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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Outline

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

Data Informed Platform for Health

Level I

- Data informed area for health (inputs & processes)
- Data informed area for health (inputs & processes)
- Data informed area for health (inputs & processes)

Primary goal

Use of data for appraisal and comparison of programmes and initiatives

Use of local data for decision-making and priority setting in the local health administration

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
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:

– Technology and Systems,
– Economic,
– Legal and Political,
– Operational, and
– Scheduling feasibility.
<table>
<thead>
<tr>
<th>TELOS framework: nature of inquiry</th>
</tr>
</thead>
</table>
| **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
## Summary of findings

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

+++ = 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
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**
Thank you,
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
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
What processes do district decision makers use...

to make health decisions?
Flow diagram of the systematic review process

Study identification
- Protocol and Eligibility criteria created
- 6108 peer-reviewed records identified
- 173 grey literature records identified
- 6281 titles and abstracts
- 3819 duplicates removed
- 2462 titles & abstracts screened for eligibility
- 2305 records excluded
- 157 full texts
- 3 full texts not available
- 154 full texts read
- 140 full texts excluded
- 14 full texts included for analysis

First screening

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

• Health Management Information Systems data (HMIS)
• Facility records
• Document reviews
• Other sources of data...
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
Interpretation: Three good practices for a decision-making process

1. Relevant and good quality data are pre-requisite
2. A structured process, including steps to help build consensus
3. A well-defined role for the community
Recommendation...

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

  “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**
- **District Hospital**: > 30,000
- **Community Health Centre**: 10,000 - 30,000
- **Primary Health Centre**: 5000 - 10,000
- **Sub Centre**: > 5,000
- **Community health workers**: 1,000

**Ethiopian Health System**
- **Primary Hospital**: 60-100,000
- **Health Centre**: 15-25,000
- **Health Post**: 3-5,000
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
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
<table>
<thead>
<tr>
<th>ID</th>
<th>Form</th>
<th>Internal number</th>
<th>Data element</th>
<th>Code</th>
<th>Thematic area</th>
<th>Levels of data Capture</th>
<th>NCH related data</th>
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<td>Total number of pregnant women Registered for ANC</td>
<td>QT</td>
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<td>Of which number registered within first trimester</td>
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<td>New women registered under Janani Suraksha Yojana</td>
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<td>Of which number received 3 ANC check ups</td>
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<td>Total number of pregnant women given T1T2 or Booster</td>
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<td>Pregnant women with Hypertension (BP&gt;140/90): New cases detected at institution</td>
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<td>Pregnant women with Hypertension (BP&gt;140/90): Number of eclampsia cases managed during delivery</td>
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<td>Pregnant women with Anaemia: Number having hgb level&lt;11 (tested cases)</td>
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<td>Pregnant women with Anaemia: Number having severe anaemia (Hgb&lt;7) tested cases)</td>
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<td>Deliveries conducted at the facility: of which number discharged under 48 hours treated</td>
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<td>Total number of pregnant women discharged under 48 hours treated</td>
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<td>Number of cases where Janani Suraksha Yojana incentive paid to: Mothers</td>
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<td>Number of cases where Janani Suraksha Yojana incentive paid to ASHAs</td>
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<td>Number of cases where Janani Suraksha Yojana incentive paid to: ANM or ANA (only for HPS states)</td>
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<td>C-section deliveries performed at facility</td>
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<td>A4.10.1</td>
<td>Pregnancy Outcome (in months): Live Birth</td>
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<td>Maternity</td>
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<td>Live birth Female</td>
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<td>Live birth Total (a) or (b)</td>
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<td>Details of Newborn children weighed: Number of newborns weighed at birth</td>
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<td>Details of Newborn children weighed: Number of newborns having weight less than 2.5kg</td>
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<td>Number of newborns breast fed within 1 hour</td>
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<td>Number of cases of pregnant women with Obstetric Complications and attended at facility</td>
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<td>Maternity</td>
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<td>Number of complicated pregnancies treated with: N Antibiotics</td>
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<td>Number of complicated pregnancies treated with: Blood Transfusion</td>
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<td>Women receiving post partum checkups within 48 hours after delivery</td>
<td>QT</td>
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<td>under Reproductive and Child Health Post - Nata Care</td>
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<td>Women getting a post partum check up between 48 hours and 14 days</td>
<td>QT</td>
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<td>PNC maternal complications attended</td>
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<td>QT</td>
<td>Maternity</td>
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<td>QT</td>
<td>STD</td>
<td>District planning and Monitoring</td>
<td>FALSE</td>
<td>under Reproductive and Child Health Medical Termination of Pregnancy (MTP)</td>
</tr>
<tr>
<td>U0100038</td>
<td>1</td>
<td>A7.18.6</td>
<td>Number of MTNs for which treatment initiated: Female</td>
<td>QT</td>
<td>STD</td>
<td>District planning and Monitoring</td>
<td>FALSE</td>
<td>under Reproductive and Child Health Medical Termination of Pregnancy (MTP)</td>
</tr>
<tr>
<td>U0100039</td>
<td>1</td>
<td>A7.18.7</td>
<td>Number of MTNs for which treatment initiated: Total (a) or (b)</td>
<td>QT</td>
<td>STD</td>
<td>District planning and Monitoring</td>
<td>FALSE</td>
<td>under Reproductive and Child Health Medical Termination of Pregnancy (MTP)</td>
</tr>
</tbody>
</table>
# Methods

## Content analysis of data forms

<table>
<thead>
<tr>
<th>WHO health system categories</th>
<th>Thematic Areas</th>
</tr>
</thead>
</table>
| 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

N = 210

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health worker (ASHA)</td>
<td>8</td>
</tr>
<tr>
<td>Community health worker (AWW)</td>
<td>19</td>
</tr>
<tr>
<td>Sub center/Additional Primary Health Centre (managed by ANM)</td>
<td>15</td>
</tr>
<tr>
<td>Primary Health Center (PHC) / Community Health Center (CHC) / Block Primary Health Center (BPHC)</td>
<td>71</td>
</tr>
<tr>
<td>District Female Hospital</td>
<td>26</td>
</tr>
<tr>
<td>District Programme Management Unit and Chief Medical officer</td>
<td>58</td>
</tr>
<tr>
<td>Private sector (for profit and NGO)</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
</tr>
<tr>
<td>Village</td>
</tr>
<tr>
<td>Block</td>
</tr>
<tr>
<td>District</td>
</tr>
</tbody>
</table>
India

Types of data available in a district health system

WHO Health System Category

- Contextual information: 5%
- Finance: 15%
- Governance: 6%
- Medical supplies: 12%
- Workforce: 6%
- Service delivery: 56%

N = 11,810
India

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

WHO Health System Categories

- Community n = 1,607
- Sub-district n = 5,254
- District n = 4,468
India
Maternal, neonatal and child health data collected in district public health system

![Bar chart showing distribution by MNCH Service Delivery Category]

- **Maternal health**: 28%
- **Neonatal health**: 18%
- **Child health**: 34%
- **Other***: 20%

**MNCH Service Delivery Category**

*Integrated MCH programme including nutrition, family planning, abortion, sanitation*
India
Inter-sectoral linkages in health data flow and sharing

Private (for-profit and not-for-profit)

Non-health departments & ministries

District Health Society

District level - District hospital & district NHM programme management unit

Sub-district level – Primary & community health centre

Community and village level – Community health worker & health sub-centre

State Health directorate and NHM programme management unit

Centre Ministry of Health & Family Welfare (Monitoring and evaluation division)

Village health, sanitation and nutrition committees

Formal data sharing

Informal data sharing
Findings:
Content analysis of district health data and inters-sectoral linkages in Ethiopia
**Volume of data available in a district health system**

**Ethiopia**

<table>
<thead>
<tr>
<th>S. No</th>
<th>Activity</th>
<th>Health Posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1</td>
<td>Number of facilities</td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Condom (number of monthly cycles distributed)</td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Oral contraceptives (number of monthly cycles distributed)</td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>Injectable (Depo-provera) (number of injections)</td>
<td></td>
</tr>
<tr>
<td>1.4</td>
<td>Daphragm (number of daphragms distributed)</td>
<td></td>
</tr>
<tr>
<td>1.5</td>
<td>IUDs (number of IUDs inserted)</td>
<td></td>
</tr>
<tr>
<td>1.6</td>
<td>Infants (number of visits)</td>
<td></td>
</tr>
</tbody>
</table>

**N= 13 forms**
Ethiopia

Types of data available in a district health system

WHO Health System Categories

N = 2,507

Service delivery: 74%
Medical supplies: 8%
Workforce: 5%
Governance: 4%
Finance: 4%
Contextual: 5%

Ethiopia

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

WHO Health System Categories

- Contextual factors
- Finance
- Governance
- Medical supplies
- Workforce
- Service delivery

- Community (Health Post) n = 209
- Sub-district (Health Centre) n = 764
- District level n = 1,534
Ethiopia

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

![Bar chart showing MNCH Service Delivery Category]

- Maternal health: 56%
- Neonatal health: 3%
- Child health: 27%
- Other *: 15%

*N = 1,170

*Integrated MCH programme including nutrition, family planning, abortion, sanitation
Ethiopia
Inter-sectoral linkages in health data flow and sharing

District Cabinet

District level
District Health Office

Private
(not-for-profit)

Sub-district level
Health centre

Private
(for-profit)

Kebele administration
Command post

Community and village level
Health Post (Health extension workers)

Formal data sharing

Informal data 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 Tadesse and Seifu Tadesse

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

Improving health worldwide

ideas.lshtm.ac.uk
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
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
Study setting: Shongom LGA

✓ Estimated population of 151,520
✓ Purposefully selected
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
Methods: Data analysis framework

Improved health decisions

Information availability

Data collection and analysis

Decision-making process

Data demand

Information use

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

Federal level
- Tertiary health care
  - DPRS Federal Ministry of Health

State level
- Secondary health care
  - DPRS SMOH
  - Department of Primary Health Care SMOH

Local government level
- Primary health care
  - Director/Coordinator Primary Health Care
  - Monitoring & Evaluation Officer
  - Programme officers SMOH

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
Conclusions

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

Acknowledgements
HealthHub Nigeria – MLE partner in Nigeria
Gombe state MoH, MLGA
Shongom LGA
IDEAS private sector study of MNCH data sharing in Uttar Pradesh and West Bengal, India

Meenakshi Gautham, IDEAS-LSHTM
Neil Spicer, IDEAS-LSHTM
Manish Subharwal, IMPACT
Sanjay Gupta, IMPACT
Nirmala Mishra, PHFI
Private sector: important service provider but limited role in public health planning or data sharing

**UTTAR PRADESH (UP)**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Government source</th>
<th>Private Source</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional deliveries</td>
<td>39%</td>
<td>17.6%</td>
<td>56.7%</td>
</tr>
<tr>
<td>Care seeking for an acute illness (fever, diarrhoea etc)</td>
<td>5.4%</td>
<td>92%</td>
<td>97.4%</td>
</tr>
<tr>
<td>Regular treatment for a chronic illness (TB, asthma, hypertension, diabetes)</td>
<td>15.6%</td>
<td>43.1%</td>
<td>58.7%</td>
</tr>
</tbody>
</table>

Source: Annual Health Survey, Uttar Pradesh, 2012-13
Difficulties in estimation of institutional deliveries without complete data

<table>
<thead>
<tr>
<th>Institutional deliveries</th>
<th>North 24 Parganas</th>
<th>South 24 Parganas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total reported institutional deliveries (to total annual <em>estimated</em> deliveries)</td>
<td>18.7%</td>
<td>28.9%</td>
</tr>
<tr>
<td>Total reported institutional deliveries (to total <em>reported</em> deliveries)</td>
<td>88.8%</td>
<td>61.5%</td>
</tr>
</tbody>
</table>

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

Secondary data sources: district level routine data

Key informant Interviews
Uttar Pradesh: 54 interviews
West Bengal: 36 interviews
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

Lack of a legal framework

Health department’s limited perceived utility for the data

Health department’s limited capacity to handle and utilise the data

Lack of communication/follow up by district/state

Inadequate, non-standardised data systems

PRIVATE FACILITIES:
- Fear of information disclosure
- Fear of effort required
- Lack of incentives
- But general willingness
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
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