic standardized supervision with reporting and a nationally representative health facility survey	There has been at least one nationally representative health facility survey in the last 5 years	There is information on quality of services but only from a convenience sample of health facilities	Records of findings from structured supervision or health facility surveys are not available	2.3
III.E.2 Capacity & practices	2.1 The health information system has a cadre of trained health information specialists who have at least two years of training and are placed at the district level	At least 75% of districts	10% to 74% of districts	1% to 9% of districts	Not in any district	0.8
	2.2 Health workers in clinics receive regular training in health information, which is either integrated into continuing education or through special workshops	Most health workers received training in the last 5 years	25% to 49% of health workers trained in the last 5 years	5% to 24% of health workers trained in the last 5 year	Less than 5% of health workers trained	2.1
	2.3 There are mechanisms in place at national and sub-national levels for supervision and feedback on information practices	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	1.5
	2.4 There is a mechanism in place from district up through national level to verify completeness and consistency of data from facilities	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	1.2
	2.5 Population projections based upon census statistics are used to calculate coverage rates (e.g. for immunization) at district level	At least 90% of districts	50% to 89% of districts	25% to 49% of districts	Less than 25% of districts	1.8
III.E.3 Dissemination	3.1 When was the last time that an annual summary of health service statistics was published with statistics disaggregated by major administrative region?	Less than 2 years ago	2-3 years ago	4-5 years ago	6 years ago or more	1.3
	3.2 Districts or similar administrative units compile their own monthly, and annual summary reports, disaggregated by health facility	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	1.4

III.E.4 Integration and use	4.1 Vertical reporting systems such as those for tuberculosis and vaccination communicate well with the general health service reporting system	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	1.7
	4.2 Managers and analysts at national and sub-national levels frequently use findings from surveys, vital registration or DSS to assess the validity of clinic-based data	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	1.4
	4.3 The data derived from health service records are used to estimate coverage with key services such as antenatal care (ANC), delivery with a skilled attendant and immunization	Yes, always	Yes, sometimes	Occasionally	Never	2.6

F. Administrative records

1. Database/mapping of infrastructure and health services

Core dimensions	Items	Highly adequate	Adequate	present but not adequate	not adequate at all	Average Score
		3	2	1	0	
III.F.1 Contents	1.1 There is a national roster of public and private sector health facilities. Each health facility has been assigned a unique identifier code that permits data on facilities to be merged	Yes	There is a database of <i>public</i> health facilities with a coding system that permits integrated data management		No	1.8
	1.2 Global Positioning Satellite (GPS) coordinates are included in the facility database for the majority of facilities	True for 90% or more of public and private facilities	True for 90% or more of public facilities	True for <90% of public facilities	Not adequate at all	1.1
III.F.2 Capacity & practices	2.1 There are human resources and equipment for maintaining and updating the database and maps	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	1.7
	2.2 The national database of facilities was updated no less than:	Less than 2 years ago	2 - 3 years ago	More than 3 years ago	Do not have a national database	3.0
III.F.3 Dissemination	3.1 Maps are available in most districts showing the location of health infrastructure, health staff and key health services	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	1.1
III.F.4 Integration and use	4.1 Managers and analysts at national and district levels commonly evaluate physical access to services by linking information about the location of health facilities and health services to the distribution of the population	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	1.2

2. Database of human resources

Core dimensions	Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average Score
		3	2	1	0	
III.F.1 Contents (continued)	1.4 There is a national human resources (HR) database that tracks the number of health professionals by major professional category working in either the public or the private sector	Yes, the national HR database tracks numbers of health professionals by professional category in both the public and private sectors.	The national HR database tracks numbers by professional category but only those working in the public sector	The national HR database fails to provide statistics disaggregated by professional category	No national HR database	1.6
	1.5 There is a national database that tracks the annual numbers graduating from all health training institutions	Yes	X	Numbers graduating from certain health training institutions (e.g. nursing; private institutions) are not tracked	No	0.8
III.F.2 Capacity and practices (continued)	2.3 There are human resources for maintaining and updating the national HR database	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	1.5
	2.4 The national HR database statistics on the number of public sector health professionals was last updated no more than:	0-1 year ago	2-3 years ago	4-5 years ago	6 years ago or more	2.2

3. Information on financing of health services

Core dimensions	Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average Score
		3	2	1	0	
III.F.1 Contents (continued)	1.6 Financial records are available on general government expenditures on health, private expenditures on health (and their components) and external expenditure on health	All components, public and private	Only public and external expenditures	Only public expenditures	No system or incomplete	0.4

	1.7 There is a system for tracking budgets and expenditures from all sources of finance (general government including social security and local government, donors, health insurance, out-of-pocket) disaggregated by sub national / district level	All sources of finance are disaggregated by sub national / district level	Sources other than out-of-pocket (government including social security and local government, donors, health insurance) by sub national level	Government budget/expenditure plus at least one more source such as donors but only at national level	No tracking or only tracking of national government expenditure	1.5
III.F.2 Capacity and practices (continued)	2.5 Adequate numbers of qualified, long-term staff are regularly devoted to work on National Health Accounts (NHA) (whether or not employed by the Ministry of Health) Note: not applicable if no NHA conducted	Yes	Adequate numbers and skills but staff are not employed long-term by any in-country agency or are not regularly devoted to work on NHA	Adequate numbers but in need of external technical support	Ad hoc staff chosen when activity takes place	0.2
	2.6 Periodicity and timeliness of routine National Health Accounts. Note: not applicable if no NHA conducted	Estimates every year with one year lag	Estimates every year with 2 year lag	Erratic	No	0.2
	2.7 NHA routinely provides information on the following 4 classifications - sources, agents, providers, functions Note: not applicable if no NHA conducted	All four	Any 3	Any 2	1 only	0.4
	2.8 NHA provides information on health expenditure by major diseases, health program areas, geographical areas and/or and target populations (according to major policy concerns) Note: not applicable if no NHA conducted	Health expenditure information is available for at least 2 major disease programs and another area of policy concern	Health expenditure information is available for at least 1 major disease program and another area of policy concern	Estimates are available of expenditure on some areas of policy concern but they exclude some important sources of finance (e.g. out-of-pocket)	None	0.3
III.F.3 Dissemination (continued)	3.2 NHA findings are widely and easily accessible Note: not applicable if no NHA conducted	NHA findings have been widely disseminated and are cited in a document that is accessible on a website	NHA findings have been disseminated to the public	NHA findings are available within the agency but have not been widely disseminated	Written report on NHA findings not available	0.1
III.F.4 Integration and use (continued)	4.2 NHA has been used for policy formulation and resource allocation Note: not applicable if no NHA conducted	There is at least one major policy document that has been substantially influenced by or cites prominently NHA findings	At least some findings from NHA have been used in budgeting and planning	Policy makers and other stakeholders are aware of the NHA findings but there is no evidence that these findings have shaped policy and planning	There is no evidence that policy makers are aware of NHA findings	0.3

4. Database on equipment, supplies and commodities

Core dimensions	Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average Score
		3	2	1	0	
III.F.1 Contents (continued)	1.8 Each facility is required to report at least annually on the inventory and status of equipment and physical infrastructure	Yes			No	3.0
	1.9 Each facility is required to report at least quarterly on its stock of health commodities (drugs, vaccines, contraceptives, other supplies)	Yes			No	3.0
III.F.2 Capacity and practices (continued)	2.9 There are sufficient numbers of adequately skilled human resources for managing the logistics of equipment, supplies and commodities	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	0.8
	2.10 Periodicity and completeness of reporting on equipment and physical infrastructure	Complete quarterly reporting	Complete annual reporting	incomplete reporting	None	1.5
	2.11 Periodicity and completeness of reporting on health commodities	Complete, monthly reporting	Complete, quarterly reporting	Incomplete reporting	None	1.7
III.F.4 Integration and use (continued)	4.3 Are reporting systems for different commodities integrated?	Fully	Partially	Somewhat	All commodities separately reported	1.3
	4.4 Do managers at national and sub-national levels routinely attempt to reconcile data on consumption of commodities with data on cases of disease reported?	Routine reconciliation, monthly	Occasional	Rarely	Never	1.0

IV. Data management

Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average
	3	2	1	0	

IV.A.1	There is a written set of procedures for data management including data collection, storage, cleaning, quality control, analysis, and presentation for target audiences, and these are implemented throughout the country	Yes, a written set of procedures exists including all the steps in data management and these are implemented throughout the country	Yes, a written set of data management procedures exists, but these are only partially implemented	Yes, a written set of data management procedures exists, but these are not implemented	No written procedures exist	2.3
IV.A.2	The HIS unit at national level is running an integrated "data warehouse" containing data from all data sources (both population-based and facility-based sources including all key health programmes), and has a user-friendly reporting utility accessible to	Yes, there is a data warehouse at national level with a user-friendly reporting utility accessible to all relevant government and international agencies	Yes, there is a data warehouse at national level but it has a limited reporting utility	Yes, there is a data warehouse at national level but it has no reporting utility	No national data warehouse exists	1.9
IV.A.3	Sub national levels have a data warehouse equivalent to the national one and have a reporting utility accessible to various audiences	Yes, there is a data warehouse at sub national levels with a user-friendly reporting utility accessible to sub national levels including the district level	Yes, there is a data warehouse at sub national levels but it has a limited reporting utility	Yes, there is a data warehouse at national level but it has no reporting utility	No sub national data warehouse exists	1.1
IV.A.4	A "metadata dictionary" exists which provides data variable definitions as well as their use in indicators, specification of data collection method, periodicity, geographic designations, analysis techniques used and possible biases	Yes, there is a metadata dictionary which provides common data element definitions as well as specification of other essential information about the data	Yes, there is a metadata dictionary but with a slightly incomplete set of definitions and specifications	Yes, there is a metadata dictionary but with very incomplete set of definitions and specifications	No metadata dictionary exists	1.6
IV.A.5	Identifier codes are available for health facilities and administrative geographic units (e.g. province, district, municipality, etc.) to facilitate merging of multiple databases from different sources	The same identifier codes are used in different databases or a complete relational table is available to merge them	Similar identifier codes are used in different databases but some work should be done to merge them	Identifier codes are available but do not match between different databases	Not available	2.7

	Summary of Result	Maximum	Score	%
IV.	Data management	15	10	64%

V. Information Products

A. Health Status Indicators

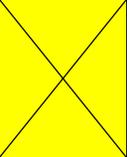
Indicators	Quality assessment criteria	Results	Highly adequate	Adequate	present but not adequate	Average
			3	2	1	
Mortality						
1. Under five mortality (all cause)	V.A.1.1 Data collection method	Method used to collect the most recent major data point	Vital registration of at least 90% of under-five deaths	Birth history from household survey or sample registration system	Other methods (such as indirect ones, recent deaths) from household survey or census	0.9
	V.A.1.2 Timeliness	For the most recently published estimate, how many years ago were the data collected?	0-2 years	3-5 years	6-9 years	1.4
	V.A.1.3 Periodicity	How many times were data collected in last 10 years?	Three or more	Two	One	1.4
	V.A.1.4 Consistency	Data points consistent over time and between sources during last decade	No major discrepancies	A few discrepancies	Multiple discrepancies	0.8
	V.A.1.5 Representativeness	Coverage of data upon which the most recently reported estimate is based	All deaths (>90%)	Sample of deaths	Local studies	1.5
	V.A.1.6 Disaggregation	Most recent data point disaggregated by demographic characteristics (e.g. sex and age) socioeconomic status (e.g. wealth or occupation or education of their parent) and by locality (e.g., urban-rural or major administrative region)	All three	Two	One	1.3
	V.A.1.7 Estimation methods	In country estimates use transparent, well-established methods	Yes			0.7

2. Adult mortality (all cause)	V.A.2.1 Data collection method	Method used to collect the most recent major data point	Vital registration of at least 90% of deaths	Sample vital registration	Direct methods from household survey or censuses (such as sibling history, recent deaths)	0.5
	V.A.2.2 Timeliness	For the most recently published estimate, how many years ago were the data collected	0-2 years	3-5 years	6-9 years	0.8
	V.A.2.3 Periodicity	Number of data collection rounds in last decade	Three or more	Two	One	0.4
	V.A.2.4 Consistency	Data points in last decade consistent over time	No major discrepancies	A few discrepancies	Multiple discrepancies	0.5
	V.A.2.5 Representativeness	Coverage of data upon which the most recently reported estimate is based	All (>90%) deaths	Sample of deaths	Local studies	0.7
	V.A.2.6 Disaggregation	Most recent data point disaggregated by demographic variables (age and sex), socio-economic status (e.g. by wealth quintiles, level of education, or occupations) and by locality (e.g. urban/rural, major administrative regions)	All three	Two	One	1.5
	V.A.2.7 Estimation methods	In country estimates use transparent, well-established methods	Yes			0.2
3. Maternal mortality	V.A.3.1 Data collection method	Data collection method for most recent data point	Vital registration of at least 90% of deaths and with good medical certification of cause of death	Sample vital registration with verbal autopsy	Direct methods from household survey or censuses (such as sibling history, recent deaths with verbal autopsy)	0.9
	V.A.3.2 Timeliness	For the most recently published estimate, how many years ago were the data collected	0-2 years	3 -5 years	6 - 9 years	1.6

	V.A.3.3 Periodicity	Number of data collection rounds in last decade	Three or more	Two	One	0.7
	V.A.3.4 Consistency	Data points in last decade consistent over time	No major discrepancies	A few discrepancies	Multiple discrepancies	0.9
	V.A.3.5 Representativeness	Coverage of data upon which the most recently reported estimate is based	All deaths	Sample of deaths	Local studies	0.8
	V.A.3.6 Disaggregation	Most recent data point disaggregated by demographic variables (age), socio-economic status (e.g. by wealth quintiles, level of education, and occupations) and by locality (e.g. urban/rural, major administrative regions)	All three	Two	One	1.2
	V.A.3.7 Estimation methods	In country estimates use transparent, well-established methods	Yes			0.8

Morbidity

4. HIV prevalence	V.A.4.1 Data collection method	Methods used to collect the most recent data point				
		1. If generalized epidemic;	1. General population survey + ANC surveillance;	1. ANC surveillance;	HIV case reporting	1.2
	V.A.4.2 Timeliness	For the most recently published estimate, how many years ago were the data collected	< 2 years	2 years	3- 4 years	1.6
	V.A.4.3 Periodicity	How many times was it measured in the last 5 years?	5	3-4	2	0.4
	V.A.4.4 Consistency	Data points and trends in last 5 years consistent	No major discrepancies	A few discrepancies	Multiple discrepancies	0.1

	V.A.4.5 Representativeness	Coverage of data upon which the most recently reported estimate is based 1. If generalized epidemic; 2. If concentrated epidemic	1. <i>Nationally representative survey + both urban & rural ANC clinics;</i> 2. <i>All major high risk populations with random sampling</i>	1. Both <i>urban & rural</i> ANC clinics 2. <i>At least one major high risk population in multiple locations</i>	1. Inadequate sample of clinics 2. One high risk population in one location	 0.7
						0.9
	V.A.4.6 Disaggregation	Recent estimates are disaggregated by demographic characteristics (e.g. sex and age), socioeconomic status (e.g. wealth or occupation or education) and by locality (e.g. urban-rural, major administrative region or geographical region)	All three -- specifically, prevalence among 15-24 year olds is estimated with an adequate sample size	Two	One	0.4
5. Underweight in children (<59 months or <36 months)	V.A.5.1 Data collection method	Method used to collect the data for the most recent estimate	Population based survey with anthropometry			0.5
	V.A.5.2 Timeliness	For the most recently published estimate, how many years ago were the data collected	0-2 years	3-5 years	6-9 years	1.1
	V.A.5.3 Periodicity	How many times was it measured in last decade?	3 or more	2	1	1.2
	V.A.5.4 Consistency	Estimates in last decade consistent	No major discrepancies	A few discrepancies	Multiple discrepancies	0.5
	V.A.5.5 Representativeness	Coverage of data upon which the most recently reported estimate is based	Nationally representative sample		Local studies	1.3

V.A.5.6 Disaggregation	Most recent data point disaggregated by demographic characteristics (e.g. sex and age), socioeconomic status (e.g. wealth or occupation or education of their parent) and by locality (e.g., urban-rural, major administrative region)	All three	Two	One	0.2
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B. Health System indicators

Indicators	Quality assessment criteria	Results	Highly adequate	Adequate	present but not adequate	Average
			3	2	1	
6. Outpatient attendance	V.B.6.1 Data collection method	Methods use to collect and validate the information	Clinic reports are validated by reviewing records at a representative sample of health facilities	Clinic reports are reviewed at each level for completeness and consistency. Inconsistencies are investigated <i>ad hoc</i>	Clinic reports not validated. There is limited or no evaluation of completeness or reporting bias	1.8
	V.B.6.2 Timeliness	For the most recently published data, how many months ago were the last data collected (typically from December of the year being reported)	0 - 11 months	12 - 17 months	18 - 29 months	3.0
	V.B.6.3 Periodicity	How many times was it nationally published in last 5 years?	Five times	Three or more times	Once or twice	1.4
	V.B.6.4 Consistency	Consistency over time and between clinic reports and sample clinic records	No major discrepancies	A few discrepancies	Multiple discrepancies	1.8
	V.B.6.5 Representativeness / completeness	Most recent statistic includes data from (i) teaching hospitals; (ii) more than 90% of public and private sector health facilities	Yes	Based upon data from (i) teaching hospitals; and (ii) more than 90% of other public sector health facilities	Data exclude teaching hospitals and/or more than 10% of other public sector facilities (or completeness unknown)	1.3

	V.B.6.6 Disaggregation - 1	Distinguishes curative consultations from visits solely for preventive services and initial visits from follow-up visits for the same illness	Distinguishes curative from preventive and initial from follow-up		Distinguishes curative from preventive but fails to distinguish initial from follow-up	2.3
	V.B.6.7 Disaggregation - 2	Statistics on curative consultations are disaggregated by disease	Yes			2.2
	V.B.6.8 Disaggregation - 3	Most recent data point disaggregated by geographic region, sex and age for relevant indicators	All three	Two	One	2.6

7. Measles coverage by 12 months of age	V.B.7.1 Data collection method - administrative statistics	Measles coverage can be estimated from routine administrative statistics submitted by at least 90% of immunizing health facilities. These statistics are systematically reviewed at each level for completeness and consistency and inconsistencies are investigated	Yes. Administrative statistics are complete and quality control is good. Population denominators are based upon full (>90%) birth registration	Administrative statistics are evaluated for completeness and consistency; Population denominators are based upon population projections	There is little evaluation of the completeness or consistency of administrative statistics or they are submitted by less than 90% of relevant facilities or no population projections are available	1.5
	V.B.7.2 Data collection method - household survey statistics	Measles coverage has been measured by at least two nationally representative household surveys in the last five years and immunization cards were shown during each survey for at least 2/3 of children	Yes	In the last 5 years there has been one nationally representative household survey measuring measles coverage and for which cards were shown for at least 2/3 of children	During the household survey, immunization cards were shown for less than 2/3 of children	1.6
	V.B.7.3 Timeliness	For the most recently published estimate, how many months ago were the last data collected	0 - 11 months	12 - 17 months	18 - 29 months	0.7
	V.B.7.4 Periodicity	How many times in the last 5 years was an annual estimate published based upon administrative statistics?	Five times	Three or more times	Once or twice	0.9

	V.B.7.5 Consistency	Data points consistent between recent surveys and reports	No major discrepancies	A few discrepancies	Multiple discrepancies	1.1
	V.B.7.6 Representativeness	Coverage of data upon which recent estimates were based	(i) Data from at least 90% of health facilities and outreach sites which immunize children including all major hospitals and both public and private sector; or (ii) Nationally representative household sample	Data from at least 80% of health facilities and outreach sites which immunize children	Data from less than 80% of health facilities and outreach sites which immunize children	1.5
	V.B.7.7 Disaggregation	Most recent survey disaggregated by demographic characteristics (e.g. age and sex), socioeconomic status (e.g. wealth or occupation or education of their parent) and by geographical region (e.g., urban-rural, major administrative region)	All three (demographic, socio-economic and geographic characteristics)	Two of three	One of three	0.9
8. Deliveries attended by skilled health professionals	V.B.8.1 Data collection method - administrative statistics	The percentage of deliveries attended by a skilled health professional can be estimated from routine administrative statistics submitted by at least 90% of relevant health facilities. These statistics are systematically reviewed at each level for completeness	Yes. Administrative statistics are complete (>90%) and quality control is good. Population denominators are based upon full (>90%) birth registration	Administrative statistics are evaluated for completeness and consistency; Population denominators are based upon population projections	There is little evaluation of the completeness or consistency of administrative statistics or they are submitted by less than 90% of relevant facilities or no population projections are available	2.0
	V.B.8.2 Data collection method - household survey statistics	The percentage of deliveries attended by a skilled health professional has been measured by at least two nationally representative household surveys in the last five years	Yes. In the last 5 years there have been at least two nationally representative household surveys measuring coverage	In the last five years there has been one nationally representative household survey measuring coverage		1.4

	V.B.8.3 Timeliness	For the most recently published estimate, how many months ago were the last data collected	0 - 11 months	12 - 17 months	18 - 59 months	1.1
	V.B.8.4 Periodicity	How many times was it measured in last 10 years?	Three or more	Two	One	1.5
	V.B.8.5 Consistency	Data points consistent between recent surveys and reports	No major discrepancies	A few discrepancies	Multiple discrepancies	1.3
	V.B.8.6 Representativeness	Coverage of data upon which recent estimates were based	Data from at least 90% of professionally supervised deliveries and from complete (>90%) registration of births	Nationally representative household sample	Local studies; incomplete reporting on professionally supervised deliveries with limited or no evaluation of completeness	2.0
	V.B.8.7 Disaggregation	Most recent estimate disaggregated by age, socioeconomic status (e.g. wealth or occupation or education of parent) and by geographical region of respondent / client	All three (demographic, socio-economic and geographic characteristics)	Two of three	One of three	1.6
9. Tuberculosis (TB) treatment success rate under DOTS	V.B.9.1 Data collection method	Methods used to collect the most recent data	Clinic reports with evaluation of reporting rate	District reports with evaluation of reporting rate	National reports with limited evaluation of reporting bias	1.6
	V.B.9.2 Timeliness	For the most recently published estimate, how many years ago were the data collected	1 year	2 years	3-4 years	2.2
	V.B.9.3 Periodicity	How many times was it measured in the last year? (should be quarterly)	4	X	< 4	2.2
	V.B.9.4 Consistency	Trend in treatment success rate consistent since 1995	No major discrepancies	A few discrepancies	Multiple discrepancies	1.8

	V.B.9.5 Representativeness	Coverage of data upon which last estimate is based - - % of sub national DOTS quarterly reports received by national TB programme in most recent year	Over 90%	75-89%	50-75%	1.3
	V.B.9.6 Disaggregation - 1	Most recent data point disaggregated by age, socioeconomic status (e.g. wealth or occupation or education) and by locality (e.g., urban-rural, major administrative region) of respondent / client	All 3 (demographic, socio-economic and geographic characteristics)	Any 2 of 3	Any 1 of 3	1.2
	V.B.9.7 Disaggregation - 2	Most recent data point disaggregated by HIV status and by drug resistance	Disaggregated by both	Disaggregated by one of these		0.5

10. Proportion of children (<59 months or <36 months) sleeping under insecticide treated bednets	V.B.10.1 Data collection method	Data collection method used for most recent data point	Household survey			0.3
	V.B.10.2 Timeliness	Time lag since last data collection	0-1 years	2-3 years	4-5 years	0.3
	V.B.10.3 Periodicity	Number of data points available over past decade	Three or more	Two	One	0.3
	V.B.10.4 Consistency	Data points consistent over time	No major discrepancies	A few discrepancies	Multiple discrepancies	0.2
	V.B.10.5 Representativeness	Coverage of most recent data points	Nationally representative sample of households	Locally representative	Local studies	0.5
	V.B.10.6 Disaggregation	By demographic characteristics, by socioeconomic status and by locality	All three	Two	One	0.2

Indicators	Quality assessment criteria	Results	Highly adequate	Adequate	present but not adequate	Average
			3	2	1	
11. General government expenditure on health (GGHE) per capita	V.B.11.1 Data collection & estimation	Data collection method	Data compiled using NHA methodology	Data compiled from administrative sources	Data imputed from secondary sources	1.5

	V.B.11.2 Timeliness	For the most recently published estimate, how many years ago were the data collected	Less than 1-year lag	2 year lag	3 year lag or more	1.5
	V.B.11.3 Periodicity	Periodicity	Yearly	Every 1-2 years	More than every 2 years	2.1
	V.B.11.4 Consistency	Consistent across components of the indicator and over time	Single source with no break in series	Various sources that are harmonized	Various sources that are not harmonized	0.8
	V.B.11.5 Representativeness	Components represented	All components: Ministry of Health, other ministries and social security, regional and local governments, extra budgetary	Ministry of Health, sub-national governments and Social Security	Ministry of Health and as well as Social Security	0.3
	V.B.11.6 Disaggregation - 1	General government expenditure available by district or subnational level	All components	Ministry of Health, sub-national governments and Social Security	Ministry of Health and as well as Social Security	0.3
	V.B.11.7 Disaggregation - 2	Share of general government expenditure funded through external resources (if not relevant, 3 is given by default)	Disbursed external resources from multilateral, bilateral, private foundations, NGOs, others	Disbursed external resources from multilateral and bilateral	Committed external resources from multilateral and bilateral	0.7
	V.B.11.8 Transparency		Data audit trail available	Replicable at 75%	Replicable at 50%	0.3
12. Private expenditure on health per capita (out-of-pocket, private health insurance and NGO)	V.B.12.1 Data collection & estimation	Data collection over 5 years	Data compiled using NHA methodology	Data compiled using 1 household survey for out-of-pocket, a survey for at least one other component, and imputations for remaining components	Data compiled using 1 household survey for out-of-pocket and imputations for the other components	0.5
	V.B.12.2 Timeliness	Time lag between most recent national publication and the time that the data were collected	Less than 1 year lag	2 year lag	3- to 4-year lag	0.3
	V.B.12.3 Periodicity	Periodicity	Data for all components available yearly	All components surveyed at least once in last 5 years	Households surveyed at least once in last 5 years	0.1

	V.B.12.4 Consistency	Consistent across components of the indicator and over time	Single source with no break in series	Various sources that are harmonized	Various sources that are not harmonized	0.3
	V.B.12.5 Representativeness	Components represented in aggregated figure	All components: Household out-of-pocket, private insurance, NGOs, firms	Households and 2 other components	Households and 1 other component	0.1
	V.B.12.6 Disaggregation - 1	Private expenditure available by district	All components	Households and 2 other components	Households and 1 other component	0.0
	V.B.12.7 Disaggregation - 2	Tracking of private expenditure funded through external resources (if not relevant, 3 is given by default)	Disbursed external resources from multilateral, bilateral, private foundations, NGOs, others	Disbursed external resources from multilateral and bilateral	Committed external resources from multilateral and bilateral	0.0
	V.B.12.8 Transparency		Complete data audit trail available	Replicable at 75%	Replicable at 50%	0.2

13. Density of health workforce (total and by professional category) by 1,000 population	V.B.13.1 Data collection method	Routine administrative records are validated with findings from a regularly conducted health facility survey/census, labour force survey and the population census	Population census, labour force surveys, health facility census/surveys and administrative records	Administrative records and either health facility census/surveys or labour force surveys	Only administrative records without validation by any census or survey	1.3
	V.B.13.2 Timeliness	For the most recently published estimate, how many years ago were the data collected	0-5 months	6-11 months	>12 months	1.3
	V.B.13.3 Periodicity	How many times was it measured in last 5 years?	5 or more	3-4	1-2	1.2
	V.B.13.4 Consistency	Variables and data definitions and classifications consistent over time and across sources	All sources are consistent. The variables have the same definitions / classification in all sources	Most of the sources are consistent. The variables have the same definitions / classification in most of the sources	Only some of the main sources are consistent	1.3
	V.B.13.5 Disaggregation- 1	Categories of health workers (ISCO: International Standard Classification of Occupations)	>15 occupations or ISCO 4 digits or national equivalent	4-14 occupations or ISCO 3 digits or national equivalent	< 4 or ISCO 2 digits or national equivalent	1.3

V.B.13.6 Disaggregation-2	Most recent estimate disaggregated by (1) gender, (2) urban/rural, (3) major administrative areas and (4) public/private sector	The data allow disaggregation by all four variables	The data allow disaggregation by three variables (excluding public and private sector)	The data allow disaggregation by two variables (excluding public/private and urban/rural)	1.5
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C. Risk Factors Indicators

Indicators	Source of Data	Results	Highly adequate	Adequate	present but not adequate	Average
			3	2	1	
14. Smoking prevalence (15 years and older)	V.C.14.1 Data collection method	Data collection methods used for most recent data point	Population based survey with self report , daily smokers over previous month			0.0
	V.C.14.2 Timeliness	For the most recently published estimate, how many years ago were the data collected?	0-2 years	3-5 years	6 or more years	0.0
	V.C.14.3 Periodicity	How many times was it measured in last 10 years?	Three or more	Two	One	0.0
	V.C.14.4 Consistency	Data points consistent over time	No major discrepancies	A few discrepancies	Multiple discrepancies	0.0
	V.C.14.5 Representativeness	Coverage of data upon which last estimates are based	Nationally representative sample	Suboptimal national sample	Local studies	0.0
	V.C.14.6 Disaggregation	Most recent data point disaggregated by (1) demographic characteristics, (2) socioeconomic status and by (3) locality	All three	Two	One	0.0
15. Condom use with higher risk sex	V.C.15.1 Data collection method	Survey with self reports and appropriate questions 1. If generalized HIV epidemic; 2. If concentrated HIV epidemic	Self reports with appropriate questions 1. General household survey 2. High risk populations	Self reports with non-standard questions 1. General household survey 2. High risk populations	1. Administrative (condom distribution) data 2. Little information on high risk populations	0.5
	V.C.15.2 Timeliness	For the most recently published estimate, how many years ago were the data collected?	0-1 years	2-3 years	4 years or more	0.8

	V.C.15.3 Periodicity	Estimates based on new data points during five years	Three or more	Two	One	0.2
	V.C.15.4 Consistency	Data service statistics and survey based data points	High	Moderate	Low	0.2
	V.C.15.5 Representativeness	Type of sample upon which last estimates are based	Nationally representative with random sampling	Purposive or other non-random national sampling	Local studies	0.4
	V.C.15.6 Disaggregation	Most recent data point disaggregated by (1) demographic characteristics, (2) socioeconomic status and by (3) locality	All three	Two	One	0.2
16. Proportion of households using improved water supply (pipe borne or borehole or protected well)	V.C.16.1 Data collection method	Data collection method	Household survey	Administrative report		2.1
	V.C.16.2 Timeliness	For the most recently published estimate, how many years ago were the data collected?	0-1 years	2-3 years	4 years or more	1.1
	V.C.16.3 Periodicity	Estimates based on new data points during five years	Three or more	Two	One	0.7
	V.C.16.4 Consistency	Data points consistent over time and between sources during last decade	High	Moderate	Low	1.2
	V.C.16.5 Representativeness	Sample general population or all major risk groups	Nationally representative with random sampling	Purposive or other non-random national sampling	Local studies	1.8
	V.C.16.6 Disaggregation	Most recent data point disaggregated by (1) demographic characteristics, (2) socioeconomic status and by (3) locality	All three	Two	One	1.0

Additional selected indicators

Additional Indicator number 1	Data collection method	Method used to collect the most recent major data point				1.0
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	Timeliness	For the most recently published estimate, how long ago were the data collected?				
	Periodicity	How many times were data collected in last 10 years?				
	Consistency	Data points consistent over time and between sources during last decade				
	Representativeness	Coverage of data upon which the most recently reported estimate is based				
	Disaggregation	Most recent data point disaggregated by demographic characteristics (e.g. sex and age) socioeconomic status (e.g. wealth or occupation or education of their parent) and by locality (e.g., urban-rural or major administrative region)	All three	Two	One	
	Estimation methods / transparency	Estimates use transparent, well-established methods				

Additional Indicator number 2	Data collection method	Method used to collect the most recent major data point				
	Timeliness	For the most recently published estimate, how long ago were the data collected?				
	Periodicity	How many times were data collected in last 10 years?				
	Consistency	Data points consistent over time and between sources during last decade				

	Representativeness	Coverage of data upon which the most recently reported estimate is based				
	Disaggregation	Most recent data point disaggregated by demographic characteristics (e.g. sex and age) socioeconomic status (e.g. wealth or occupation or education of their parent) and by locality (e.g. urban-rural or major administrative region)	All three	Two	One	
	Estimation methods / transparency	Estimates use transparent, well-established methods				

Additional Indicator number 3	Data collection method	Method used to collect the most recent major data point				
	Timeliness	For the most recently published estimate, how long ago were the data collected?				
	Periodicity	How many times were data collected in last 10 years?				
	Consistency	Data points consistent over time and between sources during last decade				
	Representativeness	Coverage of data upon which the most recently reported estimate is based				
	Disaggregation	Most recent data point disaggregated by demographic characteristics (e.g. sex and age) socioeconomic status (e.g. wealth or occupation or education of their parent) and by locality (e.g. urban-rural or major administrative region)	All three	Two	One	3.0

	Estimation methods / transparency	Estimates use transparent, well-established methods				
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Additional Indicator number 4	Data collection method	Method used to collect the most recent major data point				3.0
	Timeliness	For the most recently published estimate, how long ago were the data collected?				
	Periodicity	How many times were data collected in last 10 years?				
	Consistency	Data points consistent over time and between sources during last decade				
	Representativeness	Coverage of data upon which the most recently reported estimate is based				
	Disaggregation	Most recent data point disaggregated by demographic characteristics (e.g. sex and age) socioeconomic status (e.g. wealth or occupation or education of their parent) and by locality (e.g. urban-rural or major administrative region)	All three	Two	One	
	Estimation methods / transparency	Estimates use transparent, well-established methods				

Additional Indicator number 5	Data collection method	Method used to collect the most recent major data point				
	Timeliness	For the most recently published estimate, how long ago were the data collected?				
	Periodicity	How many times were data collected in last 10 years?				

	Consistency	Data points consistent over time and between sources during last decade				
	Representativeness	Coverage of data upon which the most recently reported estimate is based				
	Disaggregation	Most recent data point disaggregated by demographic characteristics (e.g. sex and age) socioeconomic status (e.g. wealth or occupation or education of their parent) and by locality (e.g. urban-rural or major administrative region)	All three	Two	One	
	Estimation methods / transparency	Estimates use transparent, well-established methods				

VI. Dissemination and use

A. Analysis and Use of Information

Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average
	3	2	1	0	
VI.A.1 There is continual demand for good quality and timely health information--for example for results/performance-based budgeting	Yes, health information is continually demanded	Health information is demanded on an ad-hoc basis	Health information is seldom used	None	2.0
VI.A.2 Senior managers and policy makers demand complete, timely, accurate, relevant and validated HIS information	Yes	Yes, but they do not have the skills to judge	Demand from managers is ad-hoc, usually as a result of external pressure (e.g. questions from politicians or the media)	Negligible demand from managers	1.8
VI.A.3 Graphs are widely used to display information at sub national / district offices / health facilities	Yes	Up-to-date graphs are displayed, but poorly understood	Some graphs, but they are not up-to-date	No graphs	1.7

VI.A.4	Maps are widely used to display information at sub national / district offices / health facilities	Yes	Up-to-date maps are displayed but poorly understood	Some maps, but they are not up-to-date	No maps		1.5
VI.A.5	Central HIS Unit conducts in-depth data analysis that provides answers to important questions and identifies critical changes important for population health	Yes, strategic planning and policy development are regularly based on central HIS unit analytic reports	HIS unit regularly provides information but in-depth analysis from the unit does not regularly contribute to policy development and planning	HIS unit supplies information but not on a regular or timely basis. No in-depth analysis	No central HIS unit or there is an unit but it does not have this capacity		2.1
VI.A.6	HIS data and indicators collected by any public agencies, are in principle regarded as belonging in the public domain, i.e. they should be available to all interested citizens	Public access and availability are guaranteed by law / regulations and fully implemented	Public access accepted in principle and largely implemented	Public access accepted in principle, but not implemented in practice	Access is strictly controlled		2.1

B. Policy and Advocacy

Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average
	3	2	1	0	
VI.B.1	Yes	Report made but analysis weak	Report out of date and/or poor quality	No report	0.9
VI.B.2	Regular integrated reports at least annually to national and local relevant partners	Regular integrated reports at least annually, but distributed only to Ministry of Health	Occasional reports, but not annually	No integrated reports	1.9
VI.B.3	Yes	Known among health-focused policy/decision makers	Known by a few "specialists" only;	No	1.7
VI.B.4	Systematic use of HIS information, with most accepting the HIS information as reliable and valid.	HIS information used frequently, but with reservations or disagreements due to concerns about validity	HIS information used occasionally, but with clear reservations due to concerns about validity	No	2.1

Planning & Priority

C. Setting

Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average
	3	2	1	0	
VI.C.1 Health information (risk factors, systems, status) is demonstrably used in the planning process, e.g. for annual integrated development plans, medium-term expenditure frameworks, long-term strategic plans, and annual health sector reviews	Yes, systematically used with methods and targets aligned between different planning frameworks	Commonly used for "diagnostic" purposes to describe health problems / challenges, but no synchronised use of health information between different planning frameworks	Health information is used occasionally	Never used.	2.1
VI.C.2 District health workers analyse all health statistics in their province / district, compare them with national benchmarks and act accordingly	Yes	Most health information is analysed by district health workers and any discordant activities are adjusted accordingly.	Health statistics are analysed and reported	No	1.7
VI.C.3 All indicators in the national minimum core indicator set are linked to the relevant short (1 year), medium (3-5 years), and long-term (10-15 years) targets	All indicators have relevant targets	40-80% of indicators have targets	Under 40% of indicators have targets	No targets	2.2

D. Resource allocation

Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average
	3	2	1	0	
VI.D.1 HIS information is widely used to set national resource allocations	The majority of targets/budget proposals are backed up by HIS information	Some targets/budget proposals are backed up by HIS information	Few targets/budget proposals are backed up by HIS information	None of the targets/budget proposals are backed up by HIS information	1.8
VI.D.2 HIS information is widely used, by district and sub-national management teams to set resource allocation in the annual budget processes	The majority of targets/budget proposals are backed up by HIS information	Some targets/budget proposals are backed up by HIS information	Few targets/budget proposals are backed up by HIS information	None of the targets/budget proposals are backed up by HIS information	1.8

VI.D.3	HIS information is used to advocate for equity and increased resources to disadvantaged groups and communities by e.g. documenting their disease burden and poor access to services	HIS information is systematically used to pursue equity	HIS information is regularly used to promote equity	HIS information is used for equity purposes on an ad-hoc basis	Not used for equity purposes		1.6
VI.D.4	During the last 5 years, HIS information has resulted in significant changes in annual budgets and/or general resource allocation	All resource allocation (budgets, staff allocations) are based on HIS information, resulting in major shifts	Information-driven resource allocation adopted in principle, but not yet fully implemented;	Some shifts, but links to information not clear	Budgets are not information-driven		1.5

E. Implementation/action

Items	Highly adequate	Adequate	Present but not adequate	Not adequate at all	Average	
	3	2	1	0		
VI.E.1	Managers at all levels use health information for local health service delivery management, planning and monitoring	Health information is used by managers at all levels for health service delivery management, planning and monitoring		Health Information is rarely used for management and monitoring, but no real planning done	All key decisions are centralized or HIS information is never used	2.4
VI.E.2	Care providers at all levels use health information for local service delivery, planning and monitoring	Health information is used by care providers at all levels for health service delivery, planning and monitoring		Health Information is rarely used for service delivery and monitoring, but no real planning done	Care providers other than at Central level do not use health information for service delivery, planning and monitoring	2.1
VI.E.3	Information on health risk factors are systematically used to advocate less-risk behaviour in the general public as well as in targeted vulnerable groups.	Such indicators are systematically used and tailored to fit the risk profile and situation facing each vulnerable group	Such indicators are regularly used, but generally not tailored to each vulnerable group	Only used on an ad-hoc basis	Not used	1.0

Annex 2 - Summary Assessment Report

Organizing of HMIS National assessment of Afghanistan Summary Report

The national HIS system assessment was one of the agenda of HMIS task force meeting, the participants of the meeting decided to assist and facilitate the system so the soft copies of assessment tools were distributed to 9 participants and some stakeholders, they were brief presented and guided regarding the utilization of the tools and asked them to fill out the tools and send pack to the HMN consultant up to 10 days moreover two workshops were organised for provincial HMIS officers and some stakeholders, the tools was presented in a session and they fell out the tools as group work, two interviews were performed. Totally average of 14 scoring (9 persons, 3 group works and two interviews) were prepared and analysed by the assessment software.

The result was discussed in HMIS task force and will be presented in a workshop to authorities and stakeholders for decision making.

The following organization participated in the planning and execution of the assessment:

Johns Hopkins University, National HMIS Consultant Ministry of public Health, International Medical corps (IMC), Control of communicable Disease (CDC), Bakhter Development Network (BDN), STEP, Aid Medical International (AMI), Tech-Serve, Move, data Manager of Ministry of Public Health.

Mentioned non government organizations are stakeholders of ministry of public health.

The HMIS department with facilitation of HMN consultant led the assessment.

More than 9 separate full meetings and tow workshops were held moreover there were a lot of smaller group meetings to explain the objectives, roles and performance the assessment but only in one meeting discussed the result so far and it will be discussed in full group of authorities and stakeholders in a workshop for decision making as soon as possible.

Meetings of smaller working groups were subsets of items assessed by smaller working groups and the types, number of items they assessed and approximate number of hours that they met to assess these items are as following:

Number and types of participants	Number of items	hours
a) <u>11</u> provincial HMIS officers_____	<u>40</u>	<u>2</u>
b) <u>6</u> provincial HMIS Officers_____	90	2:30
c) <u>10</u> NGOs_____	50	2
d) <u>Individuals Working on soft were</u> _____	210	2:20

The process supervised, and monitored by national HMIS Consultant and HMN Consultant,

The tools were presented in meetings, workshops and individuals, the participants felt freedom to score, the questions and answers.

There are plan to organize a national conference to conclude the assessment and review the finding. The authorities and stakeholders will be invited.

There was not any modification on assessment tools and the tools were not translated, so all participants know English but some HMIS provincial officers had difficulties and the items were discussed and translated in group works.

Some individuals have missed different items, it is around 10 items but all of them have missed additional selected indicators due to lack of indicator selection.

There were not any difficulties on understanding of the items.

Some individuals received the copy of the tools with guidance but did not fill out it, there was some discussion in group works which was wasted the time, a lot of hard copies of the tools provided for group works and it interred to the soft ware. Some participants needed more discussion regarding the items and scoring procedure and some did not have enough information about the some items.

The final assessment report is going on and will be prepared as soon as possible.

The time requires from firs planning meeting until the concluding meeting was 15 weeks.

Annex 3 - Main Achievements

Afghanistan HMN main Achievement

Ministry of Public health has received \$150000 from HMN through WHO/Afghanistan office on October 2006, which was small but very important budget for HMIS capacity building, assessment and planning moreover by coordination and supervision of different stakeholders from government, national and different organization, usually decisions are making in taskforce meeting and is prepared feedback to the taskforce. The director of APHI and the deputy minister are approved the activities and expenses.

The main achievements are as following:

- 142 participants from MoPH, HMIS officers of provinces, staff of national and international organization were trained and some of them attended in HMIS training of trainers (ToT) to conduct HMIS training at provincial levels.
- 360 health staff were trained in 28 provinces .
- A HMN Consultant was employed to manage HMN related activates.
- 24 medical record staff of 6 national hospitals were trained regarding hospital HMIS system and method of data collection.
- Establishment of 6 hospital HMIS system and providing of necessary stationeries(there are 15 national hospitals and poly clinics in Kabul without appropriate HMIS reporting system but according to the resources 6 of them had priorities)
- Providing of necessary stationeries for 29 provinces.
- Establishment of 29 provincial profiles.
- Facilitation to have up to date information at provincial levels.
- Providing of communication facilities for central MoPH, HMIS office(mobile phone, credit card and internet) as well as for 28 provinces(mobile phone credit cord).
- Supporting of supervision and monitoring of HMIS for validity, accessibility, quality and data use at different central and provincial levels.
- Providing office equipments (2 laptop, 3 computers, 4 UPSs for central MoPH office and 10 printers for provinces)
- HMIS coordination with different organization (government, NGOs and UN).
- Organizing of national HIS assessment, its conclusion was discussed HMIS taskforce meetings and will be presented in a national workshop with participation of authorities, stakeholders and donors.

Annex 4 - Budget



Between HMN and ...

Name and address of the institution:	Short project title:	Period covered by report:	
Ministry of Public Health , Great Masood Road , Kabul - Afghanistan		From:	1-Oct-06
		To:	5-Jun-07
		Report number:	
	Registry file number:	1	
		Final Report:	
Project ID Number:			

1. FUNDS AVAILABLE	US\$ Dollars	Local Currency	Exchange rate
Cash balance at start of the period (balance from last report #....)	0.00	0.00	0.00

Funds transferred from WHO during the current period	75,000.00		0.00
TOTAL FUNDS	75,000.00		0.00

2. DISBURSEMENTS and CASH BALANCE	1. Balance from previous report (US\$)	2. Funds (US\$) received since last report	3. Expenditures in the current period (US\$)	4. Expenditures in the local currency	5. US\$ cash balance at the end of period
<i>(enter expenditure categories as per budget approved)</i>		75,000.00			75,000.00
Six training workshops for central , provincial and national hospitals staff			8,756.00		66,244.00
Two laptop, 3 computers, 3 UPS and 10 printers for 10 provinces			9,160.00		57,084.00
Budget for 29 provinces(communication, HMIS training, provincial profiles monitoring and supervision)			32,000.00		25,084.00
Communication(Two set air internet cord for HMIS office, Mobile phone, credit card and four months internet taxes			1,669.00		23,415.00
Salary of HMN consultant from 20 feb. to end of May 2007			2,867.00		20,548.00
Monitoring and evaluation of 2 provinces			930.00		19,618.00

First phase of HMIS implementation for 6 national hospitals			2,047.00		17,571.00
					17,571.00
TOTAL	0.00	75,000.00	57,429.00	0.00	17,571.00
				Local currency cash balance at the end of period	0.00

We certify that the above financial report and any supporting documentation are correct and agree with the account books and other records of the institution :

Chief Financial Officer		Principal Investigator	
Signature:	_____	Signature:	_____
Name:	<u>Dr.Mohammadullah Alishungi</u>	Name:	_____
Date:	<u>June 4 2007</u>	Date:	_____

