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５．会議議事録（Meeting Minutes）
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プログラム疫学ユニット第１回調整会議録

６．JCC 議事録（PDM Version 2 含む）

１．調査日程

	Date		JICA member	Project
OCT	26	Wed	*Ms. Kaneko arrive DSM*	
	27	Thu	*Mr. Takizawa arrive DSM*	
	28	Fri	*engaged in another mission (5S)*	
	29	Sat	*engaged in another mission (5S)*	Ms. Tanaka Depart Japan
	30	Sun	*engaged in another mission (5S)*	Ms. Tanaka Arrive DSM
	31	Mon	*engaged in another mission (5S)*	NACP
NOV	1	Tue	14:00 Come back to DSM (Mr. Takizawa, Ms. Kaneko and Ms. Nishimura) 15:30 Meeting with Project Experts	15:30 Meeting with Project Experts
	2	Wed	Travel to Dodoma Meeting with the Situation Analysis Team	
	3	Thu	Workshop in Dodoma Region <Day 1>	
	4	Fri	Workshop in Dodoma Region <Day 2>	
	5	Sat	Travel back to DSM	
	6	Sun	Documentation	
	7	Mon	Move to Pwani/ Preparation for the workshop / Site visit to DHIS/HRHIS site (Kibaha DC)	
	8	Tue	Workshop in Pwani Region <Day 1>	
	9	Wed	Workshop in Pwani Region <Day 2>	
	10	Thu	9:20 Dr. Sugishita arrive DSM from Kenya 10:30 Meeting with Project Experts/JICA TZ office 16:50 Ms. Kaneko leave DSM (EK726)	
	11	Fri	9:00 Internal Discussion with Project Experts	
	12	Sat	Documentation	
	13	Sun	Documentation/ Internal discussion	
	14	Mon	9:00 Discussion with NACP/MOHSW on PDM revision 15:00 Report to CMO, MOHSW	
	15	Tue	Internal discussion	
	16	Wed	8:00 Meeting with MOHSW/NACP 16:00 Report to JICA Tz office	Ms. Tanaka Depart DSM
	17	Thu	15:00 Dr. Sugishita depart DSM	Ms. Tanaka Arrival in Japan

Project Design Matrix (PDM) Version 1
Project Title: Health Systems Strengthening for HIV and AIDS Services Project (NACP/JICA Project Phase2)

Date: 15 July, 2010
Project Duration: 4 years

Target Area: Tanzania

Target Group : NACP, National supervisors and mentors **Beneficiary: RHMTs, CHMTs and Health facilities**

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal			
Health system is strengthened through comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV and AIDS services.	Number/Proportion of regions implementing comprehensive supportive supervision/mentoring/M&E system for health sector HIV and AIDS services	Supervision reports, Mentoring reports	
Project Purpose			
Comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV and AIDS services is developed and demonstrated for scale-up.	1. Number of regions and stakeholders oriented on comprehensive supportive supervision/mentoring/M&E system for health sector HIV and AIDS services developed by the Project 2. Number of regions having well functioning comprehensive supportive supervison/mentoring/M&E system (denominator:2) 3. Proportion of health workers in the model regions recognizing comprehensive supportive supervision/mentoring/M&E system as simpler and more useful than the previous system for their service provision is increased	1. Project reports 2. Survey using questionnaire or interivew 3. Survey using questionnaire or interview	DHIS is rolled out nationwide. Human, financial and physical resources are maintained at all levels.
Outputs			
1. M&E tools are simplified and intergrated at national level.	1-1. Number of stakeholders meetings conducted 1-2. Simplified and integrated recording and reporting tools and SOP in place	1-1. Project reports, Minutes of stakeholders meetings 1-2. Project reports	Human, financial and physical resources are maintained at all levels.
2. M&E system in model regions is strengthened.	2-1. Number/Proportion of regions/districts/health facilities generating complete, timely and accurate reports 2-2. Number/Proportion of Regional Annual Health Plans and CCHPs citing information generated from DHIS 2-3. Proportion of health facilities which can cite at least one decision made from information generated from M&E system	2-1. M&E audit reports 2-2. Regional Annual Health Plans, CCHPs 2-3. Survey reports	
3. Coordination capacity of comprehensive supportive supervision and mentoring at NACP is strengthened.	3-1. Number of stakeholders meetings conducted 3-2. Annual plan of comprehensive supportive supervision and mentoring in place at the national level 3-3. Number of bi-annual supervisory visits to regions conducted according to the plan in the last one year 3-4. Number of mentoring visits to referral/regional hospitals conducted in response to the needs identified in the last one year 3-5. Improved manual and tools in place	3-1. Project reports, Minutes of stakeholders meetings 3-2. Annual plan of comprehensive supportive supervision and mentoring at the national level 3-3. Supervision reports 3-4. Supervision reports, Mentoring reports 3-5. Project reports	
4. Capacity of national supervisors and mentors is improved.	4-1. Comprehensive supportive supervision and mentoring training package in place 4-2. Number of national supervisors/mentors trained 4-3. Number of national trainers for comprehensive supportive supervision and mentoring	4-1. Project reports 4-2. List of national supervisors and mentors, Training reports 4-3. List of national trainers, Training reports	
5. Comprehensive supportive supervision and mentoring in model regions is strengthened.	5-1. Number of regional/district supervisors and mentors trained 5-2. Number/Proportion of regions/districts/health facilities received comprehensive supportive supervision/mentoring for HIV and AIDS health services 5-3. Proportion of action points/recommendations implemented by regions/districts/health facilities	5-1. List of regional/district supervisors and mentors, Training reports 5-2. Supervision matrix and reports, Mentoring reports 5-3. Supervision reports, Mentoring reports	

Activities	Inputs		
0. Conduct baseline, midline, endline survey	**Japan**	**Tanzania**	Significant proportion of trained personnel remains as implementors of tasks assigned by the Project. Structure, roles and responsibilities of national, regional and district administration for M&E and supportive supervision are maintained. Human, financial and physical resources are maintained at all levels.
1-1. Review and design recording and reporting tools and SOP	1. Dispatch of Japanese experts - Chief Advisor/M&E specialist - Epidemiology specialist - Project Coordinator/Training specialist - Other short-term experts 2. Equipment - Photo copy and fax mashine - IT equipment for DHIS operations in model regions, etc. 3. Operational cost	1. Assignment of the personnel 2. Facilities and equipment - Office space 3. Operational cost	
1-2. Pre-test revised recording and reporting tools and SOP			
1-3. Finalize the recording and reporting tools and SOP			
1-4. Conduct stakeholders meetings for dissemination of the recording and reporting tools and SOP			
1-5. Print and distribute the recording and reporting tools and SOP to regions			
1-6. Integrate the reporting forms into DHIS			
1-7. Conduct annual M&E data audit			
1-8. Orient NACP staff on 5S			
1-9. Apply 5S to all documentation at NACP			
1-10. Conduct M&E coordination meetings between M&E Unit of MOHSW and NACP			
1-11. Include revised M&E components in comprehensive supportive supervision tools			
2-1. Train healthcare workers including R/CHMTs on recording and reporting tools and SOP			
2-2. Ensure delivery of recording and reporting tools and SOP to health facilities			
2-3. Conduct situation analysis before implementing DHIS			
2-4. Install IT equipment for DHIS			
2-5. Conduct advocacy meetings on DHIS			
2-6. Train R/CHMTs on the usage of DHIS			
2-7. Condcut follow-up techinical consulatation visits on DHIS			
2-8. Train R/CHMTs on evidence based (data utilization) health planning			
2-9. Condcut stakeholders meetings to share experience/lessons			
3-1. Coordinate development of annual plan and budget for national supervisors and mentors			
3-2. Implement and monitor comprehensive supportive supervision and mentoring visits for health sector HIV and AIDS interventions			
3-3. Develop mechanism for documentation and sharing reports of comprehensive supportive supervision and mentoring visits			
3-4. Conduct national synergy meetings between supervisors and mentors			
3-5. Conduct stakeholders meetings to share experiences/lessons			
3-6. Review and print comprehensive supportive supervision and mentoring manual and tools			
4-1. Develop and print comprehensive supportive supervision and mentoring training package			
4-2. Conduct National Training of Trainers (NTOT)			
4-3. Train national supervisors and mentors			
4-4. Conduct refresher trainings to national supervisors and mentors			
5-1. Orient R/CHMTs and health facilities on comprehensive supportive supervision and mentoring			**Pre-Conditions**
5-2. Select and train regional and district supervisors and mentors			Assistant Programme Manager (NACP) is assigned by MOHSW.
5-3. Plan and conduct comprehensive supportive supervision and mentoring			
5-4. Develop mechanism for documentation and sharing reports of comprehensive supportive supervision and mentoring visits			
5-5. Conduct regional and district synergy meetings between supervisors and mentors			
5-6. Conduct stakeholders meetings to share experiences/lessons			
5-7. Integrate comprehensive supportive supervision and mentoring into Regional Annual Health Plans and CCHPs			
5-8. Conduct study tour to a country of best practice			

* Targets of the indicators will be set after baseline survey.

SITUATION ANALYSIS ON HEALTH SECTOR HIV AND AIDS MONITORING AND EVALUATION ACTIVITIES

Presenters: Joseph Chilongani
Jacklin Mosha
Bahati Andrew
Wambura Mwita

Outline

- Introduction and Methodology
- Findings
  - Quantitative Findings
  - Qualitative Findings
- Discussion and Conclusions

Introduction

- HIV M & E data are essential for
  - Guiding planning, coordination and implementation of the response against HIV infection
  - Assessing the effectiveness of HIV programmes and identifying areas for programme improvement
  - Ensuring accountability to those infected or affected by HIV and AIDS as well as to those providing resources.

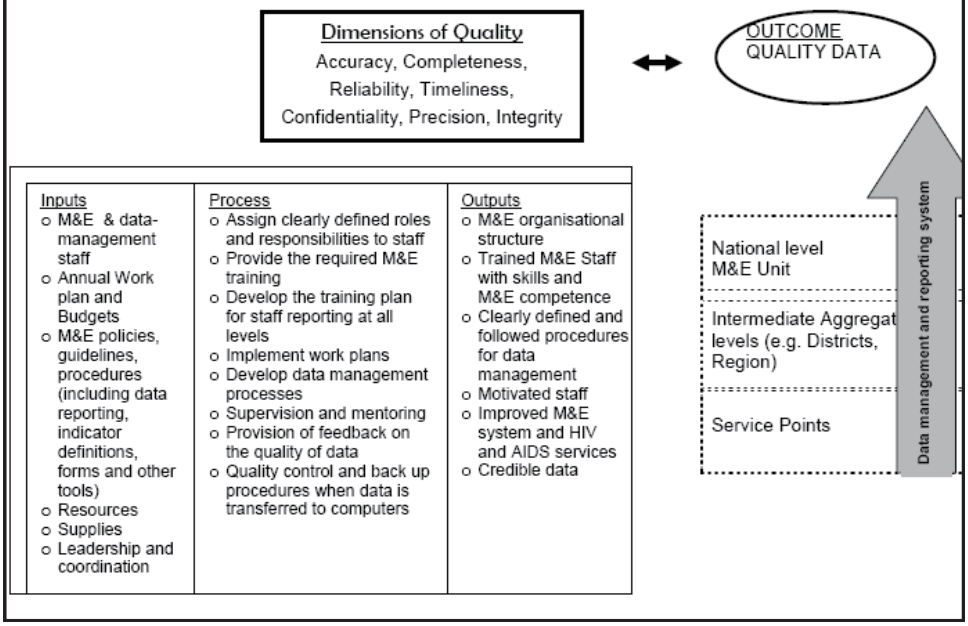
Health Sector HIV and AIDS Strategic Plan-II 2008-2012

- The objective for M&E in the HSHSP-II is:
  - To strengthen M&E system to provide relevant comprehensive information in a timely manner for programme management and planning.
- To achieve the above objective, strategies have been developed
  - Formulate a comprehensive M&E system
  - Strengthen supportive supervision for M&E
  - Build capacity for M&E at facility, district, regional & national levels
  - Establish data quality assurance system

Health Sector HIV/AIDS M & E Plan

- This document defines:
  - Key components of functional M & E system
  - Performance goals and expected Performance results from each component
- Functional M & E has 10 components
  - Modified from the organising framework for a functional national HIV M & E system of the UNAIDS

Conceptual Framework



Technical Cooperation

- Agreement reached between Tanzania and Japanese Governments
- A project launched
  - Titled “Health Systems Strengthening for HIV and AIDS Services Project” (NACP JICA 2)
  - Four years duration
  - Aimed at strengthening
    - HIV and AIDS M&E system
    - Supportive supervision

Routine Health Sector M & E System

- Routine Monitoring is a component of health sector M & E in Tanzania
- Collects data on inputs, activities, outputs, outcome for measuring the national response
- Seven interventions under NACP
  - HIV and AIDS Care and Treatment Services
  - HIV Testing and Counseling (HTC) Services
  - Home-based Care (HBC)
  - Sexually Transmitted Infections (STI) Services
  - HIV and AIDS Laboratory Services
  - Clinical Male Circumcision
  - Education, Information and Communication (IEC) Services

HIV and AIDS Interventions

- Most of these interventions record and report service provision data
- Tools
  - Are used throughout the country
  - Are standardized to feed into internationally agreed indicators
  - Are filled at service provision point while attending the client
  - End of month/quarter, data is summarized into reporting forms

Rationale

- In an effort to strengthen Health Sector M & E system
  - NACP through the "NACP/JICA 2" project
    - Conducted a study to assess the situation of the Health Sector HIV and AIDS M & E activities.
    - Findings from this study will inform the process of strengthening the routine HIV and AIDS programme monitoring
    - Inform the activities of the "NACP/JICA 2" Project.

Objectives

- Identify strengths and weaknesses of the current routine health sector HIV and AIDS M&E system
- Assess factors affecting the performance (recording, summarisation, analysis, timely reporting, information dissemination and utilisation) of the current routine health sector HIV and AIDS M & E system
- To draw precise and action oriented recommendations for formulation of the project action plan.

Desk Review

- Desk Review
  - Done to collect existing information on Health sector M & E system
    - M & E guidelines and manuals for filling tools for HIV and AIDS interventions
    - Review of registers and reporting forms
  - Review covered published articles, surveys, research, plans and other relevant written reports

Situation Analysis Study

- Conducted in Pwani and Dodoma Regions
  - Model regions as agreed in the technical cooperation
  - Interventions resulting will be implemented in these regions before being scaled up
- Design of the study: Descriptive integrating both Quantitative and Qualitative

Study Procedures-1

- Study conducted at 4 levels
  - **Level 1: Service Provision**
    - Regional and District Hospitals participate automatically
    - For every district, list all public owned health facilities providing C & T, PMTCT and STI services was generated
      - From the list, 4 disp. and 2 HC were selected
      - Heads of the facilities interviewed using M & E Assessment Questionnaire
      - One register and its reporting form selected RANDOMLY for EVERY HIV and AIDS Intervention provided at the facility to assess competence in filling registers and quality of data collected
      - For databases: Data management procedures assessed using database checklist

Study Procedures-2

- **Council, Regional and National levels**
  - Interview members of CHMT, RHMT and national M & E personnel using M & E assessment Questionnaire
  - Assess aggregation of data using data validation tools
  - For databases: Asses data management procedures
- **Conduct KII**
  - 22 KII done with Government Officials to gain their perceptions regarding the performance of HIV and AIDS M & E system
    - RMOs and DMOs
    - Seven Officers at the National level

Data Processing and Ethics

- Quantitative data
  - Double entered using CSpro
  - Managed and Analyzed using STATA
- Qualitative data
  - Transcribed and translated into English
  - Coded and entered into Nvivo
  - Analyzed using grounded theory approach
- Ethical Considerations
  - Anonymity and confidentiality of the information
  - KII participants signs consent forms
  - Electronic data kept under lock and key for 5 years
  - Hard copies locked in the filing cabinets

Outline

- Introduction and Methodology
- Findings
  - Quantitative Findings
  - Qualitative Findings
- Discussion and Conclusions

FINDINGS

Description of Service Delivery Points (SDPs)

- Facilities visited
  - 39 in Pwani Region, over 7 districts
  - 42 in Dodoma Region, over 6 districts
- Type
  - 56% Dispensary
  - 30% Health Centre
  - 15% Hospital
- Almost all – Government owned

HIV Services Offered by SDPs

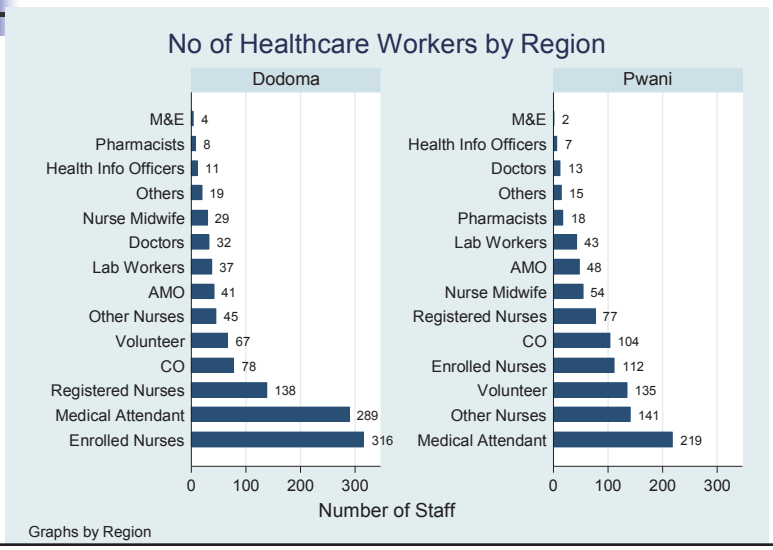
Care and Treatment	49%
STIs	89%
PMTCT	100%
HTC	80%
HBC	72%
Laboratory Services	57%
Clinical MC	24%
IEC services	48%
Others	12%

- All facilities surveyed provided PMTCT Services
- Only half of the facilities provided Care and Treatment services

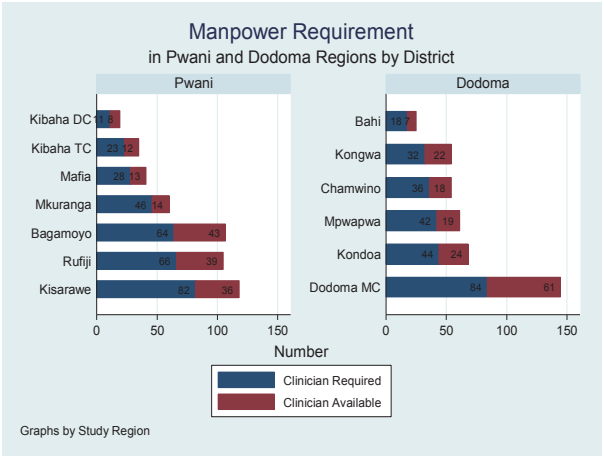
Description of CHMT and RHMT respondents

- CHMT Interviewees
  - 35 in Pwani Region, over 7 Councils
  - 25 in Dodoma Region, over 6 Councils
- CHMT Respondents
  - CTC Coordinators; Data Managers; MTUHA Coordinator
  - HBC Coordinator; DACC; DRCHCo; Others
- RHMT interviewees
  - 6 in Pwani Region; 4 in Dodoma Region
- RHMT Respondents
  - RACC; Data Manager; M&E Officer; MTUHA Coordinator
  - HBC Coordinator; RRCHCo; Others

Medical Personnel by Cadre - SDPs



Shortage for Human Resource

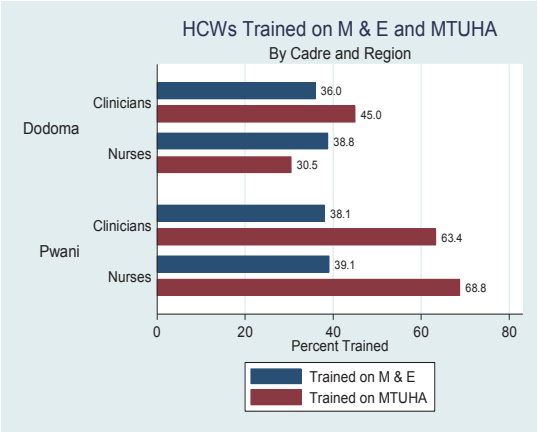


- A huge shortage of human resource at SDPs was observed, which affects M&E activities
  - A huge deficit of clinicians and nurses was reported

M&E Staff at CHMT and RHMT level

- CHMT Staff Required and Available for M&E Activities
  - Required: 2 M&E Officers
    - 66% Pwani; 56% Dodoma
  - Available: None M&E Officer
    - 69% Pwani; 88% Dodoma
  - 72% of CHMT respondents in Dodoma reported no data manager
  - Pattern not clear in Pwani, almost equal percentage distr between zero to two data managers
- RHMT Staff for M&E Activities
  - 1 M&EO available in Pwani RHMT (83%); None in Dodoma (75%)
  - 1 Data Manager available in Pwani (83%) and 1 in Dodoma (75%)

M&E Training



- M&E Training done last 5 years
  - 4 MTUHA (3 Pwani, 1 Dodoma)
  - 4 HIV/AIDS (2 Pwani, 2 Dodoma)
- A higher % of HCWs were trained in MTUHA Vs HIV and AIDS M&E system (T test 2.63, p=0.015)

Utilization of MTUHA Books

MTUHA M&E Tools	Utilization
Book 2 – Facility Records	84%
Book 3 – Outreach Records	82%
Book 4 – Supplies Inventory	84%
Book 5 – OPD register	90%
Book 6 – ANC Register	100%
Book 7 – RCH Register	94%
Book 8 – Family Planning Register	88%
Book 9 – DTC	84%
Book 10 – Reporting forms	79%
Book 11 – Dentistry Register	43%
Book 12 – L&D Register	96%

- Utilization is high for RCH Units compared to others
- OPD registers were also highly utilized
- Most registers are filled by nurses and some by by clinicians

Utilization of CTC Tools

CTC M&E Tools	Utilization
CTC1	100%
CTC2	98%
Pre-ART Register	93%
ART Register	93%
Appointment book	90%
Referral form	100%
Electronic Database System CTC	65%
Other Electronic Database System	45%
Cross Sectional Quarterly Report form	80%
Cohort Analysis Report Register	88%
Pre-ART Reporting Form	93%
ART reporting form	93%
Cohort Analysis Report Form	93%

- CTC1, CTC2 and Referral forms were highly utilized
- Few facilities reported using databases
- DHIS, PMTCT databases were in use in Pwani region
- CTC M&E tolls mostly filled by Clinicians

Utilization of STI, HTC and HBC Tools

M&E Tools	Utilization
STI Register	88%
Referral Form	63%
Contact Tracing Card	61%
STI Monthly Reporting Form	82%
HTC Clients Registration	91%
Guardian Consent Form	54%
Client ID Card	79%
Referral Form	83%
HTC Monthly Report Form	91%
HBC Registration notebook	93%
Referral Form	78%
Monthly Summary Form for HBC	81%

- Low utilization of referral form and contact tracing card for STI services
- Low utilization of Guardian consent forms for HTC services
- Services filled by Clinicians, nurses and volunteers

Utilization of PMTCT Books

PMTCT M&E Tools	Utilization
ANC Register	93%
Labour & Delivery Register	90%
PMTCT Care Register	88%
Pregnant Woman Card	86%
Mother & Child Follow-up Reg	85%
PMTCT ARV Dispensing Regist	75%
ANC Monthly Summary Form	89%
L&D Monthly Summary Form	89%
PMTCT Care Register MSF	88%
Mother & Child Follow-up MSF	85%

- Not all pregnant women receive ANC cards, instead they are given exercise books or papers due to stock outs

Factor Analysis – SDPs level

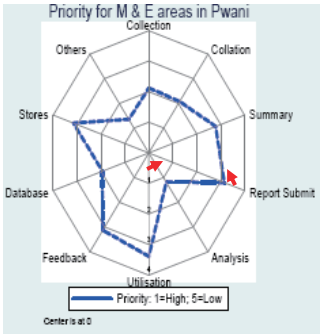
- Nine questions related to appropriateness of M&E activities were analyzed using PCA with Varimax rotation
- Three factors which accounted for 63% of the variance of the entire set of variables were observed
  - 1st factor explained 30% of total variance, "data quality issues" – data collection, collation, summarization, submission and stores management
  - 2nd factor explained 19% of the total variance, "supply of evidence and utilization", - analysis, utilization and feedback
  - 3rd factor explained 14% of the total variance, "use of databases", - use of M&E database

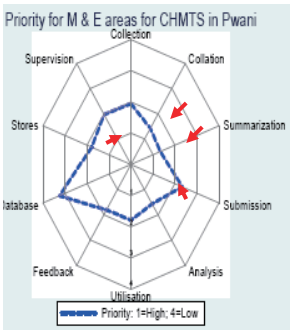
Factor Analysis at CHMT level

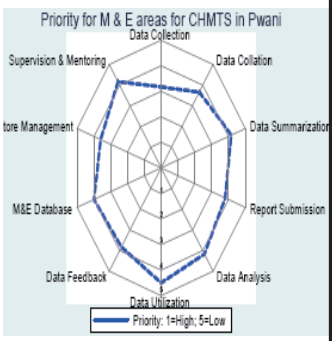
- Ten questions related to appropriateness of M&E activities were analyzed using PCA with Varimax rotation
- Four factors which accounted for 65% of the variance of the entire set of variables were observed
  - 1st factor explained 19% of total variance, "data submission issues" – data collation, submission and supervision.
  - 2nd factor explained 18% of the total variance, "data collection issues", - collection, feedback & use of databases
  - 3rd factor explained 17% of total variance, "supply of evidence and utilization", - data summary, analysis and utilization
  - 4th factor explained 11% of the total variance - use of store management facility.

M&E Activities to be Strengthened in Pwani

- Respondents were asked to list 5 activities they wanted strengthened (in order of priority)

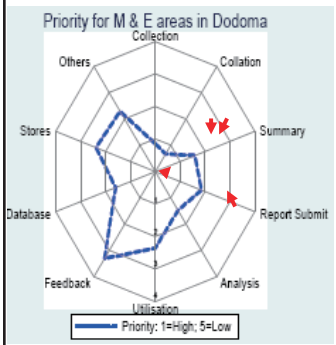


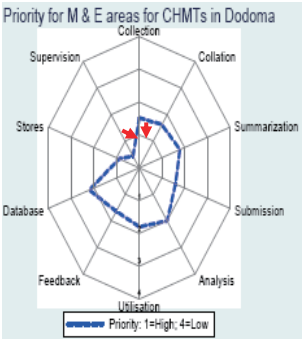


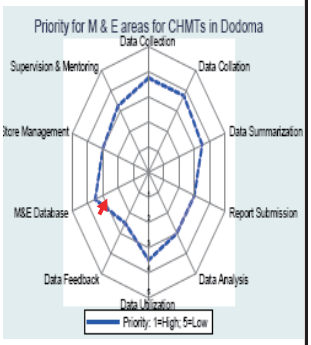


M&E Activities to be Strengthened in Dodoma

- Respondents were asked to list 5 activities they wanted strengthened (in order of priority)







Factors affecting M&E Activities-1

Data Collection	SDPs	CHMTs	RHMTS
Inadequate HCWs	31%	36%	70%
Lack of Commitment	18%	-	-
Shortage of Equipment	10%	-	-
Shortage of Registers	21%	-	-
Inadequate Training	8%	31%	-
Late submission	-	18%	-
Geographical coverage	-	-	20%
Data Collation			
Inadequate training	31%	47%	-
Inadequate HCWs	37%	16%	40%
No Commitment/Motivation	18%	26%	-
Shortage of Equipment	10%	-	-
Late data submission	-	-	20%
Irregular data review meetings	-	-	20%

Factors affecting M&E Activities-2

Data Summarization	SDPs	CHMTS	RHMTs
Inadequate HCWs	24%	-	-
Inadequate Training	17%	80%	70%
Lack of Incentives	41%	-	-
Shortage of Registers	9%	-	-
Late data submission	-	-	30%
Data Submission			
Lack of transport	85%	-	40%
Lack of incentives	-	-	20%
Late data submission	-	80%	30%
Data Analysis			
Lack of HCWs	33%	-	-
Lack of skills for data analysis	52%	85%	-
Lack of motivation	-	-	70%

Factors affecting M&E Activities-3

Data Utilization	SDPs	CHMTs	RHMTS
Data is not reliable	23%	53%	-
Lack of skills for data Utilization	70%	-	40%
User friendly data	-	-	60%
Others	7%	47%	-
Data Feedback			
No Commitment/Motivation	60%	32%	-
No Transport/funds	26%	53%	100%
Others	13%	15%	-
Use of databases			
Lack of equipment	91%	35%	-
Unreliable network	-	39%	80%
Lack of skills	-	-	20%

Factors affecting M&E Activities-4

Store management	SDPs	CHMTs	RHMTS
Lack of storage facility	92%	64%	100%
Lack of filing cabinets	-	31%	-
Others	8%	5%	-
Supervision and mentoring			
Lack of funds	-	27%	20%
Lack of transport	-	57%	20%
Lack of regular review meetings	-	-	20%
Lack of skills	-	-	40%
Others	-	16%	-

Adequacy of Supplies and Budgets for M&E Activities in Pwani

	SDPs	CHMTs	RHMTs
Insufficiency of M&E guidelines	67%	46%	
Insufficiency of Registers	36%	34%	
Insufficiency of reporting forms	28%	29%	
No Computers	69%	-	
No electronic database	-	7%	
Insufficiency or No M&E Budget	98%	89%	83%
Reasons for insufficient budget			
Lack of funds	74%	61%	20%
Low priority	-	-	40%
People not aware of importance	-	-	40%
Funding for M&E activities incase of insufficient funds			
Private Resources	100%	36%	20%
Partners	-	9%	40%
Funds for supervision	-	30%	20%

Adequacy of Supplies and Budgets for M&E Activities in Dodoma

	SDPs	CHMTs	RHMTs
Insufficiency of M&E guidelines	50%	64%	
Insufficiency of Registers	64%	64%	
Insufficiency of reporting forms	50%	64%	
No Computers	64%	-	
No electronic database	-	48%	
Insufficiency or No M&E Budget	88%	96%	100%
Reasons for insufficient budget			
Lack of funds	75%	42%	-
Low priority	-	-	33%
People not aware of importance	-	-	67%
Funding for M&E activities incase of insufficient funds			
Private Resources	100%	13%	25%
Partners	-	21%	50%
Funds for supervision	-	21%	-

Supportive Supervision for HIV/AIDS M&E in Pwani

Percent supervised	SDPs	CHMTs	RHMTs
NACP	13%	40%	17%
RHMT	26%	80%	-
CHMT	54%	-	-
Partners	44%	60%	33%
Median (IQR) Visits per Year			
NACP	2(1-2)	1 (1-1)	1(1-1.5)
RHMT	1(1-2)	2 (2-3)	-
CHMT	3(1-4)	-	-
Partners	4 (4-6)	4 (3-4)	2(1-7.5)
Median (IQR) Time in Hours			
NACP	2 (1-3)	4 (2-6.5)	3.5(3-8)
RHMT	2 (2-6)	3 (2-5)	-
CHMT	1 (1-2)	-	-
Partners	3 (1-3)	3 (2-5.5)	3(2-6.5)

Supportive Supervision for HIV/AIDS M&E in Dodoma

Percent Supervised	SDPs	CHMTs	RHMTs
NACP	14%	60%	50%
RHMT	45%	84%	-
CHMT	50%	-	-
Partners	24%	64%	-
Median (IQR) Visits per Year			
NACP	2 (1-3)	1(1-2)	2(1-3)
RHMT	2 (1-3)	3(2-3)	-
CHMT	2 (1-4)	-	-
Partners	4 (3-6)	4(3-4)	-
Median Time in Hours			
NACP	3.5 (2-6)	4(3-8)	4(3-8)
RHMT	3 (2-6)	4(3-6)	-
CHMT	3 (2-5)	-	-
Partners	3 (2-4)	6(6-6)	-

Shortage of M&E Tools, Feedback & Motivation in Pwani Region

	SDPs	CHMTs	RHMTs
Percent in shortage	44%	46%	67%
Median (IQR) time (days)	15(36)	30(12-60)	25(14-30)
Median (IQR) Freq	1(1-3)	1(1-2)	2(1-3)
Feedback	SDPs	CHMTs	RHMTs
No feedback from NACP	69%	83%	17%
No feedback from RHMT87%	51%	-	
No feedback from CHMT	64%	-	-
No Incentive	72%	71%	67%

Shortage of M&E Tools, Feedback & Motivation in Dodoma Region

	SDPs	CHMTs	RHMTs
Percent in shortage	44%	52%	75%
Median (IQR) time (days)	15(36)	60(30-180)	15(0-75)
Median (IQR) Freq	1(1-3)	1(1-2)	1(1-3)
Feedback	SDPs	CHMTs	RHMTs
No feedback from NACP	69%	88%	50%
No feedback from RHMT	87%	52%	-
No feedback from CHMT	64%	-	-
No Incentive	88%	84%	75%

Quality of data Collected

- To assess quality of data recorded in reporting forms compared to registers, concordance correlation coefficient (rho c) was calculated.
- McBride (2005) suggests how to interpret (rho c)
  - If < 0.90, poor agreement; 0.90-0.95 moderate agreement; 0.95-0.99 substantial agreement; >0.99 perfect agreement

New clients in PMTCT ANC Registers and MSF	0.89 (0.83-0.94)
New clients in PMTCT L & D Registers and MSF	0.92 (0.89-0.96)
Clients newly on ART in registers and QSF	0.999(0.999-1.0)
New clients in HTC registers and its MSF	0.81(0.73-0.90)
New clients in HBC registers and its MSF	0.08(-0.01-0.18)
Number of Clients with GDS in Registers and MSF	0.90(0.84-0.97)

Outline

- Introduction and Methodology
- Findings
  - Quantitative Findings
  - Qualitative Findings
- Discussion and Conclusions

Qualitative Findings

- Majority of respondents (86%) described what Monitoring and evaluation was:

Monitoring is continuous collection of data to assess if implementation is done according to defined rules, approaches, ways and tools in order to meet the desired objective i.e. achieve the desired goals"

KII-Dodoma

- Some of the respondents were able to contrast the terms Monitoring and Evaluation

Knowledge of M &E

"In most cases these two concepts goes together, there is no monitoring without evaluation, if you are monitoring and then you do not evaluate yourself, what does this mean? The only difference between the two is that monitoring is progressive, it is being done all the time during system or programme implementation, while evaluation needs enough time for the system to be implemented so that you can be able to see the impact. In most cases, new programmes or projects or systems have their own objectives depending on the type of the system, project or programme. In order to evaluate the system or project, it needs specific timelines for project activities to be implemented before measuring the impact and making decision for improvements basing on results".

KII-Dodoma

Attitudes towards M&E

- Most participants (91%) had positive attitude towards M&E
  - M&E ensures that intervention is implemented according to approved standards
  - Helps to develop strategies that affect challenges that affect implementation
- All KIIs admitted to have roles in M & E as administrator and in-charge of health at district / region.
- Respondents reported that M&E system is webbed with multiple factors affecting performance

M&E Activities done

- Supportive supervision
  - Supervisors use checklists developed by MoHSW
  - Interviewee in Pwani discussed different types of checklists used depending on type of supervision
  - Interviewee in Dodoma discussed about integrated supervision checklist
- Two concepts of supervision were mentioned
  - Supportive supervision
  - Comprehensive supportive supervision

Supportive Supervision

- Supervision intends not to investigate and criticize but to help, support and improve M&E performance at the facility.
- Health practitioners are coached and mentored
  - Service providers who have not been trained on HIV and AIDS interventions and data collection methods are coached and mentored
  - Helps facilities which are weak in service provision and in data recording and reporting
- Inspection as another kind of supervision
  - Inspection is conducted mostly in cases where problems have been reported and requires investigations.

Comprehensive Supportive Supervision (CSS)

- Piloted in Dodoma, other regions in different stages of training or implementation
- CSS integrates supervision of all services and programs provided at a facility.

"This is when one supervisor on a supervision visit, supervises several interventions available at the facility using a tool with details of several interventions. This takes a lot of time, 3 to 4 days and involves meetings at facility after supervision for feedback and developing a plan of action. It requires the supervisor to produce a report in triplicate (a copy to be kept at the facility visited; another copy to CHMT and one copy remains with the supervisor). …. this type of supervision is still new, training to supervisors has been done but it seem to have lots of practical challenges as it confuses most supervisors"

- KII NACP

Data collection

- Recording of client of information on daily basis in different HIV and AIDS service registers
- Providers use registers, tally sheets and summary forms
- Client information is aggregated at the facility level and submitted to the CHMT on monthly or quarterly basis
- Focal persons at the CHMT compile aggregated data from facilities and produces district HIV/AIDS monthly report, which is sent to RHMT and later to national level.
- At the national level, data from all regions are sent to the epidemiology unit at NACP where data is processed and interpreted
- Data quality is checked by supervisors at the service delivery points; data manager and others at CHMT and M&E officer and others at RHMT levels

Other M&E activities

- Monthly or quarterly reports produced are shared with VMACs, CMACs and TACAIDS.
- Reports are also shared to donors and international community
- Review meetings are conducted to discuss emerging issues from the reports produced
- Training of service providers and supervisors on how to conduct supervision are other M&E activities done
  - Not all supervisors have been trained
  - Training differs from HIV and AIDS service to another
- Only 32% of informants acknowledged that feedback was provided to service providers and supervisors

Factors affecting M&E system

- Inadequate skills in summarization, analysis, interpretation and utilization
  - Providers think are collecting data for someone else to use
- Half of the supervisors are incompetent and unaware on what they are supposed to accomplish during supervision

"…. there have been some complains from HCWs with respect to supervision. Some supervisors conduct themselves as police investigators as such HCWs run away from the facility when visited for supervision. This hinders supervision and ultimately affects the quality of data collected".

KII-Dodoma

Supervision-1

- CHMTs assessed themselves only to realize that supervisors lacked management and supervision skills.
  - Most CHMT members are inexperienced in issues related to supervision
  - They would benefit from training on management and supervision skills.
  - Supervisors lack skills on indicators used in HIV and AIDS M&E system and communication skills
  - They also lack skills on how to coach a HCW with low skills which ultimately leads to poor supervision.

Supervision-2

- Integrated supervision tool is too long and complicated for CHMT members
  - Simplification of this tool would make it user friendly
  - Most districts insisted that instead of using a general tool, specified tool for each specific service was more preferred
  - Few supervisors are trained and have a good understanding of HIV and AIDS services for integrated supervision to work
- Language used by supervisors is not well understood by HCWs due to knowledge gap between them

Other Issues-1

- So many M&E tools for HIV and AIDS data compared to HCWs available
  - Use of Computers will help
- Inadequate resources
  - No specific budget for M&E at RHMT, CHMT levels
  - Only last year was the national M&E guideline developed
- Lack of culture for sharing information in the country
  - CHMTs and RHMTs are not aware of best practices elsewhere
- Acute shortage of staff
  - Low number of staff compared to No required
  - Most of those available are low cadre

Other Issues-2

- Delays in funds disbursement
  - By end of Aug, funds in CCHP were not available for implementation of HIV and AIDS activities though the FY started in July
- Management meetings to review progress of M&E activities at CHMT and RHMT were erratic
- Geographical distribution of health facilities
  - Hard to reach areas
- Shortage of tools –registers and summary forms
  - Providers use normal /regular exercise books for recording patient data during stock-outs

Strategies for Improving M&E activities

- Cascaded supervision through heads of Health centres were being used in Dodoma
- ICAP and CHAI have established a fund for supervision and to provide incentives in Pwani
- Performance based financing strategy (p for p) being piloted in Pwani
- New M&E guideline developed to improve quality of the data
- No specific M&E plans at CHMT/RHMTs, but plans are incorporated in RCHP or CCHP which are based on current Health Sector Strategy Plans

DHIS

- It's a new health information management system being piloted in Pwani
- Electronic database (online)
- Facilitated by JICA in collaboration with UCC and MoHSW
- UCC controls the database
- It has improved data analytical process, easy to read and printable
  - Challenge: internet runs slow and is unreliable
  - Question on information ownership

Outline

- Introduction and Methodology
- Findings
  - Quantitative Findings
  - Qualitative Findings
- Discussion and Conclusions

DISCUSSION

- Quant. + qualit. tools used to triangulate & cross-validate findings
- Potential for biases exists
  - Retrospective nature of the questions
  - Efforts made to reduce social distance and build rapport
- HIV and AIDS M&E system is established
  - Standard tools for a range of HIV Services
  - Draft guideline for management of data quality, July 2010
  - Draft costed M&E Plan, Dec 2010
  - Meets in-country data requirement and adhere to international reporting norms

Challenges-1

- Shortage of HCWs for HIV and AIDS M&E
  - Those available are of low cadre
  - Huge disparity between districts
- Lack of motivation
  - Studies have shown that motivation improves performance
  - Can this be efficient and replicable for a big country like Tanzania?
- Supportive supervision
  - Inadequate supportive supervision due to transport and funds
  - Inadequate supervision due to lack of skills
  - Integrated SS tool is long and complicated for CHMT supervisors

Challenges-2

- Inadequate training on M&E Activities
  - Proportion of HCWs who reported to be trained was very low
  - Supervision and mentoring if improved and done well could be used to impart skills and solving other problems inherent within the M&E System.
- Inadequate feedback
  - Irregular management meetings to discuss M&E activities
  - SDPs - commitment/motivation; CHMTS + RHMTs - funds/ transport
- Inadequate funding
  - PER 2007-2009 (TACAIDS 2010), 643 billion Tshs was spent on HIV and AIDS services
- Stock-out of tools – affects recording of data in registers + MSF

Challenges-2

- Low utilization of data
  - Lack of skills in analyzing and interpreting affected adequate utilization of data
  - Key decision makers don't have confidence in the data collected
  - Policy makers receive data that's not user friendly e.g. it lacks yearly trends
- Databases
  - Few facilities used databases
  - Value and usability of information increases
  - In Pwani, Internet connectivity was a challenge

Recommendations

- Regular assessment of the HIV and AIDS M&E system
  - Just like any area of public sector is regularly assessed
- Substantive demand is a prerequisite for a functional M&E
  - Interest in budgetary allocation
  - Supplying registers, summary forms and M&E guidelines
- Provision of incentives to improve performance
  - Data should be credible for information to be utilized
- Training in a range of M&E Tools, methods, approaches and concepts (almost all activities including analysis and interpretation)
- Management meetings are done regularly to review data and other HIV and AIDS M&E activities

Recommendations-2

- Installation of databases at CHMT and RHMT levels to improve submission to the next level and usability of data
- Supportive supervision and feedback should be expanded and improved
- Existing registers and summary forms should be used to the maximum. New primary data should only be collected when it is absolute essential and as a last resort
  - We commend efforts of collecting HIV and AIDS data through the revised MTUHA system, the challenge is the longitudinal nature of some of the HIV and AIDS data

４．PCM ワークショップ結果

4−1．PCM ワークショッププログラム

PCM Workshop for Developing Action Plan for
Strengthening Health Sector HIV and AIDS M&E System in Model Regions

Workshop Programme

Dates and Venue: 3rd - 4th November 2011 for Dodoma Region, Dodoma VETA

8th - 9th November 2011 for Pwani Region, Njuweni Hotel, Kibaha

Objectives:
1) To analyze existing problems and challenges in health sector HIV and AIDS M&E in consideration of the findings from the situation analysis conducted in the model regions
2) To select and prioritize objectives, which are feasible, achievable and sustainable, to fit into the framework of the NACP/JICA Project
3) To formulate activities to achieve objectives
4) To set indicators to measure the expected outputs.

Timetable: Chairperson: Regional Medical Officer

Time	Event	Responsible
8:00	Registration	
8:30 - 9:00	Self Introduction of Participants	Participants
	Opening speech	RAS
	Remarks from JICA	JICA Representative
	Logistic issue	Project Coordinator
	Ground rules	Facilitator
9:00 - 9:20	Overview of the Project & Objectives of the Workshop	Project Chief Adviser
9:20 - 10:30	Presentation of the Situation Analysis	Situation Analysis Team
	Q&A	
10:30 - 11:00	Tea Break	
11:00 - 11:30	Explanation on PCM Workshop Procedures	Facilitator
11:30 - 13:30	Problem Analysis	Participants
13:30 - 14:30	Lunch	
14:30 - 16:30	Problem Analysis	Participants
16:30 - 17:00	Wrap up	Facilitator

Day 2:

Time	Event	Responsible
8:00	Registration	
8:30 - 8:45	Recap of the Day	Facilitator
	Explanation of the Workshop Procedure	
8:45 - 10:45	Objective Analysis	Participants
10:45 - 11:15	Tea Break	
11:15 - 13:30	Formulation of Activities in consideration of inputs	Participants
13:30 - 14:30	Lunch	
14:30 - 16:30	Formulation of Indicators	Participants
16:30 - 16:35	Wrap up of the workshop	NACP Representative
16:35 - 16:40	Closing	JICA Representative

4－2. 参加者リスト（ドドマ州・プワニ州）

Participants for PCM Workshop in Dodoma

Date: 3rd and 4th November **Venue: Dodoma VETA hotel**

S/N	NAME	Titile/ Organization
1	Ms. Rehema S. Madenge	RAS, RAS Dodoma
2	Dr. Mtey	RMO, RHMT Dodoma
3	Dr. Zanad Chaula	Physician, Dodoma Regional Hospital
4	Mr. Edward Ganja	RHO, Dodoma Regional Hospital
5	Mussam O. Slingu	Planning Officer, DED Mpwapwa
6	Dr. Ibrahim Katunda	Ag DMO, CHMT Mpwapwa
7	Mr. Joseph Burra	DHS, CHMT Mpwapwa
8	Dr. Elias Nyamureymburi	DACC, CHMT Mpwapwa
9	Ganja Shigela Kuoseja	Economist, DED Kongwa
10	Dr. Gatete Mahava	DMO, CHMT Kongwa
11	Dr. Malale	DACC, CHMT Kongwa
12	Dr. Rehema Lukwalo	CTC I/C, CHMT Kongwa
13	Nassari N. Obed	Planning Officer, DED Dodoma MC
14	Dr. Cyrialis Mutabuzi	DMO, CHMT Dodoma MC
15	Dr. Christopher Manumbu	TB/HIV Officer, CHMT Dodoma MC
16	Dr. Janeth Mtenga	CTC I/C, Makole HC
17	Mohamed O. Slime	Planning Officer, DED Chamwino
18	Dr. James Charles	DMO, CHMT Chamwino
19	Dr. Joyce Swai	DACC, CHMT Chamwino
20	Ms. Halima Warsama	DRCH co, CHMT Chamwino
21	Bernadelle K. January	Planning Officer, DED Bahi
22	Dr. Ntuli Kapologwe	Ag DMO, CHMT Bahi
23	Dr. Ephaphrodatus Msambili	DACC, CHMT Bahi
24	Dr. Mustafa Ngwila	ADO, CHMT Bahi
25	Sdu Ruaules	Planning Officer, DED Kondoa
26	Dr. Reginald Saria	Ag DMO, CHMT Kondoa
27	Asha Njambi	DACC, CHMT Kondoa
28	Dr. Sylvester Makondo	Senior Assistant Medical Officer, CHMT Kondoa

29	Dr. Kilama Bonita	M&E officer, MOHSW/ NACP
30	Joseph Chilongani	Researcher, NIMR Mwanza
31	Bahati Andrew	Researcher, NIMR Mwanza
32	James Kalekwa	Field assistant, NIMR Mwanza
33	Hendrica Thomas	Field assistant, NIMR Mwanza
34	Christopher Nyaruba	Consultant, Mzumbe University
35	Ms. Nae Kaneko	JICA HQ
36	Nobuhiro Kadoi	Chief Adviser, NACP/ JICA
37	Ayuko Tanaka	Epidemiology Specialist, NACP/ JICA
38	Aska Hasegawa	Project Coordinator, NACP/ JICA

Participants for PCM workshop in Pwani

Date: 8th and 9th November **Venue: Njuweni Hotel, Kibaha**

S/N	NAME	Title/ Organization
1	Bernard M.N. Nzungu	RAS Pwani
2	Dr. Beatrice Byalugaba	RMO, RHMT Pwani
3	Ms. Anna Mwaga	RHS, RHMT Pwani
4	Mr. Jehovanes John Mollel	M&E Officer, RHMT Pwani
5	Amkauahe K. Hgilahgwa	Acting TD, DED Kibaha TC
6	Dr. Issessa Kaniki	DMO, CHMT Kibaha TC
7	Dr. Mariam Ngaja	DACC, CHMT Kibaha TC
8	Ms. Zaina Kishede	HMIS FP, CHMT Kibaha TC
9	Winifrida H. Mbuya	Acting DED, DED Kibaha DC
10	Dr. Victorina Ludovick	DMO, CHMT Kibaha DC
11	Dr. Japhal Mwamafupa	DACC, CHMT Kibaha DC
12	Dr. Elizabeth Sekkaya	DVCT/HBO co, CHMT Kibaha DC
13	Edfas M. Bayella	Acting DED, DED Kisarawe
14	Dr. Paschal Nkll	Acting DMO, CHMT Kisarawe
15	Dr. Inocent Mkini	DACC, CHMT Kisarawe
16	Mr. Lenga Mteminyanda	Lab Technician, CHMT Kisarawe
17	Sipora J. Liana	DED, DED Mkranga
18	Dr. Philemon Kalugira	Ag DMO, CHMT Mkuranga
19	Dr. Joseph Mganga	DACC, CHMT Mkuranga
20	Ms. Money Goodluck	Mtuha FP, CHMT Mkuranga
21	Dr. William Mapuga	DACC, CHMT Rufiji
22	Mr. Mohamed Abubakar	DHIO, CHMT Rufiji
23	Dr. Mgimba Credianus	DMO, CHMT Mafia
24	Dr. Naomi Manzi	CTC I/C, CHMT Mafia
25	Dr. Sultan Omar	DMO, CHMT Bagamoyo
26	Dr. Job Kusenha	Ag DACC, CHMT Bagamoyo
27	Mr. Shedrack Maximillian	HIMS Co, CHMT Bagamoyo
28	Dr. Kilama Bonita	M&E officer, MOHSW/ NACP
29	Dr. Patric E. Mwidunda	MOHSW/ NACP
30	Mr. Wilfred Rohana	NSS Head/ MOHSW
31	Joseph Chilongani	Researcher, NIMR Mwanza

32	Bahati Andrew	Researcher, NIMR Mwanza
33	James Kalekwa	Field assistant, NIMR Mwanza
34	Hendrica Thomas	Field assistant, NIMR Mwanza
35	Dr. Henry A. Mollel	Consultant, Mzunbe Univ
36	Ms. Sydney P. Msamba	Consultant, University of Dodoma
37	Ms. Nae Kaneko	JICA HQ
38	Mr. Hajime Iwama	JICA TZ
39	Ms. Emiko Nishimura	JICA TZ
40	Marianvyo Msuya	Consultant, JICA TZ
41	Nobuhiro Kadoi	Chief Adviser, NACP/ JICA
42	Ayuko Tanaka	Epidemiology Specialist, NACP/ JICA
43	Aska Hasegawa	Project Coordinator, NACP/ JICA

Activities identified in Dodoma Workshop (3-4 November 2011)

Tree	Objective	Activity	Target	Responsibility	
#1	Improve accuracy and reliability of data	On job training through SS	HCPs	CHMT	
	Reporting tools are simple and easy to understand	Consultation of MoHSW on modification of reporting tools	MoHSW/NACP	RHMT	
		Modification of reporting tools	Current tools	MoHSW	
		Onjob training through SS	HCPs	CHMT	
	Recording and reporting tools are always available at the HFs	Regular SS and mentoring	HCPs	CHMT/RHMT	
	Adequate feedback is given after each SS	Training of supervisors on M&E	Supervisors	JICA/NACP	
		Procurement of IT equipments to CHMT	CHMT	JICA/NACP	
	~~M&E Officer is established~~	~~On job training of existing H/W at CHMT/RHMT level~~	~~M&E Focal person~~	~~JICA/NACP~~	Duplication→Tree#3
#2	To improve knowledge and skills on M&E to RHMT/CHMT/HCPs	~~To Conduct Series of trainings on M&E~~	~~R/CHMT and HCWs~~	~~JICA/MOHSW~~	Duplication→Tree#3
		To establish mentoring teams	RHMT&CHMT	RHMT&CHMT	
		To conduct mentoring sessions	RHMT&CHMT, HCWs	JICA/MOHSW, RHMT&CHMT	
		To develop and update training matrix at every six months	RHMT&CHMT	RHMT&CHMT	
	To improve working condition for M&E	~~To procure and IT equipment and accessories for M&E~~	~~RHMT, CHMT, HFs~~	~~JICA~~	Duplication→Tree#3
		Design by finetuning the existing softwares for (HTC, HIV care, HBC, PMTCT, SIT) to suit RHMT, CHMT,HF needs	RHMT, CHMT~~, HFs~~	JICA/MOHSW, UCC	
		~~To install software and orient users~~	~~RHMT, CHMT, HCPs~~	~~JICA&UCC~~	Duplication→Tree#3
#3	To improve knowledge on data analysis	Conduct Training on Basic Computer skills	RHMT 4 Focal Persons, CHMT 4 Focal Persons, HFs Incharge	JICA/NACP	
		To install DHIS			
		To conduct training on DHIS			
		To conduct traiing on data analysis			
	To improve documentation of data	To develop training materials	RHMT, CHMT and HF Incharge	JICA/NACP, RHMT/CHMT	
		To procure computers for data analysis	RHMT and CHMT	JICA/NACP	
		Computer PPM	RHMT/CHMT	RHMT/CHMT	
		To procure and install softwares for data analysis	RHMT/CHMT	JICA/NACP	
		To establish posts for M&E in RHMT/CHMT	RHMT/CHMT		
	To improve information sharing on data to stakeholders	To develop feedback guideline on M&E	Stakeholders and community development partners	RHMT/CHMT, JICA/NACP	
		To conduct stakeholders meeting	Stakeholders and community development partners	RHMT/CHMT, JICA/NACP	
		To establish newsletters on M&E	Stakeholders and community development partners	RHMT/CHMT, JICA/NACP	
	To strengthen Comprehensive S.S				

SS

not touch in the project

Activities identified in Pwani Workshop (8-9 November 2011)

Objective	Activity	Target	Responsible
[Group 1]			
Skilled staff in place for HIV/AIDS data management at R/CHMT level.	To mobilize funds for training of R/CHMTs on HIV/AIDS data management	Development partners including JICA	R/CHMTs
	To conduct training on HIV/AIDS data management to HCWs at R/CHMT level	R/CHMTs	JICA/NACP
M&E tools are supplied timely from RHMT to CHMTs to HFs.	HFs request for registers from CHMT in a monthly bases.	CHMTs	HFs
	CHMT conduct quarterly supportive supervision in line with needs assessment at HFs.	HFs	CHMTs
	Orientation of HCWs on ordering procedures for M&E tools	HFs staff	CHMTs
Motivated HCWs on submission of reports	To conduct training on data analysis to R/CHMTs	R/CHMTs	JICA/NACP
	R/CHMTs provide feedback to lower levels on reports submitted.	R/CHMTs/HFs	R/CHMTs
	CHMT design and provide appropriate incentive package for HCWs.	HCWs	R/CHMTs
	Training on the evidencde-based planning & prioritization	R/CHMTs	JICA/NACP
HCWs have data handling skills.	Conduct on-job training to HCWs on HIV/AIDS data management.	HCWs	CHMT members
Cascade support in data management is in place.	Orientation on cascade supervision to HFs	Cascade centres (HCs/DSPs)	R/CHMTs
[Group 2]			
R/CHMTs give feedback to HFs on HIV/AIDS	Conduct data analysis skill training to CHMTs	R/DACC, R/DHMIS Focal, R/CHMT data clerk, R/DRCHCo, CTC Co, DMO, Lab Co	JICA/NACP
	Procure and install data analysis software, computers and accesaries.	R/CHMTs	JICA
	Collect, enter and analyze data	R/CHMTs	R/CHMTs
	Develop feedback mechanism by CHMTs	R/CHMTs	R/CHMTs
R/CHMTs use data for health services	Train R/CHMTs on M&E basics	R/CHMTs	JICA/NACP
	Utilize the available data for various interventions, eg., health education, planning and programming	R/CHMTs, HFs, various district/council committees	R/CHMTs
	Conduct quarterly review meeting	R/CHMTs	R/CHMTs
CHMT can correct mistakes in registers at HFs	Update supportive supervision checklist to cover data correction items	R/CHMTs	R/CHMTs
	Mobilize resources for M&E through CCHP	R/CHMTs	R/CHMTs/JICA

５．会議議事録（Meeting Minutes）

5-1. プロジェクトマネジメント会議録

Meeting Minutes

Meeting on NACP/JICA Project (Phase 2) Management

Date and Time: 14th November 2011, 9:30 – 13:30

Venue: Ceemi

Participants:
Mr. H. Iwama, JICA Mission Team
Dr. T. Sugishita, JICA Mission Team
Ms. E. Nishimura, JICA Mission Team
Dr. A. Ramadhani, MOHSW/NACP/PM
Dr. P. Mwidunda, MOHSW/NACP/JICA
Dr. G. Somi, MOHSW/NACP/Epi
Dr. M. Ntiro, MOHSW/NACP/CSSU
Dr. B. Kilama, MOHSW/NACP/Epidemiology
Ms. H. Katuma, MOHSW/M&E
Mr. N. Kadoi, NACP/JICA2
Dr. A. Tanaka, NCAP/JICA2
Ms. A. Hasegawa, NACP/JICA2
Ms. I. Massawe, NACP/JICA2

Background

1. JICA has dispatched a mission from 1st to 17th November to review the NACP/JICA Project Phase 2 with the focus on the M&E component of the project. The team consisted of four JICA representatives. The purpose of the mission was: 1) to conduct 2-day Project Cycle Management (PCM) workshops in the model regions, i.e., Dodoma and Pwani, 2) to review the Project Design Matrix (PDM) based on the results of the situation analysis and the workshops, and 3) to discuss modification of the PDM with the MOHSW and the NACP.
2. The workshops were conducted on 3-4 November for Dodoma region and on 8-9 November for Pwani region.
3. The purpose of the meeting was to discuss and agree the modification of the PDM in consideration of the results of the situation analysis and the workshops.
4. Meeting agenda was:
   1) Presentation of the summary of the situation analysis
   2) Presentation of the results of the PCM Workshop
   3) Presentation on leadership and management in M&E systems
   4) Presentation of the proposed modification of the PDM
   5) Discussion and way forward

Introduction

5. The meeting was opened by Dr. A. Ramadhani, the Programme Manager of the NACP, at 09:30 am who welcomed all of the participants who attended the meeting. There was a brief introduction of all the participants.
6. Objectives of the mission were presented by Mr. H. Iwama, the JICA Mission Team Leader.

Presentation #1– Key Findings of the Situation Analysis on Health Sector Routine HIV and AIDS M&E

7. Some of the key findings of the situation analysis were presented by Dr. P. Mwidunda as per attached PowerPoint slides. A few questions were raised by participants and responded. The questions were on some terminology used in the situation analysis such as motivation, budget allocation for M&E activity and supervisors. It was pointed out that the report should have presented more specific information. Another participant pointed out the weakness of the situation analysis that it didn't capture private hospitals and organization behaviors of R/CHMTs.
8. There was further discussion on supervisors. One participant pointed out that DACC are supposed to be the supervisors at council level but they are not committed because they have so much to do especially dealing with politics with partners. It was responded that there are DACCs who are committed but it is true that they have a lot of things to do and they need to be assisted by people competent for M&E.
9. A report on the Patient Monitoring System has several recommendations, one of which for mid and long term solution was creating an M&E cadre at the regional and district levels.
10. MTUHA coordinators in most of the cases are health secretaries, who are non-medical personnel and have difficulty to comprehend some medical terminologies.

Presentation #2 – Results of the PCM Workshops

11. The workshop process and results were briefly presented by Ms. E. Nishimura. A problem analysis tree and an objective analysis tree created by each region were shared. Activities suggested based on the objective analysis by each region were summarized in table format and shared as per attached documents.

Presentation #3 – Leadership in M&E

12. Dr. T. Sugishita presented slides on leadership and management in M&E system. He commended the Tanzania's efforts in making centralized and standardized strong M&E system. He however insisted on thinking out of box and mindset change so as to have stronger M&E System in Tanzania with the support from JICA. He emphasized the importance of both national M&E system and programme-based M&E system and their different purposes. In order to further improve the programme-based M&E system, he introduced an idea of using "tracer indicators". He also listed some of the points for the discussion of the day.
13. A question was raised by a participant on how we can accommodate only a few indicators while we have so many partners working with and reporting to. It was responded that the prograrmme needs all the information. The suggestion was not to discard the other indicators but it is a strategy that will allow us to easily trace and utilize. Another participant expressed a concern that the tracer indicators may obscure the importance of submitting other indicators by service providers if we trace only a few indicators. The participants requested the presenter to provide more information, experiences in other countries and concrete examples of tracer indicators so as to understand it better.

Presentation #4 – Modification of the PDM

14. Mr. N. Kadoi presented a suggested modification of the PDM as per attached document. The major modification proposal was on the output #1 and #2 and activities under the M&E component of the project and reorganization of the output #3, #4 and #5. The idea of using tracer indicators was considered in the suggested modification.

Discussion

15. The JICA team suggested the adoption of tracer indicators as a strategy for strengthening routine M&E. The participants concluded that NACP technical staff shall clearly understand it with more information and will discuss further on the adoption of this strategy.
16. It was pointed out that a target should be clearly set for each indicator so as to see where to go and how far to have reached. Therefore, all the indicators shall be measurable.
17. The proposed reorganization of the outputs shall be discussed and the expression shall be refined by a smaller team.
18. Culture of data utilization and ownership shall be fostered at the original source of information, i.e., health facilities, since they are the implementers. Ownership of data also is an issue. If data is used at each level, they would know how useful and important it is for improving planning and service provision. This will create further demand for better data. M&E is like a new religion, we have to preach the importance, starting from the training institutions.
19. The capacity building should be done from the facility level. The project may use a few health facilities from the two model regions, five from each for example and build the skills of its staff and use it as the reference to go about on other part of the regions. JICA expressed its concern of the limited capacity of the project to conduct direct intervention to health facilities. The project may be able to track down activities done by CHMTs at a few selected health facilities.
20. A question was raised on the MOHSW's M&E vision in harmonization of vertical programmes into the main HMIS system. The representative of the MOHSW M&E responded that by mid January an assessment will be conducted through supervision in Pwani, will give more information to discuss this issue. The discussion among the stakeholders will be held in January 2011.
21. The JICA Mission team leader requested the NACP and the Project staff to accelerate the implementation since the implementation of the project activities has been slow especially under the M&E component.

Way Forward

22. NACP will discuss the adoption of tracer indicators as a strategy of strengthening M&E in the project model regions as soon as possible.
23. A small team including Dr. Mwidunda, Dr. Somi and JICA staff needs to work on the modification of the PDM by the end of November 2011.
24. Modification shall be presented at the next Joint Coordination Committee Meeting (to be held in December 2011).

Closing

25. Lastly the chairperson concluded that the meeting was just the beginning. NACP promised to work on the idea of tracer indicators soon as agreed. The meeting came to an end at 13:30 hrs and everybody was invited to lunch.

Meeting Memo

Meeting with CMO on Management of NACP/JICA Project Phase 2

Date and Time: 14th November 2011, 15:30-17:15

Venue: The CMO's Office

Participants: Dr. D. M. Mtasiwa, CMO
Mr. H. Iwama, JICA Mission Team Leader
Dr. T. Sugishita, JICA Mission Team
Ms. E. Nishimura, JICA Mission Team
Mr. J. Rubona, MOHSW/M&E and HSRS
Dr. G. Somi, MOHSW/NACP/Epidemiology
Dr. B. Kilama, MOHSW/NACP/Epidemiology
Mr. N. Kadoi, NACP/JICA2
Dr. A. Tanaka, NCAP/JICA2
Ms. A. Hasegawa, NACP/JICA2
Ms. I. Massawe, NACP/JICA2

Background

1. JICA has dispatched a mission from 1st to 17th November to review the NACP/JICA Project Phase 2 with the focus on the M&E component of the project. The team consisted of four JICA representatives. The purpose of the mission was: 1) to conduct 2-day Project Cycle Management (PCM) workshops in the model regions, i.e., Dodoma and Pwani, 2) to review the Project Design Matrix (PDM) based on the results of the situation analysis and the workshops, and 3) to discuss revision of the PDM with the MOHSW and the NACP.
2. The workshops were conducted on 3-4 November for Dodoma and on 8-9 November for Pwani. The results were presented to the MOHSW and the NACP representatives on 14 November in the morning at Ceemi. The participants discussed modification of the PDM and agreed way forward. The mission team held a meeting with the CMO for debriefing.

Issues raised:

3. The vertical programmes are obligated to contribute to the main HMIS first that requires only key indicators from the vertical programmes. Donors and partners come second.
4. The Health Policy and the Health Sector Strategic Plan shall be the documents that we all have to follow.
5. Only nationally agreed minimum set of information shall be collected from the service delivery sites. Anybody wants to access the information shall get permission from the

Permanent Secretary. Partners have to observe the government rules and laws when collecting and disseminate the data. No additional data shall be obtained by anybody. That act is illegal.

6. National data source should be one to avoid contradiction. All data shall be submitted to the MOHSW/M&E and the MOHSW shall be the source of national data.
7. Repetition of information collection shall be avoided.
8. Overloading service delivery sites with a lot of data requirement compromises not only the data quality but also service quality.
9. The NACP/JICA Project shall assist the MOHSW through the NACP to develop a model for strengthen link between HMIS and vertical programmes so as other programmes will follow.
10. MOHSW/M&E and NACP have to sit together so as to design the best system for the country.

Conclusion:

11. After the MOHSW/M&E and NACP (M&E) team sit together and discuss on how they can work together to make strong M&E system in Tanzania, the team shall report to the CMO.

5-3. 保健福祉省モニタリング評価ユニット・国家エイズ対策プログラム疫学ユニット第１回調整会議録

Meeting Minutes

1st Coordination Meeting between the MOHSW/M&E Unit and NACP/Epidemiology Unit

Date and Time:	16th November 2011, 9:20 – 10:30
Venue:	NACP Library
Attendants:	Mr. J. Rubona, MOHSW/M&E and HSRS -Chairperson
	Mr. J. Claud, MOHSW/HMIS - Member
	Dr. G. Somi, MOHSW/NACP/Epidemiology - Member
	Dr. B. Kilama, MOHSW/NACP/Epidemiology - Member
	Dr. T. Sugishita, JICA Mission Team - Member
	Ms. E. Nishimura, JICA Mission Team - Member
	Mr. N. Kadoi, NACP/JICA2 - Rapporteur
	Dr. A. Tanaka, NCAP/JICA2 - Member
	Ms. A. Hasegawa, NACP/JICA2 - Member
	Ms. I. Massawe, NACP/JICA2 – Rapporteur
Absent:	Dr. P. Mwidunda, MOHSW/NACP/JICA - Member

Agenda

#1 Strengthening coordination between the overall MOHSW M&E and vertical M&E subsystem of the MOHSW
#2 Clarification of mechanisms for implementation of NACP/JICA Project

Discussion on Agenda #1

1. The Health Policy stipulates that the MOHSW has to come up with well coordinated health information system with subsystems. In line with the policy, the Health Sector Strategic Plan III places M&E with special focus on HMIS as one of the priority strategies.
2. In order to strengthen the main system, the District Health Information Software (DHIS) has been introduced and being pilot-tested in Pwani region. The Clinton Health Access Initiative (CHAI) and Ifakara Health Institute (IHI) also have been supporting the HMIS strengthening initiative in other regions (Lindi and Mtwara) and selected districts (27 districts) in the country. MTUHA books (paper-based) have also been revised for the pilot which integrated RCH including most of the PMTCT data except child follow-up.
3. Problems regarding HMIS stated were as follows:
    - Linkage between the main HMIS and other subsystems (vertical programmes) has been weak.
    - Sometimes there is a contradiction between data submitted by the main system and by the subsystems to international level.
    - Some overlapping data between the systems increases workload of health service providers.
    - The programmes require more than what the main system produces. Therefore, the subsystem shall be maintained.

4. There are two ways suggested by the software developer to create linkage between the main and the subsystems:
   1) Reprogramme the subsystem under the umbrella of DHIS; and
   2) Create interface to link the two systems if the current subsystem is stable enough.
5. Structure needs to be created for MOHSW and NACP to work together.
6. In order to improve the data quality, the issue of shortage in human resources shall be also addressed. RACCs and DACCs are too busy in coordinating multiple partners in multiple interventions that they do not have sufficient time to provide continuous technical support to health service providers on M&E issues.
7. M&E cadre for health has been established and now regions and districts are allowed to employ a person who can work on M&E full time and work closely with R/CHMT to improve data quality and utilization.
8. In the long run, the MOHSW may create a structure merging (harmonizing) all M&E staff at various vertical programmes to work together under the MOHSW M&E.

Agenda #2:

9. NACP/JICA Project needs to set up a sustainable HR structure to strengthen routine HIV and AIDS M&E. In the past there was a project on adult morbidity and mortality in Tanzania in collaboration with DFID. The project was not sustained at all because there was not sustainability strategy during its implementation.
10. NACP/JICA project however needs immediate structure to work on due to limitation of the project duration, which takes sustainability into account.
11. It was suggested that NACP/JICA project should work to achieve the following three objectives in order; first to improve data quality, secondly to strengthen programme M&E system, then thirdly, to contribute to national M&E system.

Way Forward:

12. The MOHSW/M&E will continue to hold coordination meetings with the NACP M&E and NACP/JICA Project to strengthen the linkage through coordinating meetings. The project will take a facilitation role for the dialogue.
13. NACP representatives shall attend the MOHSW M&E weekly management meeting held on Mondays to develop common understanding.
14. NACP/JICA project shall consider developing HR structure at the regional/district level, which shall be absorbed into the government system before the end of the project period.
15. A small team consisting of MOHSW, NACP and JICA representatives shall report the outcomes of this meeting to the CMO.

MINUTES

OF THE 2ND JOINT COORDINATING COMMITTEE MEETING ON THE TECHNICAL COOPERATION PROJECT ON THE HEALTH SYSTEMS STRENGTHENING FOR HIV AND AIDS SERVICES

The 2nd Joint Coordinating Committee (hereinafter referred to as "JCC") meeting, for the Japan International Cooperation Agency (hereinafter referred to as "JICA") technical cooperation project entitled; "Health Systems Strengthening for HIV and AIDS Services" (hereinafter referred to as "the Project"), was held on the 29th December 2011, at the Protea Courtyard Hotel in Dar es Salaam, Tanzania. Through a series of discussions made during the meeting, the JCC members including the Chief Medical Officer (hereinafter referred to as "the CMO") of the Ministry of Health and Social Welfare (hereinafter referred to as "the MOHSW"), representatives of the Programme Manager of the National AIDS Control Programme (hereinafter referred to as "NACP") and the representative of the JICA Tanzania Office, agreed to the matters referred to, in the document that is attached hereto.

Dar es Salaam, 29th December 2011

Mr. Hajime Iwama
Senior Representative
Tanzania Office
Japan International Cooperation Agency

Dr. Deo M. Mtasiwa
Chief Medical Officer
Ministry of Health and Social Welfare
United Republic of Tanzania

Dr. Patrick E. Mwidunda
For Programme Manager
National AIDS Control Programme
Ministry of Health and Social Welfare
United Republic of Tanzania

Attached Document

MINUTES OF THE 2ND JCC MEETING

ON 29TH DECEMBER 2011
AT PROTEA COURTYARD HOTEL, DAR ES SALAAM

OPENING:

1. The 2nd JCC meeting was held on 29th December 2011 at the Protea Courtyard Hotel, Dar es Salaam. Dr. P. Mwidunda, the Acting Programme Manager of the NACP and the Coordinator of the NACP/JICA project, welcomed the participants and asked them to do self-introductions. The meeting was attended by a total of 19 participants from the MOHSW, the JICA Tanzania Office, the Regional Administrative Secretary's Offices of Dodoma and Pwani and the NACP. The list of the participants is attached hereto.

   Four handouts were distributed to the participants:
   - A Half-Year Progress Report for the Period of April – December 2011 and Operational Plan for January – December 2012,
   - Project Design Matrix (PDM) Version 2.0,
   - Explanation on the PDM Amendments, and
   - PowerPoint Slides of the JICA Project Reviewing Mission.

2. The meeting was chaired by Dr. Deo. M. Mtasiwa, the CMO of the MOHSW. He gave the opening remarks by appreciating the JICA for its continuous technical and financial support for strengthening health sector of Tanzania government especially on the human capacity development to improve the quality of health services.

3. The CMO stated that the government is trying to accelerate its efforts toward universal access to HIV and AIDS prevention, care and treatment services, for current pace of scaling up is slow. The government is aiming to double the number of the people who get tested for HIV by 2013.

4. The CMO stressed the importance of standardised M&E system in order to get evidence of interventions as highly effective and sharpen their approaches through feedback mechanism. He also mentioned that systematic supervision with injection of mentorship will have impact on the health system to improve health service quality. All these are workable interventions that the NACP/JICA project is working on in the two model regions. In order to make scale-up easy after the project, however, the MOHSW/NACP shall simultaneously expand the practice to one region per zone (6 more regions) with its own initiative. This will prepare the mindset of the people for the change. The other parts of health systems will also benefit from the outputs of the project through institutionalisation of the system to be built by the project at the national level. Other countries will also be able to learn from Tanzania's experience. He concluded his message with appreciation to the JICA and the meeting was opened at 9:30 hours.

PRESENTATION ON THE PROJECT PROFILE AND ACHIEVEMENTS:

5. The first presentation was done by Dr. P. Mwidunda on the outline of the project and its achievements by the project components during the period of April - December 2011. (See the attached PowerPoint slides, which are the summary of the progress report.)

PRESENTATION ON THE JICA PROJECT REVIEW MISSION:

6. The second presentation was done by Ms. E. Nishimura, the Health Programme In-charge of the JICA Tanzania Office, on the report of the JICA Project Review Mission dispatched from 1st to 17th November 2011. The focus of the mission was mainly on the M&E component of the project. The recommendations included 4 major strategies and several suggestions for the project to take into account, among of which was the introduction of tracer indicators for focussed monitoring and tracking outputs. (See the attached PowerPoint slides.)

ISSUES RAISED AND DISCUSSION:

7. **Inclusion of Households:**
   It was pointed out that the model approach presented in a slide didn't include community. Some interventions such as home-based care directly target households and therefore households shall be included in the figure. The suggestion was accepted.

8. **Health System Building Blocks:**
   A question was raised regarding the health system building block. According to the WHO, there are six building blocks for health system, i.e., human resource, service delivery, information, medical products, financing and good governance. If the project is aiming at strengthening health system, are all these blocks embedded in the project? It was responded that the project considers those blocks; however, people sometimes get confused by those blocks. We shall avoid compartments, for a system is complex, dynamic and interacting.

9. **Integration of M&E in Supervision:**
   During the previous phase of the project, efforts were made to integrate some vertical programme such as VCT and STI into the national system (DHIS). Supervision will be easier if all M&E systems are integrated. A question was raised regarding such integration of supervision under the current project. It was responded that supervision has been conducted vertically by interventions even within the NACP. NACP needs to make the HIV and AIDS supervision comprehensive at first. In the long run, the entire health M&E issues may be integrated in supervision; however, it is in a transitional stage. NACP has several vertical database system as well, i.e., HTC, STI, CTC and HBC. It was emphasised that all these need to feed in the national system.

10. **Mindset Change:**
An offer was made by the Senior Representative of the JICA Tanzania that JICA is willing to support a Mindset Workshop for the MOHSW/NACP. This was part of the recommendations made by the JICA Project Review Mission. It was suggested that the workshop has to be systematically and properly planned so that it can fit into the situation. The idea of the workshop was accepted.

PRESENTATION ON PDM AMMENDMENTS:

11. The third presentation was done by the Chief Advisor of the project on the amendments of the PDM. (See the attached documents.)

DISCUSSION AND AGREEMENTS:

12. **No Inclusion of Households as a Beneficiary:**
It was agreed that households shall be included as one of the beneficiaries.

13. **Coverage of the Regions to be Oriented:**
A question was raised on the coverage of the orientation beside the two model regions.
It was responded that the two model regions are operational regions and orientation is meant to orient other regions to the M&E approach used and standardised in the two model regions by the project. This will be planned targeting all other regions as part of the project. However, it doesn't include the operationalization of the approach in each region. Regarding comprehensive supportive supervision and mentoring, the project aims to expand the modelling practice through national level sharing within the project period.
It was agreed that the project will concentrate on modelling exercise in the two model regions and producing tangible outputs. The MOHSW/NACP will on the other hand try to replicate the exercise to six other regions (one region per zone) with its own initiative. This will ease the MOHSW to scale up the approaches to all other regions after the project.

14. **Unspecific Indicators:**
It was pointed out that the indicators are not specific enough. The response was that a baseline survey shall be conducted to know where we are and to define where we want to reach. After the baseline, the indicators shall be SMART and presented to the JCC again. What the project needed from this JCC was the endorsement to what kind of indicators the project will use for the measurement of achievements. The indicators were endorsed with minor modification.

15. **Unspecific Description of Activities:**
It was suggested that activities should be more specific than the way they are in the PDM. For example, when it comes to synergy meeting, frequency of the meeting, members to be involved and timeline shall be specified so that each region and council can plan the activity in line with their comprehensive health plans.

16. **Unshared Tracer Indicators:**
Tracer indicators have not been shared with the JCC members yet. They should be shared in the JCC in order to get national endorsement. The suggestion was accepted.

17. **Integration of Tracer Indicators into the National M&E System:**
Integration of the tracer indicators into the main system at the national level shall start before the end of the project so when the project comes to an end the government will be ready to take up the tracer indicators as part of the national system. The project shared concerns with all regarding the application of the tracer indicators at the national level without trial. As the impact of the tracer indicators is unknown to the project, and there might be a need to change some of the indicators after exercises in the model regions, the project suggested that the recommendations be made at the end of the project on how tracer indicators work in model regions. However, the MOHSW/NACP explained that the MOHSW shall take up the idea of tracer indicators now and shall not miss the opportunity to integrate them to the national system. It was concluded that the project would focus on the model regions, and the integration at the national level would be initiated by the MOHSW. The feedback from the model regions on the tracer indicators will be shared with MOHSW.

18. **Ownership of Data:**
The collection of data starts at the facility level but its utilisation is very poor because service providers don't know the importance of data. They collect data because the DMO is asking for the data. At the DMO's office, people are collecting data because the RMO is asking for the data. RMOs are collecting data because the NACP is asking for the data. NACP is collecting data because donors are asking for the data. There is no ownership of the data everywhere. Therefore, a call to awake has to be done and it should start from the national level to the community level sensitising/orienting people on the importance of collecting, analysing, utilising and owning data. There are some good practices of data utilisation at the health facility level. We need to stimulate, share, replicate and encourage such practices.

19. **Tentative Plan:**
A question was raised regarding the meaning of "tentative plan." It was responded that after the endorsement of the plan by the JCC, the word "tentative" shall be removed.

20. **Linkage with the National Documents:**
A question was raised regarding linkage between the project activities and the national documents. It was responded that the project was formulated in line with all the national documents including the Health Policy, the Primary Health Services Development Programme, the Health Sector Strategic Plan III and the Human Resource for Health Strategic Plan. All the planned activities are therefore supposed to contribute to the achievements described in the national documents.

WAY FORWARD:

21. With the endorsement of the amendments of the PDM and the operation plan, the project shall go ahead with its implementation of the activities. (The PDM version 2.1 and the Explanation on the Amendments attached hereto are the modified version that incorporated the suggestions made during the 2nd JCC meeting.)

CLOSING:

22. Closing remarks were made by the JICA Senior Representatives. In his remarks, he thanked all the members for their active participation in, and inputs and contribution to the fruitful discussion in the meeting. The project is part of the JICA's health programme support to Tanzania to strengthen national health system. He emphasised that capacity development is the core value of JICA's technical cooperation. JICA provides Japanese experts to work hand in hand, share experience and learn each other with counterpart organisations. The meeting was closed at 14:00 hours.

ANNEXES

1) List of Participants
2) A Half-Year Progress Report and Operational Plan
3) PDM Version 2.1
4) Explanation of PDM Amendments
5) PowerPoint Slides on the Project Achievements and Operational Plan
6) PowerPoint Slides on the JICA Project Reviewing Mission Report

List of Participants

JCC Meeting

Venue: Protea Courtyard Hotel

Date: 29th December 2011

No	Name	Organization	Designation	Telephone	E-mail
1	Dr. Deo Mtasiwa	MOHSW	CMO	0754-474346	dmtasiwa@yahoo.com
2	Mr. Hajime Iwama	JICA Tanzania	Senior Representative	0787-464617	Iwama.Hajime@jica.go.jp
3	Ms. Emiko Nishimura	JICA Tanzania	Representative - Health Prog	0754-830949	nishimura.emiko@jica.go.jp
4	Dr. Henock A. M. Ngonyani	MOHSW	Head - HSIU	0787-564359	henockngonyan@yahoo.com
5	Mr. J. J. Rubona	MOHSW	Head of M&E	0782-381449	jrubona@yahoo.com
6	Ms. E. Mwakalukwa	MOHSW	Ag. DHR	0754-287893	ellymwakalukwa@yahoo.com
7	Mr. J. M. Boyi	MOHSW	Ag. ADDS	0754-381426	jamesboyi@yahoo.com
8	Dr. Mary Azayo	MOHSW	Ag. AD - RCHS	0719-083830	mmazayo@gmail.com
9	Dr. G. Kiangi	MOHSW	Ag. DPS	0754-377168	gkiangi2001@yahoo.co.uk
10	Dr. G. J. B. Mtey	RAS - Dodoma	RMO - Dodoma	0754-623428	gjbmtey@gmail.com
11	Dr. Beatrice Byalugabe	RAS - Pwani	RMO - Pwani	0754-319764	bjkenei@yahoo.com
12	Dr. Patrick Mwidunda	MOHSW/NACP	Coordinator NACP/JICA	0784-681475	drmwidunda@yahoo.com
13	Dr. Gisenge J. I. Lija	MOHSW/NACP	Head STI	0784-284146	j.lija@hotmail.com
14	Dr. Marylad Ntiro	MOHSW/NACP	Head - CSS Unit	0754-267705	marylad2003@yahoo.co.uk
15	Dr. Anath Rwebembera	MOHSW/NACP	Ag. Head - C&T Unit	0754-265756	arwebembera@yahoo.com
16	Dr. Bonita Kilama	MOHSW/NACP	Ag. Head - EPI Unit	0784-741748	bonitakilama@yahoo.com
17	Mr. Nobuhiro Kadoi	NACP/JICA	Chief Advisor	0763-453885	mnkadoi@ybbne.jp
18	Ms. Aska Hasegawa	NACP/JICA	Coordinator		
19	Ms. Irene D. Massawe	NACP/JICA	Ass. PO		

The United Republic of Tanzania

Ministry of Health and
Social Welfare

Japan International
Cooperation Agency

NACP/JICA Project Phase2
"Health Systems Strengthening for HIV and AIDS Services"

Half-Year Progress Report (Draft)
(April 2011 – December 2011)
&
Operational Plan
(January – December 2012)

December 2011

Table of Contents

1. INTRODUCTION

1.1 Background

The four-year project entitled “Health Systems Strengthening for HIV and AIDS Services Project (hereafter referred to as the Project)” started at the end of October 2010. It was formulated through the initiative of the Ministry of Health and Social Welfare (MOHSW) with support from the Japan International Cooperation Agency (JICA) in response to the needs identified by the MOHSW through the National AIDS Control Programme (NACP) and based on the achievements made by the previous project (2006-2010). While the previous project aimed at quality improvement of STI management and VCT services including M&E system of the services, the current Project focuses on the routine HIV and AIDS M&E and the comprehensive supportive supervision and mentoring. This cut across all the HIV and AIDS interventions.

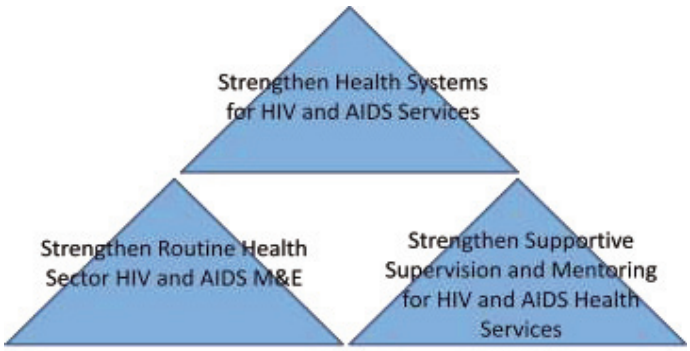


Figure 1. Structure of the Project

1.2 Project Outline

1.2.1 Overall Goal

Health system is strengthened through comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV and AIDS services.

1.2.2 Project Purpose

Comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV and AIDS services is developed and demonstrated for scale-up.

1.2.3 Outputs

In order to achieve the above-mentioned project purpose, the following five Outputs shall be accomplished and activities under each output shall be completed:

Output 1:

M&E tools are simplified and integrated at national level.

Output 2:
M&E system in model regions is strengthened.

Output 3:
Coordination capacity of comprehensive supportive supervision and mentoring at NACP is strengthened.

Output 4:
Capacity of national supervisors and mentors is improved.

Output 5:
Comprehensive supportive supervision and mentoring in model regions is strengthened.

2. IMPLEMENTATION STATUS (APRIL - DECEMBER 2011)

The following activities under each component have been implemented during this reporting period:

2.1. M&E Component

2.1.1 Situation Analysis on Health Sector HIV and AIDS M&E Activities

A situation analysis was conducted to grasp the actual situation and to identify strengths and weaknesses of the current routine health sector HIV and AIDS M&E activities at each level of the health system. A local consultant who works in association with the National Institute of Medical Research (NIMR) Mwanza was recruited for this exercise. The consultant made study design and developed data collection instruments with technical advice from the JICA Epidemiology Expert. The study design was shared with the NACP M&E Steering Committee in July 2011. The instruments were pre-tested in collaboration with the Mwanza RHMT and health facilities in Mwanza at the end of July 2011. The study targeted all councils in the two model regions and interviews were conducted at service delivery points, council, regional and national levels. Twelve field investigators were recruited and trained for the data collection. The data collection activities were conducted between August and September 2011. Both quantitative and qualitative data were collected through interviews and data verification check and analyzed using data analysis software. The draft report was submitted in the middle of October 2011 and was presented in a stakeholders' meeting organised at the end of October 2011. The comments derived from the stakeholders were reflected to the report and the final report was submitted in December 2011. The report is available for sharing.

2.1.2 Regional-level PCM Workshops to Plan Activities to Strengthen Health Sector HIV and AIDS M&E

A two-day Project Cycle Management (PCM) Workshop was conducted for each of the model regions in November 2011. The objectives of the workshops were:

1) To analyse existing problems and challenges in health sector HIV and AIDS M&E in consideration of the findings from the situation analysis
2) To select and prioritise objectives that are feasible, achievable and sustainable
3) To formulate activities to achieve the objectives for each region.

Regional Administrative Secretaries (RASs), District Executive Directors (DEDs), RHMT and CHMT members, MOHSW/M&E and NACP staff were invited to the workshops. In total, 38 participants attended the workshop in Dodoma and 43 in Pwani. Key findings of the situation analysis were presented at the beginning of each workshop to stimulate participants' thinking of issues in M&E. The process of the problem and objective analyses and formulation of activities were facilitated by a local consultant using participatory visualisation approach. Each region formulated activities that mainly focus on data feedback and utilisation at the health facility, council and regional levels. These activities proposed by two regions were integrated and taken into account in amendment of the Project Design Matrix (PDM).

2.1.3 Amendment of the current Project Design Matrix (PDM version 0)

A JICA mission team was dispatched to the Project from 1st to 17th November 2011. The purpose of the mission was to review and modify the current PDM with major focus on the M&E component of the project based on findings of the situation analysis and the results of the PCM workshops. After participating in the PCM workshops, the mission team proposed some amendments to the current version of the PDM. The proposed amendments were discussed within the NACP and some modification was made.

One of the key recommendations made by the mission team on the amendments was adoption of a strategy named "tracer indicators" to monitor routine HIV and AIDS service data. Tracer indicators are defined as **a set of minimum essential indicators for measuring and tracing outputs of health services**. This recommendation was taken seriously by the NACP and further discussed internally. As a result, NACP came up with maximum four indicators for each intervention as a pilot exercise. The indicators are as per attached list.

2.2. Comprehensive Supportive Supervision and Mentoring Component

2.2.1 Finalisation of the training package of comprehensive supportive supervision and mentoring for HIV and AIDS health services

Although the package was pretested in February and March 2011, it had to go through several processes before complete finalisation. In May 2011, a workshop was organised for a small team to incorporate suggestions made by the facilitators and the participants of the CSSM training conducted in March 2011. The improved package was then used for a training of trainers (TOT) conducted in Tanga in June 2011. Suggestions for further improvement were made by the trained trainers/facilitators at the end of the training. Some of the major issues addressed were:

1) Disharmony of contents among the participant's manual, the facilitator's guide and the slides
2) Unclear instructions to facilitators in the facilitator's guide
3) Unfriendliness of the facilitator's guide.

In order to fix these issues, an intensive work without any interruption was required. A few selected members who have been involved in the process confined themselves to do the task in August 2011. The

package has become user-friendly and contents are harmonised among the materials. The package was fine-tuned in September – October 2011. It was finalised at the end of November 2011 and sent to the MOHSW for official approval. The prepress print was proofread in December 2011 and it currently is under printing process.

2.2.2 Training of National Trainers

A two-week training of trainers (TOT) for CSSM was conducted in June 2011 in collaboration with I-TECH. The first week was allocated for facilitation skills' training and the second for actual facilitation of a CSSM training course. In total, 27 national trainers/facilitators including 8 mentors in 6 interventions and 19 supervisors have been trained. Mentors were selected from 8 national and regional level health facilities and supervisors from 9 regions including Dar es Salaam. Among these, 23 were government staff and 5 were from partners.

2.2.3 Training of National and Regional Level Supervisors and Mentors

Two CSSM trainings were organised during this reporting period under the project. The first one was organised in July 2011 in combination with the TOT and was attended by 17 national and regional supervisors from 5 regions and 12 national mentors in 9 interventions from 12 national/regional hospitals. The second was in December 2011 and was attended by 10 national and regional supervisors from 3 regions and 16 national and regional mentors in 7 interventions from 8 national and regional level health facilities.

2.2.4 Development of concept of documentation and information sharing mechanism in CSSM

Concept of CSSM documentation and information sharing mechanism was developed and included in the CSSM training materials.

2.3 OTHER RELATED ACTIVITIES

2.3.1 Training of National, Regional and District Level Supervisors and Mentors

The Reproductive and Child Health Unit of the MOHSW organised CSSM training in May 2011 in collaboration with the NACP and the Project. Five trainings were simultaneously organised by zones and were attended by 87 participants from 15 regions, namely Arusha, Kilimanjaro, Tanga, Manyara, Singida, Dodoma, Morogoro, Pwani, Mbeya, Ruvuma, Iringa, Rukwa, Mwanza, Kagera and Mara. Three supervisors and three mentors (PMTCT, C&T and TB/HIV) were invited from each region.

Another training was conducted through CDC funding in August 2011. It targeted district-level supervisors and mentors from 6 regions, namely Iringa, Mbeya, Mwanza, Shinyanga, Morogoro and Pwani.

The training package developed by the Project was used for all the trainings and the Chief Advisor participated in the training as a facilitator.

3. TENTATIVE OPERATIONAL PLAN (JANUARY - DECEMBER 2012)

3.1 M&E Component:

Output 1: Essential (Tracer) indicators for routine monitoring of HIV and AIDS health services are selected and endorsed by the MOHSW/NACP.

1-1. Finalise and endorse the selected indicators
1-2. Share the selected indicators with relevant implementing partners
1-3. Establish the data entry sheet/form
1-4. Orient C/RHMT in model regions on the essential (tracer) indicators

Output 2: M&E system in model regions is strengthened.

2-1. Assess IT situation for data analysis at regional and council levels
2-2. Procure and install hard and software based on the assessment
2-3. Collect and store the data set of the essential indicators by R/CHMTs
2-4. Build the skills and knowledge of data analysis
2-5. Establish and implement data feedback system from RHMT and CHMT to health facilities
2-6. Expand data utilization for health services by RHMT and CHMT

3.2 Supportive Supervision and Mentoring Component:

Output 3: Comprehensive supportive supervision and mentoring at national level is strengthened.

3-1. Develop annual plan and budget for national supervision and mentoring activities
3-2. Implement and monitor comprehensive supportive supervision and mentoring visits for health sector HIV and AIDS services
3-3. Develop and reinforce CSSM documentation and information sharing mechanism
3-4. Conduct national synergy meetings between supervisors and mentors
3-5. Conduct stakeholders meetings to share experiences/lessons
3-6. Conduct National Training of Trainers (NTOT)

Output 4: Comprehensive supportive supervision and mentoring in model regions is strengthened.

4-1. Select and train regional and district supervisors and mentors
4-2. Plan and conduct comprehensive supportive supervision and mentoring
4-3. Develop and reinforce CSSM documentation and information sharing mechanism
4-4. Conduct regional and district synergy meetings between supervisors and mentors
4-5. Conduct stakeholders meetings to share experiences/lessons

3.3 Synergy Component:

Output 5: Synergetic effect between M&E system and CSSM is enhanced.

5-1. Incorporate essential indicators in the CSS tool
5-2. Orient supervisors on essential indicators

ANNEX 1

Project Design Matrix (PDM)

Version Number: 2.1

Project Title: Health Systems Strengthening for HIV and AIDS Services Project (NACP/JICA Project Phase2)
Date: 30th December 2011
Target Area: Tanzania (Model regions: Pwani and Dodoma)
Project Duration: Oct 2010 - Oct 2014
Target Group : NACP, National supervisors and mentors, and RHMTs and CHMTs in model regions Beneficiary: RHMTs, CHMTs, Health Facilities and Households

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal			
Health system is strengthened through comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV and AIDS services.	Proportion of regions implementing comprehensive supportive supervision/mentoring/M&E system for health sector HIV and AIDS services	Supervision reports, Mentoring reports	
Project Purpose			
Comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV and AIDS services is developed and demonstrated for scale-up*1.	1. Concordance correlation between data in registers and in summary reports increased more than moderate level in the model regions*2. 2. Proportion of regions oriented on the M&E system for health sector HIV and AIDS services developed by the Project (Targeting all regions) 3. Proportion of RHMTs and CHMTs implementing comprehensive supportive supervision and mentoring for health sector HIV and AIDS services developed by the Project increases in the model regions as well as six other regions (one region per zone)*3.	1. Project Report 2. Survey 3. Situation Analysis Report and Survey	HIV and AIDS remains as national priority. Human, financial and physical resources are maintained at all levels.
Outputs			
1. Essential (Tracer) indicators for routine monitoring of HIV and AIDS health services are selected and endorsed by the MOHSW/NACP and integrated into the national M&E system through the initiative of the MOHSW.	1-1. Endorsed essential (tracer) indicators in place 1-2. Essential (tracer) indicators integrated into the national M&E system	The list of the essential indicators	Human, financial and physical resources are maintained at all levels.
2. M&E system in model regions is strengthened.	2-1. Increased number of data feedback from R/CHMTs to health facilities 2-2. Increased cases of data utilization applied for health services at the health facilities and councils in the two model regions	2-1. Situation Analysis Data 2-2. Reports/records of feedback (activity #2-5) 2-3. Reports/records of data utilization (activity #2-6)	
3. Comprehensive supportive supervision and mentoring at national level is strengthened.	3-1. Annual plan of comprehensive supportive supervision and mentoring in place at the national level 3-2. Increased retrievable documentation rate of CSS visits by national supervisors 3-3. Increased execution rate of mentoring visits in response to the needs identified through CSS by national supervisors	3-1. Annual plan of comprehensive supportive supervision and mentoring at the national level 3-2. CSS and Mentoring reports	
4. Comprehensive supportive supervision and mentoring in model regions is strengthened.	4-1. Increased retrievable documentation rate of CSS visits by regional supervisors 4-2. Increased execution rate of mentoring visits in response to the needs identified through CSS by regional supervisors 4-3. Increased retrievable documentation rate of CSS visits by council supervisors 4-4. Increased execution rate of mentoring visits in response to the needs identified through CSS by council supervisors	CSS and Mentoring reports	
5. Synergetic effect between M&E system and CSSM is enhanced.	Increased implementation rate of essential indicator review and feedback during CSSM in the model regions	CSS Reports	
Activities	**Inputs**		
0. Conduct baseline, midline, end line survey	**Japan**	**Tanzania**	Significant proportion of trained personnel remains as implementers of tasks assigned by the Project.
1-1 Conduct situation analysis on health sector HIV&AIDS M&E activities 1-2 Share the findings of the situation analysis with stakeholders	1. Dispatch of Japanese experts - Chief Advisor/M&E specialist - Epidemiology specialist	1. Assignment of the personnel 2. Facilities and equipment 3. Office space	

1-3	Conduct workshop for planning activities	- Project Coordinator/Training specialist - Other short-term experts 2. Equipment - Photo copy and fax machine - IT equipment for data analysis in model regions, etc. 3. Operational cost	4. Operational cost	Structure, roles and responsibilities of national, regional and district administration for M&E and supportive supervision are maintained. Human, financial and physical resources are maintained at all levels.
1-4	Hold unit head meetings to select essential indicators			
1-5	Build concensus on the selected essential indicators by NACP			
1-6	Establish the data entry sheet/form			
1-7	Orient C/RHMT in model regions on the essential indicators			
2-1	Assess IT situation for data analysis at regional and council levels			
2-2	Procure and install hard and software based on the assessment			
2-3	Collect and store the data set of the essential indicators by R/CHMTs			
2-4	Build the skills and knowledge of data analysis			
2-5	Establish and implement data feedback system from RHMT and CHMT to health facilities			
2-6	Expand data utilization for health services by RHMT and CHMT			
3-1.	Develop and print comprehensive supportive supervision and mentoring training package			
3-2.	Conduct National Training of Trainers (NTOT)			
3-3.	Train national supervisors and mentors			
3-4.	Develop annual plan and budget for national supervisors and mentors			
3-5.	Implement and monitor comprehensive supportive supervision and mentoring visits			
3-6.	Develop and reinforce mechanism for documentation and sharing reports of comprehensive supportive supervision and mentoring visits			
3-7.	Conduct national synergy meetings between supervisors and mentors			
3-8.	Conduct stakeholders meetings to share experiences/lessons			
3-9.	Review and print comprehensive supportive supervision and mentoring manual and tools			
3-10.	Conduct refresher trainings to national supervisors and mentors			
4-1.	Orient R/CHMTs and health facilities on comprehensive supportive supervision and mentoring			
4-2.	Select and train regional and district supervisors and mentors			
4-3.	Plan and conduct comprehensive supportive supervision and mentoring			
4-4.	Develop and reinforce mechanism for documentation and sharing reports of comprehensive supportive supervision and mentoring visits			
4-5.	Conduct regional and district synergy meetings between supervisors and mentors			
4-6.	Conduct stakeholders meetings to share experiences/lessons			
4-7.	Integrate comprehensive supportive supervision and mentoring into Regional Annual Health Plans and CCHPs			
4-8.	Conduct study tour to a country of best practice			
5-1.	Incorporate essential indicators in the CSS tool			
5-2.	Orient supervisors on essential indicators			
5-3.	Provide information on best practices to stakeholders			
5-4.	Initiate recognition mechanism of best performing district			

*1 "demonstrated for scale up" means "national implication of modeling exercises in Pwani and Dodoma."

*2 Based on the strength-of-agreement criteria for Lin's concordance correlation coefficient
*3 Expansion to six other regions will be done with the initiative of the MOHSW/NACP.
Note: Targets of the indicators will be set after baseline survey.

Narrative Summary	Objectively Verifiable Indicators	Numerator	Denominator	Means of Verification
Overall Goal				
Health system is strengthened through comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV and AIDS services.	Proportion of regions implementing comprehensive supportive supervision, mentoring and effective M&E strategy for health sector HIV and AIDS services	# of regions implementing comprehensive supportive supervision, mentoring and effective M&E strategy for health sector HIV and AIDS services	Total # of regions	Supervision reports, Mentoring reports
Project Purpose				
Comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV and AIDS services is developed and demonstrated for scale-up*1.	1. Proportion of regions oriented on effective M&E strategy to strengthen data feedback and utilization for health sector HIV and AIDS services developed by the Project	# of regions oriented on effective M&E strategy to strengthen data feedback and utilization for health sector HIV and AIDS services developed by the Project	Total # of regions	1. Project reports 2. Survey reports
	2. Proportion of regions implementing comprehensive supportive supervision and mentoring for health sector HIV and AIDS services developed by the Project increases to 20%.	# of regions implementing comprehensive supportive supervision and mentoring for health sector HIV and AIDS services developed by the Project	Total # of regions	
	3. Concordance correlation between data in registers and in summary reports reached at least moderate* level in the model regions.	Concordance correlation coefficient between selected data in registers and in summary reports		Survey
Outputs				
1. Essential (Tracer) indicators for routine monitoring of HIV and AIDS health services are selected and endorsed by the MOHSW/NACP.	Endorsed essential (tracer) indicators			The list of the essential indicators
2. M&E system in model regions is strengthened.	2-1. Increased number of data feedback from R/CHMTs to health facilities			2-1. Reports/records of feedback(activity #2-4)
	2-2. Increased cases of data utilization applied for health services at the health facilities and councils in the two model regions			2-2. Reports/records of data utilization (activity #2-5)
3. Comprehensive supportive supervision and mentoring at national level is strengthened.	3-1. Annual CSS plan (matrix) in place			Annual CSS plan (matrix)
	3-2. Increased documentation rate of CSS visits by national supervisors	Number of CSS reports submitted by national supervisors in a year	Number of CSS visits conducted by national supervisors in a year	CSS reports
	3-3. Increased execution rate of mentoring visits in response to the needs identified through CSS by national supervisors	Number of mentoring visits conducted in a year	Number of mentoring needs reported by national supervisors in a year	Mentoring reports
4. Comprehensive supportive supervision and mentoring in model regions is strengthened.	4-1. Increased documentation rate of CSS visits by regional/district supervisors	Number of CSS reports submitted by regioal/district supervisors in a year	Number of CSS visits conducted by regional/district supervisors in a year	CSS and Mentoring reports
	4-2. Increased execution rate of mentoring visits in response to the needs identified through CSS by regional supervisors	Number of mentoring visits conducted in a year	Number of mentoring needs reported by regional/district supervisors in a year	Mentoring reports
5. Synergetic effect between M&E system and CSSM is enhanced.	Increased implementation rate of essential (tracer) indicator review and feedback during CSSM in the model regions	Number of CSSM reports indicating evidence of review and feedback	Number of CSS visits conducted by regional/district supervisors in a year	CSS Report

Explanation on the PDM Amendments

Date: 29th December 2011

	Before Amendment	After Amendment	Remarks/Explanation
Target Area	Tanzania	Tanzania (Morel Regions: Pwani and Dodoma Regions)	
Target Group	NACP, National Supervisors and Mentors	NACP, National Supervisors and Mentors, and RHMTs and CHMTs in model regions	
Overall Goal			
OVI	Number/Proportion of regions implementing comprehensive supportive supervision/mentoring /M&E system for health sector HIV and AIDS services	Proportion of regions implementing comprehensive supportive supervision/mentoring /M&E system for health sector HIV and AIDS services	"Number" deleted.
Project Purpose			
Narrative Summary	Comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV and AIDS services is developed and demonstrated for scale-up.	The statement not changed.	A footnote added below as *1: "demonstrated for scale up" means "national implication of modeling exercises in Pwani and Dodoma."
OVIs	1. Number of regions and stakeholders oriented on comprehensive supportive supervision/mentoring/M&E system for health sector HIV and AIDS services developed by the Project 2. Number of regions having well functioning comprehensive supportive supervision/mentoring/M&E system (denominator2) 3. Proportion of health workers in the model regions recognizing comprehensive supportive supervision/mentoring/M&E	1. Concordance correlation between data in registers and in summary reports increased more than moderate level in the model regions*2. 2. Proportion of regions oriented on the M&E system for health sector HIV and AIDS services developed by the Project (Targeting all regions) 3. Proportion of RHMTs and CHMTs implementing comprehensive supportive supervision and mentoring for health sector HIV and AIDS services	A new indicator was added as #1 with its footnote *2. The concordance correlation coefficient was used in the situation analysis conducted in 2011 and could be used to evaluate the synergy effect of CSSM and M&E activities. "Strength-of-agreement" is classified in 4 levels as "Poor", "Moderate", "Substantial" and "Almost perfect". The previous #1 indicator was split into two: one is for M&E (as new #2 indicator)

	system as simpler and more useful than the previous system for their service provision	developed by the Project increases in the model regions as well as six other regions (one region per zone)*3.	and the other is for CSSM (as new #3 indicator). The two cannot be merged because the progresses of the two components are different. Footnote *3 is added to clarify that expansion to six other regions will be done with the initiative of the MOHSW/NACP. The previous #2 & 3 indicators were deleted.
Output 1			
Narrative Summary	M&E tools are simplified and integrated at national level.	Essential (Tracer) indicators for routine monitoring of HIV and AIDS health services are selected and endorsed by the MOHSW/NACP and integrated into the national system through the initiative of the MOHSW.	The previous output was changed to more achievable output at the national level. Data collection and reporting will be done as previously; however, routine monitoring activities will focus on a few selected essential indicators (tracer indicators) for easier data feedback and utilization at all levels in the two model regions. The indicators need to be selected and endorsed by the MOHSW/NACP. In addition, they shall be integrated into the national system through the initiative of the MOHSW.
OVIs	1-1. Number of stakeholders meetings conducted 1-2. Simplified and integrated recording and reporting tools and SOPs in place	1-1. Endorsed essential (tracer) indicators in place	The previous indicators are deleted and a new indicator is added.

Output 2			
OVIs	2-1. Number/Proportion of regions/districts/health facilities generating complete, timely and accurate reports 2-2. Number/Proportion of Regional Annual Health Plans and CCHPs citing information generated from DHIS 2-3. Proportion of health facilities which can cite at least one decision made from information generated from M&E system	2-1. Increased number of data feedback from R/CHMTs to health facilities 2-2. Increased cases of data utilization applied for health services at the health facilities and councils in the two model regions	The project will focus on strengthening M&E system in the model regions through routine data feedback and utilization at all levels of the model regions. The previous 3 indicators are replaced with the new 2 indicators.
Output 3			
Narrative Summary	Coordination capacity of comprehensive supportive supervision and mentoring at NACP is strengthened.	Comprehensive supportive supervision and mentoring at national level is strengthened.	The previous Output 3 and 4 are merged as a national-level CSSM output.
OVIs	3-1. Number of stakeholders meetings conducted 3-2. Annual plan of comprehensive supportive supervision and mentoring in place at the national level 3-3. Number of coordinated bi-annual supervisory visits to regions in the last one year 3-4. Number of coordinated mentoring visits to referral/regional hospitals in response to the needs identified in the last one year 3-5. Improved manual and tools in place	3-1. Annual plan of comprehensive supportive supervision and mentoring in place at the national level 3-2. Increased retrievable documentation rate of CSS visits by national supervisors 3-3. Increased execution rate of mentoring visits in response to the needs identified through CSS by national supervisors	Only key OVIs are selected and modified in consideration of measurability.
Output 4			
Narrative Summary	Capacity of national supervisors and mentors is improved.		Merged into the Output 3.

OVIs	4-1. Comprehensive supportive supervision and mentoring training package in place 4-2. Number of national supervisors/mentors trained 4-3. Number of national trainers for comprehensive supportive supervision and mentoring		
Output 5 (Output 4)			
Narrative Summary	Comprehensive supportive supervision and mentoring in model regions is strengthened.	No change.	The previous Output 5 becomes Output 4.
OVIs	5-1. Number of regional/district supervisors and mentors trained 5-2. Number/Proportion of regions/districts/health facilities received comprehensive supportive supervision/mentoring for HIV and AIDS health services 5-3. Proportion of action points/recommendations implemented by regions/districts/health facilities	4-1. Increased retrievable documentation rate of CSS visits by regional supervisors 4-2. Increased execution rate of mentoring visits in response to the needs identified through CSS by regional supervisors 4-3. Increased retrievable documentation rate of CSS visits by council supervisors 4-4. Increased execution rate of mentoring visits in response to the needs identified through CSS by council supervisors	Only key OVIs are selected and modified in consideration of measurability.
Output 5 (New)			
Narrative Summary		Synergetic effect between M&E system and CSSM is enhanced.	A new output was inserted as Output 5 that describes linkage between M&E and CSSM.
OVI		5-1. Increased implementation rate of essential indicator review and	

		feedback during CSSM in the model regions	

Health Systems Strengthening for HIV and AIDS Services Project

MOHSW/NACP & JICA

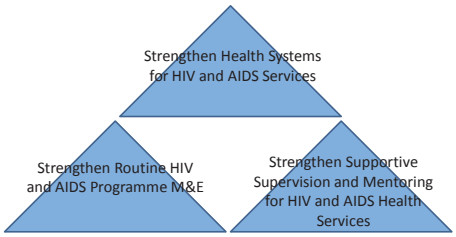
Background

- The four-year project entitled "Health Systems Strengthening for HIV and AIDS Services Project" started at the end of October 2010.
- The project was formulated through the initiative of the MOHSW with support from the JICA in response to the needs identified by the NACP and based on the achievements made by the previous project (2006-2010).
- The Project focuses on the routine HIV and AIDS M&E and the comprehensive supportive supervision and mentoring, which cut across all the HIV and AIDS interventions.

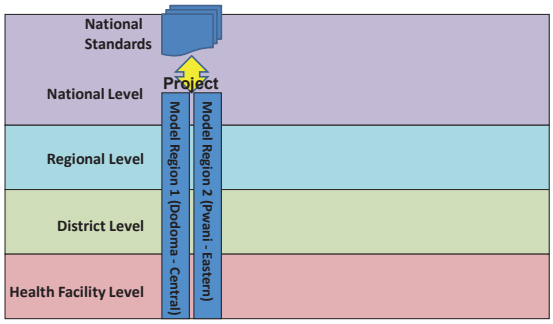
Project Profile

Implementing organisation:	MOHSW/NACP
Duration:	4 Years (Oct 2010 – Oct 2014)
Goal:	Health system is strengthened through comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV and AIDS services.
Purpose:	Comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV and AIDS services is developed and demonstrated for scale-up.
Approach:	Model Region Approach (Dodoma & Pwani)

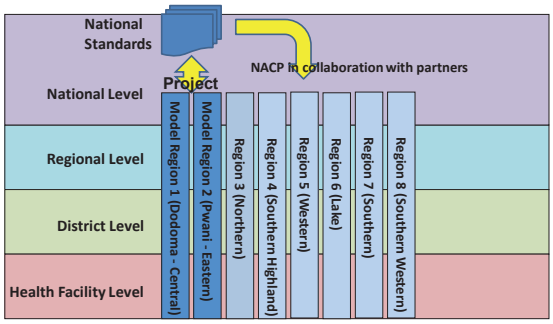
Structure of the Project



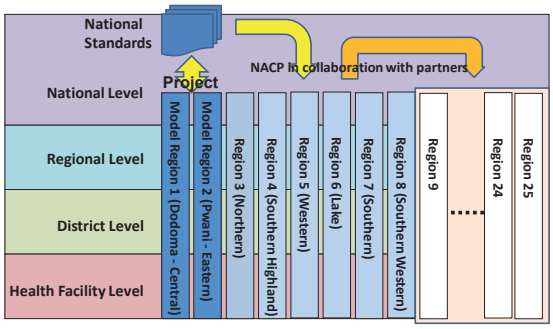
Model Region Approach



Model Region Approach



Model Region Approach



ACHIEVEMENTS
(APRIL – DECEMBER 2011)

M&E Component

- The Situation Analysis (SA) on Health Sector HIV and AIDS M&E Activities was completed in October 2011. (The SA Report is available.)
- The key findings of the SA were shared with stakeholders in October and November 2011.
- Action Plans were developed through Project Cycle Management (PCM) Workshops held in Dodoma and Pwani regions.
- Project Design Matrix (PDM) has been amended based on the findings of the SA and the results of the PCM workshop.
- Essential (Tracer) indicators have been formulated as part of strengthening M&E.

CSSM Component

- Training Package has been completed.
- Printing the Training Package is in process.
- TOT Training for comprehensive SS&M was conducted in June 2011.
- 2 trainings of national and regional supervisors and mentors conducted in July 2011.
- 5 trainings of regional supervisors and mentors conducted in collaboration with MOHSW/RCH in May 2011.

PRESENTATION BY
THE JICA PROJECT REVIEW MISSION TEAM

PRESENTATION ON PDM AMENDMENTS

Summary of Amendments

- Objectively verifiable indicators of the Project Purpose and Outputs #1, 2, 3, 4 & 5
- Narrative summary of the Output #1
- Structure of the Outputs and insertion of a new output
- Activities under the Outputs #1, 2 & 5

OPERATIONAL PLAN (JANUARY – DECEMBER 2012)

Output 1: M&E Component National Level

Essential (Tracer) indicators for routine monitoring of HIV and AIDS health services are selected and endorsed by the MOHSW/NACP.

1. Finalise and endorse the selected indicators
2. Share the selected indicators with relevant implementing partners
3. Establish the data entry sheet/form
4. Orient C/RHMT in model regions on the essential (tracer) indicators

Output 2: M&E Component Model Region Level

M&E system in model regions is strengthened.

1. Assess IT situation for data analysis at regional and council levels
2. Procure and install hard and software based on the assessment
3. Collect and store the data set of the essential indicators by R/CHMTs
4. Build the skills and knowledge of data analysis
5. Establish and implement data feedback system from RHMT and CHMT to health facilities
6. Expand data utilization for health services by RHMT and CHMT

Output 3: CSSM Component National Level

Comprehensive supportive supervision and mentoring at national level is strengthened.

1. Develop annual plan and budget for national supportive supervision and mentoring activities
2. Implement and monitor comprehensive supportive supervision and mentoring visits for health sector HIV and AIDS services
3. Develop and reinforce CSSM documentation and information sharing mechanism
4. Conduct national synergy meetings between supervisors and mentors
5. Conduct stakeholders meetings to share experiences /lessons
6. Conduct National Training of Trainers (NTOT)

Output 4: CSSM Component Model Region Level

Comprehensive supportive supervision and mentoring in model regions is strengthened.

- Select and train regional and district supervisors and mentors
- Plan and conduct comprehensive supportive supervision and mentoring
- Develop and reinforce CSSM documentation and information sharing mechanism
- Conduct regional and district synergy meetings between supervisors and mentors
- Conduct stakeholders meetings to share experiences/lessons

Output 5: Synergy between M&E and CSSM

Synergetic effect between M&E system and CSSM is enhanced.

1. Incorporate essential indicators in the CSS tool
2. Orient supervisors on essential indicators

TANZANIA

END

Thank you for your attention!

TANZANIA

Report from the Reviewing Mission For NACP/JICA Project II

29th December 2011
2nd JCC @Courtyard Hotel

Emiko Nishimura
Reviewing Mission Team
Japan International Cooperation Agency (JICA)

1

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2. **Results of the Workshop**
3. **Recommendations from the Mission**

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1 Outline of the Mission

Period: 1 Nov- 17 Nov 2011

Purpose of the Mission:

1. To conduct workshops in Dodoma & Pwani to identify the M&E related project activities and outputs, based on the results of the situation analysis.
2. To review the Project Design Matrix (PDM) .
3. To have discussions with NACP/MOHSW and other key stakeholders and reach an agreement on the revision of PDM.

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1 Outline of the Mission

Mission Members

■ Mr. Hajime Iwama	Senior Representative, JICA Tanzania Office
■ Dr. Tomohiko Sugishita	Senior Advisor, JICA Kenya
■ Ms. Nae Kaneko	Representative, JICA HQ
■ Ms. Emiko Nishimura	Representative, JICA Tanzania Office

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1 Outline of the Mission

Activities Conducted

1. Project Cycle Management (PCM) Workshop
   3-4 November –Dodoma
   8-9 November –Pwani
2. Discussion with NACP/MOHSW
   14 Nov Meeting with NACP/MOHSW
   Meeting with CMO
   16 Nov MOHSW-NACP Coordination Mtg

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2 Results of the Workshop

PCM Workshop

- 2-days Workshops were conducted using Project Cycle Management (PCM) method in Dodoma (3-4 Nov) and Pwani (8-9 Nov)
- Participants included RAS, DED, R/CHMT, NACP Representative, MOHSW Representative (only in Pwani), JICA experts and Mission Members.
  (#: 38 in Pwani, 43 in Dodoma)

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In Workshops, following activities have been done;

(1) Share the results of Situation Analysis

(2) Analyze the problems/challenges,

(3) Select objectives,

(4) Identify activities to achieve objectives, target, and responsible organizations

2 Results of the Workshop

- Core Problem:
  "Poor Quality of Data" (Dodoma&Pwani)
- Core Objective:
  "M&E system is improved" (Dodoma)
  "To have good quality of data at CHMT level" (Pwani)
- Commonly Identified Activities:
  - Skills Building on Data Management at R/CHMT
  - R/CHMTs Provide Data Feedback to HFs
  - R/CHMTs Utilize the Data for planning, various interventions

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3. Recommendations from the Mission

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Overall Suggestions

1. To Focus on Quality Improvement of Data Management
2. To Strengthen Program M&E Systems through modeling exercises in two model regions (Pwani and Dodoma).
3. To continue dialogues with MOHSW M&E Unit to contribute to strengthen national M&E System.

Major Challenges from the Field

1. To improve Data Quality
2. To build capacity for Data Management
3. To motivate and allocate Data Manager in RHMT/CHMT
4. To establish Model M&E System for HIV and AIDS Service provision

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Project Strategy 1

1. **To improve Data Quality**
2. To build capacity for Data Management
3. To motivate and allocate Field Data Manager
4. To establish Model M&E System for HIV/AIDS Service provision

Suggestions

i. Introduce Program Tracer Indicators (Essential Indicators for monitoring and tracking)

ii. Strengthen Data Feedback & Utilization

iii. Synergy between M&E system and Supportive Supervision

Project Strategy 2

1. To improve Data Quality
2. **To build capacity for Data Management**
3. To motivate and allocate Field Data Manager
4. To establish Model M&E System for HIV/AIDS Service provision

Suggestions

i. Cascade Training for Data Management (RHMT/CHMT)

ii. Mentoring Support for Data Management from RHMT-CHMT-selected HFs

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Project Strategy 3

1. To improve Data Quality
2. To build capacity for Data Management
3. **To motivate allocate Field Data Manager**
4. To establish Model M&E System for HIV/AIDS Service provision

Suggestions

i. Introduce recognition/awarding mechanism for best performing data managers

ii. Allocate Project Field Officer (M&E/CSS) in Regions who will be deployed to MOHSW as M&E Officer at the end of the Project

Project Strategy 4

1. To improve Data Quality
2. To build capacity for Data Management
3. To allocate Field Data Manager
4. **To establish Model M&E System for HIV/AIDS Service provision**

Suggestions

i. Document modeling exercises for sharing

ii. Strengthen policy dialogue with NACP and MOHSW for future scaling up

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Other Suggestions

1. Mindset Change from program thinking to systems thinking
2. Working closely with local governments officials (RAS, DED, etc)
3. Implicate only essential indicators as a set of tracer indicators at national level and may add some important indicators at regional level.
4. Monitor closely the performance evaluation of DHIS pilot in Pwani Region.

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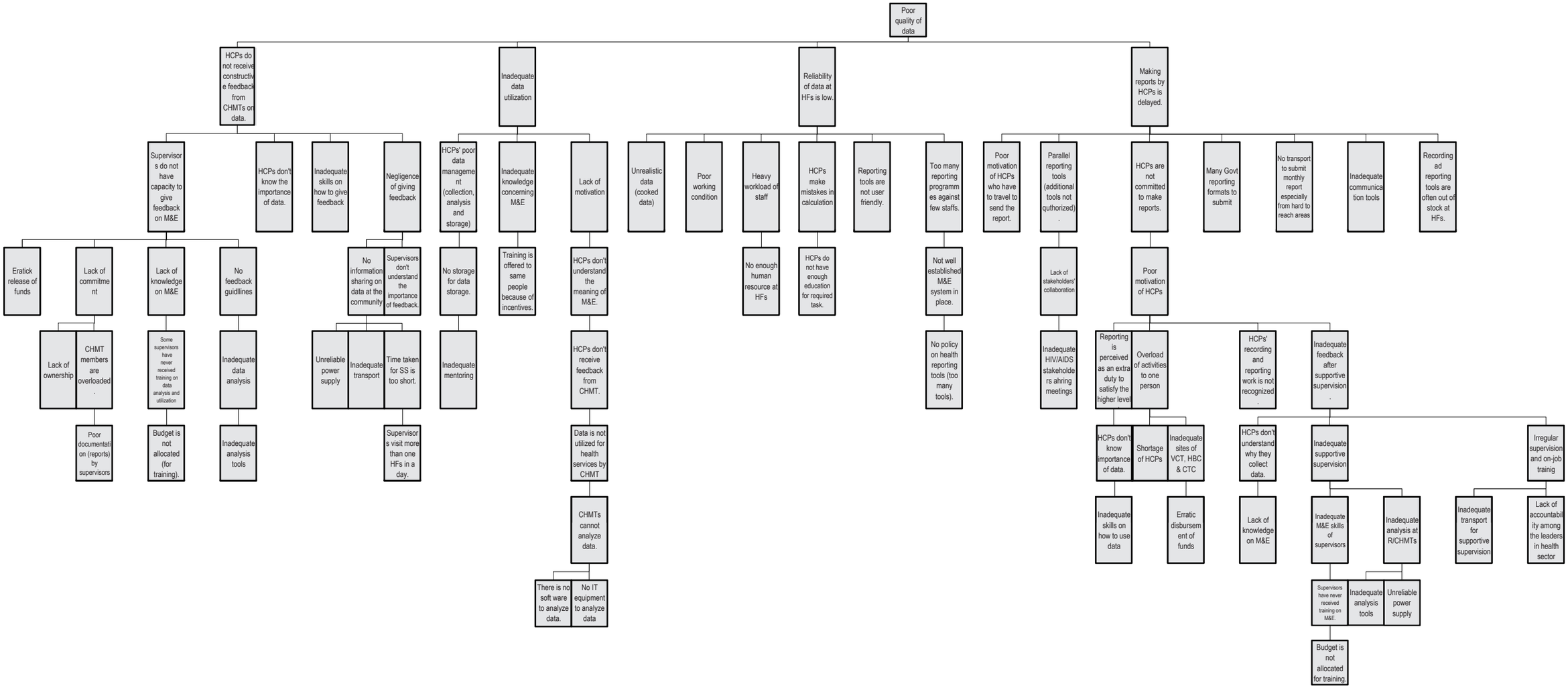
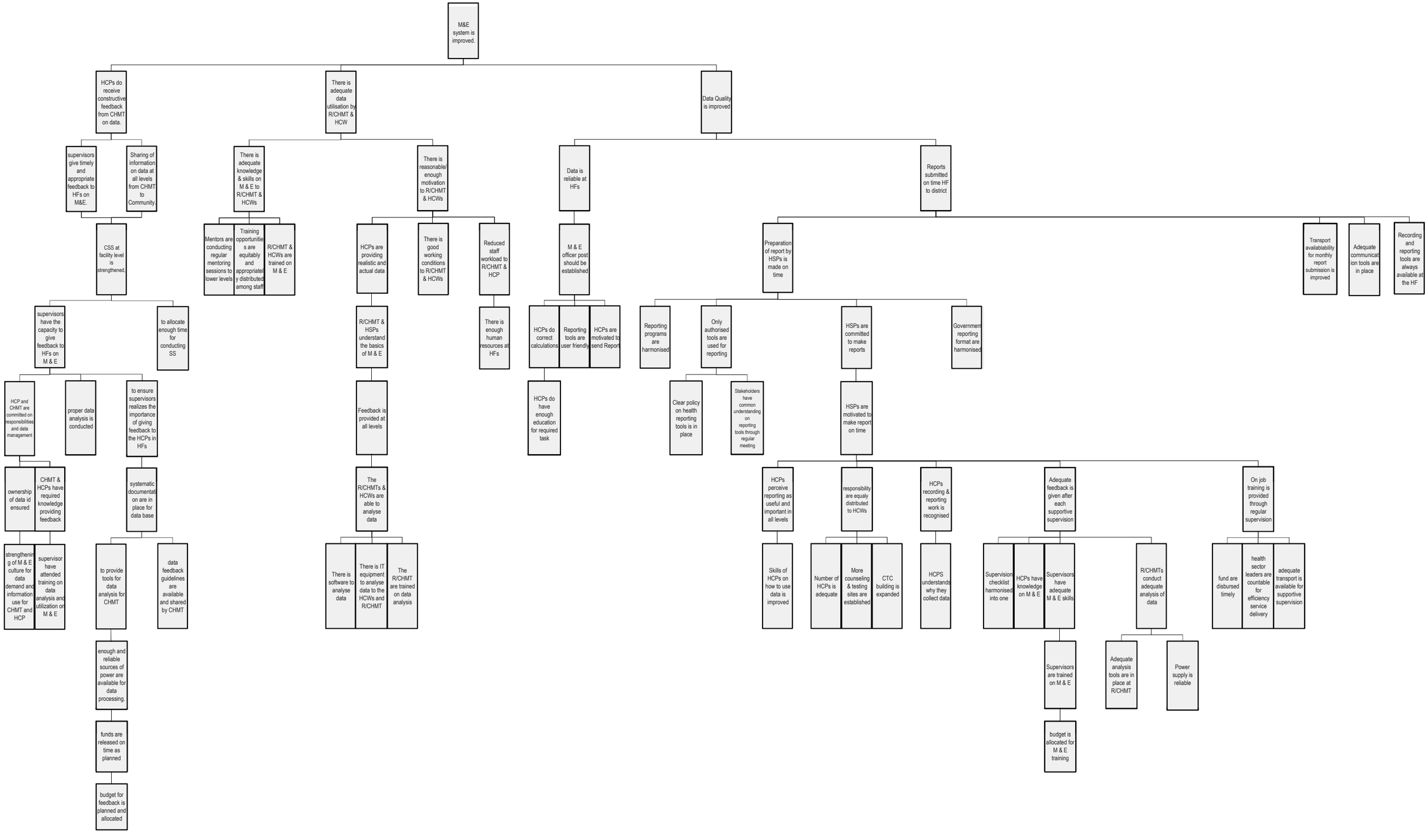
4-3-1. 問題分析及び目的分析ツリー（ドドマ州）

Problem Analysis of Health Sector Routine HIV&AIDS M&E (Dodoma)

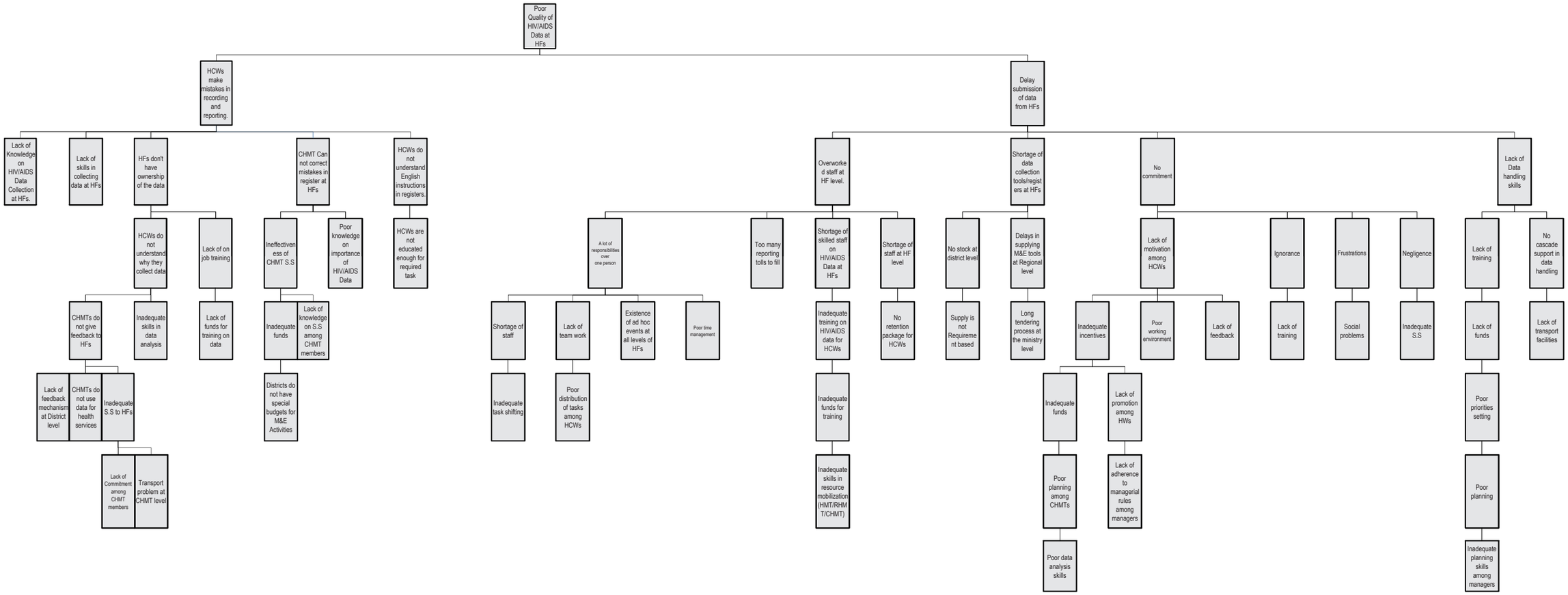


Problem Analysis of Health Sector Routine HIV&AIDS M&E (Dodoma)

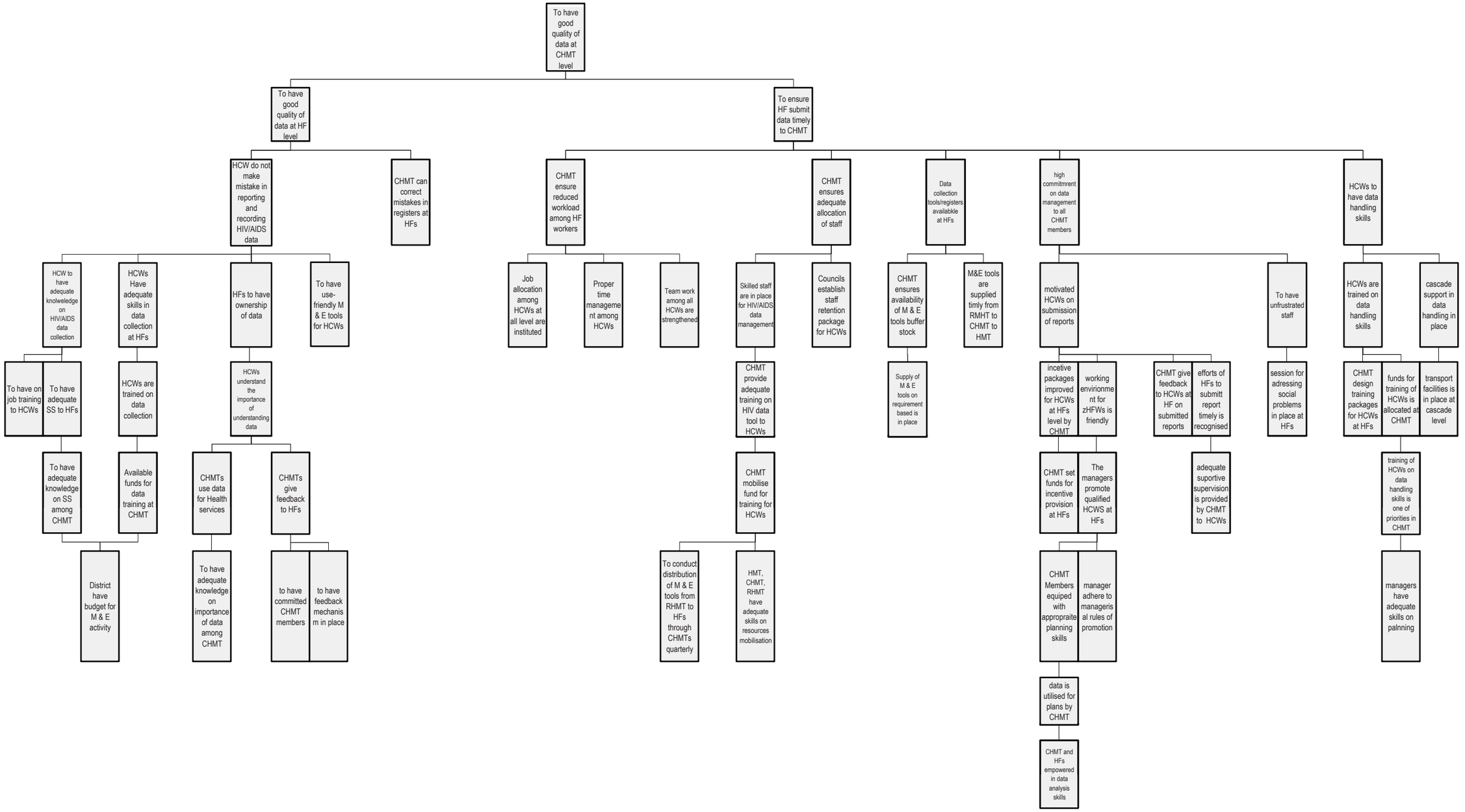


4-3-2. 問題分析及び目的分析ツリー（プワニ州）

Problem Analysis of Health Sector Routine HIV&AIDS M&E in Pwani



Problem Analysis of Health Sector Routine HIV&AIDS M&E in Pwani

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