District decision-making for health in low-income settings:

Data-Informed Platform For Health

a feasibility study from India, Nigeria and Ethiopia

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London School of Hygiene and Tropical Medicine

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Outline

1. Data Informed Platform for Health
2. Conduct of feasibility study
3. Lessons learnt from the feasibility studies
4. Next steps

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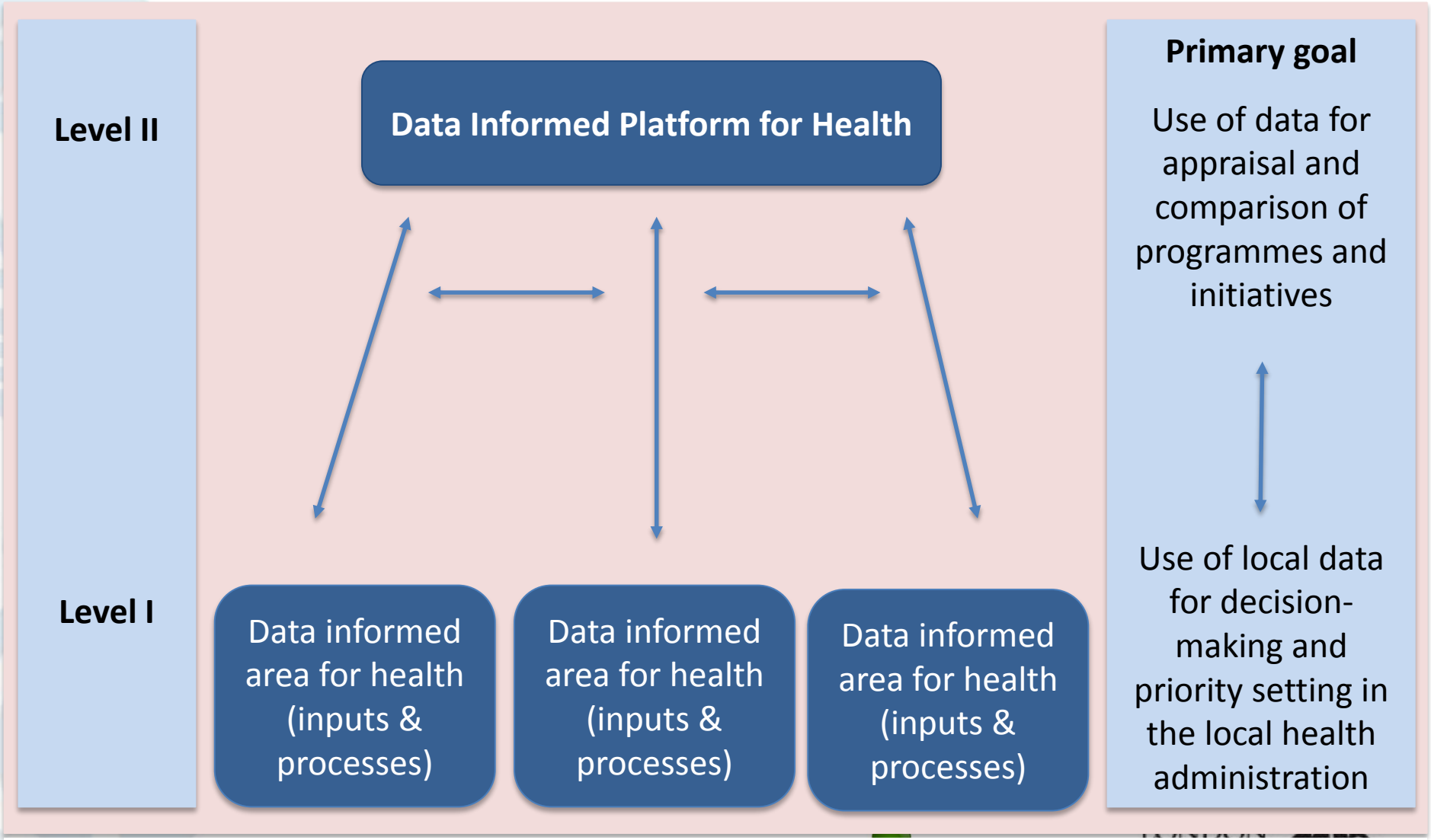
Background

- Low-resource settings often have limited use of local data for health system planning and decision-making for MNCH services.

- **Key challenges**
  - Data quality
  - Professional expertise
  - Information-system infrastructure
  - Robustness of technology
  - Culture of evidence-based decision-making
  - Health system responsiveness

- One of the possible solution: **Data Informed Platform for Health**

Generic Structure: Data Informed Platform for Health



Level I: Primary geographical unit e.g. districts
Level II: Secondary geographical unit e.g. province, state, region or zone

Data Informed Platform for Health

- District as a unit of implementation
- Bringing together diverse public sector services influencing MNCH health
- Role of private sector and NGOs
- District-level databases, potentially linked at regional or federal level
- Implementation research challenge

DIPH feasibility study: India, Ethiopia and Nigeria

Overall aim

To determine whether DIPH approach is technically feasible to implement

***Focus**: MNH related services offered by public health system and key organisations*

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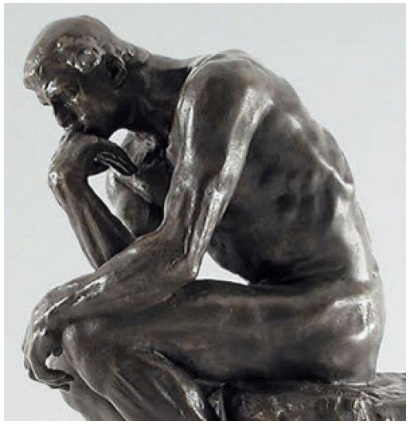
Feasibility study

TELOS framework

Greek philosophy of teleology: the study of the nature or intentions of a plan or object.

The concept is used in business and management to assess the feasibility of a new service, programme or initiative.



Five dimensions of feasibility research:

- **T**echnology and Systems,
- **E**conomic,
- **L**egal and Political,
- **O**perational, and
- **S**cheduling feasibility.

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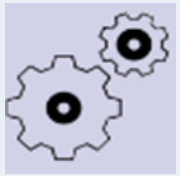
TELOS framework: nature of inquiry

	**Technology and System Feasibility**	• Do stakeholders have the expertise needed? • Are additional resources needed in the health system including infrastructure, skills-sets or job aids? • Is the health system ready in terms of the technology required?
	Economic Feasibility	• Do the resources needed exist? • Will the proposed health service or initiative lead to better use of resources to improve health outcomes, when compared with other options?
	Legal and Political Feasibility	• Are rules and regulations in place to enable stakeholders to support the new service or initiative? • Does the essential political will exist? • Is there a legal framework to engage with the private sector or other key service providers?
	Operational Feasibility	• Do existing health system procedures and protocols support the new service or initiative? • How will key collaborators be involved?
	Schedule Feasibility	• What are the prerequisites before the new service or initiative can begin? • Is the service or initiative likely to be developed in time to be useful to the health system?

Methodology

- Context: **India, Ethiopia and Nigeria**
- Collaborative effort with respective MoHs
- Selection of study districts
- Data collection:
  - In-depth field visit
  - Key informant interviews
  - Service-delivery staff interviews
  - Record and document review
- The readiness to implement DIPH is described on the basis of the relative status of the country according to the feasibility framework

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Summary of findings

Components	Specific inquiries considered	India	Ethiopia	Nigeria
Technology and Systems	• Do stakeholders have the necessary background expertise needed for DIPH? • Health system readiness in terms of necessary technology required?	+++	+	-
Economic	• Do the resources needed for the DIPH exist?	+++	±	±
Legal and Political	• Are the necessary rules and regulations in place to enable the stakeholders to support the new health system service or new initiative? • Does the essential political-will exist to support the DIPH?	+++	++	±
Operational	• Do the existing procedures and protocol of health system support the DIPH?	+++	+	++
Schedule	• What prerequisites need to be in place prior to the execution of the DIPH?	+++	++	±

+++ = sufficient, ++ = basic minimum, + = limited, ± = negligible, - = nil

Findings and lessons learnt

Potential challenges

- Utility perspective for the health systems
- Embedding in the health system
- Private sector placement
- Technical capacity building
- Standardisation of decision-making processes
- Network architecture across different levels
- Organisational barriers among public, NGO and private sector
- Data harmonisation
- Performance evaluation

Opportunities - related ongoing initiatives in the country

- M-health
- Score cards on performances

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Next steps

- **Pilot study**
- To build upon the evidence of decision-making at the district level
- Strategies to support readiness and acceptance of private sector
- Streamlining the district level leadership and health system governance

- **Scaling up of DIPH in the context of key MNCH interventions and innovations**

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Thank you,

Credit: Bill & Melinda Gates Foundation

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A systematic literature review:

To explore decision-making processes that support the use of health data at district level in low- and middle-income countries

Deepthi Wickremasinghe, Iram Hashmi Ejaz,

Joanna Schellenberg, Bilal Iqbal Avan

Improving health worldwide

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Are local health data used in decision-making?

1. Record keeping in a health post in Ethiopia - Neil Spicer
2. Data collection in Gombe State, Nigeria - Society for Family Health
3. Woman adding data to a health form in Uttar Pradesh ,India – Meenakshi Gautham

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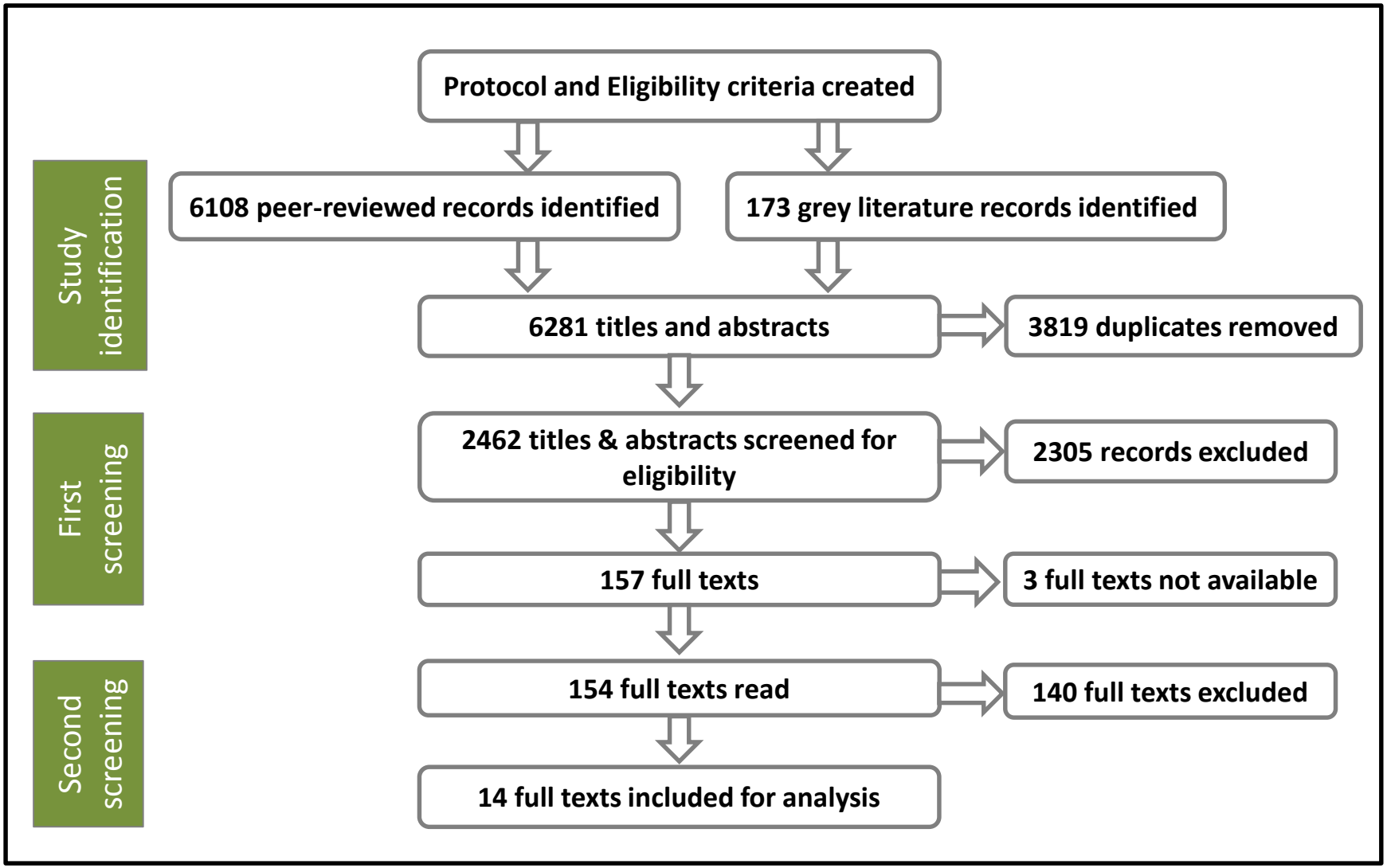
What processes do district decision makers use…

Community meeting in Gombe State, Nigeria – Society for Family Health

Flow diagram of the systematic review process



What we found:
Examples of generic decision-making processes at district level from

Cambodia

Ghana

India

Malawi

Mozambique

Nigeria

Philippines

Tanzania

Zambia

Flags from Science Kids ©

What we found:
All the decision–making processes included two steps

1. Prioritise the health issues to be addressed

2. Develop an action plan

Maternal and newborn health register in Uttar Pradesh, India – Bilal Iqbal Avan

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Health facility data in Ethiopia – Bilal Iqbal Avan

What we found: Types of data used for decision-making

- Health Management Information Systems data (HMIS)
- Facility records
- Document reviews
- Other sources of data…

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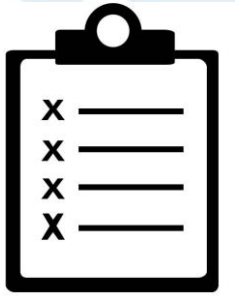
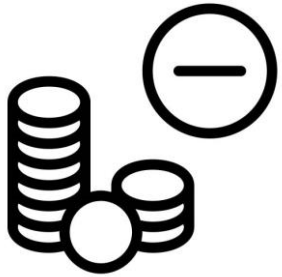
What we found:
Challenges to decision-making processes



Availability of health and health facility data of good quality

Human dynamics within a formal, data-based decision-making process



Decisions compromised by financial constraints

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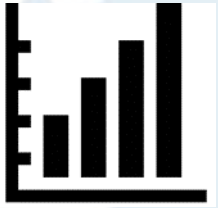
All icons from The Noun Project (Clipboard by Jerad Maplethorpe; Coins by Musket)

Interpretation: Three good practices for a decision-making process



Relevant and good quality data are pre-requisite

A structured process, including steps to help build consensus

A well-defined role for the community

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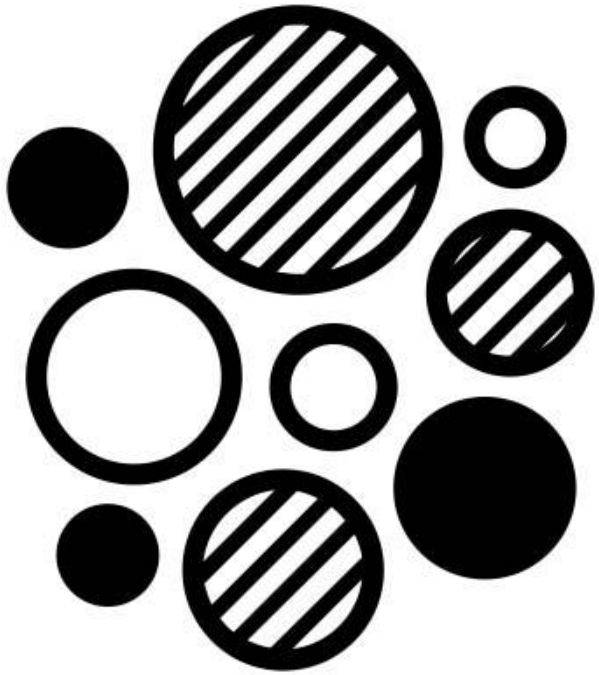
Icons from The Noun Project
(Graph by Simple Icons; Consensus by Krisada; People by Tuk Tuk Design)

Recommendation…



Wider adoption of a decision-making process would be enhanced by standardisation and pre-testing in diverse settings

Icon from The Noun Project (Bubble comparison by Meaghan Hendricks)

Content analysis of district level health data and inter-sectoral linkages in India and Ethiopia

Dr. Della Berhanu
London School of Hygiene and Tropical Medicine

Dr. Sanghita Bhattacharyya
Public Health Foundation of India

Current district decision-making process

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District decision-making: India

Objective:

- To explore district decision-making structure
- To understand use of data for planning and resource allocation

Study Area:

- North and South 24 Parganas districts in West Bengal State

Methods:

- In-depth interviews with 28 representatives of district decision-making body in India.
- Observation of 4 district decision-making meetings in India

District decision-making: Structure

- Who?
- What?
- When?
- Representative?

*"**District Health Society** is a type of district level convergence meeting, where you get all the government officials… So the meeting can determine policy for different health activities like construction, health programmes, funding, budgeting, planning, analysing current health situation of district …"*

[Health department rep.]

*As per guideline our department should participate in **District Health Society** meetings but practically they are not aware of importance, and the health department is also not taking initiative to motivate our participation … Our role is ill-defined…"*

[Non-health department rep.]

District decision-making: Process

- How?

"We have to go by the priorities set by Government of India state government. Other suggestions from local political or community can be considered and discussed depending upon its usefulness…"

[Health department rep.]

"Funds are not released based on priorities set by us, rather priorities are set based on availability of funds"

[Health department rep.]

- However…

"District Health Society only plans for health department…. mostly health department decisions are prioritised at the meeting"

[Non-health department rep.]

District decision-making: Observation on data use

For:

- Planning?

"Enormous data is being collected, but remain unutilised due to lack of time and inadequate manpower. Data is a very interesting tool if we use it in a proper way"

[Health department rep.]

"Yes data is useful for planning. E.g Mission director when visited this hospital found bed occupancy rate at 130%. Then proposal of increasing beds in maternity ward from 85 to 120 was developed and put in District Health Society meeting"

[Health department rep.]

- Fund allocation?

"There is no such link between funding and data, in my personal opinion funding is very specific (state guideline) and never linked with data …"

[Non-health department rep.]

Needs identified by stakeholders

District Health Society members identified the following three key needs in terms of current decision-making process:

1. Improve **coordination** between different departments for **knowledge interchange**
2. Increase **use of data** to identify problems and use for planning.
3. Develop a structured **decision-making tool** for District Health Society meetings.

Content analysis of district level health data and inter-sectoral linkages in India and Ethiopia

Outline

- Background
- Method
- Findings from India and Ethiopia
- Summary

Background

Why conduct a content analysis of data?

To inform us on data:

- Availability
- Duplication
- Filtration from one level to the next
- Quality

Shared data can provide comprehensive information for local decision-making, aligning health service delivery with the available resources and community health needs

Background

Indian Health System	Ethiopian Health System
District Hospital > 30,000	**Primary Hospital** 60-100,000
Community Health Centre 10,000- 30,000	**Health Centre** 15-25,000
Primary Health Centre 5000-10,000	**Health Post** 3-5,000
Sub Centre >5,000	
Community health workers 1,000	

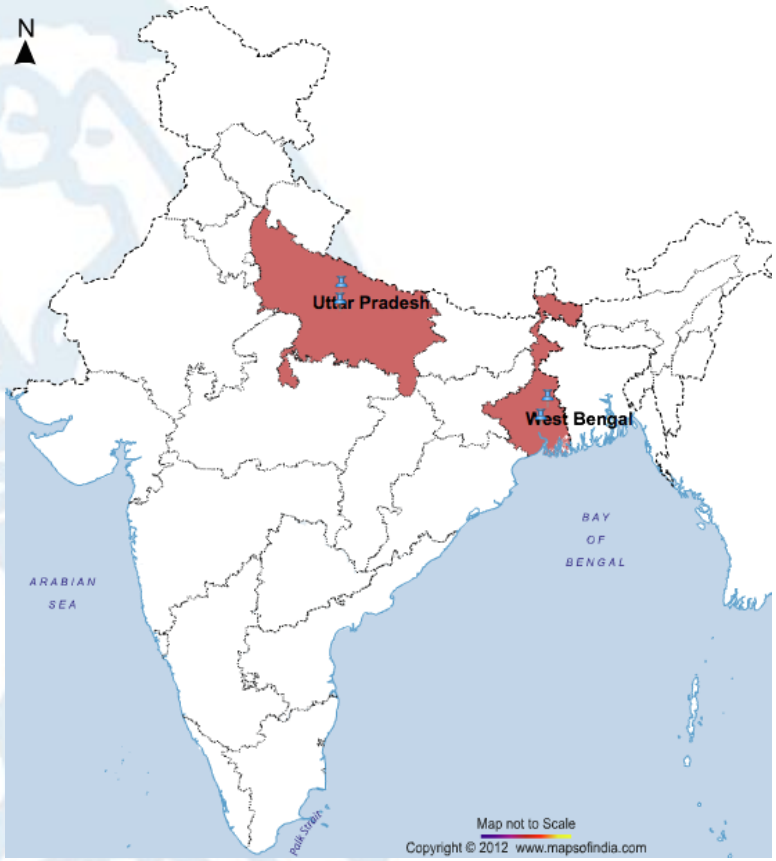
Objectives

To understand the:

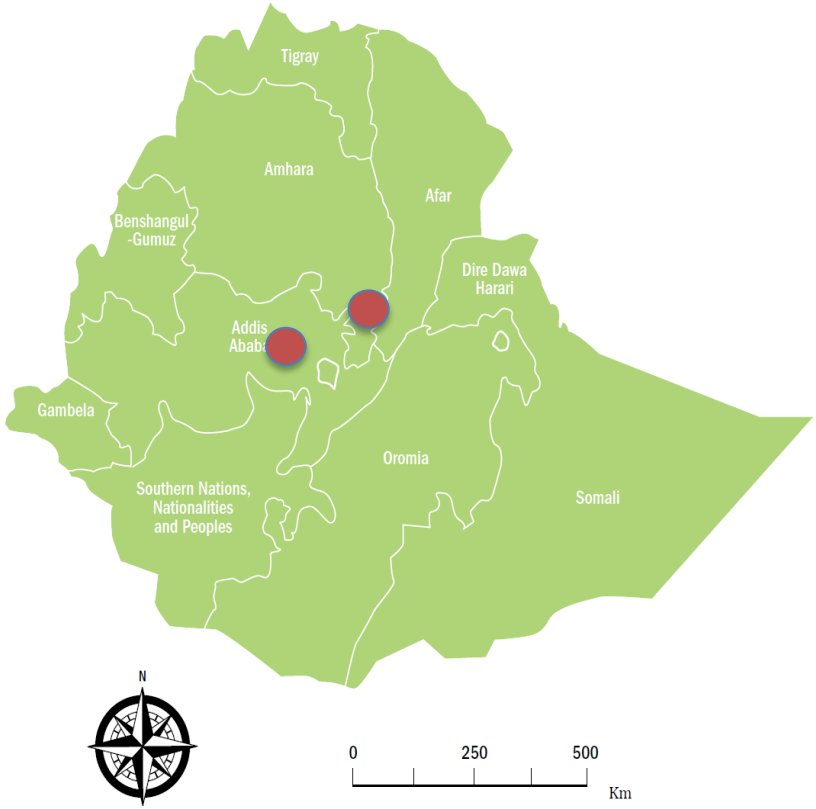
1. **Volume and types of data collected at different health system levels in a district**

2. **Data flow and data sharing between public and private health system**

Study areas



- Sitapur and Unnao districts in Uttar Pradesh State



- Dendi district in Oromia region
- Basso district in Amhara region

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Methods: Data collection

- **Visited** 8 public health facilities in each country
- **Collected** data forms from different public health system levels
- **Interviewed** individuals at the district level to understand data flow and data sharing

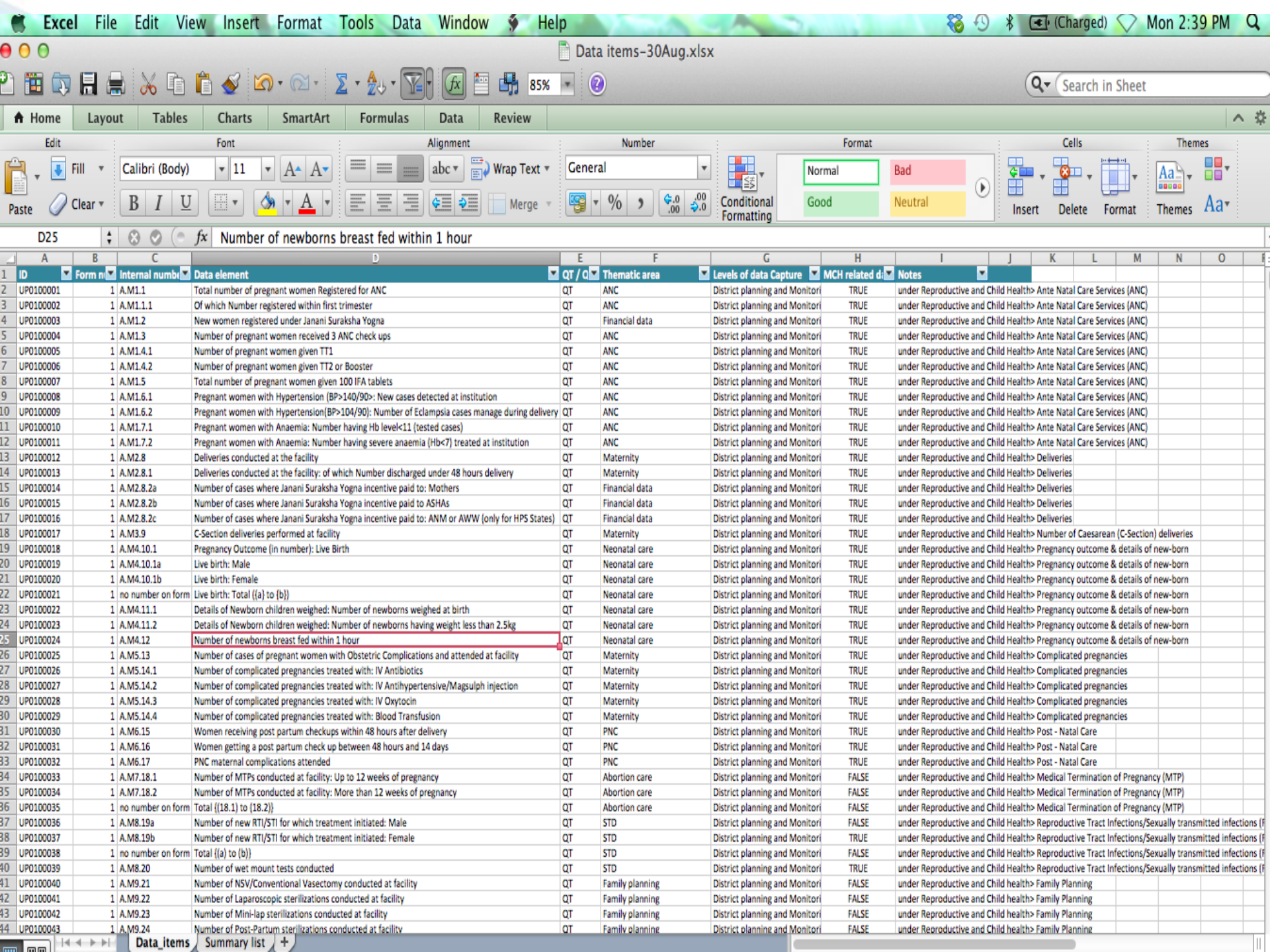
Methods: Content analysis

Data categorisation:

- Used Microsoft Access
- Categorised forms by level of completion and reporting frequency
- Identified and sorted thematic areas into the six WHO health system categories
- Each data element was then categorised into to a thematic area

Content analysis:

- To see the type and amount of data available for different health system levels
- Further analysis to understand the MCH service delivery data



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Search in Sheet

Home Layout Tables Charts SmartArt Formulas Data Review

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D25 Number of newborns breast fed within 1 hour

	A	B	C	D	E	F	G	H	I
1	ID	Form n	Internal numbe	Data element	QT / Q	Thematic area	Levels of data Capture	MCH related d	Notes
2	UP0100001	1	A.M1.1	Total number of pregnant women Registered for ANC	QT	ANC	District planning and Monitori	TRUE	under Reproductive and Child Health> Ante Natal Care Services (ANC)
3	UP0100002	1	A.M1.1.1	Of which Number registered within first trimester	QT	ANC	District planning and Monitori	TRUE	under Reproductive and Child Health> Ante Natal Care Services (ANC)
4	UP0100003	1	A.M1.2	New women registered under Janani Suraksha Yogna	QT	Financial data	District planning and Monitori	TRUE	under Reproductive and Child Health> Ante Natal Care Services (ANC)
5	UP0100004	1	A.M1.3	Number of pregnant women received 3 ANC check ups	QT	ANC	District planning and Monitori	TRUE	under Reproductive and Child Health> Ante Natal Care Services (ANC)
6	UP0100005	1	A.M1.4.1	Number of pregnant women given TT1	QT	ANC	District planning and Monitori	TRUE	under Reproductive and Child Health> Ante Natal Care Services (ANC)
7	UP0100006	1	A.M1.4.2	Number of pregnant women given TT2 or Booster	QT	ANC	District planning and Monitori	TRUE	under Reproductive and Child Health> Ante Natal Care Services (ANC)
8	UP0100007	1	A.M1.5	Total number of pregnant women given 100 IFA tablets	QT	ANC	District planning and Monitori	TRUE	under Reproductive and Child Health> Ante Natal Care Services (ANC)
9	UP0100008	1	A.M1.6.1	Pregnant women with Hypertension (BP>140/90>: New cases detected at institution	QT	ANC	District planning and Monitori	TRUE	under Reproductive and Child Health> Ante Natal Care Services (ANC)
10	UP0100009	1	A.M1.6.2	Pregnant women with Hypertension(BP>104/90): Number of Eclampsia cases manage during delivery	QT	ANC	District planning and Monitori	TRUE	under Reproductive and Child Health> Ante Natal Care Services (ANC)
11	UP0100010	1	A.M1.7.1	Pregnant women with Anaemia: Number having Hb level<11 (tested cases)	QT	ANC	District planning and Monitori	TRUE	under Reproductive and Child Health> Ante Natal Care Services (ANC)
12	UP0100011	1	A.M1.7.2	Pregnant women with Anaemia: Number having severe anaemia (Hb<7) treated at institution	QT	ANC	District planning and Monitori	TRUE	under Reproductive and Child Health> Ante Natal Care Services (ANC)
13	UP0100012	1	A.M2.8	Deliveries conducted at the facility	QT	Maternity	District planning and Monitori	TRUE	under Reproductive and Child Health> Deliveries
14	UP0100013	1	A.M2.8.1	Deliveries conducted at the facility: of which Number discharged under 48 hours delivery	QT	Maternity	District planning and Monitori	TRUE	under Reproductive and Child Health> Deliveries
15	UP0100014	1	A.M2.8.2a	Number of cases where Janani Suraksha Yogna incentive paid to: Mothers	QT	Financial data	District planning and Monitori	TRUE	under Reproductive and Child Health> Deliveries
16	UP0100015	1	A.M2.8.2b	Number of cases where Janani Suraksha Yogna incentive paid to ASHAs	QT	Financial data	District planning and Monitori	TRUE	under Reproductive and Child Health> Deliveries
17	UP0100016	1	A.M2.8.2c	Number of cases where Janani Suraksha Yogna incentive paid to: ANM or AWW (only for HPS States)	QT	Financial data	District planning and Monitori	TRUE	under Reproductive and Child Health> Deliveries
18	UP0100017	1	A.M3.9	C-Section deliveries performed at facility	QT	Maternity	District planning and Monitori	TRUE	under Reproductive and Child Health> Number of Caesarean (C-Section) deliveries
19	UP0100018	1	A.M4.10.1	Pregnancy Outcome (in number): Live Birth	QT	Neonatal care	District planning and Monitori	TRUE	under Reproductive and Child Health> Pregnancy outcome & details of new-born
20	UP0100019	1	A.M4.10.1a	Live birth: Male	QT	Neonatal care	District planning and Monitori	TRUE	under Reproductive and Child Health> Pregnancy outcome & details of new-born
21	UP0100020	1	A.M4.10.1b	Live birth: Female	QT	Neonatal care	District planning and Monitori	TRUE	under Reproductive and Child Health> Pregnancy outcome & details of new-born
22	UP0100021	1	no number on form	Live birth: Total {(a) to (b)}	QT	Neonatal care	District planning and Monitori	TRUE	under Reproductive and Child Health> Pregnancy outcome & details of new-born
23	UP0100022	1	A.M4.11.1	Details of Newborn children weighed: Number of newborns weighed at birth	QT	Neonatal care	District planning and Monitori	TRUE	under Reproductive and Child Health> Pregnancy outcome & details of new-born
24	UP0100023	1	A.M4.11.2	Details of Newborn children weighed: Number of newborns having weight less than 2.5kg	QT	Neonatal care	District planning and Monitori	TRUE	under Reproductive and Child Health> Pregnancy outcome & details of new-born
25	UP0100024	1	A.M4.12	Number of newborns breast fed within 1 hour	QT	Neonatal care	District planning and Monitori	TRUE	under Reproductive and Child Health> Pregnancy outcome & details of new-born
26	UP0100025	1	A.M5.13	Number of cases of pregnant women with Obstetric Complications and attended at facility	QT	Maternity	District planning and Monitori	TRUE	under Reproductive and Child Health> Complicated pregnancies
27	UP0100026	1	A.M5.14.1	Number of complicated pregnancies treated with: IV Antibiotics	QT	Maternity	District planning and Monitori	TRUE	under Reproductive and Child Health> Complicated pregnancies
28	UP0100027	1	A.M5.14.2	Number of complicated pregnancies treated with: IV Antihypertensive/Magsulph injection	QT	Maternity	District planning and Monitori	TRUE	under Reproductive and Child Health> Complicated pregnancies
29	UP0100028	1	A.M5.14.3	Number of complicated pregnancies treated with: IV Oxytocin	QT	Maternity	District planning and Monitori	TRUE	under Reproductive and Child Health> Complicated pregnancies
30	UP0100029	1	A.M5.14.4	Number of complicated pregnancies treated with: Blood Transfusion	QT	Maternity	District planning and Monitori	TRUE	under Reproductive and Child Health> Complicated pregnancies
31	UP0100030	1	A.M6.15	Women receiving post partum checkups within 48 hours after delivery	QT	PNC	District planning and Monitori	TRUE	under Reproductive and Child Health> Post - Natal Care
32	UP0100031	1	A.M6.16	Women getting a post partum check up between 48 hours and 14 days	QT	PNC	District planning and Monitori	TRUE	under Reproductive and Child Health> Post - Natal Care
33	UP0100032	1	A.M6.17	PNC maternal complications attended	QT	PNC	District planning and Monitori	TRUE	under Reproductive and Child Health> Post - Natal Care
34	UP0100033	1	A.M7.18.1	Number of MTPs conducted at facility: Up to 12 weeks of pregnancy	QT	Abortion care	District planning and Monitori	FALSE	under Reproductive and Child Health> Medical Termination of Pregnancy (MTP)
35	UP0100034	1	A.M7.18.2	Number of MTPs conducted at facility: More than 12 weeks of pregnancy	QT	Abortion care	District planning and Monitori	FALSE	under Reproductive and Child Health> Medical Termination of Pregnancy (MTP)
36	UP0100035	1	no number on form	Total {(18.1) to (18.2)}	QT	Abortion care	District planning and Monitori	FALSE	under Reproductive and Child Health> Medical Termination of Pregnancy (MTP)
37	UP0100036	1	A.M8.19a	Number of new RTI/STI for which treatment initiated: Male	QT	STD	District planning and Monitori	FALSE	under Reproductive and Child Health> Reproductive Tract Infections/Sexually transmitted infections (F
38	UP0100037	1	A.M8.19b	Number of new RTI/STI for which treatment initiated: Female	QT	STD	District planning and Monitori	TRUE	under Reproductive and Child Health> Reproductive Tract Infections/Sexually transmitted infections (F
39	UP0100038	1	no number on form	Total {(a) to (b)}	QT	STD	District planning and Monitori	FALSE	under Reproductive and Child Health> Reproductive Tract Infections/Sexually transmitted infections (F
40	UP0100039	1	A.M8.20	Number of wet mount tests conducted	QT	STD	District planning and Monitori	TRUE	under Reproductive and Child Health> Reproductive Tract Infections/Sexually transmitted infections (F
41	UP0100040	1	A.M9.21	Number of NSV/Conventional Vasectomy conducted at facility	QT	Family planning	District planning and Monitori	FALSE	under Reproductive and Child health> Family Planning
42	UP0100041	1	A.M9.22	Number of Laparoscopic sterilizations conducted at facility	QT	Family planning	District planning and Monitori	FALSE	under Reproductive and Child health> Family Planning
43	UP0100042	1	A.M9.23	Number of Mini-lap sterilizations conducted at facility	QT	Family planning	District planning and Monitori	FALSE	under Reproductive and Child health> Family Planning
44	UP0100043	1	A.M9.24	Number of Post-Partum sterilizations conducted at facility	QT	Family planning	District planning and Monitori	FALSE	under Reproductive and Child health> Family Planning

Data_items Summary list +

Methods

Content analysis of data forms

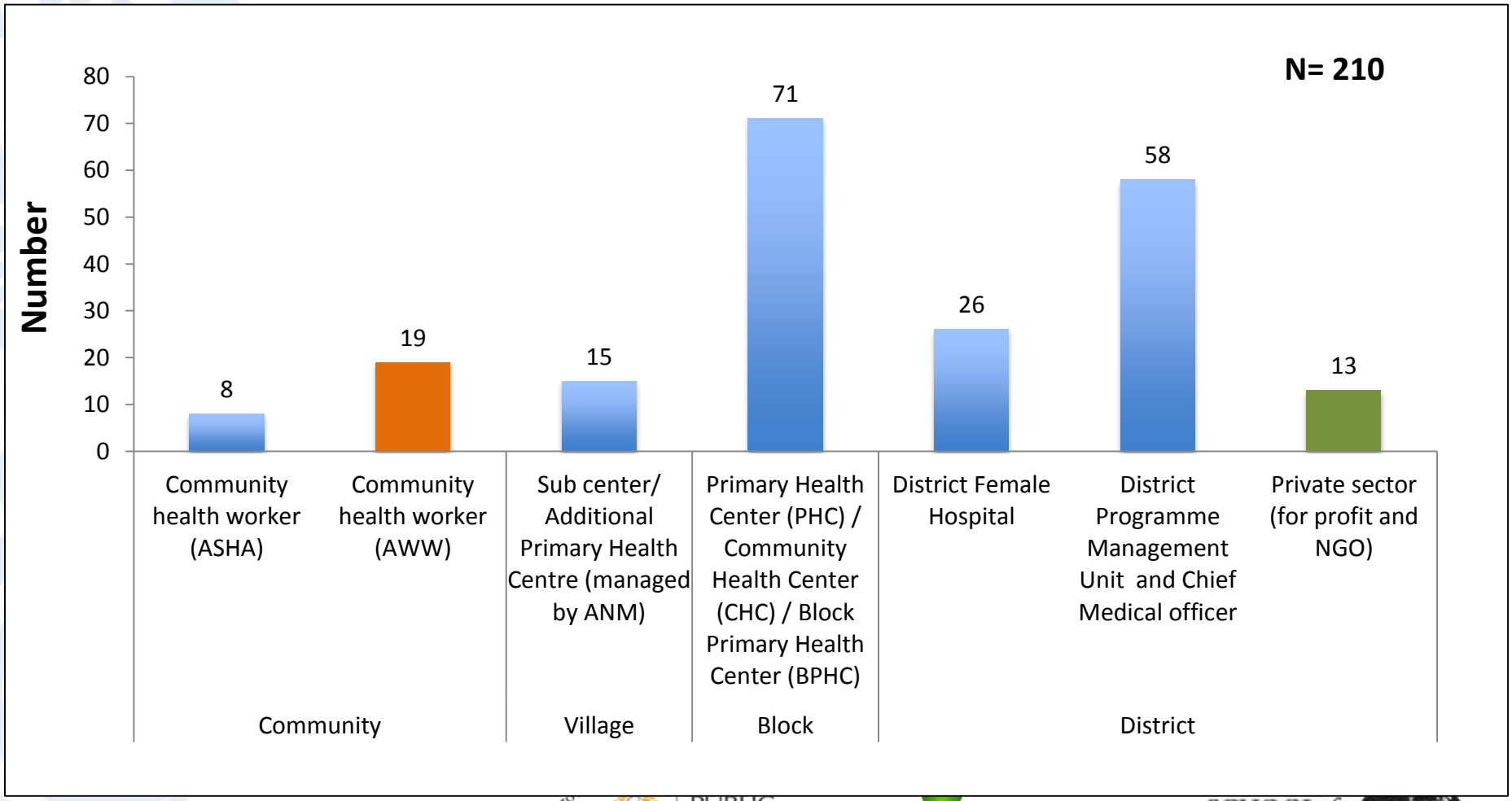
WHO health system categories	Thematic Areas
1. Service delivery	• ANC, Delivery, PNC, Newborn care, Immunisation, Nutrition • Family planning, Adolescent health • Water and sanitation • Non-communicable diseases, TB, Malaria, HIV
2. Contextual factors	• Infrastructure of facilities, households and villages • Demography
3. Medical supplies	• Resources/ supplies
4. Workforce	• Human resources • Training
5. Governance	• Management (supervision) • Grievance redress
6. Finance	• Expenditure • Financial incentive • Insurance scheme

Findings:

Content analysis of district health data and inters-sectoral linkages in India

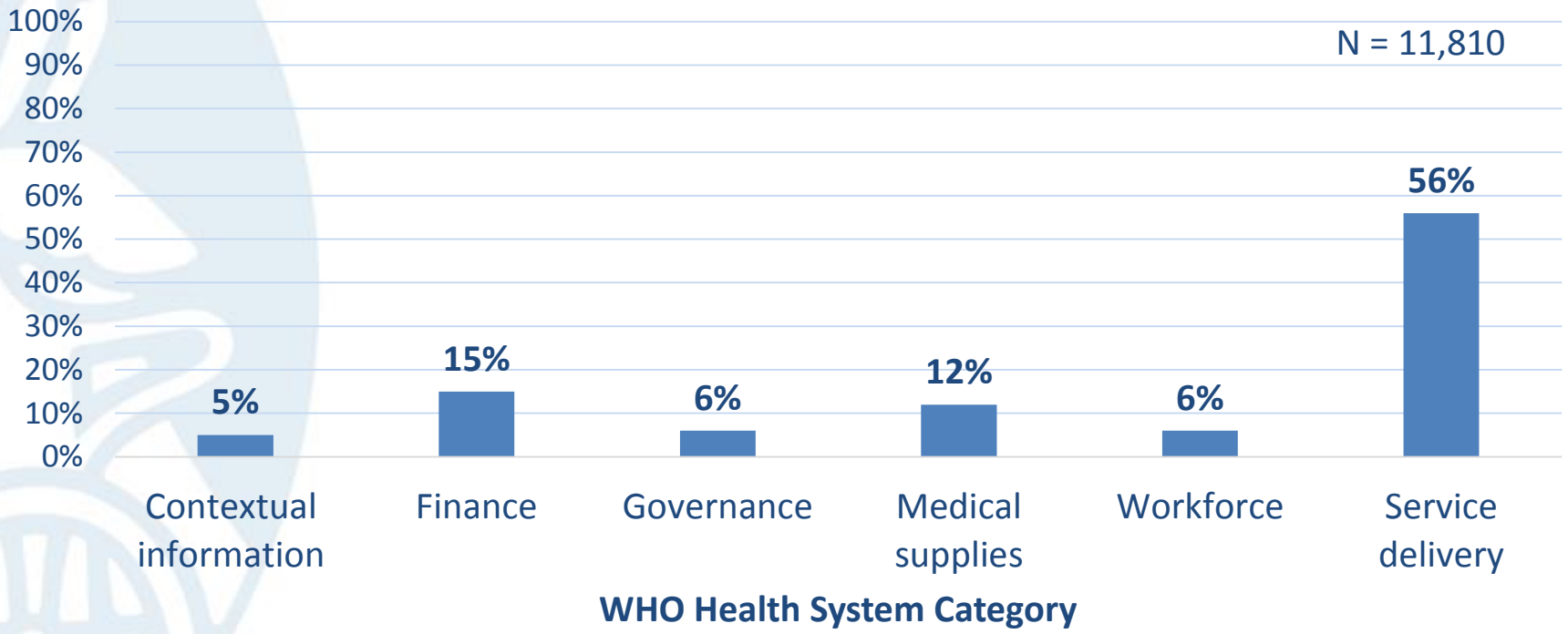
India

Volume of data available in a district health system



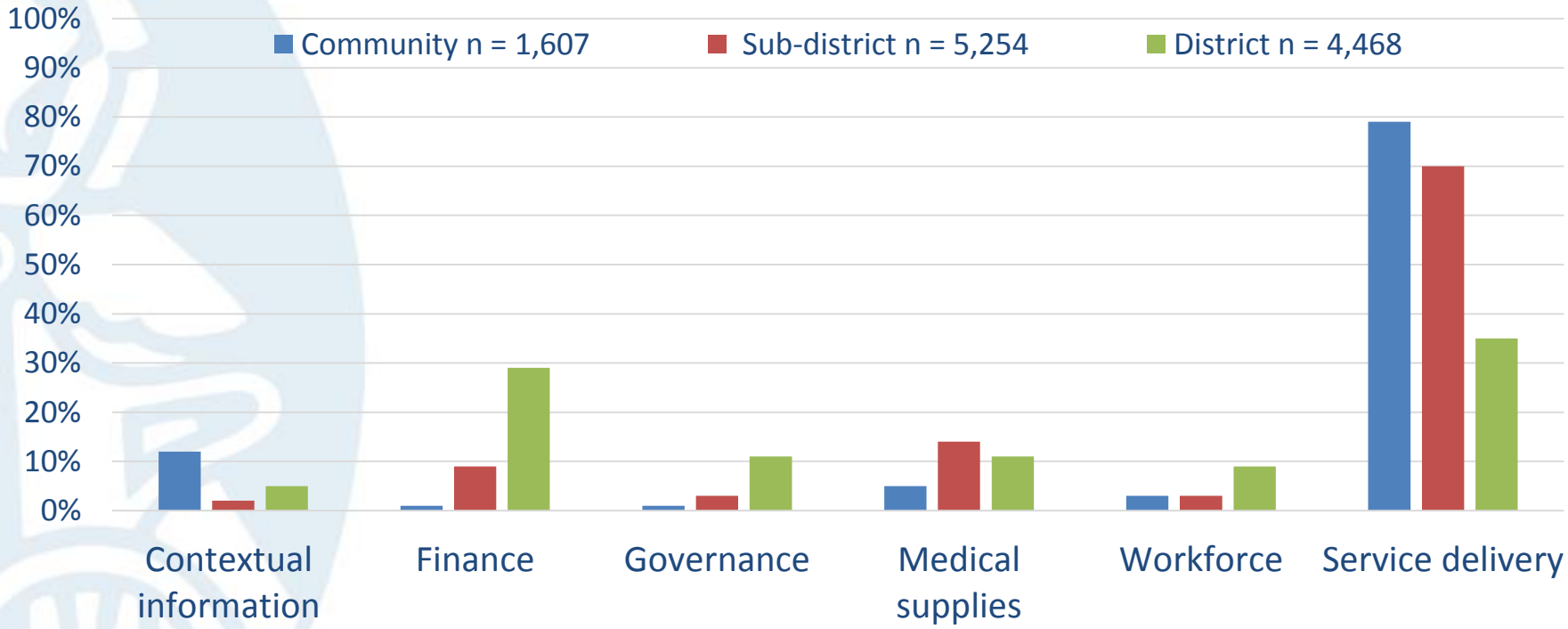
India

Types of data available in a district health system



India

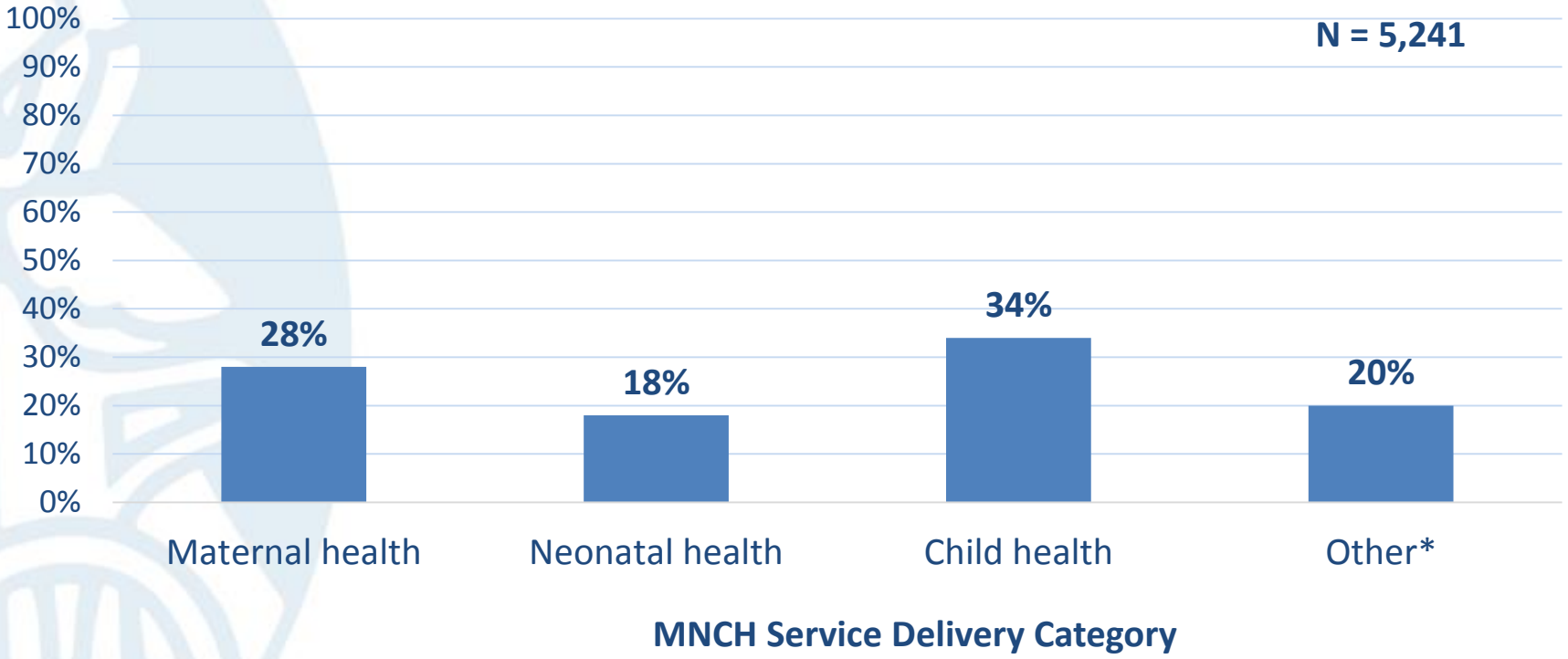
Types of data available at different levels of the district public health system



WHO Health System Categories

India

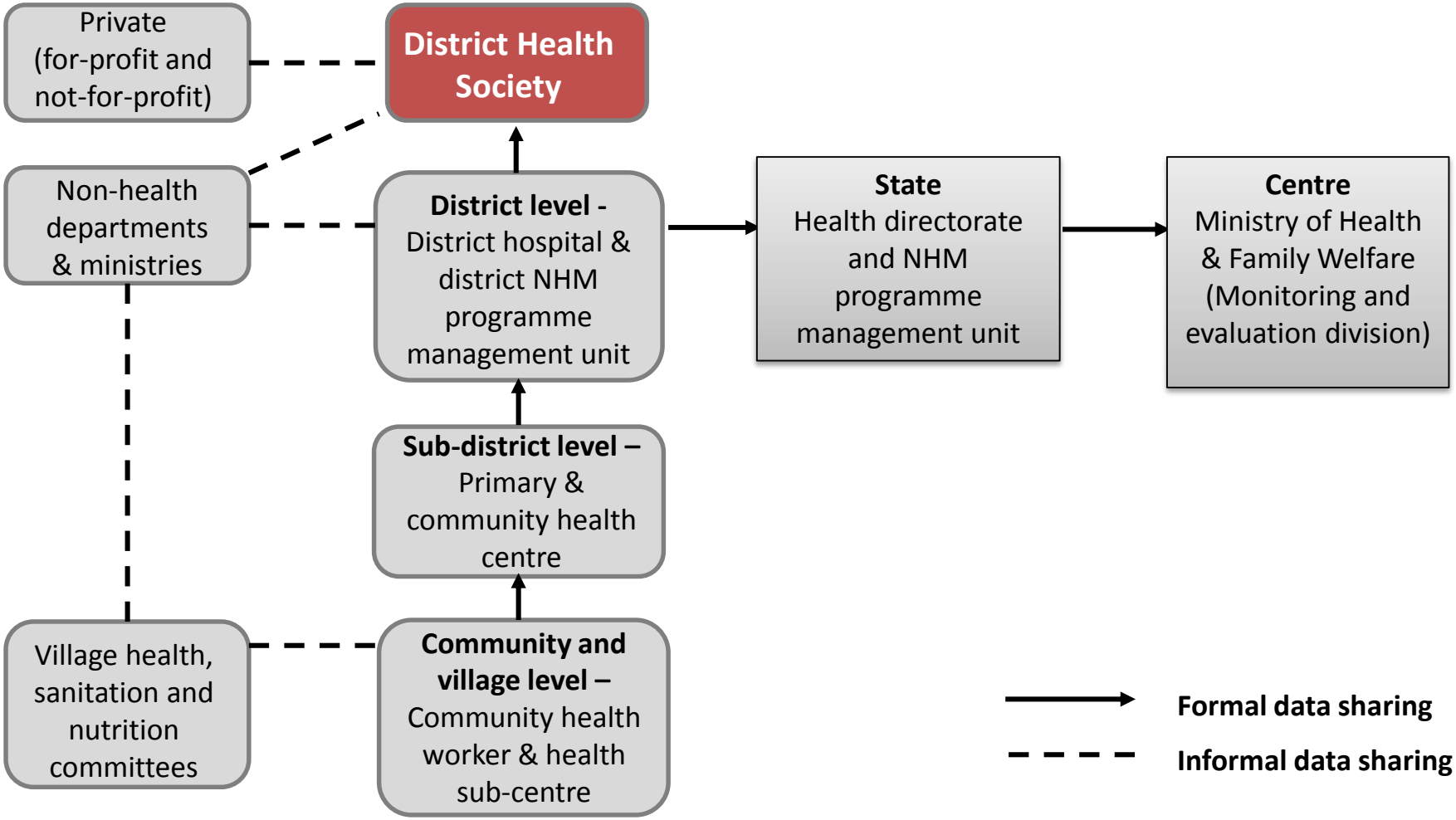
Maternal, neonatal and child health data collected in district public health system



*Integrated MCH programme including nutrition, family planning, abortion, sanitation

India

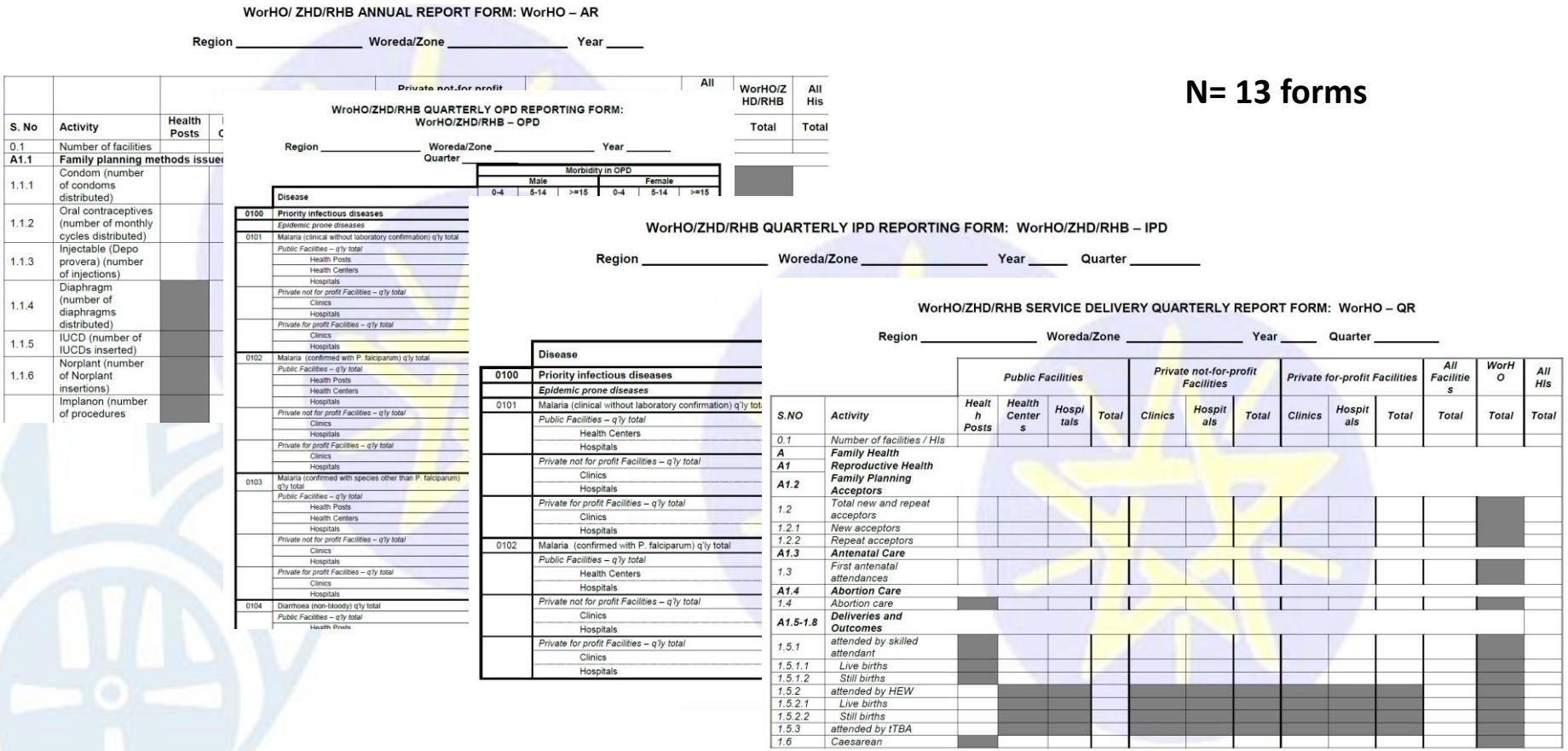
Inter-sectoral linkages in health data flow and sharing



Findings:
Content analysis of district health data and inters-sectoral linkages in Ethiopia

Ethiopia

Volume of data available in a district health system



WorHO/ ZHD/RHB ANNUAL REPORT FORM: WorHO – AR

Region _____ Woreda/Zone _____ Year _____

S. No	Activity	Health Posts	Private not-for profit	All	WorHO/ZHD/RHB	All His
					Total	Total
0.1	Number of facilities					
A1.1	Family planning methods issue					
1.1.1	Condom (number of condoms distributed)					
1.1.2	Oral contraceptives (number of monthly cycles distributed)					
1.1.3	Injectable (Depo provera) (number of injections)					
1.1.4	Diaphragm (number of diaphragms distributed)					
1.1.5	IUCD (number of IUCDs inserted)					
1.1.6	Norplant (number of Norplant insertions)					
	Implanon (number of procedures					

WroHO/ZHD/RHB QUARTERLY OPD REPORTING FORM:
WorHO/ZHD/RHB – OPD

Region _____ Woreda/Zone _____ Year _____
Quarter _____

	Disease	Morbidity in OPD					
		Male			Female		
		0-4	5-14	>=15	0-4	5-14	>=15
0100	Priority infectious diseases						
	Epidemic prone diseases						
0101	Malaria (clinical without laboratory confirmation) q'ly total						
	Public Facilities – q'ly total						
	Health Posts						
	Health Centers						
	Hospitals						
	Private not for profit Facilities – q'ly total						
	Clinics						
	Hospitals						
	Private for profit Facilities – q'ly total						
	Clinics						
	Hospitals						
0102	Malaria (confirmed with P. falciparum) q'ly total						
	Public Facilities – q'ly total						
	Health Posts						
	Health Centers						
	Hospitals						
	Private not for profit Facilities – q'ly total						
	Clinics						
	Hospitals						
	Private for profit Facilities – q'ly total						
	Clinics						
	Hospitals						
0103	Malaria (confirmed with species other than P. falciparum) q'ly total						
	Public Facilities – q'ly total						
	Health Posts						
	Health Centers						
	Hospitals						
	Private not for profit Facilities – q'ly total						
	Clinics						
	Hospitals						
	Private for profit Facilities – q'ly total						
	Clinics						
	Hospitals						
0104	Diarrhoea (non-bloody) q'ly total						
	Public Facilities – q'ly total						
	Health Posts						

WorHO/ZHD/RHB QUARTERLY IPD REPORTING FORM: WorHO/ZHD/RHB – IPD

Region _____ Woreda/Zone _____ Year _____ Quarter _____

	Disease
0100	Priority infectious diseases
	Epidemic prone diseases
0101	Malaria (clinical without laboratory confirmation) q'ly tot
	Public Facilities – q'ly total
	Health Centers
	Hospitals
	Private not for profit Facilities – q'ly total
	Clinics
	Hospitals
	Private for profit Facilities – q'ly total
	Clinics
	Hospitals
0102	Malaria (confirmed with P. falciparum) q'ly total
	Public Facilities – q'ly total
	Health Centers
	Hospitals
	Private not for profit Facilities – q'ly total
	Clinics
	Hospitals
	Private for profit Facilities – q'ly total
	Clinics
	Hospitals

WorHO/ZHD/RHB SERVICE DELIVERY QUARTERLY REPORT FORM: WorHO – QR

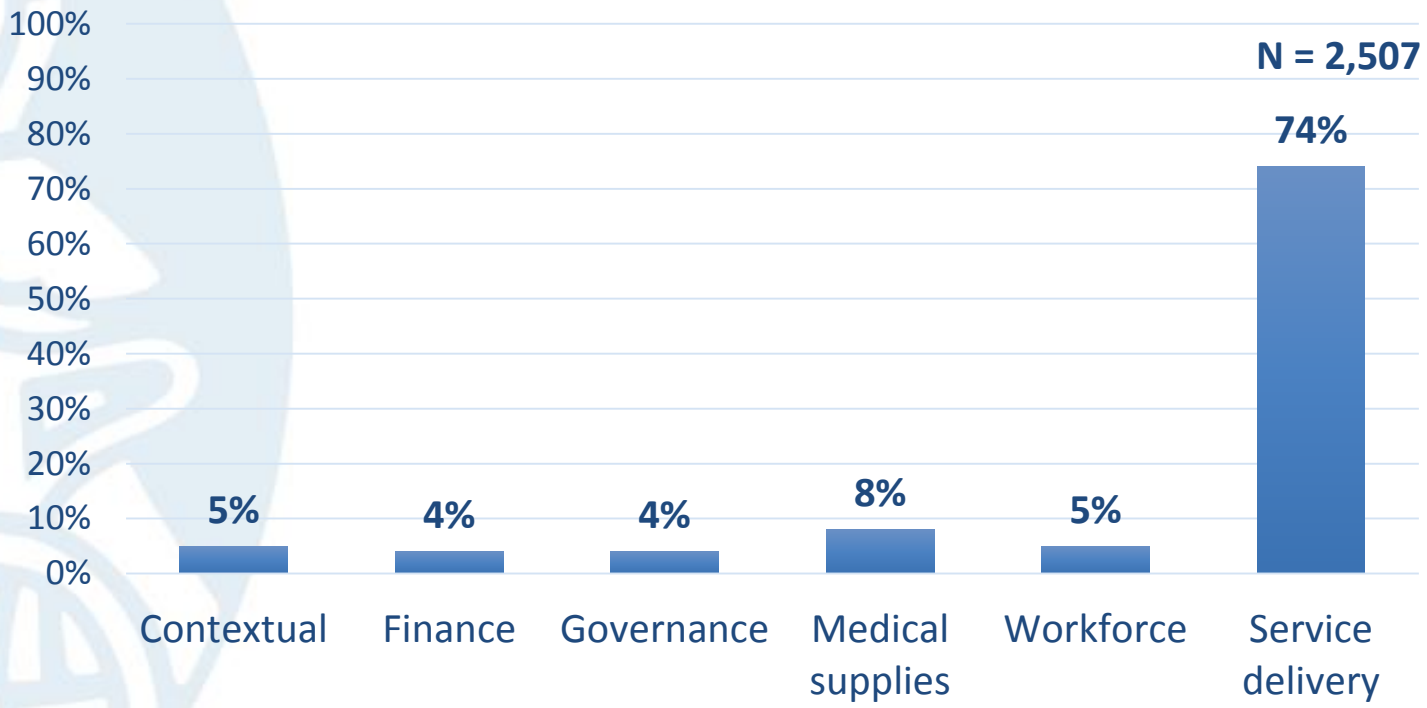
Region _____ Woreda/Zone _____ Year _____ Quarter _____

		Public Facilities				Private not-for-profit Facilities			Private for-profit Facilities			All Facilities	WorHO	All HIs
S.NO	Activity	Health Posts	Health Centers	Hospitals	Total	Clinics	Hospitals	Total	Clinics	Hospitals	Total	Total	Total	Total
0.1	Number of facilities / HIs													
A	Family Health													
A1	Reproductive Health													
A1.2	Family Planning Acceptors													
1.2	Total new and repeat acceptors													
1.2.1	New acceptors													
1.2.2	Repeat acceptors													
A1.3	Antenatal Care													
1.3	First antenatal attendances													
A1.4	Abortion Care													
1.4	Abortion care													
A1.5-1.8	Deliveries and Outcomes													
1.5.1	attended by skilled attendant													
1.5.1.1	Live births													
1.5.1.2	Still births													
1.5.2	attended by HEW													
1.5.2.1	Live births													
1.5.2.2	Still births													
1.5.3	attended by tTBA													
1.6	Caesarean													

N= 13 forms

Ethiopia

Types of data available in a district health system



WHO Health System Categories

PUBLIC HEALTH FOUNDATION OF INDIA

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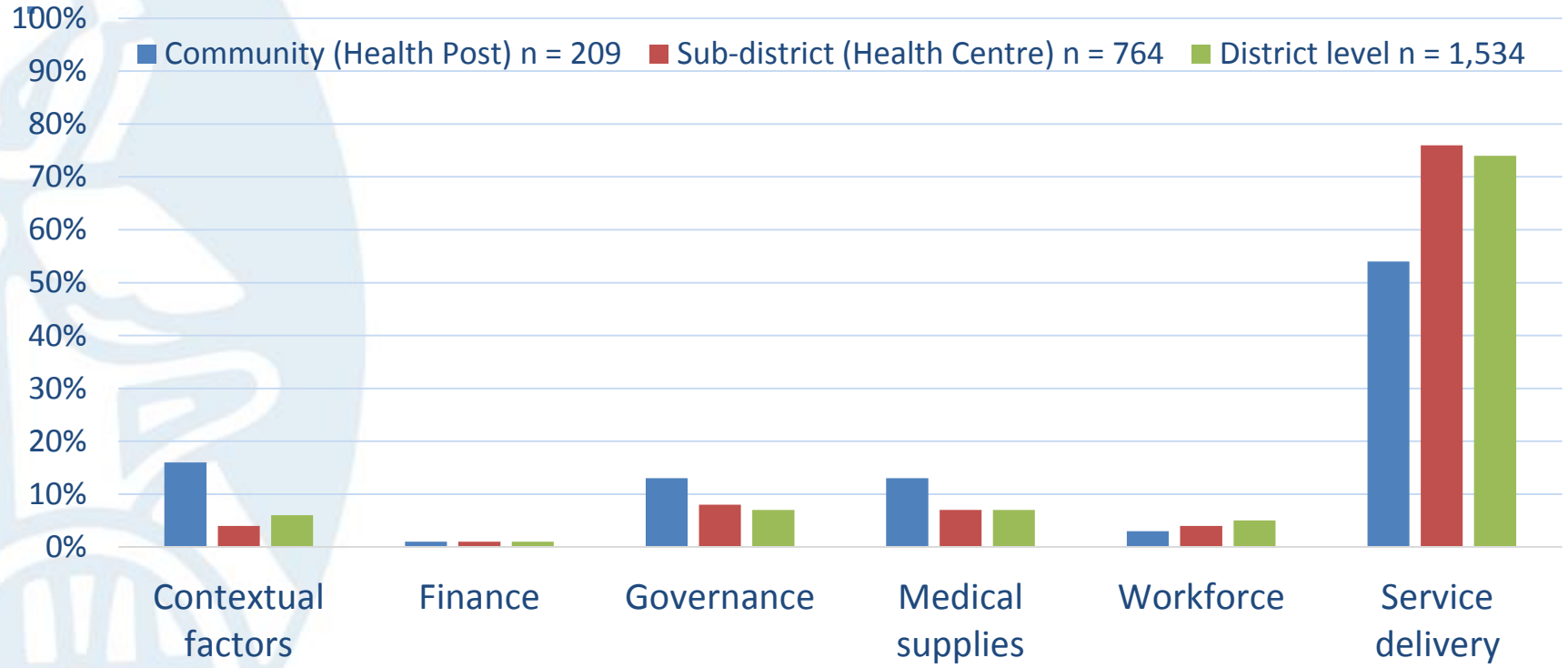
Ethiopia

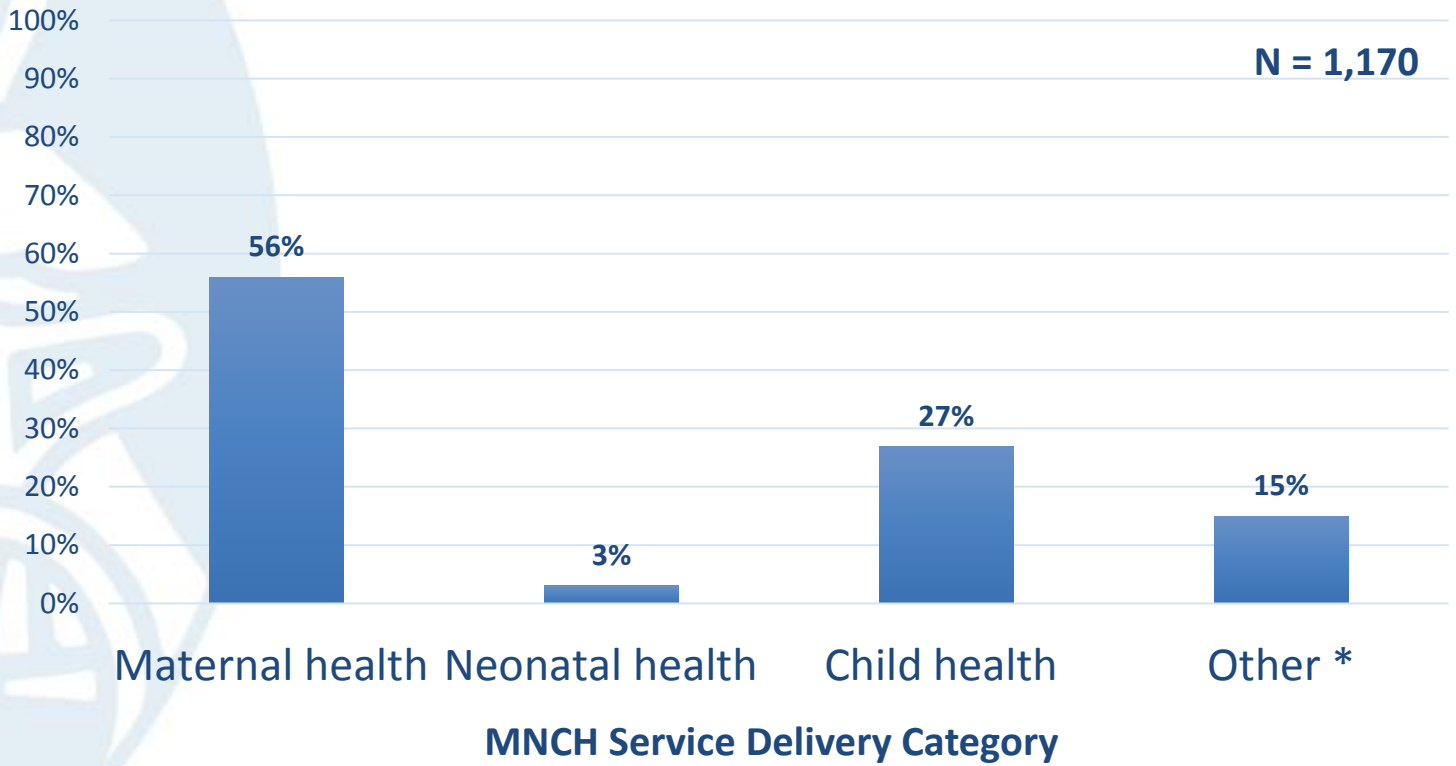
Types of data available at different levels of the district public health system



WHO Health System Categories

Ethiopia

Maternal, neonatal and child health data collected in district public health system



*Integrated MCH programme including nutrition, family planning, abortion, sanitation

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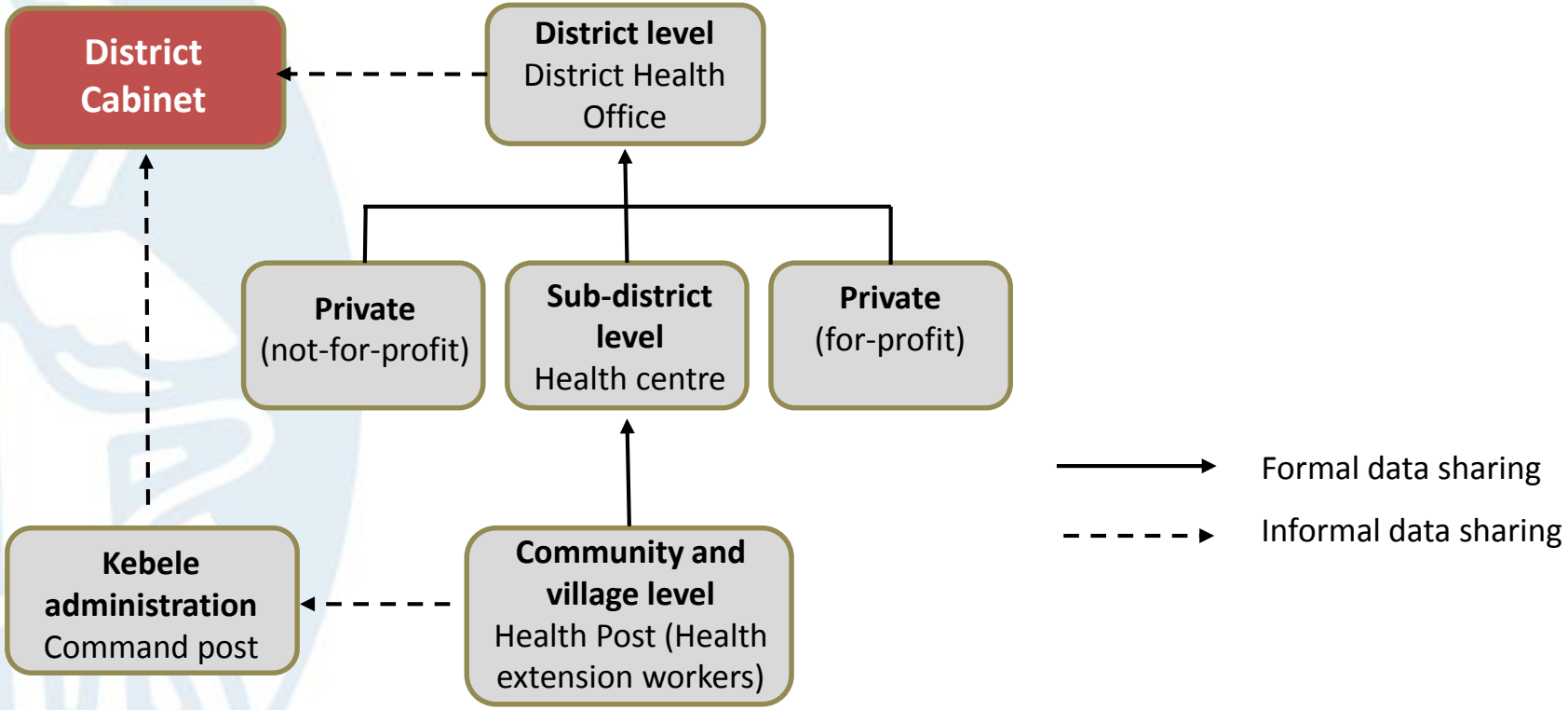
Ethiopia

Inter-sectoral linkages in health data flow and sharing



Summary

Content

- Information is available on all 6 categories in both countries
- In both countries a majority of the data is on service delivery
- Parsimony vs Diversity of forms (13 vs 210 forms)
- There is filtering of data from the community up
- Unlike in India, in Ethiopia district level collects additional data
- More data on neonates collected in India

Technique

- A new way of looking at the available district level data
- It provides an objective and quantifiable perceptive on what exits
- Allows optimisation of data utility

This study was undertaken under the Informed DEcisions for Action (IDEAS) project, London School of Hygiene and Tropical Medicine

Research team- India

Dr. Sanghita Bhattacharyya, Dr. Aradhana Srivastava, Dr. Bhusan Girase, Ms. Mayukhmala Guha, Ms. Anns Issac.

Research Team- Ethiopia

Dr. Della Berhanu, Mr. Nolawi Taddesse and Seifu Taddesse

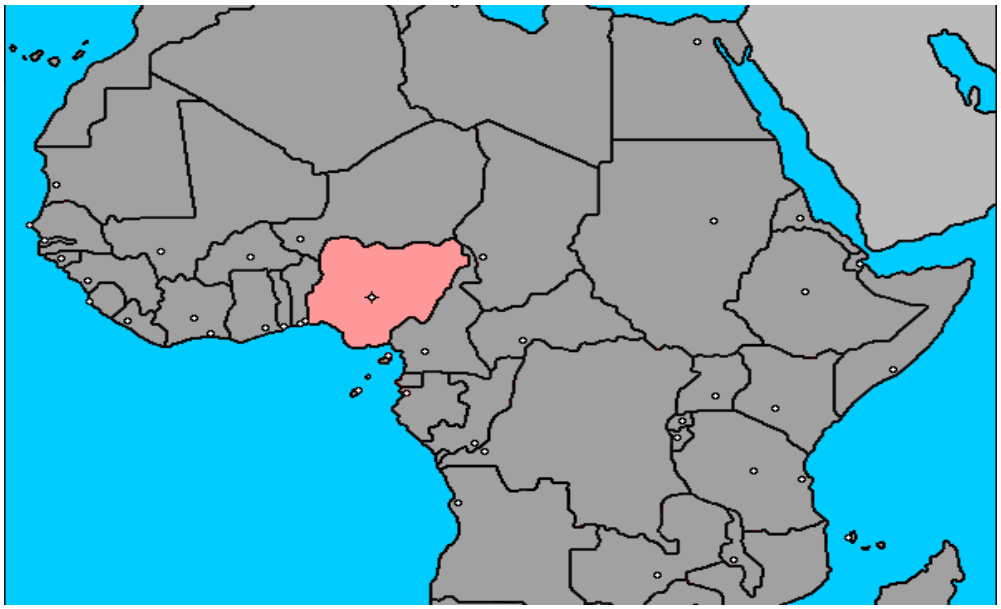
Research supervised by

Dr. Bilal I Avan

Principal Investigator

Dr. Joanna Schellenberg

Use of health data for decisions at the district level on maternal and newborn health in Northeast Nigeria



Dr. Nasir Umar
London School of Hygiene & Tropical Medicine

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Background: Three-tier system of government

Federal:

- ✓ Set strategic decisions or policy goals; resource mobilisation & distribution to attain set goals

State:

- ✓ Oversee the adoption or adaption of national health policies at the state and LGAs

LGAs:

- ✓ **Decisions on the provision of primary health care**

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Study setting: Gombe state

- ✓ Located in the North-East region of Nigeria; estimated population of 2.8 million
- ✓ Multi-ethnic and comprises 11 LGAs
- ✓ About 75% of the state is rural

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Study setting: Shongom LGA

- ✓ Estimated population of 151,520
- ✓ Purposefully selected

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Methodology: Data collection

- ✓ In-depth interviews about the generation of maternal & newborn health data and use of data collected to improve maternal & newborn care
- ✓ Key informants: drawn in collaborations with state ministry of health, state ministry for local government affairs, primary health care department of the LGA
- ✓ Interviewees: health administrators, decision-makers, health workers
- ✓ 21 of the 30 interviewees approached agreed to participate (June–December 2012, follow up May –June 2013

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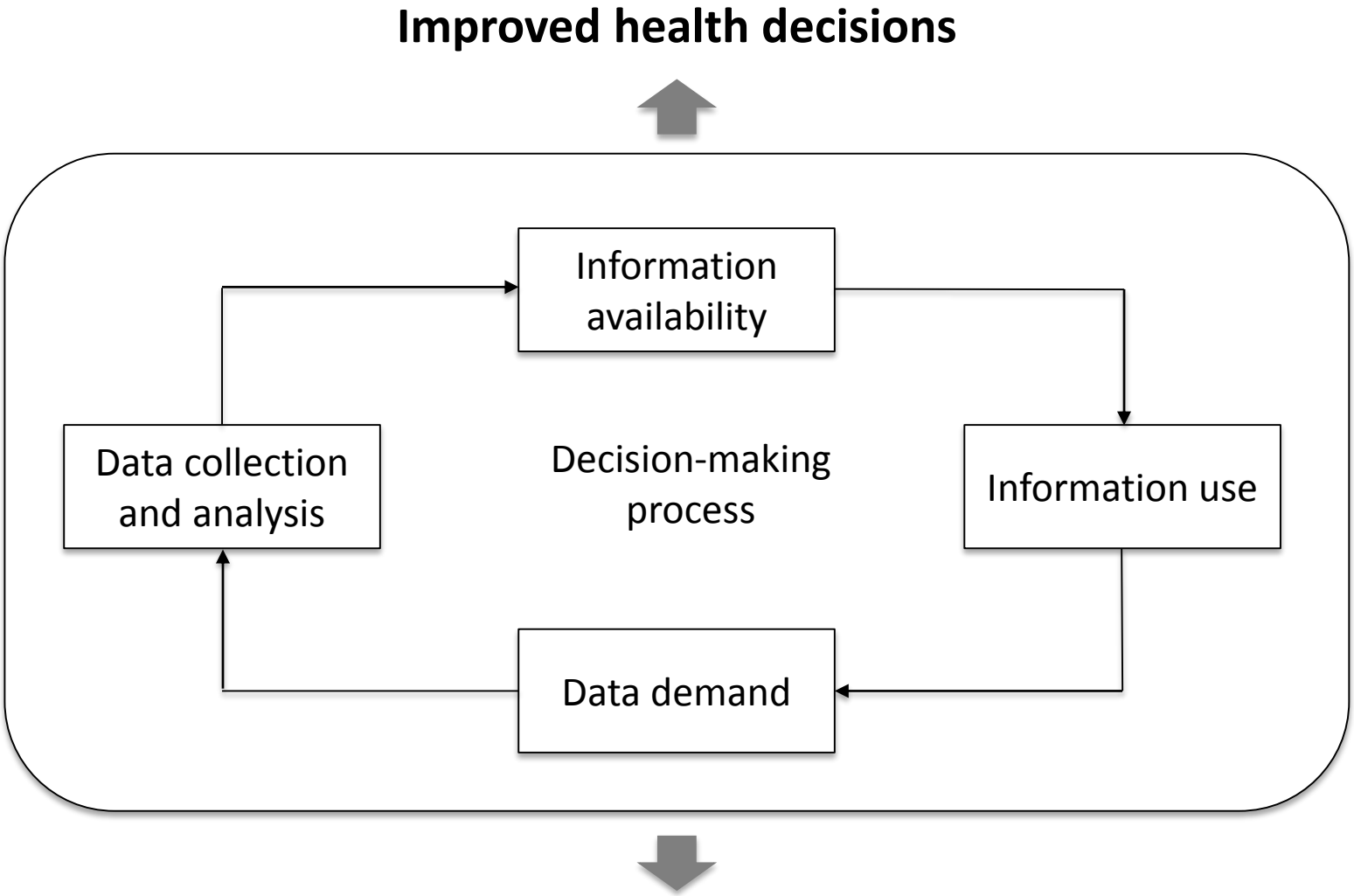
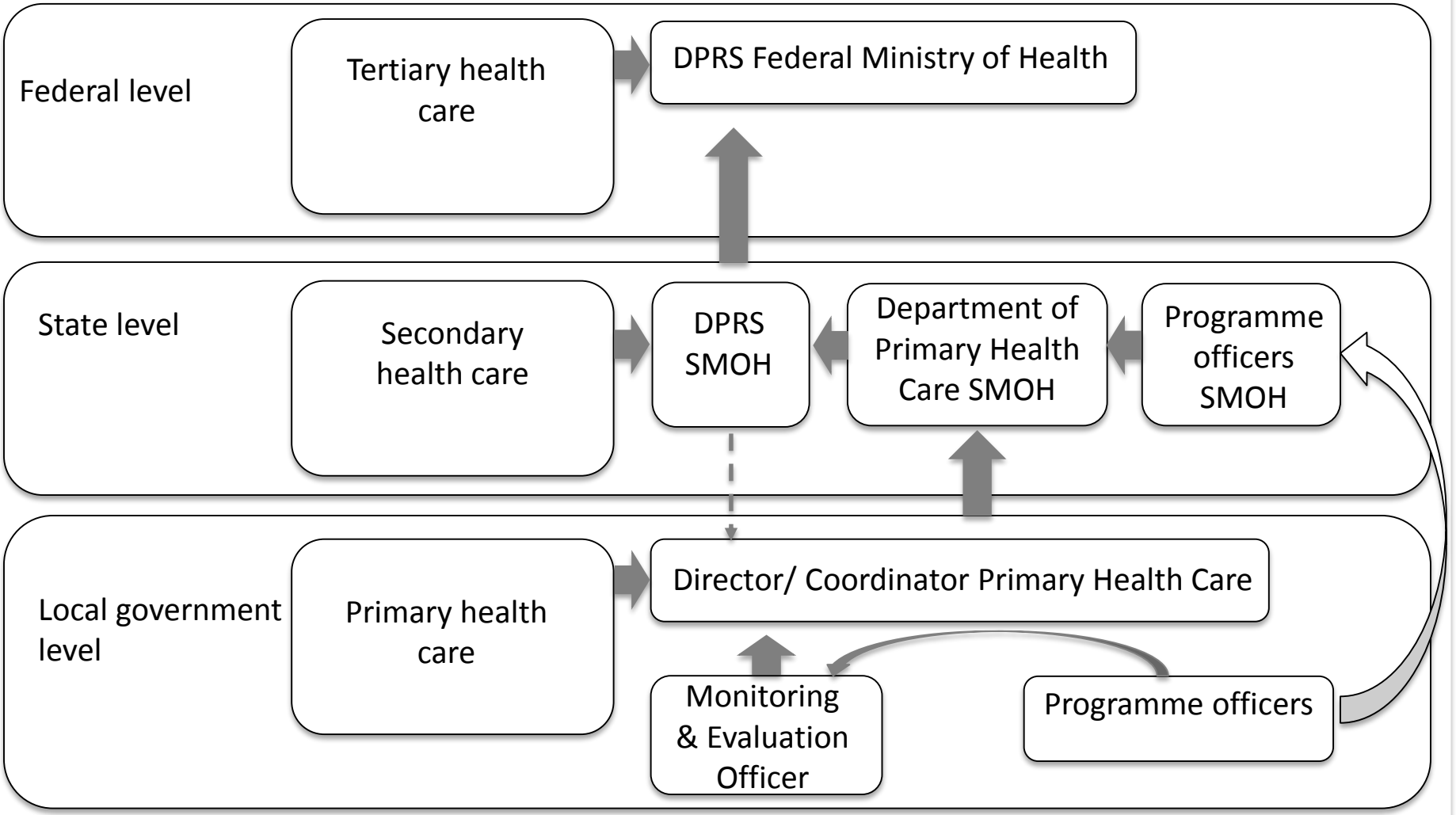
Methods: Data analysis framework

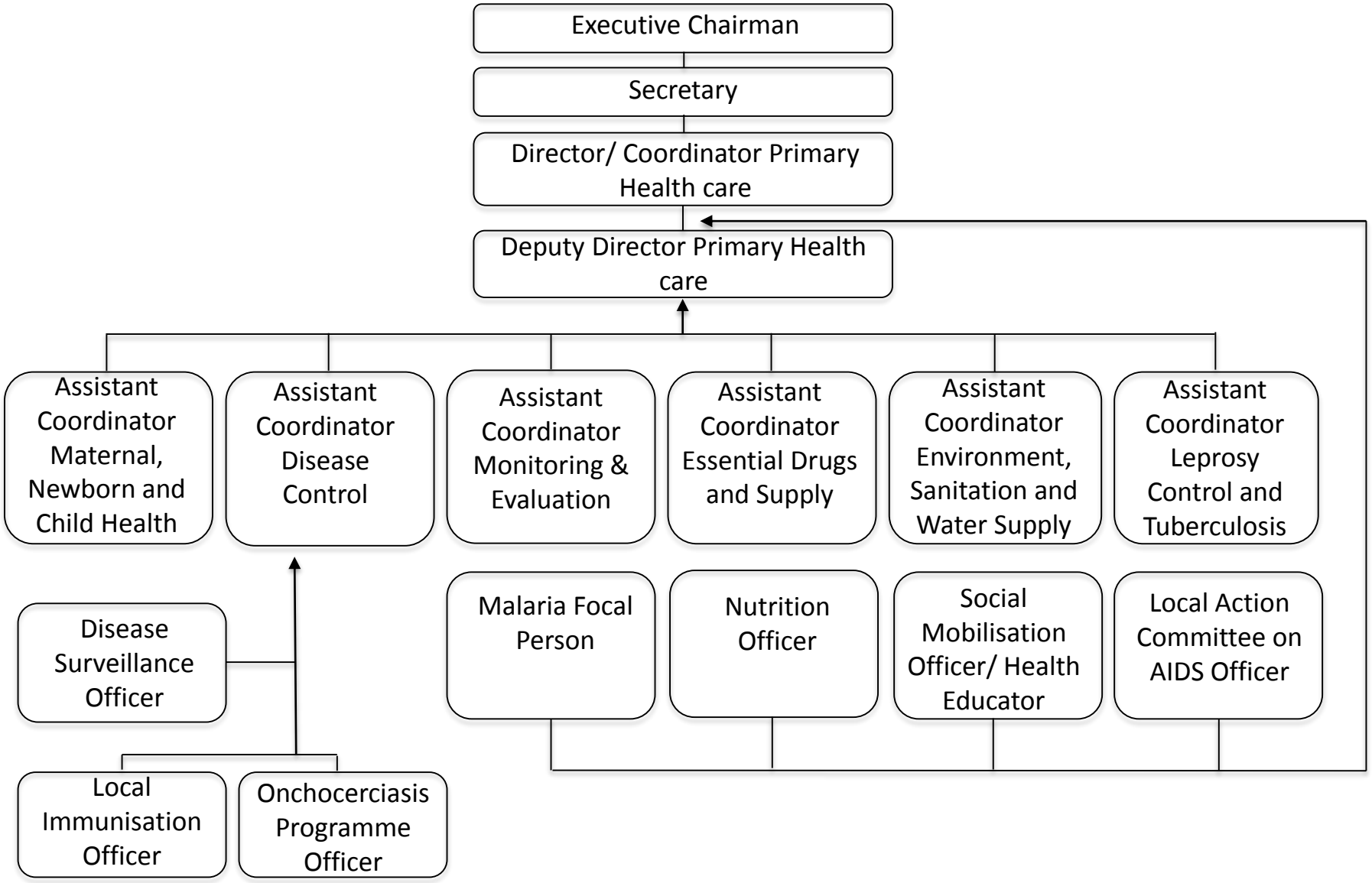


Findings: Data collection, analysis & health information availability for MNH



DPRS: Department of Planning, Research & Statistics
SMOH: State Ministry of Health

Findings: Use of health information & data demand for MNH



General findings

- **Data collection & analysis**
  - ✓ Limited skills of local government area staff to process and use health information
- **Information availability**
  - ✓ Limited access to health information by decision makers
- **Information use**
  - ✓ Inappropriate health information supplied to decision makers
- **Data demand**
  - ✓ Lack of funds for regular data management activities
  - ✓ Insufficient organisational support to demand, process and use health information
  - ✓ Limited interaction between data producers and data users

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Conclusions

Limited use of health data for decisions to improve maternal & newborn health at the LGA level in Shongom LGA

Created by Nicholas Menghini from Noun Project

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New developments

- **Primary Health Care Under One Roof**
  - ✓ One management body
  - ✓ One plan
  - ✓ One monitoring & evaluation
- **New national Health Act**
  - ✓ Linked budget earmarked for health
- **Decentralisation of power/direct funding to LGAs**
- **Improving security**

Thank you very much for listening

Research supervisor
Dr. Bilal I Avan

Principal Investigator
Dr. Joanna Schellenberg

Acknowlegements
HealthHub Nigeria – MLE partner in Nigeria
Gombe state MoH, MLGA
Shongom LGA

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IDEAS private sector study of MNCH data sharing in Uttar Pradesh and West Bengal, India

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Sanjay Gupta, IMPACT

Nirmala Mishra, PHFI

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Private sector: important service provider but limited role in public health planning or data sharing

UTTAR PRADESH (UP)

	Government source	Private Source	Total
Institutional deliveries	39%	17.6%	56.7%
Care seeking for an acute illness (fever, diarrhoea etc)	5.4%	92%	97.4%
Regular treatment for a chronic illness (TB, asthma, hypertension, diabetes)	15.6%	43.1%	58.7%

Source: Annual Health Survey, Uttar Pradesh, 2012-13

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Difficulties in estimation of institutional deliveries without complete data

WEST BENGAL

Institutional deliveries	North 24 Parganas	South 24 Parganas
Total reported institutional deliveries (to total annual *estimated* deliveries)	18.7%	28.9%
Total reported institutional deliveries (to total *reported* deliveries)	88.8%	61.5%

Source: NRHM Factsheet based on district HMIS Apr-Sept 2014

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Study objectives

1. Determine the composition and role of the private health sector in MNCH services (institutional deliveries, newborn care, immunisation, family planning)

2. Assess the status of MNCH data sharing by the private sector at the district level

3. Identify the barriers and enablers to data sharing

UP: Hardoi and Allahabad districts

West Bengal: North and South 24 Parganas

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Qualitative study

Key informant Interviews

Uttar Pradesh:	54 interviews
West Bengal:	36 interviews

Secondary data sources:
district level routine data

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Private facilities: features

Outnumber public facilities 2:1

Licensed and unlicensed

Bed strength : 5 to 500

Public private partnerships

Good data sharing for legislated services and PPPs, but not other services

Standardised and regular data sharing:

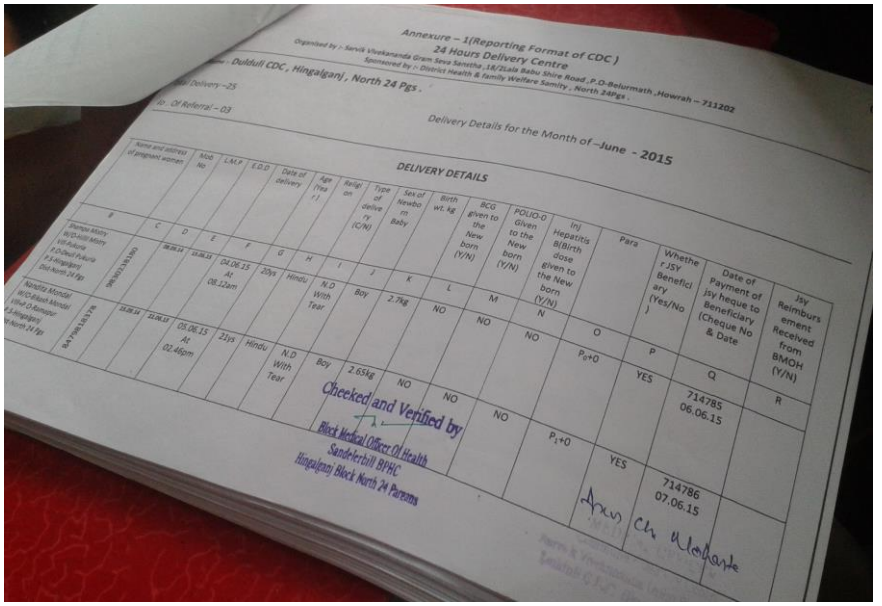
- Ultrasound services
- Medical termination of pregnancy
- Institutional deliveries by Community delivery centres
- Caesarean and normal deliveries by Ayushmati centres
- Online registration by private facilities in West Bengal

Varying and irregular data sharing:

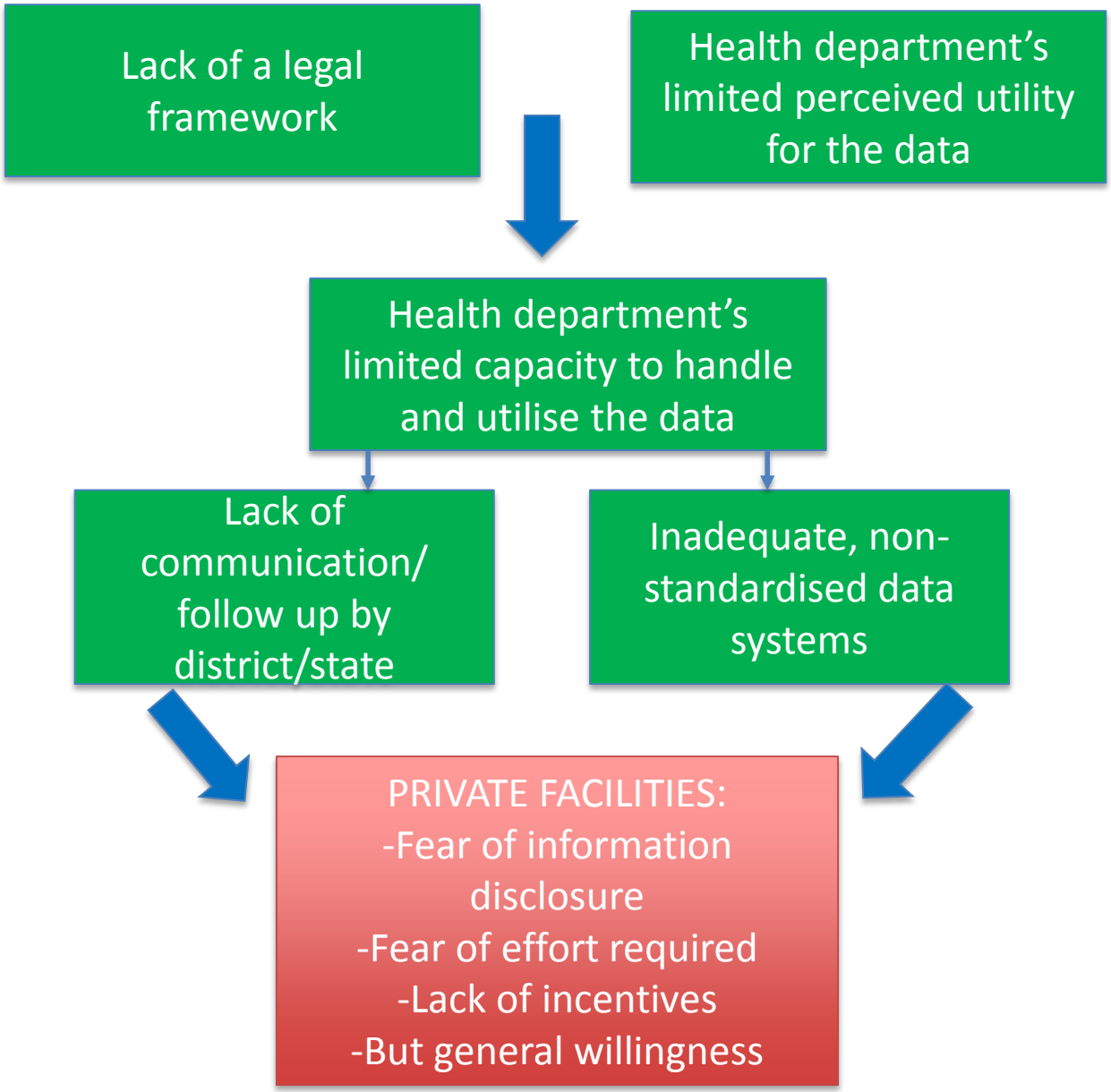
- By all other private for profit facilities, although most maintain basic data

No data sharing:

- By private unlicensed facilities



Factors affecting routine MNCH data sharing



Conclusions

- Private sector data is necessary for monitoring health services and outcomes
- Legislation is important but not the only prerequisite for public private data sharing
- Public health departments need to perceive value for data and develop data systems and utilisation mechanisms
- Private sector willingness to share public health data and also for other health engagements needs to be harnessed

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Summary

- The ‘Data-Informed Platform for Health’ introduces a data-based, structured decision-making process at district level
- Literature review shows examples of good practice, but no guideline for decision-making at district level
- Health ministry staff and other stakeholders are receptive
- Private sector (India) shows willingness to participate
- At district level, many health data are available but streamlining is needed
- Feasibility in Nigeria, Ethiopia and India
  - Challenging, need to adapt to context
  - Pilot work ongoing in India