



**Ministry of Health Resource Centre**

**HEALTH MANAGEMENT INFORMATION  
SYSTEMS RAPID NEEDS ASSESSMENT FOR  
THE MID-WEST DISTRICTS OF BULIISA,  
KIBOGA, MASINDI, HOIMA AND KIBAALE**

**Key findings and recommendations**

**September 2008**



## **Acknowledgements**

Many people have contributed to this Health Management Information System (HMIS) Rapid Needs Assessment. The input of different staff in the Ministry of Health Resource Centre, Malaria Consortium, District Health Officers, HMIS/Surveillance Focal Persons and all other stakeholders was vital while carrying out this assessment.

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The technical committee comprised of the following: Dr. Eddie Mukooyo (ACHS MOH/Resource Centre), Dr. Rukaaka Mugizi (Technical Officer – MC) and Mr. Mulira Herbert (Data Management Officer MOH/Resource Centre) and Dr Michael Mulwooza (Community Health Department-Hoima Regional Referral Hospital)

## **1.0 INTRODUCTION**

Decentralized health systems were established in Uganda in the 1990s along with the political devolution of certain central government responsibilities to the district local governments. In the health sector, district overall administrative and technical management was under the district health team, with the district health officer at the apex of management. The teams were thus mandated to handle new responsibilities like planning, budgeting, coordination, procurement of drug supplies, and logistics and supervision of health services within their districts.

This administrative shift was however fraught with challenges. Districts lacked the financial, logistical, managerial and technical skills to rise up to the occasion. This period also coincided with an exponential increase in the communicable disease burden due to HIV/AIDS, Tuberculosis and Chloroquine resistant malaria.

Recognizing these failings, the government of Uganda together with development partners in the late 1990s embarked on a comprehensive programme of radical health sector reforms to improve on efficiency, effectiveness and equity of the health sector.

Products of these reforms included a shift to the Sector Wide Approach for budget support, the Health Sector Strategic Plan 2000-2005, and the Uganda National Minimum Health Care Package. These programmes also coincided with global initiatives that shared the same strategic goals like the Roll Back Malaria initiative and the Millennium Development Goals programme. These initiatives were experiencing an unprecedented boost of funding for several multilateral and government institutions like the Global Fund.

The Uganda Government and Irish Aid like most stakeholders recognized the need for strengthened health systems that could effectively harness these opportunities to scale up on evidence based communicable disease interventions. Importantly however was the need for these health systems to generate reliable data to would inform and guide managers to plan and budget accordingly, a process upon which many strategic decisions relied on.

The Health Management Information System (HMIS) is the Ministry of Health's official routine reporting system. With decentralization, it would form the bedrock upon which all health data generated country wide would be derived from. It was thus implicitly rendered vulnerable to the challenges facing the overall decentralized health system and would need a more aggressive approach given its pivotal role in the health system.

## **Background**

The Irish Aid funded Health Systems Strengthening project (CLOVER) premised its support for health management information systems on viable, sustainable and cost effective interventions like information technology, job aides, data management skills, support supervision, health data stationery among others.

A base line comprehensive needs assessment on health management information systems was undertaken in five mid-western, Irish Aid (through malaria consortium) supported districts in the 2<sup>nd</sup> quarter of 2008 with collaboration with the Ministry of Health resource centre. This assessment was designed to provide base line qualitative and quantitative data, on the functionality of health information systems in the districts.

The exercise covered both district and health sub district HMIS departments. It encompassed a review of data bases, policy structures, and adherence to procedural layouts and interviews with key institutional and departmental personnel among other activities.

The information hereinafter highlights the key findings and makes recommendations on the way forward.

## **2.0 GENERAL OBJECTIVE**

### **2.1 General Objective**

To establish the functionality of health management information systems in the mid west districts of Kiboga, Hoima, Masindi, Buliisa and Kibaale.

### **2.2 Specific Objectives**

- To raise stakeholder awareness and advocate for their active support towards strengthening of health management information systems at all levels within the districts.
- To determine performance of the existing HMIS in terms of resources, policy and planning, HMIS Infrastructure, data sources, data management, data dissemination and use.
- To make key recommendations aimed at strengthening the functionality of health management information systems in the mid-west districts.

### 3.0 Methodology

The HMIS assessment was conducted in the five aforementioned districts. This assessment also covered all the Health Sub Districts (HSD) therein.

This exercise employed a combination of key informant interviews, discussions and consultations with relevant stakeholders, a review of relevant literature and documentation relating to HMIS related activities in all districts/HSDs visited.

Further analysis and consultations were later conducted to clarify on some specific subjects.

The assessment tool was designed by a team comprised of technical staff from MoH- resource centre, and malaria consortium.<sup>1</sup>

### 4.0 HMIS Assessment Exercise

#### 4.1 Districts

Table 1 below, shows the districts and the dates during which the HMIS assessment exercise was carried out:

**Table 1: Schedule of District HMIS Assessment**

	DISTRICT	DATE OF HMIS ASSESSMENT
1	Kiboga	18 <sup>th</sup> August 2008
2	Masindi	19 <sup>th</sup> August 2008
3	Buliisa	20 <sup>th</sup> August 2008
4	Kibaale	21 <sup>st</sup> August 2008
5	Hoima	22 <sup>nd</sup> August 2008

#### 4.2 Respondents

District/HSD level comprised of:

- District Health Officer
- Surveillance Focal Person
- Health Management Information System Focal Person
- HSD in-charge

##### Assessors

- Dr Rukaaka Mugizi (technical officer Malaria Consortium)
- Mr Herbert Mulira (senior information officer MoH)
- Dr Mulwooza Michael (malaria zonal coordinator)

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<sup>1</sup> Refer to Ministry of Health resource and Malaria consortium for copies of the assessment tool.

### 4.3 Assessment Components

HMIS components assessed, upon which findings are discussed in the report include;

- (I) Resources (human and financial)
- (II) Policy and planning
- (III) HMIS Infrastructure
- (IV) Data management
- (V) Data sources and
- (VI) Dissemination and use.

**Note:**

1. To interpret the tables, and grading system used in the report, please refer to table one below, for the different color shades and their interpretations.

**Table 1: Shows the grading system used in analysis of the findings in the HMIS assessment**

<b>Result</b>	<b>Score</b>
<b>Highly Adequate</b>	<b>80% - 100%</b>
<b>Adequate</b>	<b>60% - 79%</b>
<b>Present but not adequate</b>	<b>40% - 59%</b>
<b>Not adequate</b>	<b>Below 40%</b>

## 5.0 FINDINGS and DISCUSSIONS

### 5.1 Resources (Human and Financial), Policy and HMIS Infrastructure

**Table 2: Shows the results under the section of Resources, Policy and HMIS Infrastructure**

Summary Results	Score %						
	Kiboga	Masindi	Buliisa	Kibaale	Hoima	Mid-west district average	*National average
<b>I. Resources and Policy</b>	46%	51%	45%	37%	56%	47%	53%
<b>II. HMIS Infrastructure</b>	57%	58%	75%	54%	65%	62%	57%

*\*National Average results are obtained from the national HMIS assessment which was carried out in 2006*

#### 5.1.1 Resources, Policy and Planning

Ministry policy stipulates that districts should have a stand alone budget for HMIS activities. This was previously catered for under the stationery budget line -that is continuously diverted to other activities-it has since been considered an unreliable source of funding. Partly as a result, districts do not have a stand alone budget for HMIS. This problem is further compounded by delayed disbursement of primary health care funds by the central government to the districts.

The net effect of these chronic funding constraints is a general institutional incapacity to effectively run HMIS departments. It is however difficult to establish whether these funding constraints encumber the performance of the mid-west districts differently, especially if analyzed against the overall national performance<sup>2</sup>.

Limited resources also undermine HMIS human resource technical capacity building activities, like trainings. When they do take place, they are either donor driven or supported by the Ministry of Health, and seldom district sponsored. As a result of this local institutional incapacity, newly recruited records assistants and other health workers go for long periods without the necessary training or orientation needed to work effectively. Partly as a result, there is a lack of skills in essential information sciences like epidemiology, statistics, demography and health planning, held by data personnel in the districts

Another example of resource constrained key components for HMIS management, is the district central HMIS administrative unit. This unit is mandated to provide support functions like design, development, analysis, dissemination and use of health information in planning and management in the district/HSD. It is required to meet monthly and quarterly and should ideally be comprised of key members of the district health team- however, this doesn't occur as regularly as is required.

Districts had the relevant legislation and policy frameworks to foster the development of the health statistical system, including the establishment of district data warehouses or databanks, but these were yet to be fully implemented due to lack of the required resources.

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<sup>2</sup> Refer to Table 2, to compared mid-west district performance against national performance.



Structures mandated to provide regular monitoring of the performance of HMIS and its sub-sections are still weak despite making considerable progress over the years. MoH policy requires at the very least, a quarterly assessment of HMIS by the districts and HSD. Some institutions like Kagadi Hospital, Masindi and Kibaale districts had a system for only monitoring the timeliness and completeness of health facilities submitting HMIS reports to them, but this was only done quarterly and the system was not comprehensive enough, as it didn't cover all health facilities-excluded the purely private health facilities; and other indicators.

### **5.1.2 HMIS Infrastructure**

Estimates on how much money is required to provide adequate stationery stocks are hard to come by;<sup>3</sup> however what is certain is that the resource envelop for the stationery budget is inadequate. Decreasing PHC disbursements from the central government have played a crucial role in this predicament. Often HMIS departments have to improvise ways and means of obtaining stationery.

There has been a significant improvement compared to previous years notwithstanding- the increased use information technology to some extent decreased the need for stationery-there; however there remains a significant funding gap, which continues to undermine institutional capacity to effectively operate.

Information technology in the form of computers, internet connectivity, printers, faxes and fixed landlines and other related office accessories for printing photocopying, faxing and scanning are inadequate at Districts/HSD, HMIS departments.

The GoU through the Uganda Communications Commission and the ICT Ministry are trying to support districts with these facilities under the Uganda national IT scale up initiative, however progress is slow and the packages do not adequately cater to the unique requirements for HMIS departments-anti-virus software, technical support, maintenance and training, internet connectivity among others.

Regular power supply is not a critical problem in the mid-west districts. Power outages usually do not persist long enough to undermine districts ability to operate effectively.

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<sup>3</sup> Some estimates project it to be between 5-10% of overall annual health expenditure of the district.

Districts health departments are mandated to have up-to-date inventories of all health facilities in their jurisdictions. These lists should be updated regularly, and should ideally submit key HMIS information to the district health office. It was however observed that, though districts possessed complete and up-dated lists of government and PNFP health facilities, private for profit health facilities were absent and yet they provide a significant amount of health care services in the districts. This has a tendency to skew district performance indicators negatively, as a significant percentage of the population is not captured by the HMIS.

## 5.2 Data Management

**Table 3: Data Management Performance against National Average**

Summary Results				Score %			
	Kiboga	Masindi	Buliisa	Kibaale	Hoima	Mid-west district average	National average
<b>Data Management</b>	<b>61%</b>	<b>78%</b>	<b>67%</b>	<b>83%</b>	<b>85%</b>	<b>75%</b>	<b>52%</b>

*\*National average results are obtained from the national HMIS assessment which was carried out in 2006*

The quality of data management has shown a strong and robust improvement, especially when compared against the national average. This can largely be attributed to the sustained support malaria consortium has provided to the region over the last two years. There however remain a few areas that still pose a challenge to the system in this regard;

Ideally all data generated in the districts from all health delivery outlets should be submitted to the district HMIS department- this is MoH policy. However it was observed that HMIS departments at district/HSD level do not operate an integrated “data warehouse” containing data from all data sources and on all key health programmes within their jurisdictions. Vertical programmes like HIV/AIDS and TB programmes in particular often operate outside the district mainstream HMIS and therefore do not routinely submit or share their information.

All facilities and registered health providers (public, private, private not for profit) are required to have a unique identifier code allocated to them to ease and standardize data management. This requirement was

adhered to when applied to public and some PNFP health facilities; however, the same was not routinely in private health practitioner facilities.

Utilization and adherence to MoH's written set of procedures and guidelines, for data management- these include data transmission, storage, analysis, and presentation<sup>4</sup> for targeted audiences, was observed to be inconsistent. Less than 55% of the districts /HSD's reviewed adhered to the spelt out procedures and guidelines consistently. Regular data validation exercises are required to address these challenges, which often undermine the reliability and quality of HMIS data.

### 5.3 Data Sources

**Table 4: Data Sources Performance against National Average**

Summary Results	Score %						
	Kiboga	Masindi	Buliisa	Kibaale	Hoima	Mid-west district average	National average
<b>Data Sources</b>	<b>52%</b>	<b>63%</b>	<b>67%</b>	<b>60%</b>	<b>64%</b>	<b>61%</b>	<b>55%</b>

*\*National average results are obtained from the national HMIS assessment which was carried out in 2006*

Data sources assessed included-all points of reference for information-like health facilities, maps, graphs; the data quality controls in place and the skill pool of data managers among others.

GoU policy provides for HMIS data to be regularly submitted as a pre-requisite for registration of private health facilities. This policy therefore provides a framework within which to enforce and act on institutions and health facilities that do not abide by the rules. For example, data from private for profit and private not for profit health facilities do not meet these obligations as established by MoH-these facilities do not routinely, if at all submit HMIS data to the districts, and there is little evidence to indicate otherwise. Lack of funds by the district to enforce this policy and private health facility reluctance to submit reports are sighted as major obstacles. This significantly skews the accuracy of district data at national level.

<sup>4</sup> HMIS manuals developed by Ministry of Health 2006 clearly spell out these procedures and guidelines

Structures that ensure the quality of data from the different sources- public and private; are weak. These structures include: regular technical support supervision visits and data validation exercises. These are particularly encumbered by lack of resources.

It is therefore difficult to verify the quality of the data submitted to the HSD and districts on a routine basis from these sources. This issue will however be addressed in the anticipated M&E strategy that is being formulated by Malaria Consortium and the Ministry of Health-it will include; a framework to provide regular support supervision and undertake bi-annual data validation exercises in the districts.

The assessment also tried to establish the skills of the individuals generating the HMIS data-records assistants and HMIS focal persons. It focused on the job experience and on-the job training-the tool was designed to capture percentage of positions filled by records assistants who had at least two years of training on the job<sup>5</sup>.

None of the districts had a cadre of health information assistant's positions, all filled and who have at least two years of training and are placed at the district/HSD level. Where absent, health information is being managed by health unit in-charges, who are often not fully equipped with the skills and time to undertake this task due to other administrative and clinical commitments.

Districts/HSD's are required to have up-dated maps showing the location of health infrastructure, health staff and key health services-this facilitates the identification of all sources of district health data among other things. These maps are supplied to the districts by Uganda Bureau of Statistics. This was however only restricted to government and public not for profit health facilities. Private profit health facilities remained un-mapped throughout the districts.

Quality data sources were increasingly being outsourced by the districts for planning key interventions. For example, coverage rates and estimations for targeted populations for interventions like Immunizations are based upon census results for population projections. This information is acquired through Uganda Bureau of Statistics and all districts had access to this information through their planning departments.

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<sup>5</sup> Records assistants suffer high attrition rates and lack regular training programmes. The team felt that an estimate of two years with training would provide an insightful benchmark into the level of technical skills available to the districts through these records assistants.

Districts/HSD were making good progress in ensuring that all health units submitted their drug stock information on time-especially the essential drugs, vaccines, contraceptives and other supplies. This information on health facility stock outs was readily available through health facility stock cards in all facilities.

Districts/HSD are also required to have annual reports on functionality of their equipment and physical infrastructure submitted from all health units. However periodicity and completeness of reporting on equipment and physical infrastructure was not meeting established MoH requirements. It was observed that their seems to be a lackluster approach to enforce this requirement by the district personnel responsible. We were unable to establish why?

#### 5.4 Dissemination and use

**Table 5: Performance of Dissemination and Use against National Average**

Summary Results	Score %						
	Kiboga	Masindi	Buliisa	Kibaale	Hoima	Mid-west district average	National average
Analysis and Use of Information	78%	53%	67%	65%	76%	68%	57%
Policy and Advocacy	56%	48%	63%	50%	92%	62%	59%
Planning & Priority Setting	54%	46%	58%	33%	78%	54%	67%
Resource allocation	58%	53%	56%	25%	85%	55%	60%
Implementation /action	46%	38%	25%	33%	67%	42%	60%
<b>Overall Results</b>	<b>62%</b>	<b>49%</b>	<b>57%</b>	<b>46%</b>	<b>81%</b>	<b>59%</b>	<b>60%</b>

Analysis and use of information for planning and budgeting is progressively becoming important at district level compared to previous years. District bureaucrats are increasingly insisting on evidence to support and justify resource allocations to the overall health budget. This is evidenced in the quality of the district and HSD annual health work plans which are a culmination of a comprehensive planning process that involves the input of several data sources.

District work-plans are increasingly showing performance evaluations, highly informative situation analysis's and prioritization sections which are all indicative of an elaborate process of data analysis and interpretation. Hoima particularly stands out in this regard.

Resource allocations are increasingly being prioritized according to a hierarchy of needs and gaps. This process is anchored on information available. Key policy makers like politicians, however lack the capacity to analyze, interpret and subsequently translate this information into informed policy decisions. In addition underlying weaknesses within the data and undue political influence often results into resource disbursements that do not reflect the realities on the ground.

Resource allocations based on informed priorities was however observed at lower levels to be much weaker, although the health delivery system emphasizes the need for technical decision making at lower levels to inform the planning process. Again an institutional lack of human resource capacity and financial constraints particularly at lower health units were singled out as some of the biggest encumbrances.

Dissemination of information at district and health sub district level for policy and priority setting was found to have improved considerably, though it was yet to perform as required. Health information isn't regularly and comprehensively presented and discussed among ALL stakeholders during district and health sub-district planning meetings, though considerable progress is being made.

In addition it was observed that health information products were increasingly being used to advocate for policy change among key decision makers, as evidenced by increased demands by local leaders to strengthen HMIS in order to build local district capacity to foster this change.

District health information is by and large readily available for public consumption and other specific stakeholders like NGO's upon request. This information was available through reports, display of graphs at health facilities and at district/HSD headquarters.

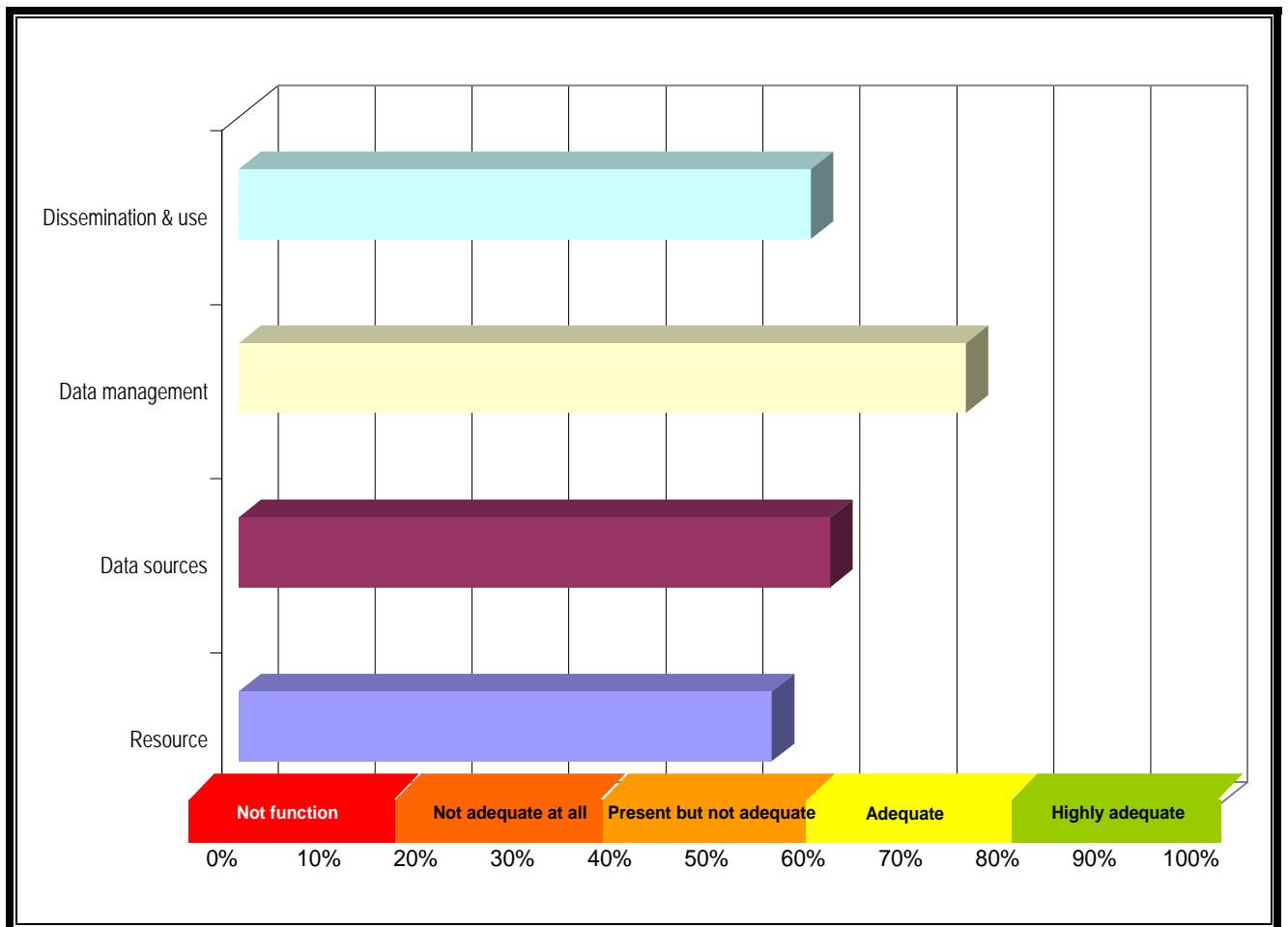
The translation of policy into action using evidence generated from HMIS remains a challenge- a lack of resources to translate policy into action is the major bottleneck undermining this component.

## 6.0 OVERALL RESULTS OF ASSESSMENT

Chart 1, provides an overview of the assessment results. It compares HMIS components against scores in percentages. Among the components assessed, only the components of data sources and data management were found to be adequate (scored above 60%).

Dissemination and use scored fairly well while data resources scored the poorest with 55% performance which translates to present but not adequate.

**Chart 1: Summarizes the overall results of the HMIS key findings in the Mid West Region**



## **7.0 CONCLUSION**

The HMIS assessment identified a number of issues which range from inadequate resources to enable the effective functionality of the HMIS system in the region, lack of HMIS skills by the majority of health workers and staff not appreciating the value of health information. The assessment also elucidates on a number of interventions; that if implemented can potentially improve the functionality of the HMIS system in the region.<sup>6</sup>

## **8.0 RECOMMENDATIONS**

Articulated below are some key recommendations that can potentially contribute towards strengthening the health management information system in the mid west region;

- 1 Malaria Consortium and the Ministry of Health/resource centre should develop a systematic program to train health managers and records personnel at all levels in data analysis and information utilization, this should be done within the quarter of Jan – Mar 2009.
- 2 Ministry of Health with support from Malaria Consortium should explore mechanisms of providing districts with databases. Options identified should be premised on cost effectiveness and sustainability. This should be done within the last quarter of 2008 (October – December).
- 3 Ministry of Health together with the district health officers with support from Malaria Consortium should convene a series of district workshops involving private not for profit and private health practitioners, with the view of developing a mechanism to integrate them into the district mainstream HMIS. This should be done within the quarter of Jan – Mar 2009.
- 4 Resource Centre with support from Malaria Consortium should develop a monitoring and evaluation framework for HMIS which will encompass data quality audits and tracking of key HMIS indicators. This should be done with the last quarter of 2008.

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<sup>6</sup> Refer to annex 1 for the district specific strength, weaknesses and opportunities).



**Annex 1: Shows the Summary of Strength, Weakness and Opportunities of the Existing Health Management Information System by District.**

District	Strengths	Weaknesses	Opportunities
<p><b>1. Buliisa</b></p>	<p><b>1. Resources, policy and planning</b></p> <ul style="list-style-type: none"> <li>• It is official policy to conduct regular meetings at district level at quarterly intervals to review HMIS information and to take action based on such information.</li> <li>• There is district capacity in health information sciences to meet health information needs.</li> <li>• There is a central HMIS administrative unit at the district for design, development and support of health information processes.</li> <li>• 100% of health offices at district/HSD level have designated full time health information officers and the positions are filled.</li> <li>• Significant HMIS capacity building occurred as part of a government driven HRD plan and support from Malaria Consortium.</li> </ul>	<p><b>1. Resources, policy and planning</b></p> <ul style="list-style-type: none"> <li>• There is no written HMIS work plan.</li> <li>• No committee for coordination of HMIS exists.</li> <li>• District statistical office has not established coordination mechanisms like a task force on health statistics.</li> <li>• There is no regular system in place for monitoring the performance of HMIS and its various sub systems.</li> <li>• No HMIS capacity building activities have occurred in the past year for health facility staff.</li> <li>• Written guidelines exist for the HMIS data collection, analysis, management but are not implemented /used.</li> <li>• District HMIS budget line items are limited and do not allow for adequate functioning of HMIS.</li> </ul>	<ul style="list-style-type: none"> <li>• The trained Health Information assistants are a vital resource that can help offer on the job support to health unit staff.</li> </ul>

	<ul style="list-style-type: none"> <li>• There is availability of IT and data base support to HMIS staff at district level courtesy of Malaria Consortium.</li> </ul> <p><b>2. HMIS Infrastructure</b></p> <p>A complete list of Government, private and PNFP health facilities exists with regular annual updates.</p> <p>There are occasional ‘stock- outs’ of recording forms, paper, data bases, pencils and other supplies but it does not affect the ability to report the required information.</p> <p>All HMIS managers at HSD level and all managers at district level have access to a PC.</p> <p>Basic communication technology infrastructure is in place at district level to ensure rapid compilation of data.</p> <p>The district level uses a diesel generator as a power source but this is not always reliable due to fuel shortages.</p> <p>IT maintenance support is always available courtesy of Malaria Consortium, and the district is</p>	<p><b>2. Data sources</b></p> <ul style="list-style-type: none"> <li>• Less than 5% of the health workers have received regular training in health information.</li> <li>• Not all facilities report on a monthly basis on the stock of health commodities.</li> <li>• There is incomplete reporting on equipment and physical infrastructure.</li> </ul> <p><b>3. Dissemination and use</b></p> <ul style="list-style-type: none"> <li>• Health information is rarely used by care providers at all levels for management and monitoring, and no real planning is done.</li> <li>• Health information is rarely used by care providers for service delivery and monitoring, but no real planning is done.</li> </ul>	
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able to meet data and information reporting requirements.

**3. Data management**

A written set of data management procedures exists but these are only partially implemented.

There is a data warehouse at district/HSD level with a user-friendly reporting utility accessible to all relevant government and NGO.

All facilities and registered health providers have been allocated a unique identifier code by the district to ease data management.

**4. Data sources:**

- A health services based health Information System brings together data from all public and private facilities.
- A systematic approach to evaluate the quality of services provided by health facilities is in place.
- The health Information system has four health Information

	<p>Assistants who have at least two years of training.</p> <ul style="list-style-type: none"><li>• There are mechanisms in place at district and HSD levels for supervision and feedback on information practices.</li><li>• There is a mechanism in place from HF's up through district level to verify completeness and consistency of data collection.</li><li>• There are human resources and equipment for maintaining and updating the data base and maps after on job training by Malaria Consortium.</li><li>• The district data base of facilities was updated less than 2 years ago.</li><li>• Maps showing the location of health infrastructure are available in the district.</li><li>• Population projections based on census statistics provided by the District population office are used to calculate coverage rates.</li><li>• Annual summaries of health service statistics was published last year with statistics disaggregated by major</li></ul>		
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	<p>administrative units.</p> <ul style="list-style-type: none"><li>• Buliisa HSD compiles its own monthly and annual summary reports disaggregated by health facility.</li><li>• Vertical reporting systems such as those for HIV and TB communicate well with the general health service reporting system.</li></ul> <p><b>5. Dissemination and use of information</b></p> <ul style="list-style-type: none"><li>• Managers and analysts at district level frequently use findings from HMIS reports to assess the validity of clinic based data.</li><li>• Each facility reports at least annually on the inventory and status of equipment and physical infrastructure.</li><li>• There is continual demand for good quality and timely health information.</li><li>• Graphs and maps are widely used to display information at district offices.</li><li>• HMIS information is readily available in a written annual</li></ul>		
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	<p>report that pulls together and analyses critical health information for all subsystems.</p> <ul style="list-style-type: none"><li>• The District ‘Under 5 mortality rate’, ‘maternal mortality rate’, ‘immunization rate’ and ‘HIV prevalence’ are well known among politicians and media.</li><li>• Policy and decision makers regularly use health information to evaluate performance and set policies on health.</li><li>• Health information is widely used by district and HSD management teams to set resource allocation in the annual budget processes.</li><li>• During the last 2 years of creation of the new district, HMIS information has resulted in significant changes in annual budgets and general resource allocation.</li></ul>		
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<p><b>2. Hoima</b></p>	<p><b>1. Resources, policy and planning</b></p> <ul style="list-style-type: none"> <li>• There is a written HMIS work plan in active use addressing all HMIS components and it emphasizes integration of different data sources and is being integrated at the district level.</li> <li>• There is a committee in charge of coordination of HMIS.</li> <li>• The district has established coordination mechanisms.</li> <li>• There is regular system in place for monitoring the performance of HMIS and its various sub systems. Late reporting and non reporting units are identified regularly. Occasional data audits though irregular are undertaken.</li> <li>• Regular monthly meetings are conducted at district level and an opportunity to review HMIS information and take action based on this information is attempted.</li> <li>• There is district capacity in health information sciences to meet health information needs.</li> </ul>	<p><b>1. Resources, policy and planning</b></p> <ul style="list-style-type: none"> <li>• Limited capacity building activities have occurred over the past year for HMIS staff.</li> <li>• District/HSD HMIS budget line items are limited and do not allow for adequate functioning of the HMIS.</li> </ul> <p><b>2. Health infrastructure</b></p> <ul style="list-style-type: none"> <li>• There is no IT equipment maintenance support available and it prevents the district from meeting data and information reporting requirements.</li> </ul> <p><b>3. Data sources</b></p> <ul style="list-style-type: none"> <li>• 5%- 24% of health workers are trained in information, either integrated in continuing education or special workshops.</li> <li>• Human resources and equipment for maintaining and updating the data bases and maps are present but not adequate.</li> <li>• There is incomplete reporting as far as reporting on equipment and physical infrastructure.</li> </ul>	<ul style="list-style-type: none"> <li>• Capacity building activities for HMIS staff can be undertaken.</li> <li>• Efforts to offer IT maintenance support to the district may improve its ability to meet data and information reporting requirements.</li> <li>• An opportunity to attend the monthly feedback meeting by the technical team on HMIS may offer a chance to generate ways to improve on its quality and effectiveness.</li> </ul>
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	<ul style="list-style-type: none"> <li>• There is a central HMIS administrative unit at the district for design, development and support of health information collection, management, analysis, dissemination and use for planning and management.</li> <li>• The district has designated full time health information officer positions and are filled.</li> <li>• HMIS capacity building activities have occurred over the past year for HMIS staff.</li> <li>• There is availability of IT and data base support to HMIS staff at district level.</li> <li>• Written guidelines exist for HMIS data collection, analysis, management and use.</li> </ul> <p><b>2. HMIS infrastructure</b></p> <ul style="list-style-type: none"> <li>• A complete list of government, private and PNFP health facilities exists and is updated every year.</li> <li>• There are occasional stock outs of recording forms, paper, data bases, pencils and other supplies but it does not affect</li> </ul>	<p><b>3. Dissemination and use of information</b></p> <ul style="list-style-type: none"> <li>• There are some graphs and maps but these are not up to date for the current FY.</li> <li>• Health information is rarely used by care providers for service delivery and monitoring, but no real planning is done.</li> </ul>	
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	<p>the ability to report the required information.</p> <ul style="list-style-type: none"><li>• Some HMIS managers at HSD level and all managers at district level have access to a PC.</li><li>• Basic communication technology infrastructure is in place at district level to ensure rapid compilation of data.</li><li>• There is reliable power supply at district level from the national power grid and a stand by generator.</li></ul> <p><b>3. Data management</b></p> <ul style="list-style-type: none"><li>• A written set of data management procedures exists, but these are only partially implemented.</li><li>• There is a data ware house at district level with a user friendly reporting utility accessible to all relevant government and NGO.</li><li>• All facilities and registered health providers have been allocated a unique identifier code by the district to ease data management.</li></ul>		
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**4. Data sources**

- There is a health services based information system that brings together data from all public and private facilities.
- There is a systematic approach to evaluating the quality of services provided by health facilities.
- The health information system has a cadre of health information assistants who have at least two years of training and are placed at the district level.
- There are mechanisms in place at district level for supervision and feedback on information practices.
- The district data base was updated less than two years ago.
- Maps are available in district showing the location of health infrastructure.
- Population projections based on census statistics are used to calculate coverage rates.
- Annual summaries of health

	<p>service statistics was published with statistics disaggregated by major administrative units.</p> <ul style="list-style-type: none"><li>• HSDs/Districts compile their own monthly and annual summary reports though not necessarily disaggregated by health facility.</li><li>• Vertical reporting systems communicate well with the general health service reporting system.</li><li>• Managers and analysts at district level frequently use findings from HMIS reports to assess the validity of clinic based data.</li><li>• Each facility reports at least monthly on its stock of health commodities.</li></ul> <p><b>5. Dissemination and use of information</b></p> <ul style="list-style-type: none"><li>• There is continual demand for good quality and timely information.</li><li>• Senior managers demand complete, timely, accurate, relevant, and validated HIS information.</li></ul>		
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	<ul style="list-style-type: none"><li>• The central HMIS unit provides information but it is limited in in-depth analysis and reports for policy development and planning.</li><li>• Public access and availability to HMIS data and indicators are guaranteed by law/regulations and which are fully implemented.</li><li>• HMIS information is readily available in a written annual report that pulls together and analyses critical health information from all sub systems.</li><li>• Integrated HMIS summary reports covering at least a minimum set of core indicators are distributed regularly to all relevant parties.</li><li>• The District ‘Under 5 mortality rate’, ‘maternal mortality rate’, immunization rate’ and ‘HIV prevalence’ are well known among politicians and media.</li><li>• Policy and decision makers regularly use health information to evaluate performance and set policies on</li></ul>		
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	<p>health.</p> <ul style="list-style-type: none"><li>• Health information is widely used by district and HSD management teams to set resource allocation in the annual budget processes.</li><li>• During the last 5 years, HMIS information has resulted in significant changes in annual budgets and general resource allocation.</li><li>• Health information is demonstrably used in the planning process.</li><li>• District/HSD health workers analyze all health statistics and compare them with national bench marks and act accordingly.</li><li>• Some target/budget proposals are backed up by HMIS information.</li><li>• Information driven resource allocation was adopted in principle, but not yet fully implemented.</li><li>• Health information is used by managers at all levels for health service delivery management, planning and monitoring.</li></ul>		
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<p><b>3. Kibaale</b></p>	<p><b>1. Resources, policy and planning</b></p> <ul style="list-style-type: none"> <li>• There is a written HMIS work plan in active use addressing all HMIS components and it is updated on a quarterly basis.</li> <li>• The district has established coordination mechanisms.</li> <li>• There is regular system in place for monitoring the performance of HMIS and its various sub systems.</li> <li>• There is district capacity in health information sciences to meet health information needs.</li> <li>• There is a central HMIS administrative unit at the district for design, development and support of health information processes.</li> <li>• The district has designated full time health information officer positions and ten (10) out of the eighteen (18) are filled.</li> <li>• Written guidelines exist for HMIS data collection, analysis, management and use.</li> </ul>	<p><b>1. Resources, policy and planning</b></p> <ul style="list-style-type: none"> <li>• There is no committee in charge of coordination of HMIS.</li> <li>• No policy exists as regards conducting regular meetings at district level to review HMIS information and take action based on such information.</li> <li>• Limited capacity building activities have occurred over the past year for HMIS staff.</li> <li>• Limited capacity building activities have occurred over the past year for health facility staff.</li> </ul> <p><b>2. HMIS infrastructure</b></p> <ul style="list-style-type: none"> <li>• There is limited availability of IT and data base support to HMIS staff at district level.</li> <li>• District/HSD HMIS budget line items are limited and do not allow for adequate functioning of the HMIS.</li> </ul> <p><b>3. Data management</b></p> <ul style="list-style-type: none"> <li>• A written set of data management procedures exist, but these are not implemented.</li> </ul>	<ul style="list-style-type: none"> <li>• Any effort to engage the private sector in HMIS would improve the health service delivery as far as planning is concerned.</li> </ul>
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**2. HMIS infrastructure**

- A complete list of government, private and PNFP health facilities exists and is updated every year.
- There are occasional stock outs of recording forms, paper, data bases, pencils and other supplies but it does not affect the ability to report the required information. For the whole of this financial year, the units have not had data bases.
- Some HMIS managers at HSD level and all managers at district level have access to a PC.
- Basic communication technology infrastructure is in place at district level to ensure rapid compilation of data.
- There is reliable power supply at district level.
- There is no IT equipment maintenance support available but the district is able to meet the data and information reporting requirements.

**4. Data sources**

- The health services based information system covers few private facilities.
- Only 1%- 9% of HFs has a cadre of health information assistants who have at least two years of training.
- Less than 5% of health workers are trained in information, either integrated in continuing education or special workshops.
- Mechanisms at district for supervision and feedback on information practices are present but not adequate.
- There are mechanisms in place at district and HSD levels for supervision and feedback on information practices but these are not adequate.
- Human resources and equipment for maintaining and updating the data bases and maps are present but not adequate.
- The district/HSD data base of facilities was up dated more than three years ago.

	<p><b>3. Data management</b></p> <ul style="list-style-type: none"> <li>• There is a data ware house at district level with a user friendly reporting utility accessible to all relevant government and NGO.</li> <li>• All facilities and registered health providers have been allocated a unique identifier code by the district to ease data management.</li> </ul> <p><b>4. Data sources</b></p> <ul style="list-style-type: none"> <li>• There is a systematic approach to evaluating the quality of services provided by health facilities.</li> <li>• Maps are available in district showing the location of health infrastructure.</li> <li>• Population projections based on census statistics are used to calculate coverage rates.</li> <li>• Annual summaries of health service statistics are published with statistics disaggregated by major administrative units.</li> <li>• HSDs/Districts compile their own monthly and annual</li> </ul>	<p><b>5. Dissemination and use of Information</b></p> <ul style="list-style-type: none"> <li>• Access to HMIS data and indicators collected by any public agencies is strictly controlled.</li> <li>• HIS information annual report that pulls together and analyses critical health information from all sub systems on an annual/biannual basis is inadequate.</li> <li>• District health workers do not analyze all health statistics and compare them with the national ones for action.</li> <li>• Few targets/budget proposals are backed up by HMIS information.</li> <li>• None of the targets/budget proposals are backed up by HMIS information.</li> <li>• Budgets are not information driven.</li> <li>• Health information is rarely used by care providers at all levels for management and monitoring, but no real planning is done.</li> <li>• Health information is rarely used</li> </ul>	
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	<p>summary reports though not necessarily disaggregated by health facility.</p> <ul style="list-style-type: none"><li>• Vertical reporting systems communicate well with the general health service reporting system.</li><li>• Managers and analysts at district level frequently use findings from HMIS reports to assess the validity of clinic based data.</li><li>• The data derived from health service records are used to estimate coverage with key services.</li><li>• Each facility reports at least annually on the inventory and status of equipment and physical infrastructure.</li><li>• Each facility reports at least monthly on its stock of health commodities.</li><li>• Complete annual reporting is followed as regards reporting on inventory and physical infrastructure.</li></ul>	<p>by care providers for service delivery and monitoring, but no real planning is done.</p>	
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	<p><b>5. Dissemination and use of information</b></p> <ul style="list-style-type: none"><li>• There is continual demand for good quality and timely information.</li><li>• Senior managers demand complete, timely, accurate, relevant, and validated HIS information.</li><li>• Up to date graphs and maps are displayed but not understood.</li><li>• The central HMIS unit provides information but limited in depth analysis and reports for policy development and planning.</li><li>• Integrated HMIS summary reports covering at least a minimum set of core indicators are distributed regularly to all relevant parties.</li><li>• The District ‘Under 5 mortality rate’, ‘maternal mortality rate’, immunization rate’ and ‘HIV prevalence’ are well known among health focused policy/decision makers.</li><li>• Policy and decision makers</li></ul>		
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	<p>regularly use health information to evaluate performance and set policies on health.</p> <ul style="list-style-type: none"> <li>Health information is commonly used for diagnostic purposes to describe health problems/challenges, but no synchronized use of HIS information between different planning frameworks.</li> </ul>		
<p><b>4. Kiboga</b></p>	<p><b>1. Resources, Policy and Planning</b></p> <ul style="list-style-type: none"> <li>There is district capacity in core health information sciences to meet health information needs.</li> <li>At district level there are designated health information officer positions and they are filled.</li> <li>HMIS capacity building activities have occurred over the past year for HMIS staff.</li> <li>IT and Database support to HMIS at district level is available largely by Malaria Consortium.</li> </ul>	<p><b>1. Resources, policy and planning</b></p> <ul style="list-style-type: none"> <li>There is no HMIS work plan.</li> <li>There is no HMIS committee.</li> <li>The District/HSD statistical office exists in theory but the mechanisms are not operational.</li> <li>No policy exists to conduct regular meetings at HSD/district level to review HMIS information and take action based upon such information.</li> <li>HMIS unit has very limited functional capacity and undertakes few HIS strengthening activities.</li> <li>No HMIS capacity building activities have occurred over the</li> </ul>	

	<p><b>2. HMIS Infrastructure</b></p> <ul style="list-style-type: none"> <li>• Basic communication technology infrastructure is in place at district level to ensure rapid compilation of data.</li> <li>• There is a reliable power supply at district level.</li> </ul> <p><b>3. Data management</b></p> <ul style="list-style-type: none"> <li>• There is a written set of procedures for data management including data transmission, storage, analysis and presentation for target audiences and these are implemented throughout the district.</li> </ul> <p><b>4. Data sources</b></p> <ul style="list-style-type: none"> <li>• The health information system has a cadre of health information assistants who have at least two years of training and are placed at the district level.</li> <li>• There are mechanisms in place at district and HSD levels for supervision and feedback on information practices.</li> </ul>	<p>past year for health facility staff.</p> <ul style="list-style-type: none"> <li>• Written guidelines exist for the HMIS data collection, analysis, management but are not implemented /used.</li> <li>• There are no District/HSD HMIS budget line items and there is inadequate functioning of HMIS.</li> </ul> <p><b>2. HMIS infrastructure</b></p> <ul style="list-style-type: none"> <li>• A list of Government, private and PNFP facilities is out of date and covers less than 50% of facilities.</li> <li>• There are stock outs of HMIS recording forms, paper, recording forms, data bases, pencils and other supplies and it affects the ability to record required information.</li> <li>• HMIS managers at district level have access to computers but not those at HSD level.</li> <li>• There isn't always IT equipment maintenance support available and it prevents the district from meeting data and information reporting requirements.</li> </ul>	
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	<ul style="list-style-type: none"> <li>• There are human resources and equipment for maintaining and updating the data base and maps.</li> <li>• The district/HSD data base of facilities was updated less than 2 years ago.</li> <li>• Population projections based upon census statistics are used to calculate coverage rates.</li> <li>• An annual summary of health service statistics is published with statistics disaggregated by health facility.</li> <li>• Managers and analysts at district and HSD levels frequently use findings from the HMIS reports to assess the validity of clinic based data.</li> <li>• The data derived from health service records are used to estimate coverage with key services.</li> </ul> <p><b>5. Dissemination and use of information.</b></p> <ul style="list-style-type: none"> <li>• There is continual demand for good quality and timely information.</li> </ul>	<p><b>3. Data management</b></p> <ul style="list-style-type: none"> <li>• No district data ware house exists.</li> <li>• Not all the health units have been allocated a unique identifier code by the district to ease data collection.</li> </ul> <p><b>4. Data sources</b></p> <ul style="list-style-type: none"> <li>• The health services based information system covers few private facilities, mostly 'Not for profit'.</li> <li>• There is information on quality of services but only from a convenience sample of health facilities.</li> <li>• About 5 – 24% of health workers receive regular training in health information which is either integrated into continuing education or through special workshops.</li> <li>• Though there is a mechanism in place at district and HSD levels for supervision and feedback on information practices, it is not adequate.</li> <li>• Maps are available in the district</li> </ul>	
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	<ul style="list-style-type: none"> <li>• Senior managers demand complete, timely, accurate, and relevant and validated HIS information.</li> <li>• Graphs and maps are widely used to display information at district/HSD offices.</li> <li>• Central HMIS unit conducts in depth data analysis that provides answers to important questions on priority issues.</li> <li>• HMIS information is readily available in a written annual report that pulls together and analyses critical health information from all sub systems.</li> <li>• Integrated HMIS summary reports covering at least a minimum set of core indicators are distributed regularly to all relevant parties.</li> <li>• Policy and decision makers regularly use health information to evaluate performance and set policies on health.</li> <li>• Health information is demonstrably used in the planning process.</li> </ul>	<p>showing the location of health infrastructure but are not adequate.</p> <ul style="list-style-type: none"> <li>• Vertical reporting system such as those for TB and HIV/AIDS communicate with the general health service reporting system though this is not adequate.</li> <li>• Facilities do not report at least annually on the inventory and status of equipment and physical infrastructure.</li> <li>• Not all the facilities report at least monthly on the stock of health commodities.</li> </ul> <p><b>5. Dissemination and use of information</b></p> <ul style="list-style-type: none"> <li>• Access to HMIS data and indicators collected by any public agencies is strictly controlled.</li> <li>• The District ‘Under 5 mortality rate’, ‘maternal mortality rate’, immunization rate’ and ‘HIV prevalence’ are known by a few specialists only.</li> <li>• District/HSD health workers do not analyze all health statistics for comparison with national</li> </ul>	
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		<p>benchmarks and act accordingly.</p> <ul style="list-style-type: none"> <li>• Few targets/budget proposals are backed by HMIS information.</li> <li>• During the last five years, HMIS information has resulted in some shifts in annual budgets and/or general resource allocation but links to information are not clear.</li> <li>• Health information is rarely used by care providers at all levels for management and monitoring, but no real planning is done.</li> <li>• Health information is rarely used by care providers for service delivery and monitoring, but no real planning is done.</li> </ul>	
<p><b>5. Masindi</b></p>	<p><b>1. Resources, policy and planning</b></p> <ul style="list-style-type: none"> <li>• There is a written HMIS work plan in active use addressing all HMIS components and it emphasizes integration of different data sources and is being integrated at the district level.</li> <li>• There is a committee in charge of coordination of HMIS.</li> <li>• The district has established</li> </ul>	<p><b>1. Resources, policy and planning</b></p> <ul style="list-style-type: none"> <li>• The official policy to conduct regular meetings at District to review HMIS information exists but is not implemented.</li> <li>• The District/HSD capacity in core health information sciences to meet health information needs is partially adequate.</li> <li>• Limited capacity building activities have occurred over the</li> </ul>	

	<p>coordination mechanisms.</p> <ul style="list-style-type: none"> <li>• There is regular system in place for monitoring the performance of HMIS and its various sub systems.</li> <li>• There is a central HMIS administrative unit at the district for design, development and support of health information collection, management, analysis, dissemination and use for planning and management.</li> <li>• The district has designated full time health information officer positions and are filled.</li> <li>• Written guidelines exist for HMIS data collection, analysis, management and use.</li> </ul> <p><b>2. HMIS infrastructure</b></p> <ul style="list-style-type: none"> <li>• There are occasional stock outs of recording forms, paper, data bases, pencils and other supplies but it does not affect the ability to report the required information.</li> <li>• Some HMIS managers at HSD level and all managers at</li> </ul>	<p>past year for HMIS staff.</p> <ul style="list-style-type: none"> <li>• Significant capacity building has taken place, but largely depending on external (e.g. Malaria Consortium) support and input.</li> <li>• There is limited availability of IT and data base support to HMIS staff at district/HSD levels which does not meet the staff needs for assistance and support.</li> <li>• District/HSD HMIS budget line items are limited and do not allow for adequate functioning of HMIS.</li> </ul> <p><b>2. HMIS infrastructure.</b></p> <ul style="list-style-type: none"> <li>• A list of government, private and PNFP health facilities exists but it is out of date and may cover less than 50% of all facilities.</li> </ul> <p><b>3. Data sources</b></p> <ul style="list-style-type: none"> <li>• The health services based information system covers few private facilities.</li> <li>• There is information on quality of services but only from a convenience sample of health facilities.</li> </ul>	
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	<p>district level have access to a PC.</p> <ul style="list-style-type: none"> <li>• Basic communication technology infrastructure is in place at district level to ensure rapid compilation of data.</li> <li>• There is a reliable power source at the district level.</li> <li>• Though IT maintenance support is not always available, the district is able to meet data and information reporting requirements</li> </ul> <p><b>3. Data management</b></p> <ul style="list-style-type: none"> <li>• A written set of data management procedures exists, but these are only partially implemented.</li> <li>• There is a data ware house at district level with a user friendly reporting utility accessible to all relevant government and NGO.</li> <li>• All facilities and registered health providers have been allocated a unique identifier code by the district to ease data management.</li> </ul>	<ul style="list-style-type: none"> <li>• Only 1%- 9% of HFs has a cadre of health information assistants who have at least two years of training.</li> <li>• Only 5 – 24% of health workers are trained in information, either integrated in continuing education or special workshops.</li> <li>• Mechanisms at district for supervision and feedback on information practices are present but not adequate.</li> <li>• Human resources and equipment for maintaining and updating the data base and maps are present but not adequate.</li> <li>• Vertical reporting system such as those for TB and HIV/AIDS communicate with the general health service reporting system though this is not adequate at all.</li> </ul> <p><b>4. Dissemination and use of information</b></p> <ul style="list-style-type: none"> <li>• Demand from managers for complete, timely, accurate, relevant and validated HIS information is ad hoc, usually as</li> </ul>	
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	<p><b>4. Data sources</b></p> <ul style="list-style-type: none"> <li>• The district data base was updated less than two years ago.</li> <li>• Maps are available in district showing the location of health infrastructure.</li> <li>• Population projections based on census statistics are used to calculate coverage rates.</li> <li>• Annual summaries of health service statistics are published with statistics disaggregated by major administrative units.</li> <li>• HSDs/Districts compile their own monthly and annual summary reports disaggregated by health facility.</li> </ul>	<p>a result of external pressure.</p> <ul style="list-style-type: none"> <li>• Access to HMIS data and indicators collected by any public agencies is strictly controlled.</li> <li>• HIS information annual report that pulls together and analyses critical health information from all sub systems is out of date and/or of poor quality.</li> <li>• The District ‘Under 5 mortality rate’, ‘maternal mortality rate’, immunization rate’ and ‘HIV prevalence’ are known by a few specialists only.</li> <li>• Policy and decision makers use HMIS information occasionally, but with clear reservations due to concerns about validity.</li> <li>• During the last five years, HMIS information has resulted in some shifts in annual budgets and/or general resource allocation but links to information are not clear.</li> <li>• Health information is rarely used by care providers at all levels for management and monitoring, but no real planning is done.</li> </ul>	
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## Annex 2: Mid West District ICT Contacts

No.	District/HSD Name	Details of District/HSD Members Interviewed				Box Number	Other forms of communication
		Names	Position	Contact Number	Email		
<b>Buliisa</b>							
1	Buliisa District	Bahemuka Leonard	HMIS Focal Person	0772-547590	<a href="mailto:bahelenards@yahoo.com">bahelenards@yahoo.com</a>	228, Buliisa	
2	Buliisa HSD	Kusiima Wilson	HMIS Focal Person	0774-106836		228, Buliisa	
		Afeta Alex	Incharge HSD	0782-526431			
<b>Hoima</b>							
1	Hoima District	Baliyula Albert	HMIS Focal Person	0772-195310		P.O. Box 2, Hoima	Radio call not functional
		Dr.Luyonga Joseph	DHO	0772-611476			
2	Bagaya HSD	Assimwe Patricia	HMIS Focal Person	0775-613213	<a href="mailto:assimwepatricia@yahoo.com">assimwepatricia@yahoo.com</a>	P.O. Box 2, Hoima	
		Dr.Sarah Mbogo	Incharge HSD	0772-410706			
3	Buhaguzi HSD	Dr.Kaweesa	Incharge HSD	0782-710505		P.O. Box 2, Hoima	
		Byenkya Philemon	HMIS Focal Person	0772-923062	<a href="mailto:philemon2005@yahoo.co">philemon2005@yahoo.co</a>		
<b>Kiboga</b>							
1	Kiboga District	Isa Kamuli	Biostatistician	0774-834816	<a href="mailto:mutazindwa25@yahoo.com">mutazindwa25@yahoo.com</a>	P.O.Box 816,	

		Dr.Allan Muruta	DHO	0772-		Kiboga	
2	Bukomero HSD	Harriet Mirembe	HMIS Focal Person	0782-896484			
		Dr.Musiitwa Michael	Incharge HSD	0772-444399		P.O.Box 17, Kiboga	
3	Central HSD	Balinda Fred	HMIS Focal Person	0782-336975	<a href="mailto:balindafred@yahoo.com">balindafred@yahoo.com</a>		
		Dr.Rukumbira Peter	Incharge HSD	0782-938729		P.O.Box 17, Kiboga	
4	Ntwetwe HSD	Sserwada Ibrahim	HMIS Focal Person	0782-286438			
		Dr. Sselebe	Incharge HSD	0772-613223		P.O.Box 17, Kiboga	
<b>Masindi</b>							
		Dr.Turyagaruka John	DHO	0782-268196	<a href="mailto:turyagaruka@yahoo.com">turyagaruka@yahoo.com</a>		
1	Masindi District	Mboine Charles	HMIS Focal Person	0772-374777	<a href="mailto:mboinecharles@yahoo.co.uk">mboinecharles@yahoo.co.uk</a>	P.O.Box 67, Masindi	
2	Kiryandongo HSD	Ocheng Vincent	HMIS Focal Person	0772-376800		P.O.Box 128, Kigumba	
3	Bujenje HSD	Tibangana Issa	HMIS Focal Person	0772-389415		P.O.Box 67, Kigumba	
		Kibuka Sholone	HMIS Focal Person	0772-362425		P.O.Box 29, Masindi	
4	Buruli HSD	Dr.Bateganya George	Incharge HSD	0772-659584			
<b>Kibaale</b>							
1	Kibaale District	Balimwijuka Edward	HMIS Focal Person	0772-554-358	<a href="mailto:ebalimwijuka@yahoo.co.uk">ebalimwijuka@yahoo.co.uk</a>	P.O.Box 2 Kibaale	

		Dr Dan Kyamanwa	DHO	0772490-345		P.O.Box 2 Kibaale	
		Mr Mugisha Justine	Bio-statistician	0772-376-558		P.O.Box 2 Kibaale	
		Mr Suleiman Ssanyu	Surveillance Focal Person	0772564-719		P.O.Box 2 Kibaale	
2	Bugangaizi HSD	Sanyu Enock	HMIS Focal Person	0772-310810			
		Tumwesige Herbert	HMIS Focal Person	0772-396109	<a href="mailto:herberttumwesigye@yahoo.com">herberttumwesigye@yahoo.com</a>		
		Dr.Olowo George	Incharge HSD	0772-574279	<a href="mailto:dr.olowj@yahoo.com">dr.olowj@yahoo.com</a>		
3	Buyaga HSD	Okello Peter	Administrator		<a href="mailto:okellopeter_8@yahoo.co.uk">okellopeter_8@yahoo.co.uk</a>	P.O.Box 4, Kagadi	Radio call
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### Annex 3: HMIS ASSESSMENT TOOL:

#### 1. Resources, Policy and Planning

Items		Highly adequate	Adequate	Present but not adequate	Not adequate at all	Rationale/ comments
		3	2	1	0	
1.1	There is a written HMIS work plan in active use addressing all HMIS components and it emphasizes integration of different data sources and is being implemented at the district/HSD level	Yes, it exists and is being implemented	The work plan exists, but the resources to implement it are not available	The Work plan exists, but it is not used or does not emphasize integration	There is no written HMIS Work plan	
1.2	There is a committee in charge of coordination of HMIS	Yes, a functional committee exists	There is a functional HMIS committee, but without resources	There is a HMIS committee, but it is not functional	No HMIS committee exists	
1.3	District/HSD Statistical Office has established coordination mechanisms (e.g. task force on health statistics)	Yes, fully operational and meets regularly	Yes, but meets only occasionally on an <i>ad hoc</i> basis	Yes in theory, but these mechanisms are not operational	No	
1.4	Is there a regular system in place for monitoring the performance of the HMIS and its various sub-systems?	Yes, it exists and is used regularly	Yes, but it is seldom applied	Yes, but never used	No	
1.5	It is an official policy to conduct regular meetings at HSD/district level to review HMIS information and take action based upon such information.	Yes, the policy exists and is being implemented	The policy exists, but there is no regularity of meetings.	The policy exists, but is not implemented	No policy exists	
1.6	There is district/HSD capacity in core health information sciences to meet health information needs (epidemiology, demography, statistics, health planning)	Highly adequate	Adequate	Partially adequate	Not adequate	

1.7	There is a functional central HMIS administrative unit in the district/HSD for design, development and support of health information collection, management, analysis, dissemination and use for planning and management	HMIS central unit is effective at coordinating, strengthening and maintaining the national HIS.	HMIS central unit is functional but lacking adequate resources	HMIS unit has very limited functional capacity and undertakes few HIS strengthening activities	There is no functioning central HMIS administrative unit in the Ministry of Health	
1.8	At District/HSD/HF are there designated full-time health information officer positions and they are filled	Yes, 100% of health offices at District/HSD/HF level have a designated, filled full time health information officer.	Yes, more than 50% half of health offices at District/HSD/HF level have a filled designated full-time health information officer position.	Less than 50% of health offices at District/HSD/HF level have a designated full-time health information officer position.	No positions	
1.9	HMIS capacity building activities have occurred over the past year <i>for HMIS staff</i> (data management, HMIS, statistics, software and database maintenance, and/or epidemiology)	Significant capacity building occurred as part of a government-driven HRD plan	Significant capacity building, but largely depending on external (e.g. donor) support and input	Limited capacity building	No	
1.10	HMIS capacity building activities have occurred over the past year <i>for health facility staff</i> (data collection, self-assessment, analysis, presentation)	Significant capacity building occurred as part of a long-term government-driven HRD plan	Significant capacity building, but largely depending on external (e.g. donor) support and input	Limited capacity building	No	

1.11	Availability of IT and database support to HMIS staff at District/HSD levels	Excellent	Adequate, usually available for occasional assistance and back-up	Limited, does not meet needs of staff for assistance and support	Not available	
1.12	Do written guidelines exist for the HMIS data collection, analysis, management and use?	Yes, written guidelines exist and are observed.	Written guidelines exist and are used, but not integrated into overall service supervision	Written guidelines exist but are not implemented/used	No guidelines exist	
1.13	Are there specific budget line items within the District/HSD budgets to provide adequately for the functioning HMIS?	Yes, there are specific budget line items within the District/HSD budgets to provide adequately for the functioning HMIS	District/HSD HMIS budget line items are limited but allow for adequate functioning of HMIS	District/HSD HMIS budget line items are limited and do not allow for adequate functioning the HMIS	There are no District/HSD HMIS budget line items and there is inadequate functioning of the HMIS.	



<b>2. HMIS Infrastructure</b>						
<b>Items</b>		<b>Highly adequate</b>	<b>Adequate</b>	<b>Present but not adequate</b>	<b>Not adequate at all</b>	<b>Rationale/ comments</b>
		<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>	
2.1	A complete list of Government, private and PNFP health facilities exists and is up-dated every year	Yes, at least 90% of all health facilities are listed. The list is updated annually.	The listing covers 50-89% of all health facilities and the listing is up to date.	Listing is out of date or covers less than 50% of all facilities	Not available	
2.2	Is there availability of HMIS forms, paper, databases, pencils, and other supplies that are needed for recording of health information?	Yes, HMIS recording forms, paper, databases and other supplies are always available for recording required health information	There are occasional "stock-outs" of recording forms, paper, databases, pencils and other supplies but it does not affect our ability to record required information	There are "stock-outs" of HMIS recording forms, paper, databases, pencils and other supplies and it affects our ability to record required information.	Health service is not able to meet reporting requirements due to lack of HMIS recording forms, paper and pencils.	
	Are computers in place at district/HSD level to ensure rapid compilation of data (PC devoted for only HMIS data management)	Yes, all HMIS managers at district/HSD levels have access to a PC	Some HMIS managers at HSD level and nearly all HMIS managers at district level have access to a PC	No, only HMIS managers at district level have access to a computer	No, all HMIS managers at both district and HSD level have no access to a computer	

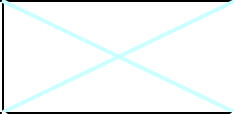
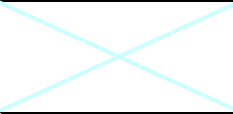
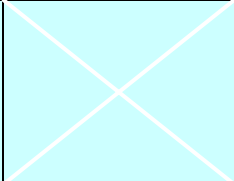
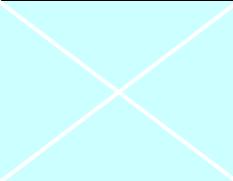
2.4	Is the basic communication technology infrastructure (telephones, internet access, e-mail) in place at district/HSD level to ensure rapid compilation of data?	Yes, the basic communication technology infrastructure is in place at district/HSD level to ensure rapid compilation of data	No the basic communication technology is not in place at all levels but we are able to ensure compilation of data as needed	The basic communication technology is not in place at the District/HSD level and it affects our ability to ensure compilation of data as needed	The basic communication technology is not in place at district/HSDI level and we are not able to compile data as needed	
2.5	Is there a reliable power source at the District/HSD level	Yes, there is a reliable power source at the district/HSD level	Power source available but not reliable	Power source available but not functional	No power source available at all	
2.6	Is there I.T. equipment maintenance support available at the district/HSD to ensure data and information reporting requirements are met and on time?	Yes, there is I.T. equipment maintenance support at district/HSD that makes possible meeting data and information reporting requirements	There is not always I.T. equipment maintenance support available but we are able to meet data and information reporting requirements.	There is not always I.T. equipment maintenance support available and it prevents us from meeting data and information reporting requirements	There is no I.T. equipment maintenance support and it affects meeting data and information reporting requirements	

<b>3. Data Management</b>						
<b>Items</b>		<b>Highly adequate</b>	<b>Adequate</b>	<b>Present but not adequate</b>	<b>Not adequate at all</b>	<b>Rationale/ comments</b>
		<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>	
3.1	There is a written set of procedures for data management including data transmission, storage, analysis, and presentation for target audiences, and these are implemented throughout the district/HSD	Yes, a written set of procedures exists including all the steps in data management and these are implemented throughout the district/HSD	Yes, a written set of data management procedures exists, but these are only partially implemented.	Yes, a written set of data management procedures exists, but these are not implemented	No written procedures exist	
3.2	The HMIS unit at District/HSD level is running an integrated “data warehouse” containing data from all data sources and on all key health programmes, and has a user-friendly reporting utility accessible to various user audiences	Yes, there is a data warehouse at district/HSD level with a user-friendly reporting utility accessible to all relevant government and NGOs.	Yes, there is a data warehouse at district/HSD level but it has a limited reporting utility	Yes, there is a data warehouse at national level but it has no reporting utility	No national data warehouse exists	

3.3	All facilities and registered health providers (public, private, PNFP) have been allocated a unique identifier code by the district to ease data management.	Yes for public, PNFP and private	Yes for public sector	Partially for public sector	no	

4. Data Sources						
Core dimensions	Items	Highly adequate	Adequate	Present but not adequate (1)	Not adequate at all (0)	Rationale/ comments
		3	2			
4.1.1 Contents	1.1 There is a health services based information system that brings together data from all public and private facilities	Yes, it covers both public and private facilities	Integrated but covers few private facilities	Covers few private facilities (e.g. only not-for-profit)	No data from private facilities	
	1.2 There is a systematic approach to evaluating the quality of services provided by health facilities. This includes both a) systematic standardized supervision with reporting of findings to HSD, district and national levels; and b) a health facility survey of all facilities or of a district representative sample at least once each 5 years.	There is both systematic standardized supervision with reporting and a district representative health facility survey	There has been at least one district representative health facility survey in the last 5 years	There is information on quality of services but only from a convenience sample of health facilities	Records of findings from structured supervision or health facility surveys are not available	
4.1.2 Capacity & practices	2.1 The health information system has a cadre of health information Assistants who have at least two years of training and are placed at the district/HSD level	At least 75% of HFs	10% to 74% of HFs	1% to 9% of HFs	Not in any HF	
	2.2 Health workers in clinics receive regular training in health information, which is either integrated into continuing education or through special workshops	Most health workers received training in the last 5 years	25% to 49% of health workers trained in the last 5 years	5% to 24% of health workers trained in the last 5 year	Less than 5% of health workers trained	

	2.3 There are mechanisms in place at district and HSD levels for supervision and feedback on information practices.	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	
	2.4 There is a mechanism in place from HFs up through district level to verify completeness and consistency of data from facilities.	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	
	2.5 There are human resources and equipment for maintaining and updating the database and maps	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	
	2.6 The district/HSD database of facilities was updated no less than:	Less than 2 years ago	2 - 3 years ago	More than 3 years ago	Do not have a national database	
	2.7 Maps are available in District/HSD showing the location of health infrastructure, health staff and key health services.	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	
	2.8 Population projections based upon census statistics are used to calculate coverage rates (e.g. for immunization) at HF level	At least 90% of HFs	50% to 89% of HFs	25% to 49% of HFs	Less than 25% of HFs	
4.1.3 Dissemination	3.1 When was the last time that an annual summary of health service statistics was published with statistics disaggregated by major administrative units?	Less than 2 years ago	2-3 years ago	4-5 years ago	6 years ago or more	
	3.2 HSDs/District compile their own monthly, and annual summary reports, disaggregated by health facility	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	

4.1.4 Integration and use	4.1 Vertical reporting systems such as those for TB and HIV/AIDS communicate well with the general health service reporting system	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	
	4.2 Managers and analysts at district and HSD levels frequently use findings from the HMIS reports, studies and surveys to assess the validity of clinic-based data.	Highly adequate	Adequate	Present, but not adequate	Not adequate at all	
	4.3 The data derived from health service records are used to estimate coverage with key services such as ANC, delivery with a skilled attendant and immunization.	Yes, always	Yes, sometimes	Occasionally	Never	
4.1.5 Inventory	5.1 Each facility reports at least annually on the inventory and status of equipment and physical infrastructure	Yes			No	
	5.2 Each facility reports at least monthly on its stock of health commodities (especially the essential drugs, vaccines, contraceptives, other supplies)	Yes			No	
	5.3 Periodicity and completeness of reporting on equipment and physical infrastructure	Complete quarterly reporting	Complete annual reporting	incomplete reporting	None	

## 5.0 Dissemination and use

5.1 Analysis and Use of Information						
Items		Highly adequate	Adequate	Present but not adequate	Not adequate at all	Rationale/ comments
		3	2	1	0	
5.1.1	There is continual demand for good quality and timely health information--for example for results/performance-based budgeting.	Yes, health information is continually demanded.	Health information is demanded on an ad-hoc basis	Health information is seldom used	None	
5.1.2	Senior managers demand complete, timely, accurate, relevant and validated HIS information	Yes	Yes, but they do not have the skills to judge	Demand from managers is ad-hoc, usually as a result of external pressure (e.g. questions from politicians or the media)	Negligible demand from managers	
5.1.3	Graphs and maps are widely used to display information at District/HSD offices	Yes	Up-to-date graphs and maps are displayed, but not understood	Some graphs and maps, but they are not up-to-date	No graphs and maps	



5.1.4	Central HMIS Unit conducts in-depth data analysis that provides answers to important questions on priority issues, identifies critical changes important for population health, prepares projections for policy and planning development	Yes, strategic planning and policy development are based on Central HMIS Unit analytic reports	Provides information but limited in-depth analysis and reports for policy development and planning	Supplies information but not on a regular or timely basis. No in-depth analysis	No Central HIS Unit or there is a Unit but it does not have this capacity	
5.1.5	HMIS data and indicators collected by any public agencies, are in principle regarded as belonging in the public domain, i.e. they should be available to all interested citizens	Public access and availability are guaranteed by law/regulations and fully implemented	Public access accepted in principle and largely implemented	Public access accepted in principle, but not implemented in practice	Access is strictly controlled	

5.2	Policy and Advocacy					
Items		Highly adequate	Adequate	Present but not adequate	Not adequate at all	Rationale/ comments
		3	2	1	0	
5.2.1	HMIS information is readily available in a written annual (or biannual) report that pulls together and analyzes critical health information from all subsystems	Yes	Report made but analysis weak	Report out of date and/or poor quality	No report	
5.2.2	Integrated HMIS summary reports covering (at least a minimum set of core indicators including MDG where relevant) are distributed regularly to all relevant parties	Regular integrated reports at least annually to district and local relevant partners	Regular integrated reports at least annually, but distributed only to MOH	Occasional reports, but not annually	No integrated reports	
5.2.3	The District/HSD "Under 5 mortality rate", "Maternal mortality rate", "Immunization rate" and "HIV prevalence" are well known among politicians and media.	Yes	Known among health-focused policy/decision makers	Known by a few "specialists" only;	No	
5.2.4	Policy and decision makers regularly use health information to evaluate performance and set policies on health.	Systematic use of HMIS information, with most accepting the HMIS information as reliable and valid.	HMIS information used frequently, but with reservations or disagreements due to concerns about validity	HMIS information used occasionally, but with clear reservations due to concerns about validity	No	

5.3	Planning & Priority Setting					
Items		Highly adequate	Adequate	Present but not adequate	Not adequate at all	Rationale/ comments
		3	2	1	0	
5.3.1	Health information (risk factors, systems, status) is demonstrably used in the planning process, e.g. for annual integrated development plans, medium-term expenditure frameworks, long-term strategic plans, and annual health sector reviews.	Yes, systematically used with methods and targets aligned between different planning frameworks	Commonly used for “diagnostic” purposes to describe health problems/challenges, but no synchronized use of HIS information between different planning frameworks	Health information is used occasionally	Never used.	
5.3.2	District/HSD health workers analyze all health statistics and compare them with national benchmarks and act accordingly	Yes,	Most health information is analyzed by district/HSD health workers and any discordant activities are adjusted accordingly.	Health statistics are analyzed and reported.	No	

5.4	Resource allocation					
Items		Highly adequate	Adequate	Present but not adequate (1)	Not adequate at all (0)	Rationale/ comments
		3	2			
5.4.1	HMIS information is widely used to set resource allocations.	The majority of targets/budget proposals are backed up by HMIS information	Some targets/budget proposals are backed up by HMIS information	Few targets/budget proposals are backed up by HMIS information	None of the targets/budget proposals are backed up by HMIS information	
5.4.2	HMIS information is widely used, by district and HSD management teams to set resource allocation in the annual budget processes	The majority of targets/budget proposals are backed up by HMIS information	Some targets/budget proposals are backed up by HMIS information	Few targets/budget proposals are backed up by HMIS information	None of the targets/budget proposals are backed up by HMIS information	
5.4.3	During the last 5 years, HMIS information has resulted in significant changes in annual budgets and/or general resource allocation	All resource allocation (budgets, staff allocations) are based on HMIS information, resulting in major shifts	Information-driven resource allocation adopted in principle, but not yet fully implemented;	Some shifts, but links to information not clear	Budgets are not information-driven	

5.5	Implementation/action					
Items		Highly adequate	Adequate	Present but not adequate	Not adequate at all	Rationale/ comments
		3	2	1	0	
5.5.1	Managers at all levels within the district/HSD use health information for local health service delivery management, planning and monitoring	Health information is used by managers at all levels for health service delivery management, planning and monitoring.	Health information is used by managers at all levels for health service delivery management, planning and monitoring.	Health Information is rarely used for management and monitoring, but no real planning done	All key decisions are centralized or HMIS information is ever used	
5.5.2	Care providers at all levels use health information for local service delivery, planning and monitoring	Health information is used by care providers at all levels for health service delivery, planning and monitoring.	Health information is used by care providers at all levels for health service delivery, planning and monitoring.	Health Information is rarely used for service delivery and monitoring, but no real planning done	Care providers other than at Distric/HSD level do not use health information for service delivery, planning and monitoring	

