



FORUM TRANSCRIPT: Private Sector Participation on Health Information Development and Use

These are all the postings that participants of this forum have posted each discussion day. The postings are organized by date of discussion.

Day 1 | October 9 - 10, 2012

POSTING #1: Bolaji Fapohunda <bolaji.fapohunda8@gmail.com>

Esteemed Colleagues:

Online Forum on Private Sector Participation on Health Information Development and Use: *Opening Address*
9-16 October 2012

“A robust routine health information system (HIS) that incorporates the private sector is pivotal to health sector performance and sustainability”

I'd like to formally welcome you to this important Forum on **“Private Sector (PS) Participation on Health Information Development and Use”**. In 2010, the 63rd World Health Assembly passed the Resolution “Strengthening the Capacity of Governments to Constructively Engage with the Private Sector in Providing Essential Health-Care Services (WHO 2010). This resolution is a testament to the relevance of the PS in improving the odds of achieving population health outcomes. Many notable initiatives have commenced or accelerated in many parts of the world since then. For example two notable initiatives in Africa are the WB led “Health in Africa Initiative” and the multi-partner agenda-setting “regional Conference on Engaging with the Private Sector, 2012”. What is not clear is why the information function is neglected in discuss and efforts to improve the performance and involvement of the private sector in health. This is in spite of the fact that information is needed to assess progress in goals that are being set for public-private sector partnership. In this Forum, we have a golden opportunity to bring the information function in. I have no doubt in my mind that we will produce ideas that will move our world forward.

Here are the main objectives of this Forum:

- Contribute to an increased knowledge and understanding of the current HIS data development practice and process in the private sector, discuss quality of information collected and the organizational, human and infrastructural capacity readiness for fulfilling this function.
- Describe health systems policy, legislative and regulatory environment and assess whether these have enhanced or debilitated the participation of the private sector in NHMIS and the implication of this for performance.
- Based on the Forum findings, recommend steps for sustaining or strengthening the private sector participation in NHMIS.

Under each objective, we have outlined key questions to focus our discussions (see the attached Program). We are sending you the key questions ahead of time for your review and reflections and to enable you prepare your comments in your spare time. However, we only want you to respond to the questions posted for each day. In other words, if we post question 1 for day 1, we do not want you to send comments on question 2. We only want you to send your answers to question 1.

Program

The program for the forum is attached. The program has a list of objectives, the key questions, and the day (s) in the week when specific questions are discussed. Please save this program for your reference.

Generally, we will post the key questions at the beginning of every two-days. In other words, every question we post will be discussed over a two-day period. At the end of 2nd day, we will synthesize comments and key findings. At the beginning of Day 3, we will share the key findings, any major follow questions, and the Forum questions for the next 2 days. To illustrate, Today, 9 October 2012, the questions we post are for discussion Today and tomorrow (10/10/12). By Tuesday evening, we will pull these questions out, collate the comments, synthesize them and itemize the key findings and any major follow up questions emanating from the discussions. By Wednesday morning, we will share the output and the key questions for Day 3 with you. These key and follow up questions will then constitute the focus of discussion for the next two days.

In your comments, please be as specific as possible. For example, if we post 3 questions, write your comments for each question under the specific question. This will enable us to keep track of your comments and assess the convergences as well as divergences in facts and opinions. If you have cross-cutting comments, that is, comments that are general to a few questions, please present them up front as general comments.

Rules of Engagement

Here are the guidelines for our discussion:

1. Let your voice be heard. The Yoruba of Nigeria have an adage: “ipolongo l’agunmu owo”. Translated, *telling it, speaking it, advertising it, is the medicine of business*. In this Forum, therefore, let us all speak out and be as participatory as possible. There are 140 of us in this Forum. Can you imagine the wealth of knowledge we will create if we can have at least one comment per person per question? We can do it! So, let’s go :-).
2. While sharing your opinions, let us be respectful of one another by being lively and succinct in our comments – taking care to refrain from ethnic or offensive grammar, jargon or felicitations. Make your contributions clear and straight to the point.
3. Every comment counts. Do not judge what others are saying. Let us be builders in our comments, getting the best out of our colleagues.
4. If you use findings/quotations from articles you have read, please give the citation/source document. This will enable our team to do more reviews if need be and to use your comments in the most optimum way.

On behalf of RHINO, MEASURE Evaluation, and John Snow, Inc., I will like to welcome you again to this all important Forum. We are now free to begin the discussion. If there are other announcements, I will pass that on to you as we go.

Here are the questions for our discussion today and tomorrow:

Day 1 & Day 2: Monday & Tuesday, 9-10 October 2012

Routine Health Data Development Process & Practice

1. What is the status of the commercial private sector (CPS) HIS in your countries? Are data being collected from this sector at all? What types of data are being collected? What processes are in place for data collection?
2. What infrastructure is in place for data collection in the private Sector: forms, hardware, capacity?
3. What is being done with the data collected? Where are the data sent? How is it utilized?
4. On a scale of 1-5, with 1 representing loosely, not integrated at all, and 5 representing tightly integrated, describe your impression of public/private sector integration on HIS in your country.

The following documents are attached:

1. A Word version of this address
2. The Program for the 6-day online Forum
3. Participants List

Thank you so much and welcome to the Forum on ***Private Sector Participation on Health Information Development and Use***.

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PS: A MS Word version of this address is attached for your reference.

POSTING #2: Susheel C. Lekhak susillekhak@gmail.com

Dear all,

I would like to introduce myself, my name is Susheel C. Lekhak, participating from Nepal, with a 10 years experience in HMIS. At present, working as a researcher in the health policy and systems field and partly working with WHO and NHSSP as a M&E consultant. My immediate response to the questions posted today are as follows:

1. What is the status of the commercial private sector (CPS) HIS in your countries? Are data being collected from this sector at all? What types of data are being collected? What processes are in place for data collection?

In Nepal, HMIS is collecting health service statistics from the CPS. According to the Department of Health Services 315 private health institutions had reported to HMIS in fiscal year 2010/11. In the year reporting coverage from those health facilities was 69.2%. (source: http://www.dohs.gov.np/sites/default/files/1/files/Annual_report_2067_68_final.pdf). But in absence of the exact number of health facilities registered and offering health services we cannot say exact reporting coverage. At present data is being collected on the service statistics of the routine priority public health programmes like immunization, family planning, safe motherhood, and hospital service summary and detail inpatient morbidity. There is no uniform and standard process adopted to collect data from the private sector. Most of the private health facilities are reporting at the end of fiscal year or at a time of service extension approval from government authorities in two or three years interval.

2. What infrastructure is in place for data collection in the private Sector: forms, hardware, capacity?

There is no formal provision of forms, hardware and capacity building activities for private sector recording and reporting. They receive a sample copy from district public health office and they have to make additional copies by themselves.

3. What is being done with the data collected? Where are the data sent? How is it utilized?

The received reports from the private health facilities are compiled in the routine monthly reports by district health offices. But if they do not report in time or not in regular monthly basis then those reports are not incorporated in routine HMIS. The compiled reports from district health offices are forwarded to Regional Health Directorates and central HMIS office. Due to the data management practice, i.e. system does not allow disaggregation by public and private health facilities, use of data is very limited.

4. On a scale of 1-5, with 1 representing loosely, not integrated at all, and 5 representing tightly integrated, describe your impression of public/private sector integration on HIS in your country.

The rating from my side is 2.

With regards,

Susheel

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POSTING #3: Kelvin Chukwuemeka <KChukwuemeka@engenderhealth.org>

1.) I will start by defining Health Information System (HIS) as a mechanism used to collect, process, transmit and analysis information for the use of training and research in health services. From my point of view relating to my definition, the status of commercial private sector health information system in Nigeria is below average even though it has improved over the past years.

- Yes data are been collected.

- Data collected are Federal Ministry of Health (FMoH) medical statistics, mortality and morbidity data, records of birth and deaths in hospitals, community data information.

- The process in collecting data are at national level, state level and Local Government Area (LGA) level

2.) Forms are the infrastructure in place for collection data

3.) The data collected are used as a management tool for making an informed decision at all levels of government, those who priveded the data and the general public.

- The data are sent to the National Health Management Information System (NHMIS).

- Its been utilized to give a unified information in order to assess the health status of the population.

4.) On a scale of 1-5, i will give Nigeria number 2 because my impression is that there is a huge backlog of unprocessed data, lack of feedback to peripheral levels, shortage of staffs and materials, finance.

POSTING #4: Michael Rodriguez from Abt Associates

Greetings fellow RHINOs! Have provided technical support to countries ranging from Namibia to Nigeria to Ethiopia to Peru to Thailand to the U.S. and have some thoughts on private sector reporting in general. Look forward to additional comments from country counterparts.

1. What is the status of the commercial private sector (CPS) HIS in your countries? Are data being collected from this sector at all? What types of data are being collected? What processes are in place for data collection?

Primarily the type of data being routinely collected from the private sector is surveillance data, communicable diseases, including some HIV testing data. Processes tend to be very informal, with much of the variation correlating to the amount of regulation and/or official oversight the public sector has over the private sector. As Susheel in Nepal noted, **“in absence of the exact number of health facilities registered and offering health services we cannot say exact reporting coverage.”** Colleagues from the AfyaInfo project in Kenya have helped the MoH address this issue by creating a master facility list that uniquely identifies facilities across both the public AND the private sector, which is a very big step in toward addressing coverage data issues.

2. What infrastructure is in place for data collection in the private Sector: forms, hardware, capacity?

For the *surveillance type of data*, there is typically standardized data collection forms (or formats) for CPS reporting. The same cannot be said of routine health stats collection from the CPS. Because of the small size of the businesses in private practices and fragmented nature of the sector in general, there are typically many different types of hardware (if at all), which means there are frequently different formats for capturing the data that they collect. Many times the data the CPS collects is only relevant to the running of their business.

3. What is being done with the data collected? Where are the data sent? How is it utilized?

See notes above.

4. On a scale of 1-5, with 1 representing loosely, not integrated at all, and 5 representing tightly integrated, describe your impression of public/private sector integration on HIS in your country.

I have yet to see a system that I would categorize as anything above a 2 with regard to public/private integration of HIS.

Kind regards,

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POSTING #5: Contributions from Dr. Theo Lippeveld, Vice President, JSI, USA.

Dear colleagues and RHINO friends.

I thank the moderator of this forum for launching a debate on such an important topic as the participation of the private sector in routine health information systems (RHIS) in low and middle income countries (LMICs). On this first day of the forum we concentrate on the current situation in LMICs. My experience comes from Pakistan, a country where the private for profit sector provides about 3/4 of the curative health services, but where its participation in the government district health information system (DHIS) is quasi zero. While most of my experience in Pakistan dates from the nineties, as far as I know this situation is still very real today. I know that some colleagues from Pakistan have registered for this forum, so I hope they can correct my statements if needed.

There are many causes why private sector providers are not participating in the DHIS reporting system, but in my opinion the root cause is that there is no overall private sector legal framework (including accreditation) in most of the provinces of Pakistan, and if there is one, it is not enforced. Private providers can operate their cabinets or clinics without any accountability on their quality. There is little or no incentive to report on the quantity and quality of the services provided. On the contrary, many would be reluctant to report because of the fear for taxation by the government.

But not only are private care providers not reporting to the government, they also do not use information for decision making in their own clinic or for their own patients. This is linked to a general lack of “information culture” by both public and private health professionals. Information is not valued as a resource for problem solving by senior managers of the health system, as well as by pre-service training institutes.

Both low reporting rates and low use of information by the private sector is certainly not typical for Pakistan and exist in many LMICs of Africa and Asia. But it is particularly harmful in a country such as Pakistan where the private sector offers their services to the majority of the population. It not only impacts individual health with high iatrogenic morbidity and mortality, and wastage of resources, but also leads to an inefficient public health system with high maternal and neonatal mortality and continuing infectious disease burden.

I wanted to describe this grim picture in a country such as Pakistan, to advocate for urgent action by LMIC governments to regulate private health services, as well as the health information systems in support of them. Privatizing service delivery could provide a valid alternative to the lack of quality of care and responsiveness in government health services, but only at the condition that the government can regulate both the delivery and financing of the health services, as well as support systems such as the routine health information system. I hope that this forum can generate an action agenda to address this situation.

Theo Lippeveld,
HIS Advisor
MEASURE Evaluation and RHINO

POSTING #6: Bharat Ban bban@nfhp.org.np

Namaste all,

I am Bharat Ban working as a Specialist and Team Leader for Nepal Family Health Program II on behalf of JSI. My response to the questions are following:

1. What is the status of the commercial private sector (CPS) HIS in your countries? Are data being collected from this sector at all? What types of data are being collected? What processes are in place for data collection?

The private sector reporting is very poor in Nepal. Although the private sector is supposed to report the service statistics to the public sector which is responsible for compiling all the data, this is not being done. Some data on family planning and safe motherhood are being collected but as mentioned above the reporting is very poor.

2. What infrastructure is in place for data collection in the private Sector: forms, hardware, capacity?

The private sector institutions have some infrastructure such as computers etc. They use the recording and reporting formats that is supplied by the public sector. The formats have to reproduced by themselves. There are persons who are supposed to record the data but the problem is there is often changes in their human resources lacking a responsible for who does recording and reporting. There is not adequate follow-up system on recording and reporting from private sector.

3. What is being done with the data collected? Where are the data sent? How is it utilized?

The data collected are submitted to the district public health office which compiles both private and public sector data on a monthly basis. The district reports the data to the center. The combined data is generally reviewed in semi annual and annual review meetings. However, there is no such mechanism where one can analyze the private sector data separately.

4. On a scale of 1-5, with 1 representing loosely, not integrated at all, and 5 representing tightly integrated, describe your impression of public/private sector integration on HIS in your country.

I will rate 2 as private sector reporting is very poor.

thanks,
bharat

POSTING # 7: "Erwin Nakafingo" <his@healthnet.org.na>

What is the status of the commercial private sector (CPS) HIS in your countries? Are data being collected from this sector at all? What types of data are being collected? What processes are in place for data collection?

In Namibia, the private sector is not reporting to the Ministry of Health. There are no formal mechanism in place yet. However, the MOH, Namibia is currently undertaking the Health Information Systems strengthening activities which includes the establishment of the HIS directorate which will oversee and coordinate all health information data collection activities in the country. The policy document and HIS strategy will address the issue of private sector reporting requirements as well. To date, health districts and regions are engaged in informal agreement with some private practitioner on data sharing especially on routine immunization among others.

What infrastructure is in place for data collection in the private Sector: forms, hardware, capacity?

The private could use the existing structure to report data, the current dataset that the MOH is using could be made available to the private sector as well. However, in the absence of formalized mechanism, legislation and other enabling environment, this is yet to be realized.

On a scale of 1-5, with 1 representing loosely, not integrated at all, and 5 representing tightly integrated, describe your impression of public/private sector integration on HIS in your country.

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Best regards,

Erwin Nakafingo

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DAY 2 | October 11, 2012

POSTING#1: Titus Kolongei tkolongei@gmail.com

Dear all

1. What is the status of the commercial private sector (CPS) HIS in your countries? Are data being collected from this sector at all? What types of data are being collected? What processes are in place for data collection?

Response: In Kenya the health information system in the private sector has shown tremendous improvement over the last few years. The private health sector have been involved in health information forums unlike before. However through the introduction of the Master Health facility list and launching of a Kenya Health information policy (2010) the future is good for strengthening of private sector health information system. The type of data being collected are mainly the outpatient and inpatient morbidity data. The processes include monthly health information data reporting using Health Information data collection tools availed by Health Information System(HIS).

(Keya seems like we are having some MODEL COUNTRIES when it comes to CPS HIS can show the way to others)

2. What infrastructure is in place for data collection in the private Sector: forms, hardware, capacity?

Response: The private sector mostly purchase their own computer hardware and accessories, however data collection tools are availed by the health information system within the ministries of health. The capacity of private health sector though have now shown improvement, health information system still require strengthening. There is need to ensure that personnel handling health information system are professionals well adept with health information systems. The main challenge of the private sector is that they tend to employ non professionals to handle data due to their fear that health information professionals may require more remuneration in terms of salary and other benefits. This is the greatest challenge being faced. In Kenya there are now many health information professional now qualifying in colleges and universities but have challenges of securing employment even in the private sector.

3. What is being done with the data collected? Where are the data sent? How is it utilized?

In Kenya the data being collected by private health sector is essentially for planning and management of health service however this may not be used uniformly for such purposes. Some still see data being collected as being a 'HIS requirement'. The data is sent to the District Health Information Systems in each respective district. The District health Information Officers in turn consolidates the data into the district health information system which is intended to provide information on the real burden of disease

4. On a scale of 1-5, with 1 representing loosely, not integrated at all, and 5 representing tightly integrated, describe your impression of public/private sector integration on HIS in your country.

In Kenya i will rate the HIS at 1 as being loosely integrated although if the option was there i could state its fairly integrated requiring further strengthening by ensuring that health information professionals are mandated to manage private health sector health information systems

Conclusion: Involvement of the private sector in development of health information policies, improvement or strengthening of health information system is a cornerstone to an effective and efficient health information system in any health care setting.

Titus Kolongei
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POSTING #2: Wanjala Pelela <wanjala2p@yahoo.com>

Yes, the private for profit Health facilities are reporting but not more than 50%, We've given them some incentives such as standard tools for reporting, trainings whenever we plan for as well as ICD10 books but because they do not employ the technical right human resources for data management, they have the challenges in compilation. Immunisation is easier as its tallied and that is over 80% reporting across the from private entrepreneurship to GOK.

In kenya target setting is by use of online planning and a few private institutions have also developed Annual

Work Plans which we could easily monitor their performance.

From the current constitution, We've The Health Bill which is compelling all stakeholders/ service providers private sector included to have mandatory reporting. Its now at cabinet level and hopefully this will be able to enforce it. We also plan to have an ACT on Health information after the Bill has been passed though we already have Health information policy which needs be enforced by the two documents i.e. The Bill on Health and the ACT on Health information which are the two documents outlined in the current MOH strategic plan 2012-2017. All this are also accorded to the Vision 2030 where Health information is a FLAG ship.

Infrastructure, that we have developed a standard platform for EMRs, DHIS2 software and given rights of access across the GOK and private. Those with internet connectivity should be able to enter their data direct into the system and provided them with some user trainings. We have also given them standard MOH tools and capacity which we think is necessary for delivery.

Annually we generate reports and share across with each facility getting a copy; We plan to start quarterly bulletins and encourage lower levels giving quarterly and monthly feedbacks. We are also writing the M&E framework which will support in information sharing and outlining responsibilities for all the stakeholders in health.

Public/private sector integration on HIS, Yes, in Kenya we have the private consodium which represents all the private facilities and are members of PPP. Even developing the indicators, SOPs/guidelines they participate and this is one way of integration.

Our starting point of engagement is by also establishing one National Health Information system (NHIS) and in our case we've Level one which is community with its own structures and linkage to Health facility. Each Health facility is assigned unique code which is a Master code (MFL code) and this can link the various databases and harmonise the Org Units in the systems. see www.ehealth.or.ke as public site; We are also building in the regulatory module which will ensure that while facilities are licensed, It need to report consistently to allow renewal of practice;

regards

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POSTING #3: Susheel C. Lekhak

Here in Nepal, we are also regularly advocating to develop a standard and complete health facility database (registry), HMIS and supporting agency are now interested to develop such database. Right now many agencies (inter governmental) and level (organizational hierarchy) are responsible for approval and accreditation of private health facilities which is creating difficulty to develop comprehensive an complete database.

WHAT RATING 2 ON HIS IMPRESSION MEAN –LEKHAK

Just for clarity, as Mr. Ban and me both ranked Nepal in the 2nd scale of ranking. I would like to share little bit justification for clarity, hope it will be helpful for we all.

Strengths:

1. Exists provision of regular reporting from private health facilities in routine HMIS
2. District Health Offices (HMIS Unit) compiles reported figure in the monthly reports and forwards a compiled copy to central HMIS.
3. Health Sector Information System Strategy (HSISS) which is a guiding strategy for health sector information system suggests to develop a complete health facility database and collected health facility information in the three piloting districts.
4. A separate reporting format is designed during the Health Sector Information System piloting in three districts.

Weaknesses:

1. The complete list of private health facilities is not available
2. Reporting is not regular and complete
3. Training not provided to the private health facilities
4. Many private health facilities don't have medical record position to maintain medical records and report to HMIS
5. Analysis and use is limited at all levels
6. Lack of participation of private sector in the health sector reviews
7. Lack of interaction programmes with private health facilities regulating authorities and associations

With regards,

Susheel

POSTING# 4: Daudi Simba <daudisimba@yahoo.com>

IN TANZANIA

1. What is the status of the commercial private sector (CPS) HIS in your countries? Are data being collected from this sector at all? What types of data are being collected? What processes are in place for data collection?

Status: Commercial private sector, specifically, Private Health Facilities, is involved in the HIS. The Ministry of Health and Social Welfare registers the facilities. Each facilities is provided with registers according to services provided and are expected to report quarterly and annually using specific reporting forms. Reporting rate is from these facilities is quite low partly due to high staff turnover rate and lack of motivation to report. Since the system is paper based, it is expected that reports will be collected during supervision. However, supervision is usually not done in many district.

2. What infrastructure is in place for data collection in the private Sector: forms, hardware, capacity?

Systems is paper based at the facility level. Some Districts have computerised HIS however reporting to the MoHSW is still paper based.

3. What is being done with the data collected? Where are the data sent? How is it utilized?

Through Public Private Partnership District are expected to plan and implement various national programmes with the involvement of the private sector. Annual reviews have reported inertia on private sector involvement by the District Health Management teams. Therefore the little data obtained from the private sector is not fully utilized.

4. On a scale of 1-5, with 1 representing loosely, not integrated at all, and 5 representing tightly integrated, describe your impression of public/private sector integration on HIS in your country.

My impression in terms of integration scale is 2.

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POSTING# 5: Brivine Sikapande (brivinesk@yahoo.com)**PRIVATE HEALTH FACILITY REPORTING IN ZAMBIA**

1. Private health Facilities reporting into the main stream routine HMIS is about 24%. The private health facilities reporting varies according to the services that are offered at their health facilities. So the reporting is targeted at only the services offered by the particular facilities.

At facility level, the system is paper based and the tools used for the collection of data are the registers and tally sheets which are then aggregated into the HIA 2; Once this information has been aggregated into the HIA2, the facilities will send it to the District health Offices on a monthly basis for input into the DHIS software. Once in the DHIS, it is compiled and transmitted to the provincial level and later to the national level

Note: That the Health Sector has a health facility listing of all the health facilities in the country including the private health facilities

2. The systems at used for reporting are paper-based even at the private health facilities

3. Data collected is reported to the District Health Office through the DHIS software and used to inform planning at the district level. It is also used to plan for services at the health facility as well as at the district level.

4. At a scale of 1-5 I would describe my impression of public/private sector integration on HIS in my country as 2 because the ministry is in the process of initiating reporting tools to all the other private health facilities. By end of 1st quarter of 2013 we expect all the private facilities across the country to have been trained in readiness for reporting through the routine HMIS.

Strengths

1. Training of private health facilities on the use of HMIS reporting tools is under; this training will ensure integration of private health facility reporting into the routine HMIS

2. Availability of a health facility listing that is update every two years to include all newly created facilities; this includes all health facilities regardless of ownership

3. The sector is bringing on board all key stakeholders including the private health facilities into the sector reviews.

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"If it aint written, then it aint there"

POSTING# 6: "Kelvin Chukwuemeka" <KChukwuemeka@engenderhealth.org>

Hello Everyone,

Good that this forum is participatory and everyone is talking about what their country do and how it's done.

- In most health sector, HIS scaling which "is not just a luxury but a pre-requisite" (Braa, Monteiro and Sahay, 2004, P. 341) for example immunization just like Wanjala from Kenya said that immunization data is easier captured. I believe that data collection from all facilities in a region, province or country are needed. Yet HIS which I also believe is a field of study needs to be explored in depth in Nigeria and to do this, the most common gateway used in Nigeria is paper-to-paper but with the help of international Non-Governmental Organizations (NGOs) in training staffs in data collection. Paper-to-computer gateway has started coming to the limelight with the use of simple software solutions.

According to Susheel who works in Nepal, I will say that your country weakness is similar with that of Nigeria because since in the 1960s, Federal Ministry of Health (FMOH) medical statistics has been in place, records of births and death in hospitals used to be published annually and quarterly.

- In the year 1988, Department of Planning, Research and Statistics were created after the reorganization of the civil service. In the same year, National Health Policy was adopted which called for the establishment of a National Health Information System by all levels of government.
- NHMIS started operating in Nigeria in the year 1999 but the data collected were not accurate and wrongly filled because the forms were complex and cumbersome.
- THE NHMIS was reviewed in the year 2004 and the focus was on health indicators and health data systems.
- The major weakness in Nigeria is the huge Backlog of unprocessed data and lack of feedback to peripheral.
- I won't overlook the good job of what most international NGO's are doing in Nigeria with the help of training of private health facilities on the use of HMIS for making informed decision, quarterly report of data and stakeholder meetings to inform them on the outcome of the data.

I thought to share this with you all and looking forward to more contributions and ideas to be shared in this forum.

Regards

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Greetings and thank you Bolaji and moderating team for providing the opportunity to share ideas and experiences.

POSTING #7: Maria Kamau <Maria_Kamau@afyainfo.org>

Am working for the AfyaInfo project in Kenya and I see that much has been contributed on the national system so I will try to add value;

Routine Health Data Development Process & Practice

1. What is the status of the commercial private sector (CPS) HIS in your countries? Are data being collected from this sector at all? What types of data are being collected? What processes are in place for data collection?

First small correction, AfyaInfo project came into existence after the Master Facility List (MFL) had been created by MOH with assistance from others and was fully operational. However, Afyainfo is currently supporting the MOH to strengthen its functionality and use, such as a recent exercise focusing on data cleaning and updating of the database to reflect changed circumstances such as increase of districts, change of users, etc. and to establish areas for further development; That said;

a) The Status: indeed the most significant milestone in integration with private sector in Kenya is this very MFL (which is simply a list) and the DHIS2 (which is the interactive data collection and management system). Out of the 8000+ health facilities existent in the databases, in MFL about 33% are private facilities and in the DHIS about 29%. However, it is well accepted that there are many more private health facilities not included in either system, especially within the urbanized towns and cities. As it stands, there are plans to expand the scope of records in MFL to include pharmacies, chemists, mortuaries, etc. majority of which are well known to be operated within the private sector. Regulatory bodies are also currently being engaged to get involved and they are excited as it will present an opportunity to add value to their regulatory systems in keeping track of who / what / where details.

b) Types of Data: The most successful data collection from private sector as mentioned is the immunization data. To some extent private facilities also provide other data sets like outpatient, HIV related data, reproductive health, etc. with varying (mostly low) degrees of completeness or timeliness.

c) Processes:

· Immunization reporting is the best because there is a direct incentive: vaccines & related supplies will not be provided or replenished unless monthly data/reports on previous services provided are presented in exchange. Moreover, the data collection tools (forms, registers, tally sheets) are provided together with vaccines & related supplies. This has been extremely effective on two counts: one, private sector's contribution to immunization services is included in national data (though I don't know to what extent it is specifically analyzed and accordingly proportioned); and two, when calculating national coverage, the likelihood of the outcome being reflective of what is on the ground is much higher (if we don't look too closely to data quality issues which applies to public sector reporting as well). The underlying point is that while the 'hard' justification for reporting is absent (regulatory framework), the 'soft' justification (incentive or what's-in-it-for-me) has resulted in favorable environment where the private sector actively participates in providing the required reports as evidence of their contribution to health service delivery.

· For the MFL, by including the regulatory bodies in updating of the records, it is hoped that there will be an added incentive to report such that license renewal or registration will require the private facilities to demonstrate that they have been reporting regularly, though this would potentially create other conflicts of interest since licensing is as much an income generating activity as it is part of the regulation processes.

2. What infrastructure is in place for data collection in the private Sector: forms, hardware, capacity? As mentioned, especially for immunization, tools and training on their use are provided.

3. What is being done with the data collected? Where does it go? How is it utilized?

Still on immunization data, it goes to MOH and is used to plan future supplies as well as analyzed to calculate regional and national coverage rates. For other data collected, it is also normally aggregated with public sector data to establish service delivery uptake. However, what could be done with greater effort (in my view) is to analyze the data from private facilities separately so as to establish proportion of services reportedly accessed, and this shared as feedback to both reporting and non-reporting facilities. It is true as mentioned by Theo that the private sector is also unlikely to be using the data themselves so may not consider it important to collect it unless forced to. Perhaps regularly providing feedback (and the forums to discuss) could create more awareness and interest. More often, when government and supporting agencies try to be more inclusive across the health sector, the reach is usually to Faith based organizations, NGOs and research institutions, but not private sector (for many reasons).

Meanwhile, enforcing regulations in this part of the world generally has its challenges (there are regulations for proper clinical practices and yet....) so I believe that the more we use the softer incentives or carrot-and-stick methods such as sharing data / feedback regularly, and at such forums naming-and-shaming reporting performance, the more likely we could perhaps encourage more positive response to data collection and use. This could especially work with the larger institutions like private hospitals where their contribution to health service

delivery should be made public (in a positive way) so as to engage them in the discourse (and perhaps create healthy competition too).

4. On a scale of 1-5, with one representing loosely, not integrated at all, and 5 representing tightly integrated, describe your impression of public/private sector integration on HIS in your country.

I would say 2, first because there is a national list in which they are included complete with geocodes that identify their exact location all over the country, and second because they do provide data to the MOH on a regular basis (though regular is relative, at least for immunization data it is monthly and consistent).

Thanks.

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Day 3| October 12, 2012

POSTING #1: Bolaji Fapohunda <bolaji.fapohunda8@gmail.com>

Greetings All!

We are now in Day 3 of this important Forum. I wanted to thank you for your participation. I thank, most especially, all our commentators. We have received about 12 postings so far. This is impressive given that this somewhat new topic area. Here are a few general takeaways from this discussion:

- CPS will collect and report service statics if the leadership exists in countries. In Kenya, Tanzania, and Zambia where a formal structure is in place for information development in the private sector, CPS are reporting. In Kenya, which appears to be the most advanced, reporting coverage is roughly 50% and about 80% for immunization program. Leadership entails the provision of structure, infrastructure as well as human capacity for data development, reporting, and use. An essential expression of the leadership is the existence of legal framework: rules, legislation and regulation, mandating CPS participation in HIS processes. When this Framework exists and are enforced, CPS will cooperate.
- In countries where reporting is occurring, reporting coverage is hard to estimate for lack of denominator data. In the absence of coverage data, it is difficult to determine the effectiveness of reporting and what/who is left out or

dropping out and why? As a cure, the development of HF registry is suggested. Evidence presented by Kenya, Tanzania, and Zambia, countries which have established HF registry, implies that this medicine might work. These countries also present good models for countries who may want set up their own HF registry. However, a fragmentary CPS renewal and registration system poses a major challenge to efforts to develop one HF registry in countries.

· In general there is very little data use in countries. In countries where use is occurring, e.g. Kenya and Zambia, data are used mainly at the central/national levels to inform planning and vaccine forecasting. Use at service delivery points is rare and ought to be encouraged. The first step to encouraging such data use is to ensure that data are provided in useable quantities and shared with facilities regularly. For the CPS, this will entail disaggregating data by facility ownership (private/public).

In the coming days, we will discuss the issue of leadership and the existence of a legal framework for CSP participation in HIS in more detail since this an umbrella condition for getting everything else in place. The questions are:

1. In your countries or countries where you work, what legislations, policies, and regulations are in place for service delivery and are they working?
2. Do these legislation, regulations, and policies offer sufficient guidance and basis for data collection in the private sector? If not, what improvements are needed?
3. Who are the key stakeholders and what are their roles and responsibilities in private-sector participation in HMIS?

Please respond as specifically as possible. A few participants already stated that a legal framework for CPS participation in HMIS does not exist in their countries. In these cases, please tell us what will be the key ingredient to make such framework happen and what key elements might be good to have in it?

I have the following follow up questions for the comments in the last two days:

Zambia--Dr. Sikapande: Your input is refreshing, thanks. Please can you illustrate with one concrete example how data is being used in the facilities? For instance take one clinic in Lusaka and illustrate how they used data for planning; what processes were used, changes made and the results. Why is reporting coverage so low (24%)? Is it because the training has not gone round? What is HIA2?

Kenya--Mr. Wanjala: Please clarify "regulatory module". What's in the module?

Kenya--Ms. Kamau: You scored Kenya 2 on our "qualitative integration rating scale" despite all the good things we have heard about this system. What further improvements will push Kenya to a 4 or 5 on this scale?

I am updating our synthesis report and will share the updated version in the next couple of days.

Thanks and have a great weekend!

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POSTING #2: "Susheel C. Lekhak" <susillekhak@gmail.com>

Provision of legislation, policies, and regulations:

At present, in Nepal, we don't have any specific legislation, policies and regulations which guides clearly recording and reporting of health (including medical) information from CPS. Health Sector Information System Strategy approved by Ministry in 2007 suggests to develop a Health Information Act. In 2009 a draft Health Information Act was developed by HMIS but due to the lack of political commitment and priority (as you know Nepal is in the political transition since 2007, constitution and peace are the main priority while other technical agendas never received attention), lack of conceptual clarity (among higher executives at ministry and department) and lack of competent leadership, this information act could not move ahead and still pending at HMIS Section.

At present Ministry, Department, and Regional health offices those providing approval for establishment and/or extension of services put one clause in the contract to report as per HMIS guideline. But in absence of systematic effort to encourage them to maintain record, report as per HMIS and lack of their participation in the different forums and decision making process the provision is not working properly.

Improvements needed:

Obviously, those provisions are not adequate and we surely need improvements. Considering the Nepalese context the following would be the probable improvement areas:

1. Formulation of Health Act to guide whole health sector including involvement and standard of CPS in health service delivery.
2. Formulation of Health Information Act
3. M&E Unit at ministry should focus on the legal, policy and regulation issues rather than being heavily engaged in operational activities
4. HMIS should be considered as a system instead of one sub-unit within the organization hierarchy
5. Strategic information management approach and frameworks
6. Dedicated efforts by HMIS to encourage CPS to increase their participation in HMIS, mechanism to validate data, their participation in review, decision making process, and key public health programmes.

Most importantly,

7. One single agency for approval or accreditation and to maintain registry of health facilities (provision should be made in Health Act) or HMIS can maintain registry provided a proper functional linkage between those units.

Key stakeholders and participation:

At present, stakeholders are not identified nor clear roles and responsibilities are mentioned.

With regards,
Susheel

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Day 4| October 15, 2012

POSTING #1: Bolaji Fapohunda <bolaji.fapohunda8@gmail.com>

Dear All:

Greetings. The updated synthesis of the takeaways from our Forum postings of Day 1 & 2 (that is 10/10/12 & 10/11/12) is attached.

The Forum is continuing to this coming Tuesday, 10/16/12. We encourage everyone to submit comments or opinions; the more inputs we have the more we learn. The questions we are discussing at this time are the following:

1. In your countries or countries where you work, what legislations, policies, and regulations are in place for service delivery and are they working
2. Do these legislation, regulations, and policies offer sufficient guidance and basis for data collection in the private sector? If not, what improvements are needed?
3. Who are the key stakeholders and what are their roles and responsibilities in private-sector participation in HMIS?

Thank you you for your participation and wishing you all a great week!

Warm regards,

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POSTING #2: wanjala pepela <wanjala2p@yahoo.com>

Thanks Bolaji for summary and questions-

In our Master Facility List (MFL) we have the List of Health facilities, Geocodes, MFL code which is automatically and uniquely assigned and the basic services offered in the facility as well as contacts. Facilities (GOK) are not provided with registration certificates by authorities but only through Gazettement by the Minister, The rest of the facilities which are private, Faith based are assessed by DHMTs, forwarded to National Regulatory bodies such as Nursing council, Clinical Officers council, Laboratory Board, Pharmacy and Poisons Board and Doctors and Dentists Board who normally give an approval; As part of the regulatory module proposed in MFL, It will link with these registration bodies who annually renew their registrations and this will enforce their reporting.

On legal provision, Though Kenya we have a Health Information policy, This must be packed up by a legal framework. We've planned to undertake this activity and also review the Health information policy to align to the current constitution and Health sector policy Framework 2012- 2030 which has given prominence to Health information and also outlined in the Strategic plan 2012- 2017 as the investment area if the sector has to achieve its objectives. Also in the Health sector policy framework, Health information system is one of the 7 policy orientation and an ACT of parliament is proposed during the Strategic period. Very soon we're going to make all these documents public to all in all our websites and DHIS under resource.

regards

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POSTING #3: Daudi Simba <daudisimba@yahoo.com>

IN TANZANIA

1. In your countries or countries where you work, what legislations, policies, and regulations are in place for service delivery and are they working

The Public Health ACT of 2009 governs the provision of health services. While some parts are working some are not due to weakness in the regulatory systems.

2. Do these legislation, regulations, and policies offer sufficient guidance and basis for data collection in the private sector? If not, what improvements are needed?

The Public Health Act requires all facilities including private to report notifiable diseases the MoH. The MoH provides a guideline on data collection and reporting that includes the private sector. The reporting rate from the private sector is very low.

3. Who are the key stakeholders and what are their roles and responsibilities in private-sector participation in HMIS?

Key stakeholders include the Association of Private Health Facilities in Tanzania. They play a role of coordinating the private health facilities owners with the Government. However, the association is not effective in ensuring that the private health facilities report to the government system.

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POSTING #4: wanjala pepela <wanjala2p@yahoo.com>

HI everyone,

- In Kenya, The Public Health ACT Cap 242 of the Laws of Kenya specifically outlines the reporting to the Director of Medical services; However, It only highlights the reporting but we need laws that address issues of data collection, analysis, Use/utilisation and dissemination.
- The current constitution outlines Health as a right and citizens have a right to access Health information. This has also been put into the Health Bill that is now under discussion at the Cabinet level and puts everyone to collect and submit reports and penalties for defaulters.
- Our Health information policy outlines the specific responsibilities of all the players the private sector included. Kenya is one country that most of the stakeholders sign the Code of contact (COC) during the annual summit and the private sector have a consodium who represent all the private service providers.
- The current health sector strategy is in line with the Health sector policy framework 2012-2030 to take the health agenda forward as outlined in the government strategy vision 2030. What is will majorly address this will be the draft M&E framework that we 're now working on based on the devolved governments. There are also technical sector teams and Inter Agency Coordinating committees that are planned to function where all players are spelled out including the external partners.

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POSTING #5: "Hussein, Faris (ADDIS/HAPN)" <Fhussenin@usaid.gov>

Hi

Sorry I missed much of the discussion as I was engaged in other competing priorities. But would like to share Ethiopia's experience with regards to the items below .

- Legislation , policy and regulation .
There is a regulatory standards for all level of services at both public and private facilities . The private health system in Ethiopia consist of a three tier general service clinics (lower , mid and higher level clinics) general and specialized hospitals, and specialty clinics , stand-alone pharmacies and lab services . In the past the standard for licensing focus much on private health facilities with special focus on infrastructure and human resource requirements for each kind of service outlet and as such did not have big impact in ensuring quality of service . The current standard for licensing is more proactive and includes clinical processes and practices as key area of regulation . The current standard also intended to work in a more supportive fashion involving professional association . This new standard is not yet fully implemented and hard to tell its validity . USAID private health sector program provided significant technical and material support for the development of the new standard.
- There are policy and regulation for data collection and reporting with regards to selected diseases of high public health significance . such data is collected both from public and private facilities although at regional and lower district level there is no segregation of data and not much is known about the case burden and /or contribution of private health facilities towards TB case detection /treatment, ART , FP services etc . USAID private health sector program is advocating for data segregation at lower level to help understand health service delivery dynamics with regards to the private sector .
- Ethiopia has been implementing HMIS, which is inclusive of all disease entities but this scheme is not being implemented by the private health facilities as government does not require them to use the national HMIS format . Much of the HMIS is paper based and there is still challenges in terms of staffing (data clerks) as the salary or this new set of cadres has not been projected in budgeting. There is considerable interest to align the private health sector with national HMIS system and converting the current paper based HMIS to electronic base (which some public facilities are doing).

Regards,

Faris

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POSTING #6: Maria Kamau <Maria_Kamau@afyainfo.org>

Dear Colleagues,

Wanjala has adequately outlined the Kenya situation with regard to questions 1 and 2 on the existing regulations / policies and the extent of their adequacy (mostly not).

With regard to question 3 i.e. the stakeholders, in brief these include regulatory bodies i.e.

- Kenya Medical Laboratory Technicians and Technologists Board (KMLTTB)
- Kenya Medical Practitioners and Dentist Board (KMPDB)
- Nursing Council of Kenya (NCK)
- Clinical Officers council (COC)
- Pharmacy and Poisons Board (PPB)

As each name suggests, they regulate the private sector players according to their various specific professions, especially with regard to those who open and run related establishments i.e. health facilities, labs, pharmacies, etc. While the regulation is focused on the type and quality of services provided, so far it's not too much on HIS kind, but more on the 'M' in HMIS i.e. distribution of HR, qualifications, years of experience, etc.). Our engagement so far with them has been around the possibility of implementing interoperability of their systems with MOH MFL, with the health facility as the unifying data (since every professional is linked to one HF or another). The ultimate aim is to engage their buy-in to enforce HMIS reporting as part of regulation. We envision that while the collaboration will initially focus on exchange of data as well as enforcing reporting to MOH as an obligation, the long term goal is to engage them in appreciating the varied use of information to improve quality and availability of services, ultimately stimulating demand for the same and other related data sets for their own use.

Another stakeholder I recently learned about is the Kenya Healthcare Federation (KHF) which is the **Kenya Private Sector Alliance (KEPSA)** umbrella health sector representative body which includes hospitals, pharmaceutical industry, medical professionals and medical insurance providers. They are said to be "dedicated to engaging the government and all relevant stakeholders towards achieving quality healthcare through enabling policies that maximise the contribution of the private sector". They are partnering with a well-known global market research company known as Ipsos Synovate to undertake research twice a year on 4 key questions related to health and seeking behavior.

This is a clear effort by the private sector at seeking for information using alternative means, with the intention of using it to inform private sector contribution in health. At this stage I don't know the extent to which they were aware of the national data collection systems or not before they considered this option.

Other stakeholders that are not so obvious because they mostly collaborate with government are Faith Based and NGO run health facilities which also belong to numerous networks and managing bodies / consortiums / councils, as well as research and academic institutions that train on health care.

The role of all these networks, regulatory bodies, consortiums and institutions should be to work with government to improve availability and use of data with regard to the private sector, rather than implement their own systems. The challenge has been the general reluctance of the private sector to report to government for various reasons including the lack of trust on how the data will be used (e.g. to increase taxes, charges, etc.), especially since feedback is rarely shared with them; More so it has been difficult in past years to get any type of information from MOH, and perhaps more efforts need to be made to create awareness of how much has changed in this regard within government. Though the use of the information by MOH is still far from optimal, its availability has significantly improved through DHIS, MFL and other developing systems.

Meanwhile Bolaji you asked an interesting question:

Kenya--Ms. Kamau: You scored Kenya 2 one our "qualitative integration rating scale" despite all the good things we have heard about this system. What further improvements will push Kenya to a 4 or 5 on this scale?

My answer to this would be that Kenya would score:

3 – If when private sector is implementing their advanced EMRs and other fancy hospital information management systems, they actively engage government so as to ensure they automate the generation of required data. Highly automated private health facilities mostly focus on tracking financial returns through the health care services provided. This is understandable but tragic when they provide MOH data on manually filled out forms, and that is IF they provide the data at all! Am sure many of these systems include HIS modules which could only be implemented at an extra cost which they decide to ‘save on’ or are not priority.

Additionally as another contributor mentioned, it would qualify to be ‘3’ if part of regulatory requirements included hiring skilled / qualified data managers and accordingly support their roles and responsibilities vis-à-vis obligatory reporting.

If private training institutions (as well as public) included in the medical training curricula, modules on collection and use of public health data and its importance in general.

4 – If private sector sat together with government at the periodically convened forums to discuss status of health services through review of data; private sector contribution would be disaggregated from public sector and their contribution acknowledged. Accordingly at these forums, such matters as level of reporting and quality of data would feature as a standard agenda with action points on how to bring about improvement; If private sector periodically engaged government to provide data for use in planning their own services and regulations.

5 – If private sector was engaged in planning and decision making for the health sector side-by-side with government, based on demonstratable evidence analyzed, compiled and presented in collaboration. That decisions are not only on health care but on data governance to ensure that high quality standards are maintained in terms of collection, use, storage, dissemination, security, recovery and overall management of public health data.

Perhaps I haven't covered all angles and I would welcome ideas from other much more developed countries where they are already at 5.

Thanks,
Maria.

Day 5 | October 16, 2012

POSTING #1: "Kelvin Chukwuemeka" <KChukwuemeka@engenderhealth.org>

Hi all,

Sorry this is coming late. Been busy with work but am sure my own contribution is not yet late.

In Nigeria, information is limited on the size and structure on the private health sector. It is quite difficult to ascertain the legislations, policies and regulations in the private health sector because a lot of existing health facilities are operating without the appropriate license by State Ministry of Health (SMOHs). In Nigeria, we have primary, secondary and tertiary health care levels. The primary level is designed to take health care delivery literally to the doorstep of the populace and act as the gatekeeper of the health care system.

In Nigeria, as in virtually all health systems, the private health sector is a critical partner. The private health sector provides half of all the services to patients of all income levels and sometimes in areas where public health sector is simply not available. Figuring out how to effectively work with the private health sector is therefore a high priority not just in Nigeria, but for any Ministry of Health in the African region.

Here in Nigeria, the mothers do not really care who is providing the health care to their sick child: but their concern is that healthcare is provided on time, the healthcare is of good quality and the payment will not result into poverty. Similarly, policy makers should not care about whomever that is providing affordable quality health services. Therefore, the private health sector must be included in the national health policies and practice if reforms are to be successful. The effective launch of the National Health Insurance Scheme (NHIS) in 2005 played a major part in developing a policy framework in the private health sector.

Private Health Maintenance Organizations (HMOs) was established to purchase health services from licensed providers on behalf of NHIS. In terms of Federal, State and local health authorities provide the regulations and policies that oversight the private health sector service delivery which are regulated by some entity with the likelihood of regulation varying between 98 – 100 % depending on the level of facility.

This counters the perception that Nigeria's private health sector is "largely unregulated". The Federal Ministry of Health (FMOH) mostly regulates the large hospitals; 80 – 90% is regulated by State Ministry of Health (SMOH) with the Local Government Area (LGA) being the next most common.

The stakeholders are;

- The Executive, Legislative and Judiciary arms of the Federal, State and Local Government Councils have roles to play to enact and implement laws to support these private health sector participation in HMIS.
- International organizations (bilateral and multilateral) and collaborating partners. Their role includes the provision of technical and financial support to ensure the successful implementation of HMIS data collection.
- NGOs do assist in the areas of training staffs to ensure adequate participation.

- The media assist in sensitization, assist health providers to disseminate knowledge and guarantee mass participation
- Community and Traditional leaders

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POSTING #2: Bolaji Fapohunda <bolaji.fapohunda8@gmail.com>

Dear All:

I wanted to thank you all, again, for your participation. The comments we have received have been illuminating and instructive. A key message from the comments we receive in the last 2 days indicates that there is lack of political will or an appearance of a lack of political will to organize the private sector, not only for HMIS, but also for participation in the governance of service delivery in Countries. **Lekhack** said that CPS have to be involved not only in record keeping and reporting per HMIS, but also in the different forums and decision making process regarding health care provision. Oversight of registration, accreditation and approval of private sector operations alone will not do it. In Tz, we learned that an health Act for information development in the private sector exists, but the regulatory system to enforce compliance is absent (*Simba, comments of 11/15/10*). In Kenya, there are policies supporting data development in the private sector, but the actual laws to support oversight of data collection, dissemination and use is absent (*Wanjala, comments of 10/15/2012*). In Ethiopia, HMIS is operational but formal guidance for private sector participation is missing (*Faris, commens of 11/15/12*). In almost all countries where we have received case stories, we learned that government needs to *systematically* organize the private sector voice and representation in HMIS, otherwise, their participation will continue to be perfunctory, few and far between. What is promising is that there is interest in integrating the private and public health sectors in these countries for health care management, including HMIS (*Faris, commens of 11/15/12*). As the Kenya case story shows, the Stakeholders that will work the system are also available; their roles only need to be harnessed to support the government system (*Kamau, comments of 10/15/10*).

With this short summary, I like to move us to our last and final questions, which are presented below:

1. We have heard that governance is a key problem in most Countries. As highlighted in the case of Kenya, we also know that lack of skilled HR to work the data system is an ever present problem in most countries. Are there other key challenges limiting data collection and reporting in the private sector in Countries? How can these be addressed?
2. Finally, what tangible messages should we be sending to the relevant Countries for strengthening HMIS in the private sector?

We will discuss these questions today and tomorrow and then we will bring this Forum to a formal close. Since our discussion started essentially on 10/10/12, we are leaving the discussion open till mid-night tomorrow, Wednesday, 10/17/12.

I have this follow up question for Mr. Lekhak: please elaborate recommendations 4 & 5 in your comments of 10/15/12:

4. HMIS should be considered as a system instead of one sub-unit within the organization hierarchy
5. Strategic information management approach and frameworks

What do these mean? How will they be operationalized at the country level?

All: We look forward to receiving your comments.

Warm regards,

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POSTING #3: Daudi Simba <daudisimba@yahoo.com>

With this short summary, I like to move us to our last and final questions, which are presented below:

1. We have heard that governance is a key problem in most Countries. As highlighted in the case of Kenya, we also know that lack of skilled HR to work the data system is an ever present problem in most countries. Are there other key challenges limiting data collection and reporting in the private sector in Countries? How can these be addressed?

Key challenge is lack of motivation/incentive for collecting and reporting. While training is thought to be necessary, simple annual reports are not filled in and reported. Yet these forms are similar to the registration forms which are filled in without training. No action is taken for non-compliance. Countries need to design incentive mechanisms for compliance and punitive actions for non-compliant private facilities.

2. Finally, what tangible messages should we be sending to the relevant Countries for strengthening HMIS in the private sector?

Strengthening HIS in private sector need to 1. System thinking - as the private sector cannot implement a good HIS in the context of inadequate HIS in the public sector. As rational beings, private facility owners must have a motive for collecting, using and reporting data. Stakeholders (MoH and researchers) should design mechanisms that will act as incentive/motive for the public as well as private sector to collect, use and report data.

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Day 6 | October 17, 2012

Posting #1: Theo Lippeveld theo_lippeveld@jsi.com

Dear RHINO Colleagues,

Thank you so much for your rich responses. As usual with RHINO Forums, I learn so much from reading about various experiences in other countries.

I would like myself to make two points at the end of this forum.

First of all, in my opinion, as long as low income countries have no broad health insurance system, it will always be difficult to motivate the private for profit care providers to report their service data. Indeed, in most industrialized countries, it is health insurance that motivates care providers to report their data so that they can be reimbursed. In countries where no such health insurance exists, or only in a limited way, a balance needs to be established between “sticks” (legislation; mandatory infectious disease reporting; accreditation mechanisms) and “carrots”. As for the carrots, one of them is social franchising. Social franchising networks guarantee the provision of quality care according to well established standards and its members can advertize the logo of the network (and attract clients). Care providers who are part of such networks, can be asked to report their data via the government or via the network as a condition for membership. Another example of carrots are public private partnerships, where participating private providers can obtain for free certain drugs (such as malaria or TB) and/or vaccines, again at the condition that they report services provided into the government system. My experience with such initiatives has been limited and was mostly in Pakistan. I invite other participants to this Forum who have such experiences to share them with us.

My second point is that, independent of reporting requirements of health information to higher levels, private care providers as well as government health workers should make better use of collected information for patient/client management or clinic management. Use of information for decision making at the level of data collection should become part of standard health care delivery practices the same way as clinical standards are. Therefore, design and implementation of (routine) health information systems should be taught at all medical and nursing schools as part of the pre-service curriculum.

I hope that all the wonderful contributions from the Forum can be summarized and lead to the establishment of an action and research agenda on RHIS and the private sector. You all are invited to continue to use the RHINO listserv to communicate your experiences on this important topic.

RHINO greetings to all of you.

Theo Lippeveld, President of RHINO

POSTING #2: "Susheel C. Lekhak" <susillekhak@gmail.com>

From my side, based on the HMIS Nepal experience, the following are the key challenges, recommendations and key messages:

KEY CHALLENGES

- Understanding and perception of public authorities towards corporate private sector – still many public authorities perceive they are responsible to collect data from public sector, private sector is profit motive then why we should provide them support, etc.
- Unwillingness of private sector to participate in HMIS – probably may fear about taxation and other public control
- Lack of regulatory frameworks (act, policy, regulations etc.) – Health Act, Health Information Act etc.
- Limited number of technical experts in HMIS – only two officer posts are there at central HMIS and few assistant (data entry clerks), one statistical officer in each district to look after around 100 health facilities. From my experience and looking the data load and quality concern these resources are not adequate)
- Lower priority and inadequate budget allocation for M&E and MIS activities (major proportion of budget goes for service delivery while small budget proportion is being allocated for M&E and HMIS, many donor and public agencies give much concern about the services while very little for data and M&E)
- Lack of resource and technical assistance- HMIS is dependent upon the program division/centres (those units are responsible for the management of public health programmes) for budget to carryout HMIS activities. In the beginning phase UNFPA provided adequate support but right now no one is there to directly support HMIS in term of finance and technical assistance)
- Absence of medical record and/or HMIS personnel (data management personnel) in CPS health facilities (at present many private hospitals don't have medical record positions)
- Facility-wise data management and analysis (in Nepal, HMIS system does not provides disaggregation by facility, only provides district-wise figures at central level, while not all districts are maintaining HF wise data, in many district data compilation is done at Ilaka level (a level in between district and facility, which is a administrative level but not functional only except reporting).
- Lack of activities and approaches (by and at central level) to encourage participation of CPS in HMIS

Recommendations

- Strong regulatory frameworks – Health Act, Health Information Act, Guidelines etc.
- HMIS should have responsibility of developing and maintaining HF registry
- Strategic plan of HMIS should also have a component to encourage participation of CPS in HMIS
- Enhance capacity of HMIS to govern and support
- Use ongoing existing forums and activities to participate private sector for capacity building, analysis and review
- Regular assessment of participation of CPS in HMIS to identify the existing barriers and to recommend way forward to improve the situation.

Q. What key messages should we be sending to the world on this important topic?

- "Participation of CPS, Completion of HMIS"
- Completion of HMIS is not only essential to measure progress towards Millenium Development Goal and Indicators but also important from Public Private Partnership (PPP) perspective.
- Health information from any agency is crucial for national plan and response.
- CPS needs input, guidance and support from HMIS
- Each country should develop adequate regulatory frameworks to govern health information from private sector

Further elaboration

4. HMIS should be considered as a system instead of one sub-unit within the organization hierarchy -- In Nepal, HMIS is being managed by a MIS Section located under the Ministry of Health and Population → Department of Health Services → Management Division. From administrative point of view the unit is under-located and many agencies are not complying HMIS directions and suggestions. They perceive HMIS is a section, we are not bond to follow direction or suggestions given by a unit located below the administrative hierarchy). **Recommendation** - Either keep HMIS at the ministry level or HMIS should have all the power and authorities to manage health information from community to Ministry.

5. Strategic information management approach and frameworks : Information management is challenging job particularly in developing countries where there lacks adequate information infrastructure, skill and resources. Still many health facilities are doing manual data management practices (filling the forms by hand and compiling or processing). To overcome such situation HMIS should develop a strategic plan covering human, financial, physical, infrastructure resources necessary to manage public and private health information.

Hope it will be enough, let me know if we need further discussion in the above points.

With regards,
Susheel

POSTING #3: Titus Kolongei <tkolongei@gmail.com>

Dear Bolaji and Team

With this short summary, I like to move us to our last and final questions, which are presented below:

1. We have heard that governance is a key problem in most Countries. As highlighted in the case of Kenya, we also know that lack of skilled HR to work the data system is an ever present problem in most countries. Are there other key challenges limiting data collection and reporting in the private sector in Countries? How can these be addressed?

I also feel that many of the senior managers manning the private health sector do not value the use of information, some of them in my view have more clinical knowledge and may have "unknown biased view" on the value of information. To some data collection is a secondary activity.

In my view the way forward is to put mechanisms in place to ensure that managers of the private health care are trained and sensitized on the importance of data collection, dissemination and use. While many private organizations generate a lot of information the managers should understand how mining of the data within their organizations can "open up" their eyes to the hitherto unknown problems. This can therefore be addressed by ensuring that we organize regular courses for senior and Middle level Managers.

2. Finally, what tangible messages should we be sending to the relevant Countries for strengthening HMIS in the private sector?

The message to the relevant countries is that they need to put mechanisms in place to ensure that the public and private sector work closely to ensure that the collect, share, disseminate and use information for decision making towards this end the Health Management Information Systems coordinated coordinated by the government should take a lead in this renewed en-devour. This is even now more possible where new technologies have provided a perfect opportunity for the private and public health sector to easily share information

Regards
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Senior Health Information Officer
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POSTING #4: mursalin831 <mursalin831@gmail.com>

Dear RHINO Colleagues,

Here are some inputs from my side.

Q1: We have heard that governance is a key problem in most countries. Are there other key challenges limiting data collection and reporting in the private sector in countries? How can these be addressed?

I am sorry to have joined this important discussion so late as there were some other pressing issues to be addressed. As already put forth by colleagues for their countries, this governance of private health sector is the real issue to be addressed in Pakistan too. In our country more than 70% of the patient load is being picked up by the private sector so missing out this vital information becomes a visible dent in the overall National Health Information System canvas. I think the first very step to ensure reporting from the private services would be to effectively regulate this sector. Recently, Health Sector in Pakistan has gone through a massive process of devolution, where several functions previously assigned to Federal Ministry of Health has now been shifted to Provincial Health Departments. An encouraging first step taken by the provincial health departments is the formulation of 'regulatory bodies' for the huge private sector. These bodies have recently started functioning and have come to existence through an act of provincial assemblies.

By virtue of this law it has now become mandatory for all health care services, both public and private, to ensure the implementation of minimum service delivery standards. But challenge remains how to streamline such a large private sector which has grown since last 65 years to such an unprecedented proportions. This comprise a fair number of quacks. At this early phase of implementation it is hard to sate if this development would really end up in regulating the private sector. Collection of desired information from this sector would certainly base upon success or failure of this initiative.

This apparent fragmentation between public and private sectors is also attributable to 'missed opportunity' that the public sector could have availed to bring two sectors together on the same page of Health Information Systems. Unfortunately, public sector has not truly recognized the complimentary role of the private sector. The Public Sector management believe that they are there to exclusively manage the public sector projects and services and without having an ownership or involvement with the private sector. There thus exist a strong need to develop a behavioral shift in favour of adopting a more 'holistic approach' by the public sector by having responsibility for the health of whole population at district or provincial levels and not only try to manage their own facilities.

These recent countrywide successful public sector campaigns for strengthening National Health Information System has now generated considerable enthusiasm and done adequate advocacy for bringing private sector into

information loop. But this would still need tremendous thoughtful process and skills on the part of the government to develop and implement mechanism of data collection and use from this crucial sector. We need to move more vigorously by interacting with the private sector through their workable regulation and a continuous dialog. As where there is a will there is the way.

Q2: Finally, what tangible messages should we be sending to the relevant countries for strengthening HMIS in the private sector?

I would say Public sector need to take a more proactive role by trying to bring private sector into the loop of National Health Information System by showing them its benefits to the overall improvements in health system in general and health indicators in particular. .

In this context Public sector should interact with multiple partners, including formal and informal organizations of the private sector, the community leaders, members of parliament and other influential groups. Public Sector need to develop a strong 'business case' for data collection and use from the private sector and then have extensive dialog with all partners. This approval legislation and its implementation could provide solid base for such a development

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POSTING #5: Tariq Azim <syed_azimus@yahoo.com>

I would like to second what Susheel has expressed. In addition to that, I think we are mostly looking at private sector from pulic health sector's view point. What's the incentive for the CPS to implement HMIS and report to the government. Legislation/regulations can work as the "stick" but where's the "carrot". We need both. There should be open dialogue with CPS to understand their perspective on health information system and how CPS can become part of the national HIS. I would suggest that for future, the "catchment population" of such forum on CPS HMIS should also include managers/owners or implementers from CPS.

Tariq Azim
HMIS Scale-up project, Ethiopia

POSTING #6: Bharat Ban <bban@nfhp.org.np>

Dear all,

1. There are other challenges limiting data collection and reporting. They are as follows:

- Most of the pvt sector has to use the HMIS forms that are developed by the public sector. The pvt sector is not involved in development of recording and reporting tools therefore it is not user-friendly to them.
- While there is budgetary provision for training /orientation on recording and reporting of tools to public sector there is no such provision to pvt sector.
- Public sector organizes training/ orientation on HMIS but pvt sectors are not invited for this resulting either no reporting or poor recording and reporting from the pvt sector.
- There is not adequate follow-up from pvt sector for regular recording and reporting. Perhaps there is underestimation of the role that pvt sector has played in delivery of health services.
- The recording and reporting is taken by the pvt sector as an extra burden hence they do not bother to report. There is also less understanding on the value of information.
- There is some fear of taxation and other issues when pvt sector have to report accurate figures.

In order to overcome these challenges HMIS should be made more participatory so that pvt sector also can contribute in design, implementation and analysis of HMIS. It should be clarified to them the role of information management.

2. Final message

- The reporting from pvt sector should be made mandatory with adequate monitoring from the public sector

Thank you.
Bharat Ban
Specialist and Team Leader for Monitoring and Evaluation
Nepal Family Health Program II

POSTING #7: Jim Setzer <Jim_Setzer@afyainfo.org>

Hi All!

Following on Theo's suggestion highlighted below and my previous request... does anyone have any examples of curricula which address these issues in pre-service training? It's a good idea and by sharing we can all benefit if anything exists.

Thanks to all,

Jim.

James C. Setzer, MPH | Principal Associate | **Abt Associates**

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POSTING #8: wanjala pepela <wanjala2p@yahoo.com

In Kenya we've the PPP and as I outlined earlier, partners including the Private sector sign an Annual COC - Code of Contact and commitment for one Health system, reporting framework and we motivate them by giving them tools and some Logistics to offer free services. Regulations are a two edged sword which applies to both public and private. I do think That, it is just more than incentives i.e. capacities/ culture/ behaviour which I urge RHINOS' and RHINOSES to facilitate countries apply PRISM tools to establish the syndrome.

Its not that countries are poor and have weak information systems but partner support and not governments financing RHIS has aggravated the problem; Most partners tend to collect information from government facilities and not support private enterprises which also give more than 20% share of the National health services. We've to make good guidance as governments and also facilitate private units as complimenters but not competitors. Information use is a culture developed and cultivated;

regards

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POSTING #9: wanjala pepela <wanjala2p@yahoo.com

In Nursing schools Yes its mandatory in Kenya but not delivered across the institutions by the experts in Health Information as its not bread and butter of Many and RHIS has the least number of hours.

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POSTING #10: mahmood iqbal memon <miqbalmemon@yahoo.com>

Dear RHINOs,

I must congratulate the participants and the organizers of the forum for discussion on this important issue, I myself apologize for joining the discussion at the end but still would like to share my experience on the issue as I am working with HIS since nearly two decades in Pakistan.

Q 1. We have heard that governance is a key problem in most Countries. As highlighted in the case of Kenya, we also know that lack of skilled HR to work the data system is an ever present problem in most countries. Are there other key challenges limiting data collection and reporting in the private sector in Countries? How can these be addressed?

In Pakistan private sector is very strong and cater the requirements of around 70% population through tertiary, secondary level hospitals and large number of individual General Practitioners and specialists clinics. Few years back we conducted a study in some major cities of two provinces of Pakistan to see how HIS of private sector health facilities is working, what is the main area of focus of services and what kind of information usually generated by hospital management for decision making. The important findings includes: Only curative services are usually provided, except for few tertiary level HFs the managements regularly produce information on revenue generated, stock positions and HR. The service delivery and disease related reports are mostly not generated.

The reasons of non provision of health information by private sector include lack of regulations, policies and incentives on provision of information to public sector. Few suggestions received from the private sector management on incentives are concession in income tax, reduction in import duties on hospital equipments, concession in electricity tariff and supply of data collection and reporting tools etc.

2. Finally, what tangible messages should we be sending to the relevant Countries for strengthening HMIS in the private sector?

3.

The HMIS in private sector can be strengthened through proper legislations, by forming regulatory authority and by constituting regular joint bodies which can regulate services and improve coordination between public and private sector. It should be made mandatory for private sector to provide preventive services according to level of HFs.

As development and continuous supply of data collection tools is an expensive affair and even public sector HFs are managing it with immense difficulty despite the fact that many donors are supporting HIS in most of the developing countries. The private HFs may be allowed to collect data at their own by using their own systems thus not overburdening them and a comprehensive reporting form for private sector HFs and clinics may be

developed and provided by state to them for regular reporting purposes. The private sector HFs can send reports to lower level of management in hierarchy which in case of Pakistan is district where the data from public and private sector can be integrated to generate holistic picture of the health status as well system in a given population thus helping managers in framing the policies and planning for improvement.

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POSTING #11: Kchukwuemeka@engenderhealth.org

Dear all,

It has been a great time sharing ideas and comments from y'all. Bolaji, thanks for chairing this forum and hope we would all learn from each other after this forum.

The key challenges limiting data development and use in the private sector are:

- 1.) Inadequate coordination of data flow because there's a lack of policy in the HMIS private sector.
- 2.) Complexity and overlap of data collection instruments.

The recommendation to address these challenges are:

- 1.) Develop accurate synthesis models
- 2.) Developing methods for selecting which values to synthesis
- 3.) Developing ways to provide feedback on the quality of synthetic data inferences.

Key messages are:

Recognizing policy as political and complex processes: Policy therefore proceeds through a set of stages from understanding the nature of the problem (setting agenda) to exploring possible problem resolution options, weighing up costs and benefits, making a rational choice about best options (decision-making), and finally implementation, possibly followed by evaluation.

Engaging key stakeholders: The key actions that are essential to consider when analyzing health policy include the Government, health providers and the community. Conduct of research, or existence of evidence of data collected does not guarantee input into the policy development process unless decision makers are appropriately engaged.

Thanks to all participants in this wonderful forum.

Regards

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POSTING #12: daudisimba@yahoo.com

With this short summary, I like to move us to our last and final questions, which are presented below:

1. We have heard that governance is a key problem in most Countries. As highlighted in the case of Kenya, we also know that lack of skilled HR to work the data system is an ever present problem in most countries. Are there other key challenges limiting data collection and reporting in the private sector in Countries? How can these be addressed?

Key challenge is lack of motivation/incentive for collecting and reporting. While training is thought to be necessary, simple annual reports are not filled in and reported. Yet these forms are similar to the registration forms which are filled in without training. No action is taken for non-compliance. Countries need to design incentive mechanisms for compliance and punitive actions for non-compliant private facilities.

2. Finally, what tangible messages should we be sending to the relevant Countries for strengthening HMIS in the private sector?

Strengthening HIS in private sector need to 1. System thinking - as the private sector cannot implement a good HIS in the context of inadequate HIS in the public sector. As rational beings, private facility owners must have a motive for collecting, using and reporting data. Stakeholders (MoH and researchers) should design mechanisms that will act as incentive/motive for the public as well as private sector to collect, use and report data.

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POSTING #13: Bolaji Fapohunda <bolaji.fapohunda8@gmail.com>

Esteemed Colleagues:

As promised, we have now come to the end of this historic discussion on *Private Sector Participation in Health Sector Development and Use*. Here are few key points from the discussion of the last two days:

Key Challenges to CPS data development and use

- Motivation is poor. Training alone is not enough. Comments from Pakistan indicate that data collection in this country is as simple as the hospital registration form that are filled effortlessly by the HW and can be completed with no training if motivation was higher than it currently is (Simba/Memon).
- The public sector mindset of “*the private sector is not my business*” is harmful not only to data collection in the private sector, but also to their involvement in the governance of private sector services delivery (Lehhak).
- Lack of resources: man (size, skill, training), money, materials (infrastructure, equipment), and technical assistance (important for best-practice transfer across boundaries) is a key challenge (Memon/Wanjala).
- Fear of the unknown by CPS, present in the absence of a clear guidance and posture from the public sector. (Lehhak).

A few of the recommendations

- Incentives, incentives, incentives! Countries need to design incentive mechanisms for compliance and punitive actions for non-compliant private facilities that will allow CPS to see what’s-in-it-for-them of collecting and reporting data. Incentive could include income tax relief, reduction in import duties on hospital equipments, concession in electricity tariff and supply of data collection and reporting tools etc., OR free drugs (such as malaria or TB) and/or vaccines (Memon/Lippeveld, 10/17/12; Kamau, 10/11/12)
- Promote regular assessment of participation of CPS in HMIS to identify the existing barriers and to recommend improvements to HMIS.
- Provide the required inputs for data collection & reporting by CPS; data collection tools are expensive and cannot be left as the solely responsibility of the Private sector.
- Develop an analysis plan/dashboard/synthesis model to guide the extraction of useable information from data collected at the private/public sectors at regular intervals. This use of this plan will ensure the availability of relevant information in usable quantities and can kick-start data use.
- Encourage use of information at all levels, particularly at the data collection points (Lippeveld, 10/17/12). Information use for decision making at this level, Lippeveld added, “...should become part of the standard health care delivery practices the same way as clinical standards are”. To ensure that skilled manpower is

available to work the system, Lippeveld recommended that design and implementation of (routine) health information systems should be taught at all medical and nursing schools as part of the pre-service curriculum .

- Institutionalize the provision of regular *feedback* to District and lower levels & the CPS, the data collectors.

Here are a few of the concrete, simple, and low-cost actions that are emerging from the comments:

- Countries to add design and implementation of (routine) health information systems to the medical and nursing schools' pre-service curriculum.
- Countries to assess their CPS HIS situation and implement action plans. Assessment here does not have to be a huge exercise; even something as tiny as systematically documenting the current data situation in the Private sector and the support system for data development and use will yield tremendous benefit to the entire HMIS
- Countries to develop analyses plan/dashboard/synthesis model to guide data extraction and analysis in countries where this does not already exist.
- Countries to simplify/harmonize data collection plans
- Countries to institutionalize the provision of regular *feedback* to districts & Facilities, both public and Private

Talking about feedback, in the coming days, we will be sending you a short evaluation questionnaire to find out your impressions on how we have conducted this Forum. Your impressions will help to tailor future RHINO fora. We ask that you please respond to us. In addition, as Theo Lippeveld noted, we will be sending you an updated synthesis of the Forum discussion and next steps.

In closing, I like to thank the team at JSI and MEASURE Evaluation who worked tirelessly to make this Forum possible: Theo Lippeveld, President of RHINO; Evis Haake, RHINO Coordinator, Natasha Kanagat, M&E Advisor and former RHINO Coordinator; and my humble self. I have enjoyed your participation and your generous comments regarding the moderation of the Forum. I thank, most especially, those who have sent comments, opinions and insights.

We are grateful to USAID for making the monies available to run this Forum and for all their efforts in being at the fore front of efforts to make the world a healthier place for all us.

The Forum is now officially closed. From all the Team at JSI, its good bye for now!

Warm regards,

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