

RHIS Profile:

This document outlines the reporting structures of the routine health information systems (RHIS) that include malaria data. In Mozambique, this includes the Mozambique National Health Information System for M&E (SIS–MA), a reporting platform (but also commonly used as a term for the health management and monthly reporting system) and the integrated disease surveillance and response system, the Boletim Epidemiológico Semanal (BES), known in English as the Weekly Epidemic Bulletin. SIS–MA was first introduced into the National Health Service in June 2016 as the main source of health information, replacing the Módulo Básico. Since June 2016, DHIS 2 houses the SIS–MA, BES, and monthly reporting of WHO and Global Fund malaria indicators collected at public health facilities and communities. The SIS–MA also allows the integration of pilot systems based on mobile phones or tablets.

	SIS-MA	BES
	<p>When Started: March 2015</p> <p>Scale-up status: National</p>	<p>When Started: 1990; malaria added as a disease of obligatory notification in 2006.</p> <p>Scale-up status: National</p>
National	<p>Reporting format/platform: DHIS2</p> <p>Managed by: Ministry of Health (MOH) Department of Health Information (DIS)</p> <p>Dissemination: NMCP and Directorate of Planning & Cooperation (M&E Department)</p> <p>Key tasks: Coordination, data analysis, decision making, and planning. Quarterly DQAs using 2 key indicators.</p>	<p>Reporting format/platform: DHIS2 DHIS2 (integrated into SIS–MA)</p> <p>Managed by: Ministry of Health (MOH) Department of Epidemiology</p> <p>Dissemination: NMCP and Directorate of Planning & Cooperation (plus all other Programs)</p> <p>Key tasks: Coordination, data analysis, decision making, and planning. Quarterly DQAs using 2 key indicators.</p>
<p>Subnational 1 Selected region type: Provincial</p> <p>Number of regions: 11 provinces</p> <p>Average (or range) number of districts per region: 7-23 districts per province</p>	<p>Reporting format/platform: DHIS2</p> <p>Managed by: Provincial DIS</p> <p>Reported to: Provincial managers and national Department of Provincial Planning & Cooperation.</p> <p>Reporting frequency: monthly</p> <p>Reporting frequency (details): day 10 in all months</p>	<p>Reporting format/platform: DHIS2</p> <p>Managed by: Epidemiology focal point</p> <p>Reported to: Provincial managers, national DIS, and Epidemiological Surveillance Focal Point.</p> <p>Reporting frequency: Weekly</p> <p>Reporting frequency (details): Weekly on Fridays</p> <p>Key tasks:</p>

	<p>Key tasks: M&E and DQA activities on all health facilities each quarter</p>	<p>M&E and DQA activities on all health facilities each quarter</p>
<p>Subnational 2 Selected district type: District</p> <p>Number of districts: 159 districts (53 municipalities)</p> <p>Average (or range) number of facilities or other sub-unit per district: Average of 10 facilities per district</p>	<p>Reporting format/platform: DHIS2</p> <p>Managed by: District Health Statistics Unit. Data entry by Malaria Focal Person</p> <p>Reported to: District managers and DIS</p> <p>Reporting frequency: Monthly</p> <p>Reporting frequency (details): Monthly by 15th</p> <p>Key tasks: Transfer data from paper forms to web-based platform, where it is available to all subsequent levels. Summarize data to generate district report.</p>	<p>Reporting format/platform: DHIS2</p> <p>Managed by: District Epidemiological Surveillance Focal Point</p> <p>Reported to: Epidemiologic Surveillance Office (Vigilancia epidemiologica)</p> <p>Reporting frequency: Weekly</p> <p>Reporting frequency (details): Weekly on Fridays</p> <p>Key tasks: Transfer data from paper forms to web-based platform.</p>
<p>Facility Level</p>	<p>Reporting format/platform: Paper forms</p> <p>Community reporting format:</p> <p>Managed by: Health workers or managers, Community Health Workers (CHW)</p> <p>Community managed by:</p> <p>Reported to: District Statistical Focal Point at District health office</p> <p>Reporting frequency: Monthly</p> <p>Reporting frequency (details): Monthly by 25th, covering 20th of last month to 20th of current month</p> <p>Key tasks: Data collection, aggregation, and transmission, and feedback to CHWs during monthly meetings. Some facilities have support for verification and analysis.</p>	<p>Reporting format/platform: Paper forms</p> <p>Community reporting format:</p> <p>Managed by: Health workers or managers, CHW</p> <p>Community managed by:</p> <p>Reported to: District Epidemiological Surveillance Focal Point and District Statistical Focal Point</p> <p>Reporting frequency: Weekly</p> <p>Reporting frequency (details): Weekly on Tuesdays</p> <p>Key tasks: Data collection, aggregation, and transmission, and feedback to CHWs during monthly meetings. Some facilities have support for verification and analysis.</p>

*Private facility reporting is minimal and mostly comes from Maputo and nearby sites. Private facilities cannot be disaggregated in the system.

Table 1: Key Malaria Indicators by System: Indicate Y or N for each reporting element captured by the system.

Number of malaria cases		SIS-MA	BES
Suspect or Fever		N	N
Tested (diagnostically)		Y	N
Diagnostically confirmed (positive)		Y	Y
Clinical or presumed or unconfirmed		Y	N
Outpatient		Y	N
Inpatient		Y	N
Uncomplicated		Y	N
Severe		Y	N
Age categories (e.g., <5, 5+)		Y	Y
Sex disaggregation (M, F)		N	N
Pregnant women		Y	N
Number of malaria deaths			
Age categories (e.g., <5, 5+)		Y	Y
Sex disaggregation (M, F)		N	N
Pregnant women		N	N
Commodities - Availability or Stock Out			
RDT		Y	N
ACT		Y	N
Severe Malaria Treatment <i>Severe malaria treatment could include injectable artemether, artesunate, or quinine.</i>		N	N
SP		Y	N
Commodities - Consumption			
RDT		N	N
ACT		N	N
Severe Malaria Treatment <i>Severe malaria treatment could include injectable artemether, artesunate, or quinine.</i>		N	N
SP		N	N
IPTp Doses			
1 dose		N	N
2 doses		Y	N

3 or more doses	Y	N
Completeness of reporting	Y	Y
Note	Age disaggregation for hospital inpatient data only for number of malaria deaths. SIS–MA reports on IPTp2 and IPTp4+.	

Data Quality Activities:

Routine data quality reviews/audits:

Data quality checks are not performed routinely, and there is no feedback to data collectors or specific outputs for data analysis performed routinely within and outside SIS–MA. Apart from training staff to prevent and detect data quality errors, DIS is advocating and using the RDQA tool, but its use is not uniform. NMCP’s M&E manual outlines data quality checks through assessment of data reporting and case detection and data verification. Every district should complete a monthly data quality verification, but this is compromised by the dependency of supportive supervision on health partner funds rather than government funds; this dependency was exacerbated by the economic crisis in 2016. SIS–MA has built-in checks to minimize data quality errors, which is expected to help improve the current situation.

Malaria Score Cards:

NMCP publishes quarterly, semiannual, and annual score cards (progress reports). MOH sporadically publishes an epidemiological bulletin, which includes malaria cases and deaths at: <http://www.misau.gov.mz/index.php/boletins-epidemiologicos>.

Data availability:

NMCP at the national level has access to data from all described systems and uses it for reports and planning purposes.

Data use:

Provincial NMCP managers analyze and include routine data regularly for presentations. Malaria data is rarely analyzed at sub-provincial levels. Staff from these levels should be able to organize, summarize, and display data in tables and graphs, but this is mostly done with partner support due to limited finances and time. District and provincial officers should be able to electronically manage surveillance data.

Additional Context:

–Mozambique has 3,298 health facilities, 1,625 of which are public and 1,993 of which are private. As of 2018, Mozambique had 2,263 Official CHWs. WHO’s 2018 Service Availability and Readiness Assessment (SARA) for Mozambique visited 1,643 of the public facilities, accounting for 1,575 primary level facilities (health posts and health centers), 54 secondary level facilities (district and rural hospitals), 7 tertiary level facilities (provincial hospitals) and 7 quaternary level facilities (central hospitals).

–Since the introduction of SIS–MA (DHIS2) in Mozambique as the main source of the health information system in June 2016. In 2019 Malaria Consortium and the Clinton Health Access Initiative (CHAI) conducted assessments of the RHIS. Moreover, NMCP has in place all necessary guiding tools such as strategic plan and policy, M&E plan, and the M&E manual. In addition, NMCP is rolling out an integrated Malaria Information Storage system (iMISS).

–Apart from SIS–MA and BES, there are a number of activity reporting subsystems that feed into the NMCP’s M&E system, including IRS monitoring, LLIN monitoring, lab information systems, CHW program, entomology, MCH information system, and LMIS. Many of these sub-systems are ad hoc without clear tools and standard reporting procedures.

–Major challenge is the ability of SIS–MA to integrate the multiple malaria activity reporting systems.

–Principal partners, donors, stakeholders involved: Bilateral/Multilateral —>GFATM, PMI, WHO, CHAI, Gates Foundation; NGOs—>World Vision, PSM (Chemonics), IMaP (Chemonics), Vector Link (Abt Associates), Malaria Consortium, FDC, Food for Hungry, PIRCOM, Network of Journalists Against Malaria, Good Bye Malaria, CISM; Government—> INS, Traditional Medicine National Institute, INE; Training Institutions—>UEM, ISCISA, nursing training institutions.

–Priorities for system strengthening capacity building, MOH has developed new training materials on HMIS, M&E, and health planning that will be used in 2017 to train all health workers and NHS managers.

–Private and military health services are not reported due to lack of legislation.

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U.S. President’s Malaria Initiative

