Zimbabwe Health Sector
Performance Monitoring and Evaluation Policy Guidelines and Strategy

Ministry Of Health and Child Care

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Four interlinked stakeholder participatory phases were conducted: an M&E Systems assessment through review of national programming policy documents and Health Sector programming literature; key informant Interviews with health sector programme managers and service providers at National and Provincial, District and health facility levels; review of data collection tools and data capture screens; and stakeholder participatory review and planning meetings.
A full list of those consulted is found in Annex 1. The Ministry of Health and Child Care (MoHCC) would also like to sincerely thank people who offered special technical and editorial assistance during the development of this Policy and Strategy document. Their names are listed at the end of Annex 1.

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Foreword

The Government of Zimbabwe National Monitoring and Evaluation Policy 2015 noted that "*The weakest link in the implementation of policies, programmes and projects has been the absence of a National Monitoring and Evaluation Policy to give guidance and credence to the achievements of results through correct diagnosis*". In line with the Zimbabwe National Monitoring and Evaluation Policy 2015, the Ministry of Health and Child Care (MOHCC) commissioned the development of this overarching Health Sector Performance Monitoring and Evaluation (M&E) Policy Guidelines and Strategy. So far the M&E function in the MOHCC has remained fragmented and scattered in several different programmes, without a national overarching M&E mechanism.

These Policy Guidelines and Strategy shall serve as the main strategic reference guide for results oriented performance measurement of the Health Sector in national development. The subsequent implementation of the Performance M&E Policy Guidelines and Strategy is aimed at improving effectiveness, technical compliance, capacity, synchronisation, institutionalisation and sustainability of M&E in the health sector.

It is standard practice that a policy is developed first, followed by a strategy to translate the policy into action. The Ministry of Health and Child Care decided to base its M&E policy on the Government of Zimbabwe National Monitoring and Evaluation Policy 2015. Ministry then adopted and adapted the policy statements in the National Policy to be in line with "health sector language". By combining these extracted policy statements together with the recommendations from stakeholder consultations and the One Health Sector policy guidelines, this strategy document has been developed in line with the Three Ones principle.

It is my sincere wish that all stakeholders in Zimbabwe's health sector will use the policy and strategy guidelines outlined in this document to ensure strengthened M&E across the many programmes, processes and activities of Zimbabwe's health sector towards measuring, documenting and communicating improved health for all Zimbabweans.

Major General (Dr.) G. Gwinji
Permanent Secretary, Ministry of Health and Child Care

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Acronyms

CBO	Community Based Organisation
CSO	Community Service Organisation
DHE	District Health Executive
DHIO	District Health Information Officer
DHIS2	District Health Information System 2
DPME	Department of Performance Monitoring and Evaluation
DPPME	Division of Policy, Planning, Monitoring and Evaluation
EPMS	Electronic Patient Monitoring System
FBO	Faith Based Organisation
FSW	Female Sex Workers
GFATM	Global Fund to Fight AIDS, TB and Malaria
GOZ	Government of Zimbabwe
EHR	Electronic Health Record
HIO	Health Information Officer
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HOD	Hospital Head of Department
HRIS	Human Resource Management System
ICDS	Inter-Censual Demographic Survey
ICT	Information Communication Technology
IT	Information Technology
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, Newborn and Child Health
MODO	Ministry of Health and Child Care and Donors
MOHCC	Ministry of Health and Child Care
MOT	HIV Modes of Transmission
MRCZ	Medical Research Council of Zimbabwe
MSM	Men Who Have Sex with Men
MTR	Mid Term Review
NASA	National AIDS Spending Assessment
NGO	Non-Government Organisation
NHS	National Health Strategy
OPC	Office of the President and Cabinet
OSDV	On-Site Data Verification
OVC	Orphans and Vulnerable Children
PCU	Programme Coordination Unit
PEPFAR	US President's Emergency Plan for AIDS Relief
PHE	Provincial Health Executive
PLHIV	People Living with HIV
PME	Performance Monitoring and Evaluation
PPME	Policy, Planning, Monitoring and Evaluation
PPP	Public Private Partnership

PWID	People who inject drugs
RBM	Results Based Management
SADC	Southern African Development Community
SBCC	Social and Behavioural Change Communication
SDP	Service Delivery Point Survey
SEIS	Social Economic Impact Studies
TAP	Technical Assistance Plan
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
VMAHS	Vital Medicines and Health Services Survey
VMMC	Voluntary Medical Male Circumcision
WDS	Weekly Disease Surveillance
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic and Health Survey
ZimASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZNFPC	Zimbabwe National Family Planning Council
ZSARA	Zimbabwe Service Availability and Readiness Assessment Survey

M&E Operational Definitions

Monitoring and evaluation are complementary processes. Below are some of the key internationally accepted concepts and definitions that are referred to in this document:

Monitoring: Monitoring is the continuous, routine and regular assessment of ongoing activities and/or processes. It aims to provide management and main stakeholders of an ongoing intervention with early indication of progress (or lack thereof) towards the achievement of objectives.

Evaluation: Evaluation is the episodic assessment, as systematic and impartial as possible, of the overall achievements of activities and/or processes. It aims to understand the progress that has been made towards the achievement of an outcome at a specific point in time. All evaluations are linked to outcomes (and/or impact) as opposed to only immediate results (outputs).

Indicator: An indicator is a quantitative or qualitative factor or variable that provides a simple and reliable means to measure achievement, to reflect changes connected to an intervention, or to help assess the performance of a development actor.

Data source: A data source is a tangible set of information, usually in the form of reports, survey results, monitoring forms from the field, or official government data sets. Data sources provide the values of the indicators at a specific point in time.

Information products: Information products are standard reports/documents that departments or organisations produce at regular intervals after receiving and analysing data.

M&E results chain: The causal sequence for a developmental intervention that stipulates the necessary sequence that must be followed in order to achieve the desired objective, beginning with inputs, moving through activities and outputs, and culminating in outcomes, impact and feedback.

Inputs: Inputs are the resources that are needed to implement the programme/project and its activities. Inputs can be expressed in the form of the people, equipment, supplies, infrastructure, means of transport and other resources needed for a specific project or activity.

Outputs: Outputs are the immediate results of the activities conducted. They are usually expressed in quantities, either in absolute numbers or as a proportion of a population. Outputs are generally expressed separately for each activity.

Outcomes: Outcomes are the medium-term results of one or several activities. Outcomes are what the immediate outputs of the activities are expected to lead to. Outcomes are therefore mostly expressed for a set of activities. They often require separate surveys to be measured. Organizations produce outputs and not outcomes. Outcomes can only be contributed to and in most cases are shared by Departments and across Ministries.

Impact: Impact refers to the highest level of results, the long-term results expected of the project. Impact therefore generally refers to the overall goal or goals of a project.

SECTION 1:

INTRODUCTION & BACKGROUND

SECTION 1: INTRODUCTION AND BACKGROUND

1.1 Structure of the M&E Policy Guidelines and Strategy

These Performance M&E Policy Guidelines and Strategy are divided into the following four sections:

Section 1: Introduction and background to the M&E Policy Guidelines and Strategy

Section 2: M&E Policy Guidelines

Section 3: M&E Strategy

Section 4: Implementation Arrangements

1.2 Introduction

In compliance with the Zimbabwe National M&E Policy requirements, the MOHCC has developed this Health Sector Performance Monitoring and Evaluation Policy Guidelines and Strategy. Its development draws on a wealth of national M&E policies, practices and guidance of other organizations inside and outside the MOHCC system. This Health Sector Monitoring and Evaluation Policy Guidelines and Strategy will provide a framework for strengthened accountability, organizational learning, quality improvement and informed decision-making in programming and operations, as well as contribute to the institutionalization of the M&E functions into the MOHCC.

1.2.1 Foundations and Anchorage of M&E Policy Guidelines and Strategy

The development of the Health Sector Performance M&E Policy Guidelines and Strategy was informed by the review and translation of the National and Health Sector Policy and Development framework. This was complemented by a rapid participatory assessment of the National Health sector M&E Systems against the global contemporary technical guides. The M&E Policy Guidelines and Strategy document is in particular anchored to the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimASSET); the Zimbabwe National M&E Policy 2015, and the Zimbabwe National Health Strategy 2016 – 2020 (Figure 1).

Figure 1: Foundations of the Health Sector M&E Policy Guidelines and Strategy

1.2.2 Targeted users of the Health Sector M&E Policy Guidelines and Strategy

The M&E Policy Guidelines and Strategy cover programming, service delivery and management needs of MOHCC as a sector lead agency and all other categories of health sector implementing partners. These include other government Ministries, Departments and Agencies (MDAs), Non-Government Organizations (NGOs), Faith based Organizations (FBOs), Private Sector Health firms, Community Based Organizations (CBOs), research and training institutions, development partners and other sector stakeholders.

1.2.3 Programmatic scope of the Policy Guidelines and Strategy

The Policy Guidelines and Strategy are designed to cover or be applicable to all health sector programme management and service delivery levels: specifically the National, Provincial, District, Health Facility (Hospitals and Clinics) and community levels. Much as this is a national programming document, the Health Sector Policy Guidelines and Strategy are also designed to meet the M&E needs of Zimbabwe at regional (i.e. SADC) and global levels (i.e. for WHO, UNAIDS, GFATM) reporting and programming obligations.

1.3 Purpose and Outcomes of the M&E Policy Guidelines and Strategy

1.3.1 Purpose

The purpose of this Health Sector Performance Monitoring and Evaluation Policy Guideline and Strategy is to:

a. Institutionalize the Government of Zimbabwe National Monitoring and Evaluation policy into MOHCC
b. Establish an overarching health sector results oriented and coordinated Performance Monitoring and Evaluation system that will spell out the guiding principles, roles and responsibilities of different players, and the organizational structures of the performance monitoring and evaluation system in the health sector.

1.3.2 Outcomes

In pursuit of the above purpose, these M&E Policy Guidelines and Strategy shall aim at attaining the following outcomes:

i. Institutionalized, well-resourced and coherent performance based health sector M&E System
ii. Strengthened leadership, structure, planning, coordination and management of health sector performance based M&E System
iii. Strengthened systems for health surveillance, research and data management
iv. Strengthened interdepartmental coordination: M&E, HIS, ICT and all other departments.

1.4 Guiding Principles

The Performance Monitoring and Evaluation (M&E) Policy Guidelines and Strategy shall be guided by the same principles as annunciated in the National Health Strategy and those in the Government of Zimbabwe National Health Policy as indicated below:

- **Managing for Results:** In line with the government policy of Results Based Management that focuses on results, all interventions and operations shall clearly define the results or benefits for the people of Zimbabwe. The results are targeted at improving the quality of life of the citizenry.
- **Value for Money:** M&E shall ensure that resources allocated achieve the intended results in the most economic, efficient and effective manner.
- **Ownership and Inclusivity:** M&E shall ensure that the public identifies with MOHCC programmes and projects and that these programmes and projects benefit all Zimbabweans.
- **Utility:** M&E shall provide information which is readily usable by all stakeholders.
- **Integrity and Credibility**: M&E shall be based on reliable, evidence-based data. At project and programme levels, M&E shall use realistic and practical techniques and indicators for measurement of results and progress.
- **Transparency**: Information pertaining to M&E shall be easily accessible to the general public, and clear communication on the availability and use of resources shall be provided.
- **Accountability**: Individuals and institutions shall be required to explain how allocated resources are used for implementing agreed outputs and outcomes.
- **Ethical service delivery and data management**: M&E shall provide due regard for the welfare, beliefs and customs of those involved or affected, upholding a strict moral code.
- **Confidentiality**: Institutions and individuals shall be assured of their right to provide information to monitors and evaluators without their identity being publicised.
- **Gender equality and equity**: M&E shall ensure the use of gender disaggregated data in decision making.

1.5 Rapid Formative Health Sector Assessment

1.5.1 Rapid Formative Assessment Scope

To inform the development of the Health Sector Performance M&E Policy Guidelines and Strategy, a rapid assessment of the Health Sector M&E system was undertaken. The assessment used the framework of the 12 components of a functional Monitoring and Evaluation system which are grouped into three subsets that relate to each other as summarized below:

a) Components relating to people, partnerships and planning

Human resources, partnerships and planning required for supporting data collection and data use:

i. Organizational structures with Health Sector M&E functions
ii. Human resource capacity for health sector M&E
iii. Partnerships to plan, coordinate, and manage the health sector M&E system
iv. Health sector M&E planning
v. Health sector M&E work plan costing
vi. M&E Advocacy, Communication and M&E culture

b) Components relating to collecting, verifying, and analyzing data

Mechanisms through which data are collected, verified, analyzed, stored and reported

vii. Routine programme monitoring
viii. Surveys and surveillance
ix. National and sub-national databases
x. Supportive supervision and data auditing
xi. Evaluation and research

c) Component relating to using data for decision-making

Purpose of the M&E system: using data for decision-making.

xii. Information dissemination and use

1.5.2 Results and recommendations from rapid assessment

A complete description of highlights from the rapid assessment is provided in Annex 2.

A summary of the recommended actions to improve the M&E system is provided in Table 1 below:

Table 1: Priority Actions to improve the national M&E system for Zimbabwe's health sector

Components	Recommended Priority Actions
Organizational Structures for M&E and Human Resource Capacity	a) Conduct a thorough MOHCC M&E organizational review to enable restructuring and staffing with requisite multi-disciplinary technical personnel such as: IT, epidemiologist(s), statistician(s), sociologist(s) and demographers to strategically develop, coordinate and sustain the sector-wide M&E agenda. b) Establish operational mutually re-forcing interdepartmental **relationships** between the MOHCC M&E, Health Information Systems and IT departments and other relevant departments. c) Promote **inter-operability** of the different electronic information systems (DHIS2, EPMS, EHR,HRIS etc) d) Designate focal persons per programme to support departments/directorates without M&E personnel e) Establish M&E units/desks and officers positions at district health departments. f) Support originating departments in data entry into electronic systems to reduce the burden on the district health information personnel and improve data quality. g) Regular training of the data management personnel, especially when there are new data collection tools or changes in the electronic systems (DHIS2, EPMS, EHR etc) or new personnel join units. h) Develop and regularly review health sector M&E technical assistance and capacity building plan in line with needs and anticipated changes in data management and other M&E general requirements.
M&E Partnerships	a) Establish an MOHCC wide and Health Sector wide M&E Technical Working Group (TWG) with clear Terms of Reference (TORs) to technically strengthen and steer health performance based M&E functions. b) Management and planning structure at provincial, district and hospital level to formally include HIO and M&E officers to strengthen performance based M&E, the results based management (RBM), quality and efficiency.
M&E Plans and Work Plan Costing	a) Develop and adopt overarching comprehensive M&E Framework, policy guidelines and strategy. b) Foster integration of inter departmental M&E planning. c) Strengthen and institutionalize M&E planning in the health sector. d) Undertake a full health sector M&E systems assessment at the midterm review of the National Health Strategy in 2018.
M&E Advocacy and Culture of M&E	a) Review structures at provincial, district and hospital level to formally include participation of HIO and M&E staff. b) Strengthen bi-annual and annual sector wide performance reporting c) Ensure that M&E and HIS generated information products (dashboards, reports, website content, emails, newsletters, maps, tables, charts,) are availed and readily accessible to all levels of care. d) Allocate at least 7% of the total health sector budget to M&E. e) Hold monthly, quarterly annual reviews to review and consolidate reports then give feedback.

Routine Programme Monitoring, Support Supervision and Data Bases	a) Mobilize resources for adequate supplies of data collection tools. b) Review the existing tools and reduce the number of routine data collection tools at the service delivery level by fast tracking the roll out of patient level electronic data collection systems. c) Promote data bases inter-operability d) Align the data capture and reporting tools with DHIS2 data entry fields and provide matching instructions e) Changes in data collection tools should be preceded by training of those responsible for entry and verification. f) Provide refresher training programme for clinical level data entry personnel and service providers in alignment to staff reshuffling policy and schedule. g) Explore alternative internet connectivity providers or mechanisms to reduce the connectivity failures. h) Regularly review standard indicators, tools, guidelines, documenting procedures for data management at all levels i) Budget, mobilize and provide resources for on-site data verification (OSDV), supportive supervision and mentorship for all management levels. j) Develop health sector public, private partnership (PPP) strategy and operational guidelines to enhance buy-in of reporting by private sector run health facilities
Surveillance and Surveys Research and Evaluation	a) Develop a national comprehensive evaluation and research agenda b) Coordinate national evaluations, surveys and programme performance reports c) Develop and regularly update a repository for health sector research and surveys undertaken d) Hold an annual or every two year National Health Sector Research Conference
Dissemination and data use	a) Undertake health sector stakeholder information needs assessment annually b) Develop the health sector policy guidelines to guide data use to address the current contextual, technological, access rights, and copy right, protection needs. c) Develop simplified guidelines to support data driven decision making at all levels of care. d) Enhance stakeholders' access to the health sector information products through establishment of a resource centre and regularly updating the MOHCC website.

SECTION 2:

MONITORING AND EVALUATION POLICY GUIDELINES

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The Zimbabwe National M&E Policy (Section 8) requires all ZimASSET Clusters, Ministries and Departments to develop M&E strategies and policy guidelines to ensure effective implementation of government policies, programmes and projects.

The following policy guidelines (adopted from the Government of Zimbabwe National M&E policy and adapted to apply to the health sector) shall apply to the Zimbabwe health sector. They provide a framework for institutionalizing M&E into the health sector.

2.1 Organizational structures responsible for M&E

Section 6.4a of the National M&E Policy requires each Ministry to have a well-structured M&E unit with visibility and authority within the organization. In line with this requirement, specific M&E structures shall be required for strengthening the performance of the health sector.

The Ministry shall:

a) Have a single health sector monitoring and evaluation system led by a well-defined M&E department, with clear visibility and authority within the MOHCC
b) Ensure that health sector national and subnational levels, programmes, projects and institutions have a Monitoring and Evaluation Unit or desk with a clear mandate to execute their M&E functions
c) Ensure that each of these M&E Units/desks have established positions (i.e. establishment posts that are reflected in the entity's official organizational structure and budget) for personnel with requisite skills and qualifications on a full time basis
d) Ensure that the established positions in the M&E Units have job descriptions
e) Ensure that 7% of programme budgets is ring-fenced for monitoring and evaluation.

2.2 Human Resource Capacity for M&E

The Ministry shall:

a) Have all M&E units staffed by personnel with M&E-related skills and competencies.
b) Develop and implement a national M&E training programme
c) Ensure that training institutions have M&E as an integral part of their pre-service training programmes
d) Provide on-the-job training and mentoring to health workers to equip them to carry out M&E responsibilities at each level of care
e) Build and maintain a data base of competent M&E trainers and/mentors, and all trained health workers.

2.3 Partnerships to plan, coordinate and manage the monitoring and evaluation system

The Ministry shall:

a) Create effective linkages with other ministries and organizations with health related activities
b) Establish and coordinate a health sector M&E technical working group with explicit roles and responsibilities, and representation from all relevant stakeholders
c) Advocate for and support M&E across the sector
d) Ensure that all stakeholders comply with the Policy Guidelines and Strategy.

2.4 National Health Sector M&E Policy, Strategy and Plans

The Ministry shall,

a) Develop and regularly update a national M&E strategy that is linked to the National Health Strategy, including identified data needs, national standardized indicators, data collection procedures and tools as well as roles and responsibilities for implementation
b) Develop an annual costed monitoring work plan
c) Conduct a midterm review and end term evaluation of the National Health Strategy.
d) Ensure that all institutions and programmes have functional M&E plans or action plans that are structured along the national health sector M&E strategy principles
e) Guide, support and ensure that all health sectoral programmes at national and subnational level integrate the M&E plans or action plans and activities in their overall programme work plan to enhance institutionalization
f) Ensure that the costs of the M&E plans are included in the official Government budget.

2.5 Health Sector M&E Advocacy, Communication and the Culture of M&E

The MOHCC shall strongly advocate for and support M&E across the sector through:

- Frequently communicating on the performance of the sector M&E system
- Sharing national M&E system information products (reports, website content, emails, newsletters, maps, tables, charts, etc.)
- Ensuring that the M&E personnel are part of the management and planning team at all programme and facility levels
- Ensuring that M&E personnel have opportunities for lateral and vertical career development within the organizations and sector
- Ensuring that planning and management decisions reflect use and reliance on M&E generated data/ information products.

2.6 Routine programme monitoring

a) The MOHCC shall, in collaboration with the implementing partners, develop and regularly review national standard guidelines on:

   i. The procedures for recording, collecting, collating and reporting programme monitoring data from health information system (clinical and non-clinic based interventions)

   ii. How data quality should be maintained (e.g., avoiding double counting, assure reliability and validity)

   iii. Systems for monitoring and managing all health and non-health commodities related to program areas

   iv. How to secure reporting of health data by the private sector.

b) The MOHCC, working through the M&E TWG, shall develop and ensure that:
   i. Operational definitions of routine monitoring indicators from the national M&E system are systematically used by all groups delivering services in programme areas
   ii. The same services use standardized data collection and reporting forms
   i. Outputs of routine program monitoring contribute to the indicators as defined in the national M&E plan.

c) The MOHCC and sector implementing partners shall ensure that supplies and equipment are available for verification as part of routine program monitoring.

d) The MOHCC and sector implementing partners shall ensure that data quality is maintained, including through verification, reconciliation of discrepancies, data quality audits and regular systematic feedback.

e) The MOHCC and sector implementing and development partners shall guide and support the mobilisation of financial resources to support routine M&E.

2.7 Surveys and surveillance

a) The MOHCC, working through the National Health Sector M&E TWG, shall develop and ensure that:
   i. An up to date inventory of all health related surveys and surveillance conducted in the country is maintained
   ii. Health facility surveys are conducted every two to three years
   iii. National surveys or surveillance with behavioral component in the general population are conducted every two to three years
   iv. Biological surveillance targeting the appropriate populations is conducted every two years or more frequently.

2.8 Data Bases

i. The MoHCC (through inter-departmental collaboration) in collaboration with implementing partners, and with the support of development partners shall ensure that:
    i. There is a central data repository developed, managed and maintained by the MOHCC
    ii. The overall health electronic data base (DHIS) electronically capturing and storing data generated by the health information/M&E system is sustained (and updated accordingly) as the master or overall national health sector repository
    iii. There are streamlined structures, mechanisms procedures and time frames for transmitting, entering, extracting, merging and transferring data between databases within the health sector M&E system
    iv. Quality control mechanisms are in place to ensure that data are accurately captured
    v. Human resources for maintaining and updating the national and sub national databases are adequate.

2.9 Supportive Supervision, Data Quality Assurance and Audit

The MOHCC in collaboration with health sector implementing partners shall guide and ensure that:

i. Standardized guidelines and tools for supportive supervision are developed/reviewed and standardised across the sector
ii. Data quality assessment and review is periodically conducted
iii. Supportive supervision is conducted according to the national protocols, feedback is given and recommendations are followed up
iv. A protocol with clear timeframes for auditing routine service data from health service delivery points and community based programmes exists, is used, feedback is given and follow up on recommendations is done.

2.10 Research and Evaluation

The MoHCC in collaboration with health sector implementing partners shall guide and ensure that:

i. An inventory (register/database) of health sector research and evaluation institutions and their activities in the country is developed and updated annually
ii. There be mandated, competent and functional committees or review boards at national and provincial level responsible for coordinating and approving health research and evaluations exist with their performance assessed annually. These shall operate with the guidance of the Medical Research Council of Zimbabwe (MRCZ) and the Institute of National Health Research
iii. A costed and funded health sector research and evaluation agenda exists, is reviewed regularly, guides research and evaluation and is used when approving new studies

iv. Research and evaluation findings are regularly disseminated and discussed, and used for health sector planning and policy formulation.

2.11 Data/Information dissemination and utilization

The Zimbabwe National M&E Policy requires that monitoring and evaluation results are usable to inform decision making to improve service delivery.

a) The MOHCC shall ensure that all institutions maintain an M&E Recommendation Implementation Tracking Plan which will keep track of review and evaluation recommendations agreed upon, follow-up actions, and status of the actions
b) The MOHCC, working through the M&E TWG, shall develop and ensure that:

i. Health sector stakeholder information needs have been assessed regularly
ii. Guidelines are available to support the analysis, presentation and use of data at all levels in collaboration with the relevant departments.
iii. Stakeholders have access to the data or information products in the public domain (e.g. online or central information center)
iv. Information products are regularly disseminated
v. Feedback is provided on submitted reports.

SECTION 3:

MONITORING AND EVALUATION STRATEGY

SECTION 3: MONITORING AND EVALUATION STRATEGY

3.1 Goals and objectives of strategy

Section 6.4 of the Zimbabwe National M&E Policy requires all Clusters, Ministries and Departments to develop and submit their M&E strategy to the Office of the President and Cabinet (OPC). In compliance with this requirement, this M&E strategy was developed, guided by the National M&E Policy, recommendations from assessment of the existing health programme-specific M&E plans and international best practices.

The goal of this strategy is to establish an overarching integrated results based coordinated Performance Monitoring and Evaluation system for the MOHCC and the entire health sector.

The **Specific objectives** are

1. To establish a coordinated and sustainable Monitoring and Evaluation System throughout the public health sector
2. To strengthen monitoring and evaluation capacity in the public health sector to enable the tracking of implementation progress and take the necessary corrective measures
3. To provide up to date quality health status and health system performance information

Strategies listed in the section are a direct translation of the policy guidelines into action. The strategies have been crafted such that they capture all the 12 components of the functional M&E system. Together with the policy requirements, the recommendations of the Rapid Health Sector Assessment formed the basis for developing the under listed strategies.

3.2 Strategies

1. To establish a coordinated and sustainable Monitoring and Evaluation System throughout the public health sector

Strategies:

- Institutionalize monitoring and evaluation into the health sector
- Conduct performance reviews
- Periodically update the monitoring and evaluation strategy
- Develop annual costed monitoring and evaluation plans
- Strengthen community involvement in monitoring and evaluation

2. To strengthen monitoring and evaluation capacity in the public health sector to enable the tracking of implementation progress and take the necessary corrective measures

   Strategies:

- Strengthen monitoring and evaluation Human resources capacity
- Strengthen monitoring and evaluation partnership and coordination
- Strengthen resource mobilization for monitoring and evaluation

3. To provide up to date quality health status and health system performance information

Strategies:

- Strengthening sharing and utilization of data
- Develop national monitoring and evaluation information repository
- Strengthen compliance with M&E requirements

3.3 M&E Action plan

Table 2 below provides more specific outputs for the listed strategies in the form of an overarching monitoring and evaluation action plan. This plan will guide implementation of monitoring and evaluation strategies and activities, under the leadership of the Director and Deputy Director for the Performance Monitoring and Evaluation department.

Note that this plan should be read in conjunction with the GOZ M&E policy and MOHCC Performance Framework. A separate, more detailed and costed Health Sector Performance M&E Action will be made available.

Table 2: MONITORING AND EVALUATION ACTION PLAN 2018-2020

Objective	Outcome	Strategy	Outputs	Activities
To establish a coordinated and sustainable Monitoring and Evaluation System throughout the public health sector	Institutionalized health sector performance monitoring and evaluation	• Institutionalize monitoring and evaluation into the health sector • Conduct regular performance reviews • Periodically update the monitoring and evaluation strategy • Develop annual costed monitoring and evaluation plans • Strengthen community involvement in monitoring and evaluation	M&E Roles and responsibilities for each level of care defined	- Source Technical assistance to define M& E roles and responsibilities at each level of care.
			M&E focal points/desks for each level of care with clear mandates established	- advocate for M&E positions at each level of care - Mobilise resources to support M&E function in critical areas
			Comprehensive functional assessment of M&E across the health sector (MESS)	- technical assistance to conduct NHS mid-term review together with M&E System Assessment
			Rationalized M&E positions (including rationalized roles and responsibilities)	-Technical Assistance and internal review (PCU and MOHCC) - Propose the redefined M&E structure to HR Department
			Functional M&E TWG	- establish M&E TWG at National and Provincial levels
			Quality electronic based data collection and monitoring system in place	-Mobilise resources for fast-tracking and scaling up EHR roll out -Advocate for accelerated uptake of EHR. - capacitate for monitoring through EHR.
			M&E mainstreamed in all job descriptions	- Lobby HR to review all Job descriptions to incorporate an M&E component
			NHS Performance Framework printed and distributed	- mobilise resources for printing and distribution of NHS performance framework
			Health Sector Performance M&E Policy guideline and strategy distributed	Production, printing and distribution of M&E policy Guidelines and Strategy
			Costed harmonized annual M&E	- develop and cost harmonised

Objective	Outcome	Strategy	Outputs	Activities
			Plans	M&E annual plans
			Midterm Review for the NHS 2016-2020 report	- Source Technical Assistance for Midterm review for the NHS 2016-2020 - Mobilise resources for Mid-term review of NHS
			End term review of NHS 2016-2020 report	- Source Technical Assistance for End term review for the NHS 2016-2020 - Mobilise resources for END-term review of NHS
			NHS 2021-2025 developed, printed and disseminated	Resource mobilization for Technical Assistance to develop NHS 2021-2025, stakeholder consultation, printing, launch, dissemination.
			Availability of a harmonized joint Support and Supervisory tool	- Revision and updating of harmonized joint support and supervision tool
			TMT support visits report	-TMT support visits - Mobilise resources for TMT visits - Organise TMT visits - Update Integrated support and supervision tool
			Joint Review Missions report	- Mobilise resources and coordinate joint review missions (HDF, CCM)
			Integrated Routine Data Quality Assessments (RDQA)s undertaken	- Mobilise resources for Integrated RDQAs. - Coordinate Integrated RDQAs
			M&E, ICT and HIS inter-departmental working relationship established	-Formulate and strengthen inter-departmental coordination committee for better coordination and programming
			Adequate resources for integrated performance M&E	- Advocate resources for integrated performance M&E
			Institutionalise Events management	- implement Events management starting with

Objective	Outcome	Strategy	Outputs	Activities
				department of PM&E
			Functional community monitoring and evaluation systems	- Technical Assistance for establishing functional community M&E systems. - advocate for resources for establishing functional community M&E systems
			Population based survey reports	- Contribute to planning, resource mobilisation and implementation of national surveys such as ZDHS, MICS, VHMAS etc.
To strengthen monitoring and evaluation capacity in the health sector to enable the tracking of implementation progress and take the necessary corrective measures	Increased monitoring and evaluation capacity in the health sector	• Strengthen monitoring and evaluation Human Resources capacity • Strengthen monitoring and evaluation partnership and coordination • Strengthen resource mobilization for monitoring and evaluation	Capacity building plan	- Training needs assessment - Mobilise resources for developing capacity building plan - Technical assistance for developing capacity building plan
			Availability of a M&E training curriculum and manual (pre-service, in-service and on-the job training)	- Source for Technical Assistance to develop M&E training curriculum - Mobilise resources for developing M&E training curriculum
			M&E diploma	-Explore the feasibility of starting health related M&E diploma at Harare Polytech and other institutions of higher learning in line with Health information diploma
			M&E Trainers available	- Training of M&E Trainers - Mobilise resources for M&E TOTs
			M&E trainings	- Mobilise resources for M&E in-service training -Conduct in-service M&E training
			Trainsmart utilisation at all levels of	-Monitoring use of Trainsmart

Objective	Outcome	Strategy	Outputs	Activities
			care	
			Technical support and supervisory visits conducted	-Conduct integrated technical support an supervisory visits -Mobilise resources for integrated support and supervisory visits
			M&E Regional and International Capacity Building	-Mobilise resources -Conduct a learning visit in a developing country with a good M&E system -Capacity building courses
To provide up to date quality health status and health system performance information	Increased data utilisation	• Strengthening sharing and utilization of data • Develop national monitoring and evaluation information repository • Strengthen compliance with monitoring and evaluation requirements	Health managers capacitated and motivated in data use	Health Managers training in DHIS2 and other information systems for health
			Standardised reporting format (weekly, monthly, quarterly, annual)	- Review current reporting formats (weekly, monthly, quarterly, annual) - Develop new report templates (monthly, quarterly, annual)
			Availability of consolidated monthly generic reports	- Monthly technical review meeting with M&E officers
			Quarterly consolidated performance progress update report (Generic & Performance framework)	- Quarterly M&E review meeting to consolidate generic report - Updating of the performance framework
			Bi-Annual Performance reviews (MODO) report	- Coordinate pre-MODO consolidation of reports - Coordinate MODO review meetings (guidelines for holding MODO meetings) - Tracking local, regional and international recommendations. - Preparing documents for regional and international meetings/ conferences.
			Annual Secretary Report	- Coordination meeting to finalise Secretary Report

Objective	Outcome	Strategy	Outputs	Activities
			Availability of a repository of national evaluations, reviews and surveys	- Coordinate national evaluations, surveys and programme performance reports - Create/ develop a data repository for Ministry (across all departments and programmes)

SECTION 4:

IMPLEMENTATION ARRANGEMENTS

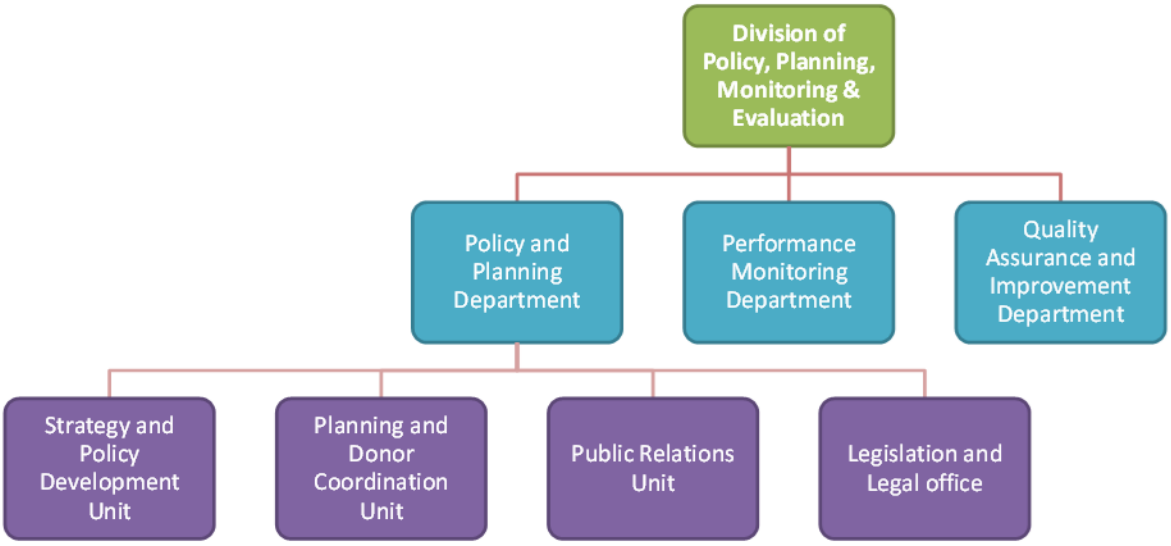
SECTION 4: IMPLEMENTATION ARRANGEMENTS

4.1 Structure of the Performance and Evaluation Management Unit

The MoHCC in line with the requirements of the Government of Zimbabwe National Monitoring and Evaluation Policy, section 3.2.1.3 has a Monitoring and Evaluation department headed by a director in the Division of Policy, Planning, Monitoring and Evaluation (DPPME). The Monitoring and Evaluation Department and Policy Planning department are under one Division in the MoHCC, making it possible to link monitoring and evaluation to the planning process.

The Department of Monitoring and Evaluation (DPME) establishment currently has two positions only, that of a Director and the Deputy Director. This structure is grossly inadequate to meet the needs of the health sector. Going forward, the Ministry of Health and Child Care will be reviewing the Monitoring and Evaluation department structure after a comprehensive health sector monitoring and evaluation needs assessment has been conducted.

Position of the PME department in the Division of PPME



However there are programme-specific M&E positions in donor funded programmes such as Malaria, TB, HIV, MNCH and Nutrition. These positions together with the two established Ministry positions in the M&E Directorate will for the time being, be the nucleus of monitoring and evaluation activities in the health sector.

4.2 Functions of the Director Performance Monitoring and Evaluation

The responsibilities of the Director for Performance Monitoring and Evaluation include among other duties, developing and ensuring the effective implementation of a national integrated performance M&E framework for the health sector. The director will be responsible for coordinating, planning and monitoring performance measurement and evaluation of functions, developing and implementing performance measurement and evaluation standards, processes and tools. The director will develop and maintain a Performance Monitoring and Evaluation department of the MoHCC specifically to:

- Develop and maintain an integrated framework for the M&E system and framework for the health sector
- Guide the process of identifying, revising and designing key indicators for the national integrated performance monitoring and evaluation framework for the health sector
- Develop and implement an integrated framework and system to ensure effective implementation of the National Health Strategy
- Devise and maintain clear mechanisms for accountability and making sure they are adhered to
- Provide expert advice on the development and implementation of results-based management
- Ensure that monitoring and evaluation systems are linked to planning, budgeting and resource allocation systems
- Undertake regular support and supervisory visits to support implementation of M&E and to identify areas where adaptations might be needed
- Develop mechanisms to track and evaluate the implementation of recommendations made at regional and international fora
- Facilitate the institutionalization of monitoring and evaluation activities in all institutions, program and projects
- Foster participatory planning and monitoring by training and involving stakeholders in the M&E activities
- Coordinate with relevant departments to ensure that current information for M&E is available
- Establish mechanisms to support and monitor compliance with applicable M&E standard operating procedures
- Provide professional leadership, advice, support and supervision in M&E to the MOHCC and the health sector
- Produce monthly, quarterly and annual M&E reports based on agreed national indicators that will guide decision making and program implementation.
- Support staff in the department to design personal and management development plans in relation to their work and career needs.

M&E functions are cross cutting and essential to all departments and programs. M&E is very closely linked with Health Information and ICT. The department of monitoring and evaluation will find itself working very closely with the Health Information Unit in many areas, including the following:

- Synthesizing data and information from different sources to update health indicators
- Advising on the development of sets of indicators to be used by different departments

- Participating in the design and analysis of surveillance
- Analyzing data from community health monitoring system
- Design, development of instruments and implementation of surveys, assessments and researches
- Aligning data capture and reporting tools (both paper and electronic)
- Collaboration in Routine Data Quality Assessments and reviews
- Training on data analysis and utilization
- Compilation and Development of the Annual National Health Profile, etc
- Discussing results at different fora
- Sharing results with media through press releases, fact sheets etc
- Developing data sharing guidelines and policies
- Promoting integration of various health information systems (DHIS2, SAPs, EHR, HRIS, LIMS etc)

The department of M&E will also work very closely with the ICT Unit in many areas, including the following:

- Promote Inter-operability between some databases, the EHR, etc
- Use of ICT platforms for M&E advocacy, data and information communication portals like the website and intranets for disseminating M&E work to partner organisations etc
- Ensuring stakeholder access to health sector information products
- Scaling up extension of the electronic health record and reporting systems.
- Automation of tools
- Automation of M&E (data capture, assessment and reporting) tools – making sure that all source documents for M&E are electronic is a high priority as it directly results in cost efficiencies and more robust M&E systems
- M&E Data storage and data communication channels – this means that M&E should contribute to the building of ICT infrastructure necessary for MoHCC to be able to confidentially store data as well as transmitting it (internet bandwidth and information communicating gadgets) for the purposes of analysis and dissemination
- Data analysis software models, hardware and people skills.
- Various Trainings both ways – ICT training for M&E as well as M&E training for ICT.
- Routine ICT support for M&E (include maintenance and upgrading of systems, hardware and networks)
-

4.3 Roles and Responsibilities

The Performance Monitoring and Evaluation Department in the MOHCC

The Performance Monitoring and Evaluation Department in the MOHCC is responsible for the overall coordination of M&E activities in the health sector.

- Implementing this performance monitoring policy guideline and strategy
- Oversight of the implementation of M&E in the health sector;

- Establish and maintain a repository for all information on M&E
- The setting of norms and standards for M&E (continuously review performance review formats and ensuring M&E tools are in line with international best practice);
- Promoting the use of M&E findings in the Ministry to improve the quality of interventions
- Organizing performance review meetings:
    - Ensure all reports to be presented at the review meetings are prepared in an agreed format and on time
    - Compile performance review meeting reports
- Assessment of monitoring and evaluation capacity within the Ministry on a systematic basis
- Conducting periodic training to build capacity in monitoring and evaluation.
- Coordinate periodic evaluations and surveys

The Role and Responsibilities of Divisions, Institutions and Departments

Divisions, Institutions and Departments shall:

- Ensure that the resources deployed are effectively and efficiently utilized to provide services for the intended beneficiaries
- Set up internal mechanisms to facilitate continuous monitoring
- Be responsible for carrying out evaluations on current and completed interventions under their purview
- Provide resources in their annual budgets for the establishment or strengthening of internal monitoring and evaluation capacity
- Provide information to the department of M&E

The Role and Responsibilities of Programme /Project Managers

Managers of programmes and projects shall:

- Ensure that the resources allocated are effectively and efficiently utilized to provide services for the intended beneficiaries
- Establish mechanisms to facilitate continuous monitoring of interventions for which they are responsible
- Prepare and submit quarterly, annually and any other reports to M&E departments for consolidation

The Role of Communities

Communities through their structures shall:

- Provide information on health issues in the catchment areas to their nearest health facilitate
- Provide community observations on health status and health care provision

Role of NGOs

- Provide reports as per memorandum of understanding

4.4 Compliance with Health Sector Performance Monitoring and Evaluation Policy Guidelines and Strategy

All stakeholders shall comply with the Zimbabwe National Monitoring and Evaluation Policy 2015, as well as the Health Sector Performance Monitoring and Evaluation Policy Guidelines and Strategy to ensure effective implementation of Government policies, programmes and projects.

Compliance with this Policy includes adhering to guidelines, standards, operating procedures and regulations.

Compliance Requirements and Obligations shall include:

- Reporting obligations according to agreed formats and timelines
- Abiding by the principles of the National M&E Policy
- Abiding by the M&E criteria
- Abiding by the agreed quality, quantity, time and cost standards.

4.5 Data Management

To generate the data needed for construction of values of the indicators, the M&E Strategy has identified and generically described the data sources and management plan essential for the timely generation of the performance indicators.

This section therefore presents a generic guide to the data sources that will be vital for generating the needed data; how and when the data will be collected, aggregated, analysed stored, retrieved, accessed and disseminated, the responsible lead institutions and supporting health sector partners.

4.5.1. Key Data Sources

Zimbabwe health sector M&E will make use of both routine and non-routine or periodically generated data, primary and secondary data as well as quantitative and qualitative data. Over the National Health Strategy 2016-2020 period and beyond, it is expected that data will be generated from sources summarized in Table 3 below.

Table 3: Key Data Sources

Data Source	Lead Institutions	Reporting Frequency
Routine Programme Data		
• Routine Health sector programme service coverage data - clinical /facility generated data	MOHCC	Monthly, weekly and Quarterly
• Routine Generic programme service coverage reports from the provinces and districts	MOHCC	Monthly
• Routine Clinical facilities and Non-clinical Health Sector programme data from other line ministries, departments and agencies, councils and commissions i.e. Defense, Prisons, Police, ZNFPC	MOHCC	Monthly and Quarterly
• Routine programme data from nongovernment sector- *(health, non-clinical sector interventions by non-public/non-government umbrella organizations and networks i.e. for CSOs, FBOs, CBOs, client networks such PLHIV networks*	MOHCC, PCU- MOH, MOHCC, Umbrella organization & net works	Quarterly

Data Source	Lead Institutions	Reporting Frequency
• Field Monitoring and Support Supervision data by National ,Provincial and district offices of both public & non-public sectors		Quarterly & bi-annually
• Health Sector Sentinel Surveillance Surveys (sero-surveillance for pregnant women)	MOHCC	Every 1- 2 years
Non Routine Sources		
• Zimbabwe Demographic and Heath Survey (ZDHS), ZIMPHIA, IBBSS	ZimStat, MoHCC	Every 5 years
• Multiple Indicator Cluster Survey (MICS)	ZimStat	Every 5 years
• National Population Census	ZimStat	Every 10 years
• Inter-Censual Demographic Survey (ICDS)	ZimStat	Every 10 Years
• Vital Medicines Availability and Health Services (VMAHS) Survey	MoHCC	Quarterly
• Client Satisfaction Surveys	MOHCC	Annual
• Zimbabwe Service Availability and Readiness Assessment Survey (ZSARA)	MOHCC	3 – 5 years
• Integrated Bio and Behavioral Surveillance Surveys	MOHCC	3-5 years
• Malaria Survey	MOHCC	Every 2 years
• Living conditions Among Persons with Disability Survey	MOHCC	Every 5 years
• Health services delivery and related Services Assessments and Facility Surveys	MOHCC	Biennially
• Service Delivery Point (SDP) Survey	MoHCC	Every year
• Programme/ Projects specific reviews and Evaluations	Projects	Every 2-3 years
• HIV and AIDS Workplace Survey	NAC, MOHCC,	Every 2-3 years
Other Essential Assessments and Special Studies		
• Independent Health Sector Wide Reviews/ Assessments (SWAPS) & Health Sector Strategy (MTR) & End of Term Review	MOHCC	2 -3 years
• Assets, inventory, procurement and supply management and administrative records analysis	MOHCC	Annually
• Stakeholders and Service Mapping	MOHCC	Biennial
• OVC Situation Reviews	MOHCC and Dept of Social services	Every 5 years
• Situation of Women and Children	UNICEF	Every 5 years
• HIV Modes of Transmission (MOT)	NAC, MOHCC	3 – 5 years
• Household - Social Economic Impact Studies (SEIS)	ZimStats	Every 3 -5 yrs.
• Size Estimation of national target populations, key population sizes (including estimation of MSM, FSWs, PWID, and modeling & projections)	MOHCC	Annual
• Condom Surveys, Treatment Adherence Cohort studies; Drug resistance studies	MOHCC	3 – 5 years
• Health Accounts, Budget & Expenditure Analysis/studies	MOHCC	Biennial
• National AIDS Spending Assessment (NASA)	NAC	3 – 5 years

4.5.2 Key Information Products

The National Health Sector has a diversity of stakeholders with a diversity of information needs. The strategy will ensure that the varying information needs of the different stakeholders are met by packaging the available information to meet the diverse needs. A number of information products, packaged differently for the various audiences will be produced. They include the following:

- HMIS Service Coverage Reports (Quarterly and Annual Progress Reports) from DHIS2
- Community/ Non-clinical interventions Service Coverage Reports (Quarterly and Annual Progress Reports)
- Surveillance Reports
- Brochures, leaflets, fact sheets

- Assets registers and inventory, Procurement and Supply Management (PSM) reports
- Health Sector interventions and providers Mapping reports and Mapping Atlas
- Research and Survey Reports
- National AIDS Spending Assessment (NASA) reports
- Budget and Expenditure Analysis Reports
- Health Sector Joint independent Assessment reports
- Programme and project Mid Term Review (MTR) Reports
- M&E Calendar & Wall Charts
- Estimates and spectrum based projections reports
- Biennial HIV Report
- Newsletters

Depending on the indicators being reported upon, the information products above will contain information/data analyzed by different social characteristics including: gender, age group, social-economic status, occupation, education, marital status, key and general populations, displaced populations and location. This will be done to enhance the usefulness of the information to manage and plan the various interventions in the services of the national health Sector.

4.5.3 Addressing Adhoc and Emerging Information Needs

The main reference frame for the M&E Strategy is the National Health Strategy (NHS) 2016-2020. However, the needs beyond the indicators of the NHS performance framework will be catered for as they arise using innovative means.

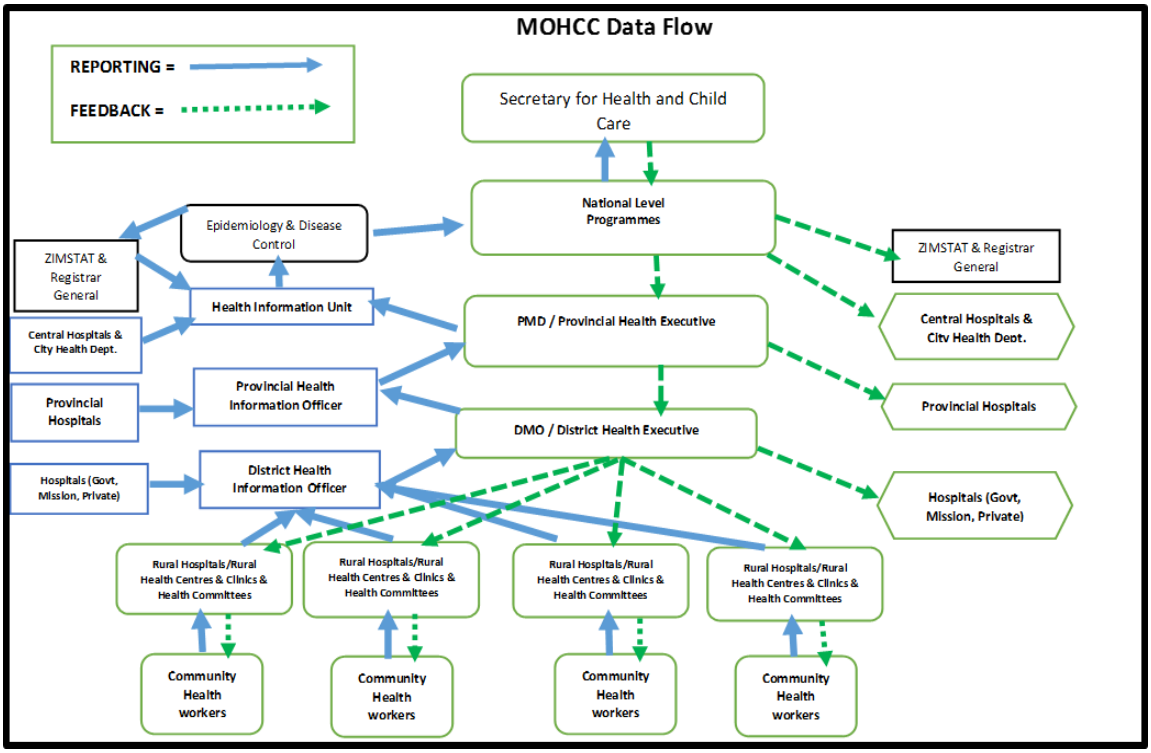
Requests for new indicators shall be made in writing to MOHCC or other partners in the Health Sector who will in turn be considered to determine whether they can be accommodated within available resources based on technical appraisal by the ME TWG.

4.5.4 Data and Information flow arrangements in the services of the National Health Sector

As highlighted in the first part of this section, the Health Sector Performance M&E Strategy will utilize different data sources involving a multiplicity of actors. It is important that simple data/information flows and reporting framework is built, and to secure the consensus of stakeholders to synchronize and make smooth the M&E system functions in the Health Sector. **Figure 2** Illustrates the flow of data/ information from the community level service delivery points right up to the national health sector data repositories or data bases, and the feedback system.

MOHCC will support the establishment and functioning of fast data and information flows in the Health Sector at all levels.

Figure 2: Ministry of Health and Child Care Data Flow


MOHCC Data Flow
REPORTING =
FEEDBACK =
Secretary for Health and Child Care
National Level Programmes
Epidemiology & Disease Control
ZIMSTAT & Registrar General
Health Information Unit
Central Hospitals & City Health Dept.
PMD / Provincial Health Executive
Provincial Hospitals
Provincial Health Information Officer
DMO / District Health Executive
Hospitals (Govt, Mission, Private)
District Health Information Officer
Rural Hospitals/Rural Health Centres & Clinics & Health Committees
Community Health workers
ZIMSTAT & Registrar General
Central Hospitals & City Health Dept.
Provincial Hospitals
Hospitals (Govt, Mission, Private)

Information Flows

Reporting to MOHCC

An effective national M&E system requires that data flow structures and reporting mechanisms are clearly defined to avoid double counting. The Diagram in **Figure 2** presents data flow and the information linkages from the community and health facilities level to central MOHCC.

Reporting from Community to health facilities

All Community Health Volunteers and community health service delivery within the catchment area of a health facility are to report community based health data to that health facility on a monthly basis following the current prevailing reporting timelines.

Reporting from NGOs and the Private Sector

All NGOs, Private, Faith-based and local authority health facilities, operating in the district are to submit copies of their health data to the district health information office on a monthly basis (following the current prevailing reporting timelines). In urban provinces, they shall report directly to the city health department health information office.

Reporting from Health facilities to District Office

All health facilities within a given district are to report to the DMO through the District Health Information Office (where applicable) on a weekly, monthly and quarterly basis. In an instance where there is no DMO in urban provinces, all health facilities are to report directly to the city health Director's office through the health information unit (following the current prevailing reporting timelines).

Reporting from District Office to Provincial Office

The districts within a given province are to enter reported data and submit electronically to the Provincial Medical Director through the provincial health information unit on a weekly, monthly, and quarterly basis (following the current prevailing reporting timelines).

Reporting from Provincial Office to Central Office

The provinces, city health and central hospitals are to validate the electronic reports then submit to the Permanent secretary through the national health information unit on a weekly, monthly and quarterly basis (following the current prevailing reporting timelines).

Reporting from Other Government ministries and institutions

Government ministries and institutions report through their focal points to their counterparts at the MOHCC. Where appropriate, these institutions may report directly to any level at MOHCC.

Reporting from MOHCC to GOZ and Donors and Partners

MOHCC Head Office will report directly to the Government of the Republic of Zimbabwe and share special reports with donor agencies like Global Fund, PEPFAR and UN Agencies as per agreed timelines.

Information Dissemination

Reports should be accessible in a public repository with a view to ensure transparency and facilitate knowledge management and application of lessons learned. The reports need to be adequately shared and disseminated to the health sector stakeholders, facilitated by M&E to ensure the achievement of national health goals.

Information from the monitoring and evaluation of the national Health Sector Services will be disseminated widely to various stakeholders using different channels that will include the following:

a) Zimbabwe National MODO (Review and Planning Meeting) that brings together various stakeholders. This stakeholders' forum will enable all categories of health stakeholders to share performance reports and other resource information for the strategic development of the Health Sector nationally. It will also be the channel for sharing information on the Health Sector in the preceding implementation period with key focus on the scope of service coverage, the best practices and management of challenging and emerging issues.

b) Quarterly health sector M&E TWG, coordination and planning meetings at National, Provincial and district levels.

c) Provincial level monthly PHE meeting. These will also be used to monitor progress in implementation of health activities within the province, share any available information, identify any lessons learnt, challenges and constraints and then map strategies for the way forward.

d) Use of the print and electronic media by having airtime and space in the widely circulated newspapers.

e) Websites and other electronic platforms or email communication. This will require regularly uploading and updating the MOHCC and other selected intranets, websites and repositories.

f) The MOHCC, Provincial, District, other public and private resource centers and reference collections.

g) Stakeholder mailing lists — electronic and manual

h) Stakeholder dissemination workshops and health and related research conferences

i) Coordination meetings of the umbrella agencies

j) Training Workshops and Seminars

k) National exhibitions at different fairs and exhibitions

l) Other National and International stakeholders conferences

Data sharing agreements with stakeholders

Sharing of raw data between MOHCC and external stakeholders should be accompanied by a data sharing agreement. The agreement must state in non-technical language the purpose(s) for which they are entering into the agreement, i.e. how the data will be used, what studies will be performed, or what the desired outcomes are perceived to be as a result of obtaining the data. The source of the data will come from any and all public health institutions or databases. The data will only be used for research and/or analytical purposes and will not be used to determine eligibility or to make any other determinations affecting an individual or organisation/institution. Furthermore, as the data will be shared, it will be subjected to all applicable requirements regarding privacy and confidentiality determined by the GOZ.

Annex 1: List of persons met/ consulted

Key Informant Interviews

Name	Position & Organization
1. Dr Robert Mudyiradima	Principal Director, Policy, Planning Monitoring and Evaluation (PPME, MOHCC)
2. Dr Abigail Rugare Kangwende	Director PME, MOHCC
3. Mr. Amon Mpofu	Director M&E, National AIDS Council (NAC)
4. Dr Davies Dhlakama	M&E Manager, PCU, MOHCC
5. Dr W. Nyamayaro	Provincial Medical Director (Mash West)
6. Dr Nyasha Masuka	Provincial Medical Director, (Mat North Province)
7. Dr Bernard Madzima	Director, Family Health
8. Dr Portia Manangazira	Director Epidemiology and Disease Control EDC, MOHCC
9. Mr. Stephen Banda	Director Policy, Planning and Coordination
10. Mr. Golderberg Tendai Magwandu	Director, Environmental Health Services
11. Dr Agnes Mahomva	President, Zimbabwe Medical Association, & Country Director ,EGPAF
12. Prof M. Tshimanga	Principal Investigator, MPH Project, University of Zimbabwe
13. Mr. Rodrick D	Deputy Director, Water, Sanitation and Waste Management
14. Mr. Trymore Chawurura	Deputy Director, ICT, MOHCC
15. Dr Regis Chikomborero Choto	Deputy National ART Coordinator, AIDS TB Unit, MOHCC
16. Mr. Andrew Tangwena	M&E Officer National Malaria Programme, MOHCC
17. Mr. Henry Chidawanyika	Project Director, Zimbabwe Health Information Support Project (RTI/MOHCC)
18. Mr. Llyod Machacha	M&E Officer Nutrition, MOHCC
19. Mr. Lameck Munangaidzwa	M&E Officer, PCU, MOHCC
20. Dr Pamela Magande	M&E Analyst, PCU, MOHCC
21. Mr. Christopher Ncube	-M&E Officer PCU, MOHCC
22. Mr. Andrew Hukuimwe	Provincial Health Information Officer, Mashonaland West
23. Mr. Joseph Kwangwari	Provincial M&E Officer, Mashonaland West
24. Mr. Richard Chigerwe	Health Services Manager, Harare City Council
25. Mr. Innocent Mukeredzi	Team leader, Epidemiology and Disease Control, Harare City Council
26. Mrs. N Koni	Health Information Officer, Epidemiology section, Harare City Council
27. Ms. A. Dururu	M&E Officer, Harare City Council
28. Mr. Godwin Tanya	Hospital Administrator, Chinhoyi Provincial Hospital
29. Ms. Mary Titira	Matron, Chinhoyi Provincial Hospital
30. Ms. Margret Gavara	District Nursing Officer, Chinhoyi Provincial Hospital

31.Mr Consitilia Bure	Information officer, Chinhoyi Provincial Hospital
32. Ms. Colleta Solopa	Information officer, District Information officer
33. Ms. Gladys Chishiri Funda	District Information officer, Makonde District, District Information officer
34. Dr Dandadzi Terence	District Medical Officer, Dzimbi District Hospital
35. Ms. Clemencia Chimbare,	District Health Information Officer, Dzimbi District Hospital
36. Ms. Joy Madondo	Nurse- In Charge, Nyabira Clinic
37. Ms. Sibonginkosi Mafundirwa	Environmental Health Technician, Nyabira Clinic
38. Ms. Rutendo Buruni	Data entry Clerk, EPMS, Nyabira Clinic

Technical Working Group Workshop; October 11th, 2017 Rainbow Towers, Harare

Name	Position & Organization
1.Ms Linda Tungamira	PM&EO, MOHCC, Mash central
2. Ms Tuso A. Tanda	PM&EO, MOHCC, Midlands
3. Mr. Joseph Kwangwari	PM&EO, MOHCC, Mash West
4. Mr. Lameck Munangaidzwa	M&E Officer, PCU, MOHCC HQ
5. Ms Mary Musvipa	Acting Principal Tutor/ Director Nursing Services, MOHCC
6. Dr Mandy Sibanda	Director Oral Health, MOHCC
7. Dr Hardwicke Matikiti	Deputy Director Oral Health
8. Mr Ndlovu Mgcini	Chief Lab Tech GAL, Govt Analyst
9. Dr Davies Dhlakhama	M&E Manager, PCU
10. Mr Innocent Mukeredzi	Head Health Information & Surveillance, City of Harare
11. Mr Brilliant Nkomo	Strategic Information Coordinator.
12. Dr Abgail Rugare Kangwende	Director, PME, MOHCC
13. Mr Lovejoy Gamba	ADER ZMFPC HQ
14. Mr Trymore Chawurura	Deputy Director ICT, MOHCC
15.Mr Farai Machanga	PM M&E, ZNFPC HQ
16.Mr Albert Matikiti	PMEO, Gwanda, MOHCC
17. Mr Chamunorwa Ndudzo	PMEO, MOHCC, Masvingo
18. Mr Victor Makaza	M&EO, National AIDS Commission (NAC) HQ
19. Mr Nembaware Josiah	M&EO, National AIDS Commission (NAC) HQ
20. Mr Tseretse Maphosa	STI/HIV Coordinator, MAT North, MOHCC
21. Dr Mkhokheli Ngwenya	Deputy Director, Child Care MOHCC HQ
22. Mr Masimba Dube	Pharmacist, MOHCC DPS HQ
23. Ms Rudo Mhonde	M&E Analyst, UNFPA, Harare
24.Mr Absolom Mbinda	M&EO, MOHCC, HQ
25. Ms Sharon Nyakavi	Intern, MOHCC Head Office
26. Mr Zacharia Grand	PMEO, MOHCC, Manicaland
27. Ms Siyame Eneti	Mental Health Manager, HQ
28. Mr Lloyd Machacha	M&EO, Nutrition, MOHCC HQ
29. Dr Pamela N Magande	M&E Analyst HQ

30. Ms Sarudzai Mrambiwa	PA, MOHCC HQ
31. Ms Pamela Mupawenda	PA, MOHCC HQ
32. Ms Tambudzai Jezenga	Transport Assistant, MOHCC HQ
33.Ms Lisa Samapundo	Intern, MOHCC HQ
34. Mr Wilbert Chimutsa	Transport Assistant, MOHCC HQ

Stakeholder Debriefing Workshop; October 12th 2017; Rainbow Towers, Harare

Name	Position & Organization
1. Dr Tonderai Nhende	DMO, Chegutu, MOHCC
2. Ms Cynthia Musara	M&EO, MUCHIP, Harare
3. Ms Fadzai Mutseyekwa	IRME, MUCHIP, Harare
4. Mr Farai Machinga	PM M&E, ZNFPC
5. Mr Lovejoy Gamba	ADER, ZNFPC
6. Mr Chamunorwa Ndudzo	PME Masvingo, MOHCC
7. Dr Endris Mohammed	OI Specialist , MOHCC Harare
8. Mr Victor Makaza	M&EO NAC
9. Mr Mgcini Ndlovu	Chief Tech, MOHCC GAL
10. Mr Lameck Munangaidzwa	M&EO, MOHCC HQ
11. Dr Magande Pamela N	M&E Analyst, MOHCC, HQ
12. Dr Hardwicke Matikiti	D/D Oral Health Services, MOHCC
13. Mr Mangoya E	Principal Auditor, MOHCC
14. Dr Tendai Nkomo	Esigodini, Mat South
15. Dr Patience Dhliwayo	D/D NMCP, MOHCC HQ
16. Mr Anglebert Mbenga	GM-M&E, HSB
17. Mr Trust Chiguvare	M&E, CDC
18. Dr Elizabeth Gonese	PHS, CDC
19. Ms Dube Peggy	Principal Tutor, Harare Hospital
20. Mr Henry Chindawanyika	Director Zim HISP, RTI, MOHCC HQ
21. Mr Tongai Chokuda	M&E, Zim HISP, RTI, MOHCC HQ
22. Dr Rugare A Kangwende	Director PME,MOHCC
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Annex 2: Highlights of the Rapid Health Sector M&E Assessment Findings

Components 1 & 2: Organizational Structures for M&E and Human Resources Capacity for M&E

1.Organizational Structures for M&E, and 2. Human Resources Capacity for M&E	
Achievements, Strengths and Opportunities	**Weaknesses, Threats, Disabling Factors & Gaps**
a) MOHCC has a department of Performance Monitoring and Evaluation in the division of Policy, Planning, Monitoring and Evaluation (PPME) and an establishment for the Director and Deputy Director for Performance Monitoring and Evaluation. b) MOHCC programmes such as HIV, TB, Malaria, Nutrition and Reproductive health have strong and functional M&E units with technically skilled personnel at national and provincial level. c) MOHCC programmes and projects carry out M&E functions even though they do not have exclusive M&E Units. d) MOHCC has functional Provincial and District Health Information Units or desks with established positions and staffed with relevant personnel. e) MOHCC has functional donor funded provincial M&E Units/desks staffed with relevant personnel. f) The Ministry has functional provincial ICT Units/desks staffed with relevant personnel. g) MOHCC National, Provincial and District Hospitals and clinics have established Records units and some of them have Data Entry Clerks. h) There is a wide range of professionals such as M&E specialists, epidemiologists, biostatisticians, demographers in the job market. i) Key health sector supporting programmes/projects have strong M&E units and some of their implementing partners have M&E operational units.	a) Inadequate human resources for M&E Department in the MoHCC (there are only two positions, i.e. for the Director and Deputy Director on the establishment). b) Fragmented /vertical programme specific M&E units working in silos. c) Most M&E positions are not on the MOHCC establishment. d) Most M&E personnel are currently donor seconded or funded thereby threatening sustainability. e) Functional relationships between the Health Information systems (HIS) department, the M&E and the IT dept./unit are not adequately defined f) The districts Health Information desks personnel capacity seems overstretched regarding the volume/numbers of paper based data collection tools originating from the reporting facilities.
Recommended Priority Actions	
~~a)~~ MOHCC M&E organizational structure should be reviewed with the aim of capacitating it to be able to coordinate and sustain the Health sector M&E agenda. ~~b)~~ The MOHCC M&E establishment should be reviewed, and additional positions established to enable it to lead and strategically foster intra-ministry /sector M&E operations. c) Establish operational mutually reinforcing functional relationships between the MOHCC M&E, Health Information Systems and IT departments and other relevant health units. d) Establish M&E system to support the entire MOHCC, not only donor funded programmes. e) Designate focal persons to support departments/ directorates or programmes without M&E personnel. g) Establish M&E units/desks at districts health departments. ~~h)~~ Increase the establishment of the Health Information department to match the high volumes of reporting tools. i) Promote integration of services at national level to develop and sustain health sector M&E. j) Regular training of data management personnel, especially when new data collection tools are introduced, and/or when changes made to DHIS2 and other electronic data platforms. k) Develop, review and implement (if existing) a Health Sector wide M&E technical assistance Plan (TAP) and capacity building plan in line with needs and anticipated changing skills for data management/ M&E general requirements.	

Component 3: Partnerships for M&E

3. Partnerships for M&E	
Achievements, Strengths and Opportunities	**Weaknesses, Threats, Disabling Factors & Gaps**
i. There are number of M&E Technical Working groups (TWG) at programme level. ii. The MOHCC is an active member in other health sector related M&E TWGs and networks. iii. The Provincial and District Health Executive (PHE and DHE	i. There is no MOHCC wide or Health Sector wide M&E TWG/ forum or platform. ii. The PHE, DHE and HOD structures at provinces, districts and hospitals respectively are not formally structured to include the Provincial Health information officers, M&E officers, the District Health information officers and the

3. Partnerships for M&E	
Achievements, Strengths and Opportunities	**Weaknesses, Threats, Disabling Factors & Gaps**
committees), the Hospital Heads of Department (HOD), Clinic staff meetings/ forum and the health/clinic development committee structures at provinces, districts and hospitals, clinics and community levels respectively provide opportunity for data/information validation, M&E programme assessment, information utilization and networking for M&E. iv. The MODO (which brings together health sector development and implementing partners biannually) is an important structure for M&E development and use in the sector programming.	hospital Health information officers. Though invited at times, these categories of staff are of the view that their inclusion would enhance their being appreciated, their motivation, their contribution, attention to data use, performance assessment of M&E itself, performance based M&E and indeed overall results based management (RBM).
Recommended Priority Actions	
i. Establish an MOHCC Health Sector M&E Technical Working Group / forum or platform with clear Terms of Reference to strengthen technically and steer a coherent health performance based M&E function. ii. The PHE, DHE and HOD structures at provinces, districts and hospitals respectively should be formally structured to include the Provincial Health information officers, and M&E officers, the District Health information officers and, the hospital Health information officers. This will strengthen performance based M&E, the results based management (RBM), quality and efficiency.	

Components 4 and 5: M&E Planning and costing

M&E Planning and Costing	
Achievements, Strengths and Opportunities	**Weaknesses, Threats, Disabling Factors & Gaps**
i. The National Health Strategy (NHS) 2016-2020 has enshrined M&E through inclusion of clear indicators, baselines and performance targets. *ii.* The development of the performance monitoring and evaluation framework for the NHS is underway. *iii.* The key health sector programmes and projects have 3-5 year annualized M&E plans and performance frameworks which are strong pillars for a functional M&E system. *iv.* There are MOHCC directorates and programmes with no explicit M&E plans, but have M&E activities embedded in general programme work plans. *v.* A sizeable number of key health sector actors have M&E Plans that are synchronized/ aligned to the NHS. *vi.* Most of these M&E Plans have: ○ A full complement of indicators that are in line with global indicator standards and reporting needs ○ Baselines, mid and end of term targets for most of the core outcome indicators ○ Defined data sources with specified reporting frequencies ○ Coordination arrangements ○ Defined data flow, defined reporting mechanism and key information products ○ Capacity building for M&E ○ Costed interventions annualised, as is needed for functional M&E.	*ii.* Lack of an overarching and comprehensive guiding M&E policy and strategic guidelines. *iii.* Limited integration between the M&E Plans of the different health sector programmes and projects. *iv.* Limited institutionalization of M&E planning/programming in the health sector. v. Limited number of comprehensively costed M&E plans, where the costing is restricted to tools and training, not the broader M&E competence.
Recommended Priority Actions	
i. Develop and adopt an overarching comprehensive guiding M&E policy, strategic guidelines and M&E framework. ii. Establish and foster integration between the M&E Plans of the different health sector programmes iii. Strengthen and institutionalize M&E planning/ programming in the health sector. iv. Undertake a full health sector M&E systems assessment at the midterm review of the National Health Strategy for Zimbabwe in 2018. v. Guide the costing of key M&E interventions to enhance the costing of the available M&E work plans.	

Component 6: Advocacy, communication and the culture of M&E

Advocacy, Communication and the Culture of M&E	
Achievements, Strengths and Opportunities	**Weaknesses, Threats, Disabling Factors & Gaps**
i. Existence of sector performance agreements and follow up by the (Office of the President and Cabinet?) OPC for all sectors to have sector M&E strategies and Plans and to logically feed the ZimASSET sector allocated outcome targets. ii. The Health sector partners attach importance to the collection and utilization of data and M&E outputs. Data are consistently used for policy and practice by the MOHCC and its partners ~~iii.~~ The provinces and districts produce routine reports including the generic reports~~.~~ iv. MOHCC has annual health information profile reports which chronicles the health sector performance. v. MOHCC HIS and M&E senior staff (Principal Directors and Directors) sit on the top management forum e.g. MODO that directs the health sector agenda. vi. Use of ICT platforms for advocacy and communication.	i. Delayed production and limited visibility of annual health profiles that serves partly as a performance reporting tool. ii. The PME Directorate does not have adequate numbers of staff needed to follow up the MOHCC and sector M&E coordination requirements. iii. Quarterly reports and reviews (teleconference between the MOHCC and provinces) are mostly donor funded. iv. MOHCC website not regularly updated.
Recommended Priority Actions	
i. Undertake an extended organizational review as part of the sector full Systems Assessment (not just a rapid or snapshot one). ii. Strengthen bi-annual and annual sector wide performance reporting. i. Support the MOHCC leadership and other sector partners to regularly and easily access and increase the use of health sector data dash boards. v. Ensure that M&E and HIS generated information products (reports, website content, emails, newsletters, maps, tables, charts,) are regularly and more visibly displayed at fora from national to community levels. vi. Allocate at least 10% of the total health sector budget to M&E and this prioritize advocacy. vii. Hold quarterly teleconference between the Ministry and provinces to review reports and give feedback.	

Component 7: Routine Programme Monitoring and Data Bases

Routine Programme Monitoring and Data Bases	
Achievements, Strengths and Opportunities	**Weaknesses, Threats, Disabling Factors & Gaps**
i. There are health information officers, ICT and M&E officers who support DHIS2 at all levels. ii. The MOHCC has a strong routine data collection system with a wide range of data collection and reporting tools to capture data at all levels, including at the community level from Village Health Workers. iii. MOHCC has set standardized timelines of reporting which are also used by its partners. iv. The Health Sector projects have specific routine data collection and reporting tools to capture data at all levels of health care. v. The Health sector programmes have specific standardized routine data collection and reporting tools for mandatory programme and financial reporting for implementing partners. vi. The Ministry has standard reporting formats for the generic reports by the health departments at province	i. The MOHCC is growing in terms of ICT needs. However the MOHCC organogram has no established positions and staff responsible for the DHIS2 at national, province and district levels. ii. Inadequate supplies of data collection tools resulting in the use of old versions and improvised data collection tools, thereby reducing data quality. iii. Some data, especially that generated by specific programmes, are yet to be captured in DHIS2 iv. Some MOHCC data capture and reporting tools / formats are not timely aligned with DHIS2 screen data entry fields (i.e. VMMC fields) v. Frequent changes of paper based data collection tools due to changing needs and as per guidance by the global partners to improve the data usefulness at times strains available capacity. vi. Introduction of new and/or changes to existing data collection tools not being preceded/matched with training of those

Routine Programme Monitoring and Data Bases	
Achievements, Strengths and Opportunities	**Weaknesses, Threats, Disabling Factors & Gaps**
and district levels. vii. The MOHCC has a DHIS2 web based data base aligned to most of the tools and accessed from national to district levels to capture most health services delivery data. viii. Routine reporting, specific action alerts, data review and relevant action triggering of Weekly Disease Surveillance (WDS) are functional from community to national level. ix. Routine reporting to the MOHCC through the same channels by non-government, private and mission/NGOs health facilities. x. Routine reporting to the health sector platforms/ meetings such as MODO and other sector partners like NAC and Environmental Health promotion agencies. xi. Electronic systems being developed by the MOHCC with ultimate objectives of efficient patient management, improved quality of evidence and enhanced information systems. These pilots include "EHR", being piloted by MOHCC. xii. Institutionalized mechanisms exist for submission and tracking of monthly and quarterly service delivery data/reports all the way from Community to National level xiii. There are adopted operational MOHCC mechanisms for Data Quality Assurance (DQA) by both supervisor verification and in-built DHIS validation.	responsible for entry and verification. vii. Limited skills and training of some clinical level data entry personnel and service providers. viii. Frequent reshuffles of the clinical level service providers between departments results in unmatched skills for data entry. ix. Limited number of staff responsible for data capture in DHIS2 against the volume of reporting tools. x. The DHIS2 is on and off. In some cases described as "mostly off" or "most of the times down". xi. Some programme levels departments not submitting generic reports and not sure why. xii. The national MOHCC synthesis/ composite report at times not produced in a timely way xiii. Some non-clinical intervention routine reporting (i.e. Social and Behavioral Change Communication (SBCC)/interventions in malaria were reported yet to be well developed/ structured). xiv. Limited resources for the Hospital/ District and Provincial teams planned field visits/On-Site Data Verification (OSDV) and hands on mentoring for staff originating the tools/reports xv. Lack of demonstrable inter-operability between some databases and EHR xvi. The production of key regular reporting documents such the health profiles and performance reports is sometimes not timely.
Recommended Priority Actions	
i. Budget for, mobilize resources and procure adequate supplies of data collection tools. ii. Review the existing tools and explore the possibility of reducing the number of routine data collection tools at the service delivery level by removing the overlaps where possible. iii. Promote data bases inter-operability. iv. Align the data capture and reporting tools / formats with DHIS2 data entry fields, add more of the needed filters/validation and remove redundant entry fields (where they exist) that enhance chances for entry errors and provide matching guidance/instructions. v. Scale up/fast track the extension of the electronic systems to take care of the necessary frequent changes in the tools. Provide refresher training for clinical level data entry personnel and service providers in alignment to staff reshuffles policy and schedule. vi. Explore alternative reliability of web connectivity providers or mechanisms to reduce the connectivity failures or stability DHIS2. vii. Conduct regular (annual) M&E and programme review meetings and staff to refresh knowledge, skills and expected roles/responsibilities as well as reporting scope and schedules. viii. Compile annual national MOHCC profiles and other synthesis/ composite reports including the quarterly reports in a timely way. ix. Review and adopt health sector standard indicators, tools, guidelines, documenting procedures for recording, collecting, collating and reporting routine programme monitoring data for some non-clinical based interventions such as SBCC interventions**.** x. Budget, mobilize and provide resources for the Hospital, District and Provincial teams planned field visits/OSDV and hands on mentoring for staff originating the tools/reports. *xi.* Develop health sector public, private partnership (PPP) strategy and operational guidelines to enhance buy-in into of reporting by private sector run health facilities	

Components 10 and 11: Supportive supervision, data auditing; Surveillance and Surveys, Research and Evaluation

Surveillance and Surveys, Research and Evaluation

Achievements, Strengths and Opportunities	Weaknesses, Threats, Disabling Factors & Gaps
a) The health sector has had a number of rich population level data collection exercises that are vital for impact, outcome, output and coverage as well as process indicators needed for performance assessment. These have included surveys, surveillance, assessments, data mining and estimates exercises in the last 3 -5 years. Notable of these include: i. Zimbabwe Service Availability and Readiness Assessment Survey (ZSARA 2015) ii. Demographic and Health Survey (2015) iii. Vital medicines and Health Service Availability Survey (2015) iv. Client Satisfaction Survey National Medicines Survey in Public and Private Sector (2013) v. World Bank Health Expenditure Review (2015) vi. National Baseline survey on Life Expectancies of Adolescents (2013) vii. TB Prevalence Survey (2013/2014) viii. TB Drug Resistance Survey (completed every two years) ix. ANC Survey PMTCT effectiveness survey x. ART Adherence Study xi. Analysis of the EPMS data xii. AIDS Mortality Study xiii. The MOHCC different programmes have explicitly indicated the research priorities in their guiding programming documents for 2015.	a) There is no one National comprehensive Evaluation and Research Agenda. b) There is lack of a sector wide inventory for research and surveys undertaken that is annualized and regularly updated.
Recommended Priority Actions	
a) Develop a National comprehensive Evaluation and Research Agenda. b) Develop and annually update an inventory for Health Sector Research and Surveys undertaken. c) Hold an annual or every two year National Health Sector Research Conference.	

Components 12. Data dissemination and use

Data Dissemination and Utilization	
Achievements, Strengths and Opportunities	**Weaknesses, Threats, Disabling Factors & Gaps**
a) The programming documents such as the strategies, strategic plans and M&E plans of the MOHCC use the available data. The available data is mainly used for situation analysis, baselines and targets. b) The MOHCC and other sector partners run websites to share the available information. c) The MOHCC maintains a resource centre with the key information products from its information systems, routine monitoring, surveillance and surveys. d) A number of partners produce flyers, brochures and pamphlets as key information products to disseminate information. e) All departments and programmes at all levels make use of the meetings as a forum for information sharing and dissemination. f) Departments also give information on request in hard and electronic forms. g) The sector also produces a lot of reports, both within programmes and for external reporting, that are key for information sharing. h) The MOHCC, Provincial and District health departments make use of the Weekly Disease Surveillance (WDS) reports and information for planning. This WDS is also shared out in a weekly surveillance bulletin	a) There is lack of information sharing agreements. b) The stakeholders feel that the website is not regularly updated. c) Some reports such as the annual health profile are not generated in a timely way. The latest annual bulletin available is for 2014.
Recommended Priority Actions	
i. Undertake health sector stakeholder information needs assessment annually. *ii.* Develop/review the health sector policy guidelines to guide communication, publication, branding, (writing/housing styles) and dissemination as well as data/sharing. This shall address the current contextual, technological, access rights, and copy right, protection needs, among other aspects. *iii.* Develop relevant and user friendly guidelines to support the analysis, presentation and use of data (e.g. graphs on walls showing cumulative coverage) at the Province, District and facility levels. iv. Ensure stakeholders have access to health sector information products through ensuring that a copy of every document/ information product is deposited with the Resource Centre.	

Annex 3: List of documents reviewed

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23. Zimbabwe National AIDS Council. 2014. *Monitoring and Evaluation Plan for Extended Zimbabwe National HIV and AIDS National Strategic Plan 2015 -2020.* Harare, Zimbabwe