

WORKING PAPER

Strengthening Tanzania's Routine Health Information System

Incorporating Family Planning Quality Assessment Indicators

November 2018



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ABBREVIATIONS

CHMT	council health management team
CPR	contraceptive prevalence rate
DMO	district medical officer
FGD	focus group discussion
FP	family planning
KII	key informant interview
LGA	local government authority
MOH	Ministry of Health
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MOHSW	Ministry of Health and Social Welfare
NBS	National Bureau of Statistics
NGO	nongovernmental organization
QII	questionnaire individual interview
RHIS	routine health information system
SDG	Sustainable Development Goal
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Background: Universal access to family planning (FP) services significantly improves maternal health outcomes by ensuring that those who need but cannot access FP services, most of whom are poor and marginalized women, will receive them. In Tanzania's Lake Zone area, even with the increase of FP interventions by the public and nongovernmental organization (NGO) sectors, there are great disparities in FP outreach between urban and rural areas. The team explored the benefits of incorporating FP quality assessment indicators in a decentralized routine health information system (RHIS) in rural districts in the Lake Zone. The overall question was, what are the benefits of incorporating indicators related to FP quality assessment in a decentralized RHIS in rural farming districts around Lake Victoria?

Methods: The study was conducted in Magu District, Mwanza Region, using mixed methods. The study collected quantitative and qualitative data through questionnaire-guided individual interviews (QIIs), key informant interviews (KIIs), and focus group discussions (FGDs). Data sets from primary and secondary sources were analyzed to demonstrate the potential for integration of FP indicators in the RHIS and DHIS 2, the district's software platform for health information.

Findings: Most respondents (66%) considered RHIS to be a highly effective resource in decision making for improving FP services; 28 percent asserted that RHIS was a moderately effective tool. About a quarter (24%) of all respondents mentioned the absence and inadequacy of FP-related services at health facilities and the low demand for and uptake of FP at health facilities as a constraint to assessing the quality of FP services in an RHIS. Respondents mentioned low data literacy among service providers assigned to the RHIS (22%), delays in data transmission to the RHIS (16%), and inadequate financial and human resources for providing comprehensive FP services (14%) as critical gaps in the ability of the current RHIS to assess the quality of FP services. Close to half (40%) of the respondents asserted that incorporating FP quality assessment indicators in the RHIS would trigger use of FP.

Although the RHIS-DHIS 2 infrastructure has been established in Magu District, evidence of the system's functionality is limited, as exhibited by the gaps we identified in the completeness, timeliness, representation, and accuracy of the data captured in the system. The lack of FP-related services and commodities at health facilities limits the information system's effectiveness. Limited training opportunities were mentioned as causes of low data literacy among service providers, while inadequate financial and human resource for providing comprehensive FP services hinders the effectiveness of the RHIS.

Most facility-based service providers and community health workers affirmed that incorporating explicit assessment indicators of FP quality in routine data collection would likely stimulate demand at the facility level and trigger local government action through council health management teams (CHMTs) regarding human and financial resources as well as technical materials.

Recommendations: The information system needs review to incorporate explicit and stand-alone indicators for capturing FP patterns and trends that can be presented to a CHMT without additional technical analysis. To improve FP uptake, health service providers and community health workers should be incentivized, particularly with periodic in-service trainings to upgrade knowledge and skills. There is a need to explore and invest in technology options for data transmission that are appropriate and cost-effective for rural settings. Guaranteeing a steady supply of FP commodities and appropriate counseling space would motivate and engage

clients effectively, ensuring health facility readiness. CHMTs should receive regular trainings to enhance evidence-based decision making and focus on outcomes.

Conclusion: The ministry emphasis on strengthening the RHIS by incorporating explicit and stand-alone FP quality assessment indicators at the health facility level seeks to promote health system accountability within a decentralized governance system. Despite the heterogeneity and challenges of technology and infrastructure, local government authorities have opportunities to improve the basic determinants of an effective RHIS that can inform the DHIS 2 in a timely and accurate manner.

INTRODUCTION

Poverty reduction remains central in the global development agenda through the Sustainable Development Goals (SDGs) adopted by the United Nations, with health recognized as a crucial determinant. A healthy community is one in which a diverse group of stakeholders collaborate to use their expertise and local knowledge to create an environment that is socially and physically conducive to good health. The community has the capacity to identify, address, and evaluate its own health concerns on an ongoing basis, using data to guide efforts (Institute of Medicine, 2015). The SDG3 Target 3.7 is: “By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health in national strategies and programs (United Nations, A/RES/70/1, 2015).” Adapting SDG targets to a national context requires systematic reviews of the existing health policy landscape and how government commitments are translated into subnational and local plans.

A strong health information system that produces reliable, timely, and good-quality data is critical for enabling health program managers and institutions to monitor, improve, and review health system performance and make evidence-informed decisions. The Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDCGECH) generates volumes of data from its RHIS, which feed into DHIS 2 and subsequently into the national health information system.

The RHIS in Tanzania is structured to capture data on disease, fertility, morbidity, mortality, and outbreaks. Routine health indicators are presented in three categories: health status indicators, health service indicators, and resource indicators. These indicators capture core facility-based data, community-based data, and disease surveillance data. FP is an important component of a health facility service package. FP data sets provide quantitative assessments of generic variables including number of health workers trained by FP method, percentage of facilities providing FP by method, number of FP clients seen by method, number of FP clients by zone, percentage of facilities with stockouts by FP method, and percentage of clients adopting FP after spontaneous or induced abortion. Under the health services indicator category, the only indicator related to FP is contraceptive prevalence rate (CPR). Under the health status category, none of the indicators relates to FP.

The health information system is intended to reduce fragmentation by enhancing data accuracy and facilitating decision making based on trends in health outcomes, including FP. But the presentation of progress using quantitative assessment indicators fails to attract the immediate attention of service providers and decision makers, because of its numerical complexity and a lack of detail on qualitative variables. Consequently, the absence of qualitative assessment indicators limits the usefulness of the data sets.

This gap implies that the collection, reporting, and use of FP-relevant data within the RHIS do not effectively inform resource allocation for delivery and use of FP services. Presenting patterns and trends through qualitative indicators has the advantage of showing directly observable progress on FP-related services with resonance to clients and service providers. This study suggests that a rigorous and comprehensive RHIS-DHIS framework with both qualitative and quantitative FP indicators simplifies the interpretation, ultimately influencing interventions among service providers and decision makers within the local government system. Consequently, the country can substantially benefit from the cumulative visibility of FP service quality improvement in population health and broader sustainable development.

There is robust evidence that strategic interventions leading to universal access to sexual and reproductive health services, including FP services, would significantly improve maternal health outcomes by ensuring that

those who need but cannot access FP services, most of whom are poor and marginalized women, will receive them (Ministry of Health and Social Welfare (MOHSW) [Tanzania Mainland], Ministry of Health (MOH) [Zanzibar], National Bureau of Statistics [NBS], Office of the Chief Government Statistician, & ICF International, 2015).

In Tanzania, high unmet need for FP among married women (25%) and a continuing high rate of population growth (currently estimated at 2.7%) present major challenges to social and economic development. While the CPR improved significantly between 2004 and 2010 from 20 to 27 percent (NBS/Tanzania & ORC Macro, 2004; NBS & ICF Macro, 2010), progress has slowed in recent years (National Family Planning Technical Working Group, 2016). A key objective of the Government of Tanzania's Family Planning 2020 (FP2020) commitments is "to implement new strategies to address regional disparities in family planning coverage as well as inequalities in access to family planning" (United Republic of Tanzania, MOHSW, 2013). The assumption is that governance and health sector reforms to decentralize the health sector will expand space for local autonomy and problem solving, but conditions for real-time transformation need to be explored. Further, it is acknowledged that data are increasingly becoming an important tool for decision making in all sectors, including healthcare.

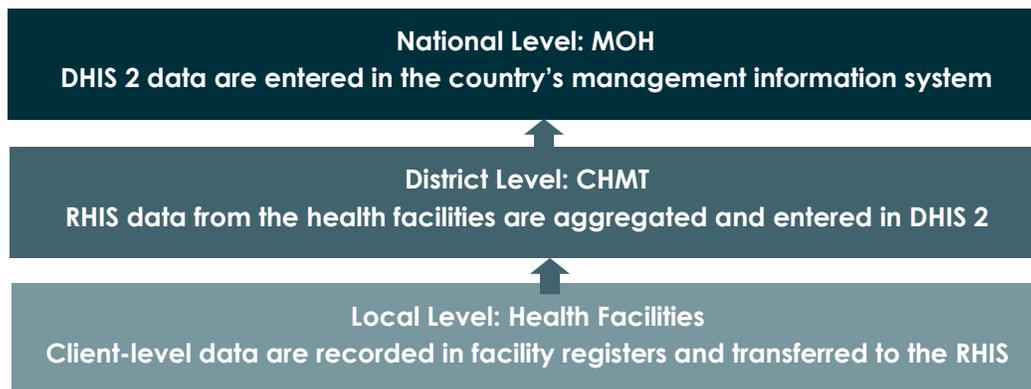
In Tanzania's decentralized health system, even with the increase of FP interventions by the public and NGO sectors, there are great disparities in meeting the needs of urban and rural areas. Currently, the RHIS and DHIS 2 are used to capture prevalence and trends through mainly quantitative indicators that are generically linked to health status, health services, and resources without referring to specific service-user-based outcomes such as attitude toward contraception and FP-related care.

This study explored the benefit of incorporating FP quality assessment indicators in a decentralized RHIS in rural districts in Tanzania's Lake Zone.

Dataflow in Tanzania's Decentralized Health System

In the United Republic of Tanzania, the health data information flow from public facilities is mainly from the bottom up, with data generated at health facilities then transmitted via the compilation processes to the district and national levels. Health facilities transfer data from their facility registers to the RHIS. These data sets are compiled and transmitted to the DHIS 2 at the council level. Under the direction of the office of the district medical officer (DMO), council-level data are summarized and analyzed to inform decision making within the CHMT and advise the local government authority (LGA). The aggregated data are relayed to the MOHCDGEC's management information system.

Figure 1. Conceptual dataflow in Tanzania's decentralized health system



Under the supervision of LGAs and with technical support from the MOHCDGEC, CHMTs were established to provide leadership using a factored approach to quality improvement. Their role is to promote the allocation of sufficient resources and improve working conditions for health workers. The DMO leads the CHMT and is a key player in planning, coordinating, and implementing the delivery of health services at the local level. The CHMTs create opportunities to strengthen health governance by using data from DHIS 2 for contextual decision-making and resource allocation, yet rural areas continue to be underserved and poorly assessed. This situation raises concerns about the effectiveness of decentralized health information systems in contributing to competent local health systems with potential to drive comprehensive health outcomes that include FP.

Comprehensive data systems contribute to effective evidence-based decision making. Resource allocation for FP within decentralized governance relies on illustrations based on assessment indicator sets. It would be valuable to expand the indicator sets to include qualitative assessment indicators in the RHIS at the facility level, and correspondingly in DHIS, to facilitate effective decision making and resource allocation at the LGA level.

Research Questions

The study answered the following research questions:

Primary Question:

What is the benefit of incorporating indicators related to FP quality assessment in a decentralized RHIS in rural farming districts around Lake Victoria?

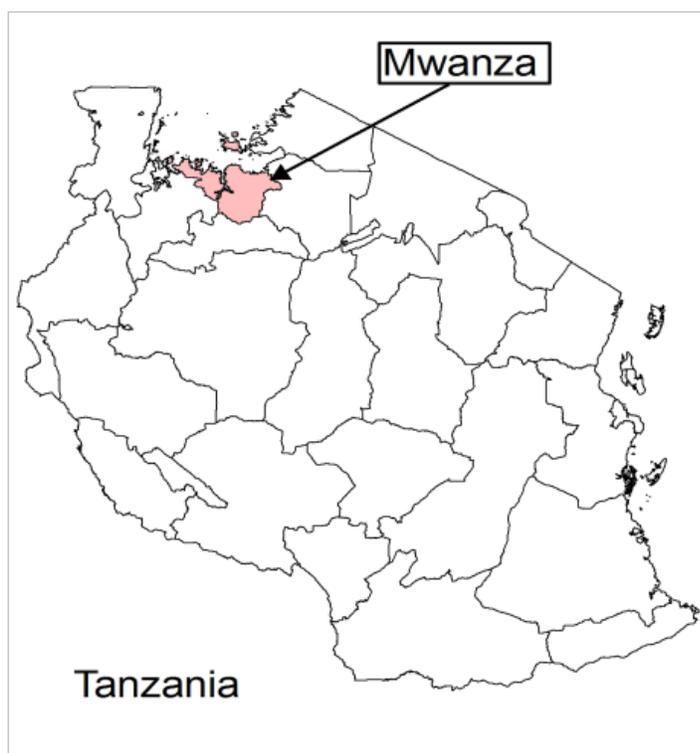
Secondary Questions:

1. What is the perceived effectiveness of RHIS to be a key resource in decision making for improving FP services?
2. What are the gaps in the current RHIS in assessing the quality of FP services?
3. What is the benefit of incorporating FP quality assessment indicators in the RHIS?
4. What are the incentives for incorporating FP quality assessment indicators in the RHIS?

METHODS

The study was conducted in the administrative district of Magu, Mwanza Region, in the Lake Victoria zone of Tanzania. There are 38 public health facilities in the district. Twenty-three public health facilities (about 61%) were purposefully selected to participate in the study. At each facility selected, primary data collection targeted two stakeholder categories: service providers and health administrators. The key criteria for inclusion were availability of staff and an operational RHIS linked to DHIS 2. The study was conducted using mixed methods, combining both quantitative and qualitative methods.

Figure 2. Study site, Magu District in Mwanza Region



A review of secondary information was conducted covering the following documents:

- Guidelines on indicators within the existing RHIS and DHIS 2
- Recommended FP service and care indicators
- Most recent national Demographic and Health Surveys
- MOHCDGEC guidance documents on DHIS 2 and RHIS
- Reports of public and private FP interventions in Magu District
- Reports from the district health information coordinator, DMO, and CHMT

Primary data were collected from the following sources:

- Quantitative data were obtained through QIIs with 30 facility-based health service providers and 20 community health workers.
- Qualitative data on the current operationalization of the RHIS and DHIS 2 to inform decision making at the district level were collected to understand the effectiveness of and gaps in the RHIS and DHIS 2. This information was gathered through KIIs with the DMO, district health information coordinator, members of the CHMT, program staff of civil society organizations implementing FP interventions, private health facility staff, and private pharmacy staff.
- Qualitative data on views of the link between the current RHIS and DHIS 2 and FP were collected through FGDs with public facility-based health service providers and community health workers. Four FGDs were conducted involving 40 health workers. Two groups of health facility workers with 10 participants each and two groups of community health workers with 10 participants each participated in the focus groups. Focus group participants were from the same groups of health workers who participated in the QIIs.

Table 1. Study participants

Participant Group	Data Source	Number
Health service providers	QII	30
Community health workers	QII	20
DMO	KII	1
District health information coordinator	KII	1
CHMT members	KII	4
Staff of civil society organizations with FP interventions	KII	2
Private pharmacy staff	KII	2
Private health facility staff	KII	2
Health service providers	FGD	20
Community health workers	FGD	20
Total		102

Data Analysis

Coded quantitative data from structured interviews were analyzed using Statistical Package for Social Scientists (SPSS). Descriptive qualitative data from FGDs and KIIs were used to explain relationships across variables and triangulation of data. We analyzed and triangulated the data across data sets from both primary and secondary sources to illustrate the potential for integration of FP indicators in the RHIS and DHIS 2.

Ethical Clearance

The Lake Zone Institutional Review Board at the National Institute for Medical Research granted ethical clearance for the study. The study team was oriented on health research ethics and good practices. Each study participant provided written consent prior to individual interviews and FGDs.

RESULTS

Characteristics of Study Participants

Among the health workers interviewed, there were more males than females (56% versus 44%). The oldest respondent in the structured interviews was 67 years old while the youngest was 25 years old.

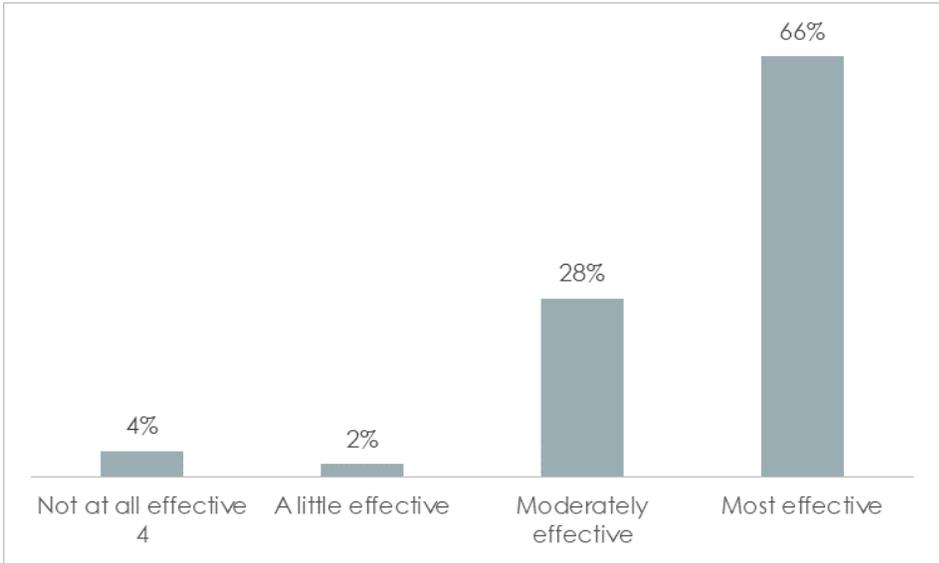
Perceived Effectiveness of RHIS as a Key Resource in FP Decision Making

Health facility workers and community health workers were asked to provide opinions on the perceived effectiveness of RHIS being a key resource in decision making for improving FP services. The majority (66%) of respondents considered RHIS to be a highly effective resource in decision making for improving FP services while over a quarter (28%) of the respondents asserted that RHIS was a moderately effective tool. Only one respondent indicated that RHIS provided little effectiveness and two respondents were completely opposed to the majority, stressing that RHIS is not an effective resource in decision making for improving FP services (Figure 3). The perceived effectiveness of RHIS as a key resource in decision making for improving FP services was further confirmed during KIIs and IDIs.

RHIS is a very important tool to us in CHMT. We depend on it to make important decisions to improve health services in terms of understanding demand and resources allocation. —Male CHMT member, 40 years old

The CHMT heavily depends on RHIS-DHIS 2 data to make important health services decision including FP.—Female health facility worker, 30 years old

Figure 3. Perceived effectiveness of RHIS



Gaps in the RHIS in Assessing Quality of FP Services

An equal number of facility-based service providers and community health workers (24%) identified one of the gaps to be the absence or inadequacy of FP-related services and the low demand for and uptake of FP at health facilities. They explained that this is due to the communities served by the facilities having limited awareness of FP services and commodities available, the benefits of FP, and the potential side effects.

*We normally receive few clients coming for FP services at this facility because of the local beliefs circulating among clients that FP services have negative health impacts, particularly among first users. It is widely believed that first users face problems such as continuous bleeding during menstrual period and a possibility of giving birth to a disabled child.—*Female community health worker, 39 years old

Almost the same percentage of respondents (22%) indicated that low data literacy among service providers assigned to the RHIS was a crucial gap.

*There is overall shortage of trained service providers who can effectively make the information system work. For example, there is only one trained service provider who can effectively interact with the RHIS at this facility.—*Female health facility worker, 42 years old

A minority of respondents (16%) reported delays in transmission of data to the RHIS.

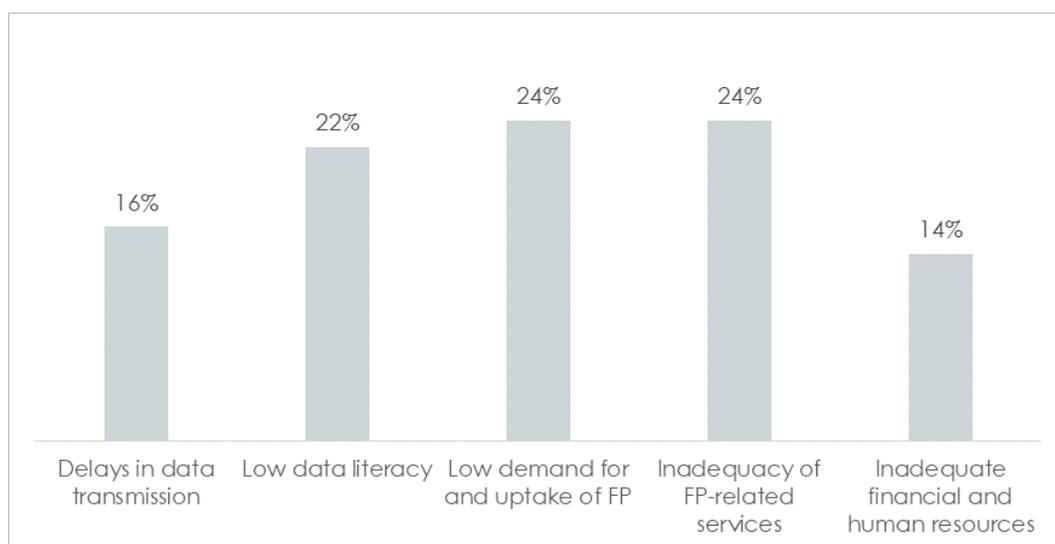
*There are always delays in entry of data into RHIS by health service providers at health facility level.—*Female health facility worker, 39 years old

A relatively similar minority (14%) mentioned inadequate financial and human resources for providing comprehensive FP services as critical gaps in the current RHIS in assessing quality of FP services. These gaps were also confirmed by the qualitative part of the study.

*Unavailability of FP-related services and commodities at health facility level (such as permanent methods) and absence of service providers trained on such methods are a major concern.—*Male community health worker, 36 years old

*There is no privacy for FP service delivery to clients at this health facility, a factor that limits the popularization of such services. In addition, the lack computers and printed forms for data entry limit our FP related input into the RHIS.—*Female health facility worker, 50 years old

Figure 4. Gaps in the current RHIS



The Benefit of Incorporating FP Quality Assessment Indicators in the RHIS

Close to half of the health workers (40%) asserted that joint health services planning is necessary at the LGA level to determine strategies for meeting FP demands. They further indicated their belief that incorporating FP quality assessment indicators in the RHIS triggers the use of FP data and subsequently improves uptake of FP services.

Incorporating FP indicators into the RHIS will increase visibility of [and] demand for FP services that will lead to improvement and effective delivery of FP services at facility level and prioritization at district level.—Female health worker, 51 years old

Incorporating FP indicators will lead to increase FP use by ensuring availability of quality FP services, hence attracting more clients.—Female community health worker, 45 years old

This will increase FP use from health service providers educating the community about FP services.—Female health worker, 30 years old

A minority of respondents (20%) said improved decision making for prioritization and allocation of FP resources in the local government depends on the comprehensiveness of the RHIS. Fewer respondents (18%) indicated the need for strengthening service providers' competence to integrate FP in routine service provision.

Incorporating FP indicators will lead to increased competence and commitments among health service providers in delivering FP services.—Male community health worker, 54 years old

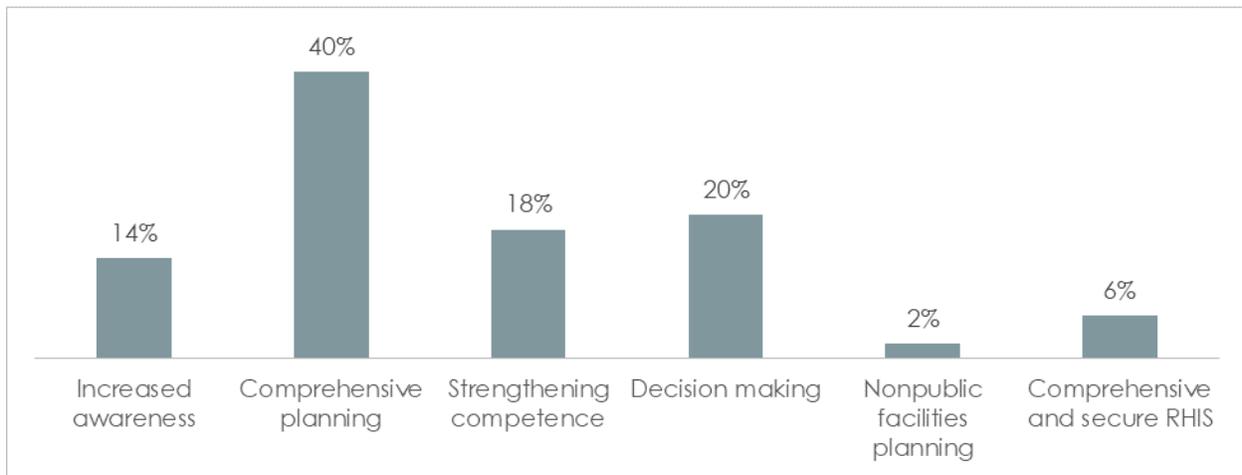
Some respondents (14%) also indicated that the incorporation of FP quality assessment indicators would lead to a notable increase in awareness of FP services among clients at the facility level.

When responding on the benefit of FP quality indicators, a small minority (6%) reported that a comprehensive and secure RHIS should include FP indicators assessing quality of care. Only one respondent indicated that

including FP indicators would enable CHMT to engage nonpublic service providers in planning for complimentary health services that integrate FP. This perspective is described by responses from the qualitative component of the study, as narrated by a community health worker.

Incorporating FP indicators into routine health information system will lead to secured data which can be used by CHMT to mobilize nonpublic service providers to plan for comprehensive and complimentary health services that are inclusive of FP.—Female community health worker, 47 years old

Figure 5. Benefits of incorporating FP quality assessment indicators in the RHIS



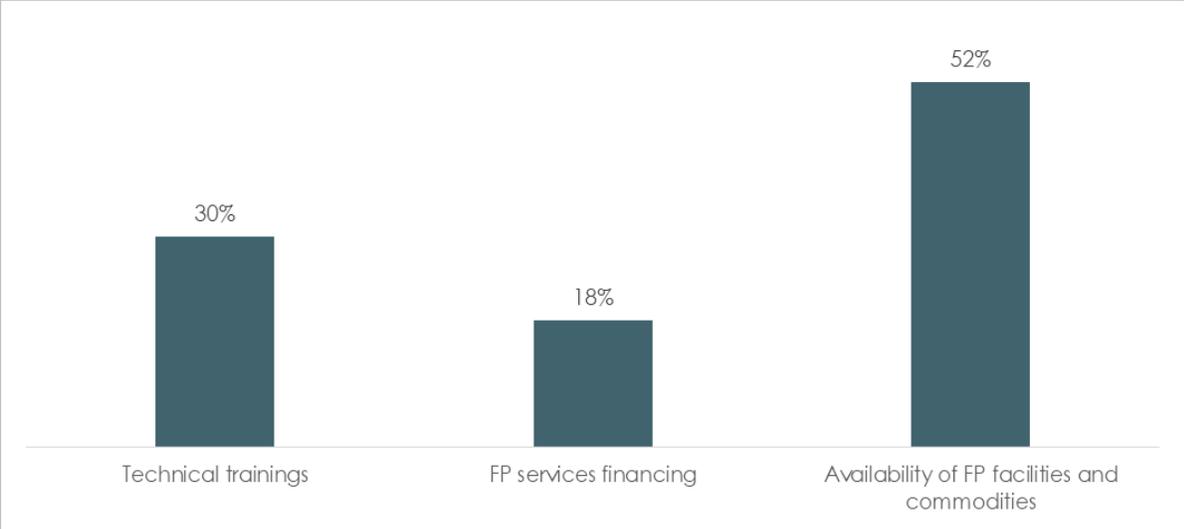
Incentives for Incorporating FP Quality Assessment Indicators in the RHIS

About half (52%) of the combined health workers identified the availability of FP services at facilities as a priority incentive for incorporating FP quality assessment in the RHIS. Almost one-third (30%) identified technical trainings for FP service providers to be the most-recommended incentive while a minority of respondents (18%) mentioned results-based financing to be the most-recommended incentive for incorporating FP quality assessment indicators in the RHIS.

Training of FP service providers is important in building their capacity and keeping them updated with new techniques of delivery. . . Currently, most service providers fail to demonstrate effective skills and knowledge in delivering FP services.—Male community health worker, 54 years old

I think the availability of all resources necessary for FP services in terms of human, financial resources and equipment.—Female frontline health worker, 50 years old

Figure 6. Incentives for incorporating FP quality assessment indicators in the RHIS



DISCUSSION

Despite the combined assertions of most facility- and community-based health workers acknowledging the effectiveness of RHIS as a key resource in decision making, the functionality of the system suffers due to delays in data transmission, low data literacy, low demand for and uptake of FP, shortage of FP-related services, and inadequate financial and human resources to fully support the system.

The absence or inadequacy of FP-related services at some health facilities evidently limits the inputs and usefulness of the information system. In turn, social marketing is impaired when service provision cannot deliver on what is being promoted. Lack of method choice and patient privacy are typical examples of shortcomings in FP services. Many FP-related commodities and services, such as permanent methods, are not readily available at most health facilities. The assurance of auditory and physical privacy, a key component in quality of FP care, is often neglected due to the absence of privacy rooms for FP counseling and services in the majority of health facilities. Inadequate record-keeping materials, including computers, compromise data collection and limit the storage and analysis of data sets that would identify limitations of RHIS as a basis for promoting FP services.

In exploring the gaps in the current RHIS, the findings indicate that low awareness and knowledge of voluntary FP methods among clients visiting facilities contribute to low demand for and uptake of FP services. Myths and misconceptions about FP among potential clients and users are built into a local belief system that questions the benefits of the methods, even suggesting that using FP can lead to disabled children and bleeding profusely during menstrual periods.

Limited training opportunities were mentioned as a cause of low data literacy among service providers. All health workers reported a lack of refresher trainings on FP services and routine management of data. The majority of health service providers are operating without updated knowledge and skills, which undermines quality of care. This affects not only the quality of FP service provision, but also data quality and the ability of health providers, managers, and administrators to understand the RHIS, analyze the data, and track trends and gaps in information.

Inadequate financial and human resources for providing comprehensive FP services limit the effectiveness of the RHIS in assessing the quality of FP services. Budgets for information management are unpredictable, hugely limiting the consistency of planning and delivering necessary FP services at health facilities. The absence of permanent FP methods and commodities can be attributed to a lack of financial resources from the local government. Staff shortages affect the quality of care provided and the quality of data collected and transmitted. On average, a lone health service provider with basic competence in FP service delivery is stationed at each health facility. The provider is burdened with many responsibilities and often pays little attention to data collection.

Delays in data being transmitted to the RHIS are caused by most health facilities lacking computers equipped with appropriate applications for data capture and reporting. Those responsible for data management at these facilities must travel to other health facilities with access to the RHIS or go directly to the district hospital at the end of every month for data entry. Frequent network failure also contributes to delays in data transmission.

This study found that incorporating FP quality assessment indicators in the RHIS could benefit communities by increasing FP use. Most service providers and community health workers affirmed that tracking attitudes

toward FP, availability of commodities, and quality of FP care-related services such as pregnancy risk assessment and counseling—key FP indicators not currently computed in the RHIS—would stimulate demand at the facility level by providing more information to FP providers and potential FP clients on the availability of specific services and commodities. Trends in FP uptake provided through such stand-alone quality indicators would also trigger local government action through CHMTs. The data could inform allocation of human and financial resources, enable service providers to effectively track stockouts, and broaden the choice of FP methods available to clients.

LIMITATIONS

One limitation to this study was that the sampling was purposive, excluding facilities operating without access to the RHIS, and therefore missed the opportunity for rigorous comparison. Secondly, this study was conducted in a rural limited-resource setting, so the findings may not be generalizable to urban settings or relatively better resourced areas.

RECOMMENDATIONS

Effective dataflow from the facility-level RHIS to DHIS 2, with subsequent data analysis, provides a strong basis for evidence-based decision making and health sector resource allocation in LGAs. Given the global push to accelerate progress toward universal health coverage, strengthening data systems remains critical in reconciling demand and supply of services at scale, including FP-related services.

Despite the infrastructural challenges in rural settings, this study recommends the following actions:

1. Consider incorporating explicit and stand-alone FP quality assessment indicators in the RHIS, particularly attitude toward contraception and FP and quality of FP-related care. The addition of such indicators will greatly contribute to strengthening the tracking of quality. Ultimately, reinforcing improvements in the quality of FP services will increase demand for and uptake of FP.
2. Incentivize health workers by providing in-service trainings. The huge potential for facility-based service providers who work hand-in-hand with community health workers in increasing access to voluntary FP should be harnessed by providing incentives, particularly periodic upgrading of knowledge and skills. Further, results-based incentives for practitioners are likely to stimulate community outreach for FP, particularly in rural settings where health facilities are major sources of information and services.
3. Explore and invest in technology options for data collection and transmission. Data infrastructure and technology are key constraints in data transmission between the RHIS and DHIS 2. Appropriate and cost-effective investments should be made in this area without falling below the standards established by the national health management information system.
4. Strengthen collaborations for FP services delivery with private health service facilities, pharmacies, and NGOs. Health governance structures in LGAs need to facilitate and prioritize collaboration with all sectors of health delivery through community-based interventions. This entails integrating plans and approaches to increase the delivery of information, build knowledge, and ensure delivery of high-quality FP services.
5. Ensure health facility readiness by guaranteeing a steady supply of FP commodities and counseling space at health facilities to motivate and engage FP clients effectively.
6. Provide regular, competence-based training on the RHIS. Accelerating the adoption of innovations and recommendations for improving the RHIS depends on the commitment of health governance structures in local government, particularly the CHMT. Regular trainings and promoting self-assessment of the CHMT on the RHIS-DHIS platform should be considered to enhance evidence-based decision making and focus on outcomes.

CONCLUSION

Increasing the attention of FP service providers to quality of care and including metrics for quality in a health information system can drive meaningful changes toward improvements in the local health system and consequently influence resource allocation. Gaps in quality assessment indicators limit local governments' ability to use the RHIS as a basis for prioritizing FP as a core poverty-reduction strategy. Interpreting data from the RHIS to DHIS 2 requires a clear and easily understood visual presentation of patterns and trends using stand-alone quantitative and qualitative indicators. Incorporating explicit FP quality assessment indicators will contribute to an effective health information platform that links RHIS and DHIS 2 through direct visualization and provides direct evidence for action and accountability within a decentralized governance system.

Recommendations from this study can contribute to a more comprehensive RHIS that demonstrates the crucial role and benefits of FP in health outcomes and broader development objectives.

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