



FACILITATING CHANGE

Leadership Forum Series on Health Information Systems

Report on the Southern Africa Regional Forum

October 25-29, 2010 | Windhoek, Namibia



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Introduction

Well-managed and coordinated health information systems (HIS) are critical to making informed decisions that have a direct impact on the provision of lifesaving, disease-reducing public health interventions. From the community to the policy leadership level, accurate and timely data ensure both the sustainability and accountability of health investments by governments and donors and improve program and policy decisions.

Too often, however, HIS are hard to access, not credible, and fragmented. Coordinated leadership and country ownership are frequently lacking, as well. Country ownership has been broadly embraced by the donor community as a critical element of development aid. Transitioning to country-owned and -managed HIS operations helps form the basis for sustainability, accountability, transparency, and evidence-based decision making. Also, there must be multisectoral representation in initiatives to establish or improve national HIS, as implementers must work in a broader context that extends beyond just one ministry or organization.

The U.S. Agency for International Development (USAID) and other sponsors have, therefore, used the country ownership approach in organizing the **Leadership Forum Series on Health Information Systems**. To date, two forums have been held. The first was for six East African nations and was conducted in Addis Ababa, August 2009; the second was for nine countries in the Southern Africa Region and was convened in Windhoek, Namibia, October 2010. The following report covers the Windhoek event. Additional information from that event can be found at www.hisforum.org.

Hosted by the Namibian Government, the Southern Africa forum invited representatives from ministries of health, finance, information and communications technologies, and related government entities from the nine Southern Africa countries. Country delegates were joined by representatives from USAID, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the World Bank, the World Health Organization (WHO), the Norwegian Agency for Development Cooperation (Norad), the International Telecommunication Union (ITU), the Health Metrics Network (HMN), and the U.S. Centers for Disease Control and Prevention (CDC).

Forum organization and facilitation were provided by the Training Resources Group, Inc. (TRG). An advance survey on HIS in the invited countries was conducted by Futures Group International. The USAID-funded Analysis, Information Management & Communications (AIM) Activity acted as Secretariat for the effort, providing organization, coordination, and logistical support services. The Namibian Ministry of Health and the U.S. Embassy in Windhoek provided invaluable services and support.

In all, 43 delegates from Angola, Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe participated in the forum. Most of the delegates were combined in cross-country working groups: Angola and Mozambique; Botswana, Lesotho, and Swaziland; and South Africa, Zambia, and Zimbabwe. The Namibia delegates formed a fourth working group.

Also present was a delegate from the first forum, who shared his experiences, and guest speakers from the host country's health leadership. Representatives from the donor and sponsoring organizations, the forum Secretariat, and other contract support groups were in attendance to manage and provide support for the proceedings. A rapporteur team of eight compiled summary notes for each session. A concurrent media outreach operation was staffed by the Namibian health team. A photographer provided visual coverage of the event.

The primary goal of the forum series is to foster country ownership in meeting the formidable challenges to building national HIS. These challenges include governance and multisectoral engagement, strategic planning and financing, policy and regulatory environments, and a number of others. The emphasis on ownership acknowledges a change in the relationship between national governments and donors and the desire to increase recipient control over donor funds. The target audience is policy and political leadership, rather than technical experts at the project level.

Building on the experience of the Addis Ababa forum, the specific objectives for the Windhoek event included the following:

- 1. Delegates will broaden their perspectives on implementation options, challenges, and roles related to HIS by interacting with colleagues from other countries and sectors.*
- 2. Delegates will develop a shared awareness of the options and strategies for improving coordination of country HIS.*
- 3. Delegates will explore leadership roles in managing HIS as a national asset.*
- 4. Delegates and donor participants will work together to develop preliminary follow-on plans to promote stakeholder engagement and commitment to HIS.*
- 5. Donor participants will highlight relevant follow-on resources (information, financial, and technical assistance) available in their respective sectors to strengthen HIS.*

The agenda was designed to encourage team building across relevant sectors. To that end, the agenda included technical and country team presentations, small-group interaction, and networking opportunities. Delegates shared country experiences, assessed strengths and areas for improvement, and outlined leadership strategies for strengthening and harmonizing national HIS. The forum series builds on ongoing efforts to strengthen national HIS and accelerate the implementation process, including enhancement of national institutional HIS capacity and creation of a working policy environment, where health data are used to improve the delivery of health services.

Some of the key tools used to stimulate thinking, cross fertilization of ideas, and discussion include impact stories, a continuum, a donor panel, and country team presentations. At the end of the week-long event, an evaluation was undertaken to help improve follow-on work and future forum design.

The Windhoek forum's closing session noted the following achievements:

- Consensus on multisectoral efforts in the nine countries.
- Agreement on the use of strengths/gaps analyses as a pivotal tool for assessing national HIS.
- Confirmation on the need to explore the role of stakeholders at all levels.
- Recognition of the importation of collaboration and a transparent approach.
- Continued involvement of donors as change agents.

Donors committed to review and respond to support requested as a follow-up to the forum. The event organizers called upon donors and delegates alike to commit to modeling new behaviors, setting organizational norms, and acting on the HIS strengthening agenda, where possible. To maintain critical momentum after the forum, it was agreed that proceeding notes would be made available to all forum participants, along with a report summarizing the forum proceedings; a resource request form would be created and forwarded to country team delegates; a central location for submitting the resource forms would be established and used as a coordinating mechanism in support of donor response; and an e-mail network would be established for further dialogue, information sharing, and networking among the participants.

Responses to the evaluation survey for Windhoek included many good suggestions for how to improve future forums and kudos for the Namibian event. Most gratifying, however, was that the country team delegates took to heart the essence of the forum effort and committed to advocating for and leading the change to country-owned and -managed HIS, to multisectoral involvement as the backbone of HIS, to building and maintaining strengthened HIS, and to emphasize the importance of evidence-based policy decisions in the provision of health services.



Opening session (John Novak, USAID)

The U.S. Agency for International Development (USAID) is one of several U.S. Government agencies supporting the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) initiative, which is currently making the transition from an "emergency" program to a long-term, sustainable health initiative that will be integrated into national health systems. Thus, this global health initiative can now support health systems strengthening across the health sector.

This forum embraces a variety of delegates representing various ministries, as well as AIDS councils and networks. Nine countries in Southern Africa are represented. The event has received support from, among others, the Namibian Ministry of Health and Social Services, the U.S. Embassy, USAID, the International Telecommunication Union (ITU), the Health Metrics Network (HMN), the Norwegian Agency for Development Cooperation (Norad), the U.S. Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO).

"I think the HIS Forums provide a unique opportunity for attendees, who normally wouldn't be sitting together, to meet and discuss what the real aim of a health information system might be. Then to hear from other countries what they are or aren't working on is also empowering In my mind, these conferences serve as a great mechanism for change."

– Country representative

At the first forum, held in Addis Ababa in August 2009, it was agreed that there should be multisectoral representation to improve national health information systems (HIS). Implementers must work in a broader context beyond just one ministry or organization. In addition, these initiatives must be country-owned and -led, per the Accra Action Agenda and Paris Declaration principles.

This forum will foster country ownership to meet the challenges to national HIS. Delegates will assess strengths and areas for improvement, as well as outline leadership strategies. Delegates will assume leadership roles in governance, technology, and financing, and work to create a policy environment wherein health data are used to improve the delivery of health services. HIS will thus involve information/data exchange and evidence-based decision making.

Opening remarks (Dr. Richard Kamwi, Minister of Health and Social Services, Namibia)

Namibia is engaged in strengthening the current national HIS. Developing the health matrix system is a core strategy in the five-year strategic plan of the Ministry of Health and Social Services.

In terms of background, at independence, the National Health Information System (under the Directorate for Primary Health Care) was established. It provides a comprehensive source of data on a large number of health-related indicators. It was designed to improve service delivery, quality, and effectiveness of strategies, as well as monitor trends in disease occurrence. It also provides information for policymakers and health personnel.

To meet challenges, there has also been a scaling-up of activities surrounding HIV and AIDS, malaria, and TB. This has created an intense need for an upgrading of the National Health Information System. Other current challenges are both technological and resource related, but there is also a need for a new attitude toward HIS, new ways of working together, and holding stakeholders accountable.

To do these things requires boldness of leadership and perseverance of purpose. HIS is a tool for enhancing decision making. The cost of health interventions can be high if wrong decisions are made or wrong policies are formulated.

This is the age of the Paris Declaration, based on the “three ones”: one plan, one budget, and one report. It is thus vital that governments and ministries own the HIS reforms. All development partners must help strengthen country systems and not create parallel systems that could be disruptive. Partners must also ensure they set aside budgets to strengthen the national systems.

Efforts to improve HIS will not be easy, but they must be done. Progress has been made across the region, with lessons learned and experience gained using various reporting systems. We should share our experiences. Each sector in government has a role to play in resolving the joint challenges, including technology, finance, and planning.

Countries must identify strategies to harness appropriate technology to strengthen their HIS. But what we build should be sustainable, efficient, and flexible for future development. Countries must be in the driver’s seat in employing new information and communication technology (ICT).

Information today is an asset and prerequisite for policy makers and communities. We live in an evidence-based world in clinical and policy making settings. Evidence is required to support investments in specific health areas. They must be able to compare benefits of competing investments.

Pre-forum interview results (Anita Datar Garten, Futures Group International)



Technical experts in the invited countries were interviewed to gain a “snapshot” of HIS in each nation. This was done in advance of invitations being sent out, so some people who were questioned are not present. The survey provides us not only with an idea of in-country HIS status, but also an overview of efforts in the Southern Africa Region from different perspectives.

The methodology followed an interview guide, with questions asked about who is contributing and coordinating HIS, challenges, and promising practices in each country. The difficulty of doing “cold call” interviews

presented limitations and challenges, but the survey captures the flavor of HIS in each country and shows broad themes.

Finding highlights include:

■ Common challenges

- There is a need to strengthen multisectoral coordination. Increased collaboration across all sectors is vital.
- Engaging the private sector is difficult, but its data must also be included.
- Human resources – training a stable of health workers – is a key issue.

- There is a need to improve evidence-based decision making. Feedback often does not get down to the lower levels. This is important to help with data quality and confidence.

■ Promising practices

- *Angola* – There is a multisectoral body established in the Ministry of Health that leads HIS activities, with participation from key stakeholders (statistics, agriculture, planning, armed forces, etc.). This coordinating body ensures planning and the transition from paper to computerized systems.
- *Botswana* – The Ministry of Health and the University are addressing human resources, with graduates given specialized training in HIS. A human resources development plan is being implemented.
- *Lesotho* – The Ministry of Health invites all partners to annual operational planning. Donor-driven implementation is being replaced by country-driven and -owned implementation.
- *Mozambique* – The Ministry of Planning and the National Institute of Statistics are collaborating to establish a central data repository in order to improve reporting.
- *Namibia* – The Ministries of Health and Finance are working together to ensure collaboration. A health systems review and strategic plan have been implemented. Data-driven strategic planning is being implemented.
- *South Africa* – There is a steering committee to implement an ICT strategy for health care delivery and for managing the health information strategic plan. Fragmented systems are being replaced by a strategic business planning process.
- *Swaziland* – The HIS committee has developed a five-year strategic plan to strengthen HIS. Multisectoral coordination is there to identify HIS gaps.
- *Zambia* – A multisectoral body has been developed to implement the strategic plan, with revision of the health management information system (HMIS).
- *Zimbabwe* – A multisectoral committee is developing a strategic plan for 2009–2014. It is identifying core indicators, data sources, and the timing of data needs.

■ Reflections from each sector

- *Health* – A multisectoral approach is needed. A forum would help to create dialogue.
- *Telecommunications* – Countrywide communication is necessary to ensure a common interest.
- *Statistics* – These ministries need to work together with ministries of health.
- *Finance* – HIS strengthening requires investment.

It was stressed that common challenges provide a starting point for developing stakeholder engagement, and that there were examples of promising practices that highlighted country-owned and -driven processes.

Finally, the reflections from each sector reinforced the importance of the work being done during this conference.

Forum objectives, agenda, methodology (Pamela Foster, Training Resources Group, Inc.)

The objectives of the forum are that delegates would use it to broaden their perspectives, develop a shared awareness of options and strategies for improving coordination of country HIS, and explore leadership roles at all levels in managing HIS as a national asset.

After delegates leave they will be charged with the potential to make change, with action plans that can be carried forward to each country. Donor participants will provide insight on resources available to strengthen HIS and how to access these resources.

The methodology for the forum will be working groups, with maximum interaction among delegates. Documentation will be made available and distributed to delegates.

East Africa Regional HIS Forum: Lessons learned (Gilbert Uwayezu)

During the previous forum in Addis Ababa, various health information systems (community based, primary care, etc.) were identified, but there was a lack of knowing whom to bring on board to get ideas and formulate strategies. There needed to be discussion with ministries of health, finance, local government, statistics, etc., to bring them to the table for sharing ideas. In the Ministry of Health, for instance, the Permanent Secretary's office became a key location for HIS facilitation.

Although there will be times when there should not be centralization in the Ministry of Health, a central repository of health data is essential. There is, thus, a complex system of the interlinking of departments and ministries.

The Rwanda Health Enterprise Architecture Framework has three main elements: the Ministry of Health and other government systems, an interoperability layer, and an external systems layer. If these various layers are collecting data, there needs to be a system for sharing information among them. There is also a team of experienced local programmers who are trained in relevant aspects of programming. They are able to be flexible and adapt the system to the needs of the Ministry of Health. Having in-house people do this also supports sustainability.

Once the system is running, somebody who comes for consultation would get treatment and information. If he or she moves to another health center, there will be a check to determine if the client is registered, so information on the client can be shared. Thus, it is easy to make a well-informed diagnosis on the patient. In addition, if there is a health insurance company and a patient needs treatment in a health center, the center will need to have access to the system to see if the patient is insured.

One should check to see if there is an existing system that may work or whether a new system for information sharing needs to be compiled. There are also different policies in each country – data management policies, etc. – so a joint health sector review meeting is conducted annually for one or two weeks during which participants discuss common issues. If the Ministry of Health has a sound policy framework, donors will also be keen to come on board.

Discussion:

In Zimbabwe, many people live in rural areas where there is no electricity. It becomes difficult to capture data and share it in a central registry.

It is a challenge, but in a small country like Rwanda it is easier. More than 50 percent of health centers have access to electricity. Solar panels are used in other locations to provide power. One can organize the data, even using forms, in other ways apart from the computer. Even at health centers, there are registers that are not filled, so they work on how to improve the database systems and move toward automated systems.

The card that identifies users of the service – How easy is it to capture everyone in a country, and who will change information on the health data? Is there a database of health professionals who can change the data?

Data managers exist in all centers. The system is being implemented so each patient who comes in will have information recorded. This also assists if there is an outbreak by showing diseases in time. A well-informed and structured database is important. Access rights to the information (pharmacies, doctor's rooms, etc.) are important, but this is under development.

In collecting information, is there a focal person to collect the information, or do they go from house to house collecting the information?

There is a mobile-based system used by community health workers. Most were given mobile phones, and they can log onto the system and download a form to be completed. The country has 95 percent mobile network coverage.

Toll-free numbers are available, so people can phone for information. Statisticians follow up by compiling the information from the centers. It reduces the time for getting information, as it is sent immediately. There is an attempt to improve the data so they can be distributed automatically.

Now there is a level where there is a need for getting information centralized and for sharing it within different systems. Originally, the idea was to use ID cards, but not everyone has an ID, so that system is being rethought. The system should have a good infrastructure, be sustainable, and have commitment, especially from the top level of government. There is also a focus on transfer of knowledge. A sustainability plan for HIS is currently being worked on. This will be a partnership using different skills.

How long did it take to get to this point?

It began in 1996, with a system for collecting aggregated data from centers. In 2006, the system was changed from access based toward new technologies, but efforts to meet the need for different systems (the Rwanda Framework) started in 2003.

Country ownership and leadership in HIS (Joan Dzenowagis, WHO)

Current challenges in the HIS environment include economic stresses, pressure to make aid more effective, greater private-sector involvement, and new partners in health. There is also a fragmentation of funding sources, and governments are in reactive mode.

One response is a new emphasis on the concept of "ownership." The aim of this approach is to increase recipient control over donor funds provided, with a focus on the policy and political level, rather than on the project level. It requires deeper knowledge of social values, political cultures, and policy processes. Donors need to harmonize their own approaches so as not to conflict.

A continuum, or model, can be used to discuss and compare HIS functions, which may not all progress at the same rate. By thinking of HIS in this way, we can gain a more holistic view of the HIS "ecosystem," generate questions, and grasp the complexity of everything being done, but it is not prescriptive.

The model includes seven levels:

- Governance and multisectoral engagement
- Strategic planning and financing
- Policy and regulatory environment

HIS Country Ownership & Leadership Continuum

<p>GOVERNANCE & MULTISECTORAL ENGAGEMENT</p>	<p>National coordinating mechanism not established or at early stages; agencies and sectors operating independently.</p> <p>Priorities, projects; pilots, not usually linked, depend on donors and funds.</p> <p>Project stakeholders provide incentives for country/project data sharing and use.</p> <p>Stakeholders represented at project level.</p>	<p>National coordinating or approval mechanism for large projects; agencies/sectors linked on key projects, some shared priorities</p> <p>Priorities, projects; defined and linked to short- and medium-term goals</p> <p>MoH provides limited incentives for data sharing and use</p> <p>Stakeholders represented for large, cross-sector projects</p>	<p>National coordination mechanism: active national body with oversight, control; agencies and sectors involved</p> <p>Priorities, major projects linked to medium-term goals, included in national plan</p> <p>MoH provides broad and specific incentives for data sharing and use</p> <p>Stakeholder participation in national planning process</p>
<p>STRATEGIC PLANNING & FINANCING</p>	<p>Planning specific to vertical projects, may not be led by or include MoH.</p> <p>Comprehensive national planning at early stages.</p> <p>Financing plan not established; funding linked to specific projects.</p>	<p>Planning includes MoH for major vertical projects; cross-linkages developed by MoH.</p> <p>National plan developed, but not vetted with all parties.</p> <p>Financing plan at early stages; project funds available; more sustainable sources of funding sought.</p>	<p>Planning led by MoH, includes major stakeholders and sectors.</p> <p>National plan developed/adopted by major stakeholders.</p> <p>Financing aligned with priorities; donors, gov't, private-sector funding identified for medium term.</p>
<p>POLICY & REGULATORY ENVIRONMENT</p>	<p>National policies at early stages.</p> <p>Overall picture of the relevant sectors not clear; policies need to be identified, compiled, and reviewed.</p>	<p>National policies emerging in priority areas; plan elaborated for additional areas.</p> <p>Sectoral policies under review for alignment, comprehensiveness; gaps identified for new or revised policies.</p>	<p>National policies adopted in priority areas; regular policy review established; impact being considered.</p> <p>Plan agreed for sectoral alignment; progress being made on new and revised policies.</p>
<p>INFORMATION USE</p>	<p>MoH cannot meet international reporting obligations.</p> <p>Information primarily used by projects.</p> <p>Overall health information picture not clear metrics not adopted.</p>	<p>MoH meets major international reporting obligations.</p> <p>Information used for specific or limited decision making.</p> <p>Information picture emerging; metrics adopted, efforts to transition/rationalize.</p>	<p>MoH meets all international reporting obligations.</p> <p>Information increasingly shared and used in broader decision-making context.</p> <p>Overall information picture defined, metrics adopted, planning for transition and use.</p>
<p>INFRASTRUCTURE</p>	<p>ICT supports specific projects or vertical programs; broader infrastructure investment push by private sector, large donors.</p>	<p>Shared infrastructure between some projects, agencies, or sectors; government policies increasingly support private-sector investment.</p>	<p>Government investment in fundamental infrastructure to be shared; efforts to stimulate investment and alignment of private sector, donors.</p>
<p>HUMAN CAPITAL DEVELOPMENT</p>	<p>MoH expertise on ICT, policy and informatics at early stages; reliance on technical cooperation; required skills may not be available in private sector.</p>	<p>MoH increasing expertise; HR development plan in progress; taps technical cooperation and private sector for expertise.</p>	<p>MoH able to draw on internal expertise, technical cooperation and private sector as needed.</p>
<p>SYSTEM & DATA INTEROPERABILITY</p>	<p>MoH information flows and data processes not fully defined, aggregation not feasible.</p> <p>Project-specific systems.</p> <p>Standards not in use; data sharing not possible.</p>	<p>MoH system has defined information flows and data processes; some aggregation.</p> <p>Parallel systems.</p> <p>Standards at early stages of adoption; some data sharing.</p>	<p>MoH system had defined information flows and data processes, aggregation at all levels.</p> <p>Major systems connect; planning is standards based.</p> <p>Standards for data and interoperability adopted; data sharing increasingly possible.</p>

- Information management and use
- Infrastructure
- Human capital development
- System and data interoperability

When a government adopts the “ownership” approach to HIS, it takes a holistic view and examines rights, roles, and responsibilities of stakeholders involved in HIS, treating health information as a national asset. “Ownership” is proactive, rather than reactive: knowing where you are and what you have, knowing where you want to go, defining/delivering the steps to get there, understanding what others are doing, and knowing what to ask for in an ongoing dialogue with all stakeholders, including donors and partners.

HIS: Practical implementation and challenges (Ramesh Krishnamurthy, WHO)

It is important to think about the practicalities when donors come in with a project proposal.

- Governance
- Multisectoral engagement (ministries, cell phone operators, etc.)
- Planning and finance (how will it be sustained after a few years)
- Interoperability (Cell phone structures mean that the process of collecting data will have to be refined; this will become a technical issue.)
- Infrastructure
- Information use (think about cellular infrastructure, GSM coverage maps, etc. If there is no coverage, the Ministry of ICT would have to be involved, and there would be a cost to consider. There would also have to be a scaling-up component after the initial period.



Discussion:

There is an issue of motivation and ownership in the collection of data. What is the motivation for people to give accurate data, and who owns the data?

Ownership is managing information as a national asset. There should, therefore, be no rationale for guarding data or giving inaccurate data. Thus, the term “data ownership” is obsolete; now it is “governance of data” (rights, rules, responsibilities, and risks). Patients have rights and risks, so the policies of the national HIS must protect them. At all levels we need to ask questions about ownership/motivation.

The health care worker is under pressure, and people sometimes pre-fill forms to comply and give estimates that are not accurate. There also needs to be an incentive for the person to complete the data. If, however, you let them use the data (and give graphs, etc.) on an outbreak, for instance, they can see the value of the data collection (in identifying that outbreak). It is also true that if there is more than one

donor asking for the same data, the donors need to communicate to reduce the burden in the health sector and establish one data point.

Identifying “champions” is also key in terms of a motivating factor; there must be an incentive mechanism for this. In some countries, hospitals that focus on outbreak reports have monetary incentives. There is an incentive, therefore, to be accurate. In Rwanda’s performance-based financing, they are given incentives based on the data sent in. It encourages people to send in data on time and accurately. Improvements are being seen.

What is the relationship with financing?

In Rwanda, people who send in data never get feedback, so showing people the results of the data collection is an incentive. There is also an incentive that shows health centers that are performing well in terms of data collection. People are publishing in order to win prizes, and that becomes their incentive.

Primary health care and health information systems – simple data are required that can be generated and used at the lowest level. People must make decisions at the lowest village/constituency level, so the most important thing is a focus on looking at data at the lowest level. Data collection tools are all vertical, putting the health worker on the ground under a lot of stress. Politicians and decision makers should make it simple to assimilate the data and give it to the right people.

Health community workers in India go on foot to each village, carrying 18 books of 18 vertical data collections. With a data harmonization exercise, the information could be rationalized. The burden, literally, was falling entirely on them. There needs to be coordination at the policy and donor levels to ensure the health workers have their burden reduced. This will also increase the quality of the data collection. The complexity of vertical campaigns and service delivery need to be thought about at the policy level.

Is the database in Rwanda housed at the Ministry of Health or Ministry of Home Affairs?

There is an attempt to find ways to share data between units or between ministries. If someone is developing a system, then there is an attempt to ensure the system will be interoperable with existing systems.

A framework for health information systems is being adapted in 86 countries. An assessment tool for strategic planning and costing is in the open domain with ISO standards. The Global Fund, Norad, etc., are asking that this framework be used, and money is available for this purpose.

Donor panel (John Novak, USAID)

Donors and sponsors taking part in this effort are USAID, HMN, ITU, Norad, the World Health Organization (WHO), CDC, and the U.S. Department of Defense (DOD).

What do we expect from you, and how can we support you?

Each of the donors comes with distinct approaches and has specific comparative advantages. The delegates at this forum are a small subset of HIS donors. There is also a different mix of donors in each country. All donors support development activities in different ways.

What would donors like to see to invest? The ideal would be a multisectoral national strategic plan for HIS. Some already exist; some are in development. This is important: We need to know where we are and where we are going. We need to know what we are trying to achieve. There should be a common vision and objective. What are the priorities in each country? Who will be leading the initiative (leadership)? Who will take responsibility?



Donors can offer technical assistance to facilitate progress and give joint support for common needs. (This could be across countries – joining one other to bring countries together around a common need, resulting in economies of scale and linking country teams with available in-country resources, with country offices providing support rather than headquarters.)

In terms of follow-up actions, there will be a donor committee that will coordinate responses. This will result in coordinated response to requests from countries and organizations. There will also be a single point of contact, where requests will be passed on to all of the organizations, who in turn will decide which organization will attempt to provide support. There will also be an e-mail list and Web site that can have active discussions on topics. This way groups can stay connected and share information.

In the long term, existing donor mechanisms can be leveraged, and country teams will be able to integrate these initiatives into their country plans. Also, there will be reinforcement of country-led HIS activities, as well as a dialogue with country teams.

Discussion:

What is the time lapse between requests and response? There can be changes on the ground, if the response takes a long time. There are also middlemen who assist with technical assistance and proposals. Where do they fit into this new model?

There is an attempt to simplify the process, and we should be able to do it within a few days. For instance, in Uganda, USAID sent out a consultant within three weeks of the request. Short-term assistance can be delivered relatively quickly. There are certainly some immediate and tangible needs, and there should be an “event follow-up” (this was a concern after the last forum). There should be a response to those. The intent is not to replace anything that already exists. If there are already relationships with country colleagues, this won’t replace that, but will supplement it.



Country Ownership Strategies: Leadership Forum on Health Information Systems

RESOURCE REQUEST FORM

Country name: _____

Requesting authority: _____

Country POC and contact information:

(Name)

(Phone number/s)

(E-mail address/es)

Problem statement (no more than 200 words):

How does this request support the national HIS strategy (no more than 100 words):

What resources can the country team contribute?

Please return completed form to myhisforum@gmail.com by January 21, 2011.



The Health Metrics Network deals with technical assistance and funding assistance. The funding has dried up to instead focus on tools to assist with the development of country-led strategic plans. WHO functions similarly. There is a regional office in Brazzaville, and there is energy spent on frameworks and tools. The e-health unit works closely with ITU on a global observatory for e-health, looking at policies and producing country profiles. There is also a national e-health toolkit.

Norad is involved in support through the Global Fund and the U.K. Department for International Development. The focus is on reforms within agencies in terms of financial support for health systems strengthening. There is the joint platform for health systems strengthening and support, with a broader focus on maternal, neonatal, and child health. There is bilateral support with certain countries and support for capacity building efforts through university collaborations (development of software applications for DHIS), capacity building programs, and the establishment of masters programs at the country level.

International Telecommunication Union is not too well known and deals normally with ICT ministries. It is a United Nations agency, with a global focal point for developing telecommunication and ICT networks. Three sectors include the radio spectrum, the standardization sector, and the development sector (assisting developing countries to develop ICT networks, training, and policy-related issues). Work is undertaken jointly with other donor partners. Support is provided through the country ICT ministries.

USAID will have a new mechanism in January 2011 – Human Resources for Africa – which has \$50 million to assist SADC countries with health systems strengthening and human resources in health. There will be an African implementing partner. Human capacity in HIS is a missing element in each country, so this mechanism can be used first to build the core competencies of the ministry of health in each country and to assist with monitoring and evaluation and tools to use data. Also, it could be used to help create a health cadre, train students pre-service, and create career paths. However, USAID cannot act without a strategic plan and roadmap for the country. Assistance is needed to help with the process of developing that plan, which will be essential.

CDC resources are available through the country teams. The focus is on technical assistance on system interoperability, laboratory information, and the like.

The DOD program is quite different, with a focus on military health systems (at the invitation of the country military health system). Dialogue between the military and national ministries of health often does not take place. HIV and AIDS prevention programs, diagnostic programs, ICT infrastructure, telemedicine activities are some areas where DOD is involved in technical assistance and support.

How will the donor cooperation idea work? There are many countries, each with specific needs. How will donors ensure each country can benefit from this program? How will the process work out? How much money is available? Some donors are not operating in some countries, so how will they assist in those countries?

The starting point should not be money, but what you want to achieve. The central e-mail address will be the conduit. When donors see what is being sought, programs can be assessed according to scope, magnitude, and impact.

The aspect of sustainability is important. Technical assistance should use expertise within countries for sustainability. Otherwise, there is no added value by bringing in external experts. There should also be ownership. We must also beware of parallel systems.

WHO looks at what local resources can be tapped to solve problems. Under the PEPFAR country operation plans, more resources must be used to support in-country institutions. This represents a change in policy. However, there will also be a need for external expertise.

Along with in-country integration of HIS, there should also be integrated HIS systems among the donors.

The strategic plan can assist in addressing some of these issues. Creating national buy-in is essential. A starting point is a multistakeholder engagement to develop a national plan. The intent is to integrate current “silo” programs into one system, but this will be a long-term process. It will also be done differently in each country. Even the ministries of health in each country are not clear on how many donors are involved and what data they are taking from the country. It is important for countries to identify this. There is particular interest in the donor community to integrate technical and financial activities.

There is a new mechanism that the Futures Group is implementing for costing the HIS strategy. It is quite specific and assists in putting together the elements of an HIS policy. It is just one of many areas of support that are available.

Are there resources for those who wish to do long-term training rather than short courses in the area of HIS so they can become experts in their own countries?

There are many existing training programs in the world that could be accessed, so donors could identify people. It is a good idea, though it is difficult, to “build the boat as you sail it.” There have been a lot of concerns about human resources in each country, so the whole human resources “ecosystem” must be looked at. What is being done, for instance, about conditions of service to make it attractive for employees to stay in the public sector? Governments also have a role to play in addressing that question. The global public health informatics initiative is an effort to do 10,000 training programs in the world for capacity building. The health informatics reference group focuses on the human resources aspect of HIS, and has looked at core competencies and signed agreements with WHO to engage in long-term training initiatives. USAID looks at retention, as well as pre-service training, but there can never be assistance to cover the entire training needs of a country. So country ownership implies making difficult decisions about who will be trained, for how long, and what financial input the country itself will make. We should plan today so that in five years there is a trained cadre of human resources. This again will be part of the strategic plan.

It is good that donors have been rethinking their efforts since the previous forum and have implemented this joint initiative in Windhoek. All actors in development must have capacities in place to support each ministry/program in its maturation, but this requires a lot of resources.

Leading at all levels in HIS (Joan Dzenowagis, WHO)

Leadership is more important than ever, especially working with people from different cultures and perspectives. Leadership skills can be learned and practiced. In managing change, there can be a high risk of conflict, which damages trust and leads to a lack of buy-in. Good leadership is required at all levels to prevent it.

Applying the Continuum:

- ***Governance and multisectoral engagement:*** A broad strategic view is required to build relations over the long term and skills to create synergies, including communication skills to formulate and “sell” policies to different stakeholders.
- ***Strategic planning and financing:*** A holistic view and understanding of the flow of information and the processes to select, deploy, and manage ICT solutions.

- **Information use:** The ability to analyze and use information to show progress, status, and for making decisions are core skills in a data culture.
- **Infrastructure:** An understanding of the interaction and complexities of HIS dynamics and their impacts on HIS functioning, budgeting, and management is essential.
- **Human capital development:** Finding and using expertise is not enough. In-service and pre-service training and transfer of knowledge should form part of a country HIS.
- **System and data interoperability:** Integration is required, with an appreciation for the principles, standards, and other elements for interoperability, data integrity, and protection.

The road to ownership is not easy, but effective leadership can help us get there. “Leader” does not just refer to the person “in charge.” Leadership is power – the ability to influence. This can include power from position (the formal authority to discipline or reward others), but can also be based on information, knowledge, and personal biases. It should be personally developed and earned. It transcends hierarchies and crosses borders.

Even if you are not in authority you still have power to impact change by:

- **Showing up** – Presence and engagement; meeting people and building bridges.
- **Speaking up** – The power of “voice.” The ability to frame the debate and articulate the consensus.
- **Teaming up** – The power of partnering and opening doors; giving as well as getting.
- **Looking up** – The power of values and higher principles that help people transcend conflicts and problems; helping others to see the bigger picture and set their own sights higher.
- **Not giving up** – The power of persistence. Keep at it, and adjust where needed, keeping the long-term goal in mind.

“Even if you are not in authority you still have power to impact change by showing up, speaking up, teaming up, looking up, and not giving up.”

– Joan Dzenowagis, WHO

“We think of power as being “top down,” but this shows us a different idea of power. Using the five points you discuss, we realize that we, too, have power, and we, too, can influence change.”

– Discussant, Windhoek, Namibia 2010

Discussion:

We think of power as being “top down,” but this shows us a different idea of power. Using the five points you discuss, we realize that we, too, have power, and we, too, can influence change.

Creating an information culture in HIS (Theo Lippeveld, Measure Evaluation)

Information culture is one of the most important outcomes of the country-owned HIS. One of the objectives of this forum is that delegates will explore leadership roles. We look at HIS as a national asset, but a national asset for what? The answer – for improving decision making in the health information system at all levels.

There have been spectacular increases in global health money flows to address infectious diseases. If money is no problem, then the problem is how best to spend it.

Millennium Development Goals are also an incentive for producing better health outcomes, but the major constraints remain. These include lack of leadership and country ownership, fragmentation, lack of good models, a health workforce crisis, weak logistics systems for commodity security, and weak health information systems.

What is wrong with existing HIS? Problems include poor quality (or plethora) of data, centralized information management with little feedback, fragmentation, etc. The result is we have a situation where information is not valued. Demand is not high. What data exist are poorly used at all levels.

Brainstorming:

What interventions can be made to improve use of information for decision making?

- Feedback is vital: What are the data used for? Make people feel part of the system. This will encourage people to work more.
- We lack capacity to use the data.
- We need to simplify data collection.
- More emphasis is needed on training at all levels.
- Advocacy is needed on the importance of information.
- Health workers need to be motivated.
- Information needs to be accessible; it must include what you need, and the ability to find it easily.
- A sense of leadership and ownership of data needs to be created.
- Systems design should be taken away from the monitoring and evaluation people and given to managers and policy people. The monitoring and evaluation people want to over collect information, of which there is too much. Involve management in design.

We need performance criteria, not vague interventions. We need to measure how we improve information systems. We need the production of relevant and quality information, as well as continued use of information for decision making at all levels. Having data in and of itself doesn't make any sense. It only makes sense if it leads to actions. We need to have a better understanding of the factors that influence the use of information and HIS performance.



Performance of Routine Information Systems Management (PRISM) framework: The framework is a logical model of inputs, processes, outputs to outcomes, and impact.

- Inputs are assessments.
- Outputs will be better performance.
- Leads to health system improvements.
- Leads to improved health outcomes.

The key is the processes. We need a data collection system, computers, ICT, etc., but there are other factors. We are working within an organization and are dealing with individuals. Strategic planning requires using information, which adds value in improving your planning. Also, we should consider the attitudes and values of individuals, as well as knowledge and skills. There needs to be training in problem solving. Tools have been developed to diagnose the quality and use of the data. Other tools help one to understand the behavioral and organizational factors.

Interventions can be technical (data warehouses, etc.); organizational (self-assessment of people at each level, so they do not need feedback; they can assess themselves); and/or behavioral (skills and capacity building). We need to develop problem-solving approaches and problem-solving and advocacy skills, and promote a culture of information.

What is promoting a “culture of information”? In a health system, it is promoting the values and beliefs for a generation of quality data and for use of information to accomplish its goals and mission. It implies an important role for senior management (health system policy makers and managers).

What is the rationale for promoting a culture of information?

- The whole organization needs to know that information is a key organizational value.
- We should clarify expectations regarding behaviors and performance levels for use of information.
- It will improve transparency and create ownership and demand for information.
- There will be a need for less supervision and less external control, leading to fewer costs.

How do you promote a culture of information?

- Role modeling by senior management on use of information generated for decision making.
- Emphasis on HIS performance during review meetings.
- Dissemination of success stories on the use of information for advocacy.
- Institutionalizing the use of HIS information by such means as disseminating district-level indicators through the media, allocating resources based on HIS indicators, and using HIS information as a criterion of the annual performance appraisal.

Discussion:

Senior management – it is important, but it is not everything.

The role of senior management is the starting point, but not the end point. However, if senior managers do not start with it, then nobody will start with it.

Information is used as leverage to control, empowering those who collect data on the ground. How do we implement behavioral change to empower people with the power of information? There are dynamics between management and data collectors.

In an organizational culture, there must be a focus on results. This includes logistics management and other areas, but it comes back to how we can focus the organization on a results orientation. Information culture has to be part of the organizational culture. Senior management has to be involved, but with “flatter” organizations, where change can come from the bottom up. Change managers need to be employed by some ministries. It is a unique skill.

Senior leaders seem to be more concerned with intellectual property rights.

Ownership needs to be a value rather than a legal framework, but ultimately the culture of information must be part of a policy plan and documented, as well as the regulatory and legal environment. We should start with organizational change, however, and you can capture aspects in a regulatory environment later.

A culture of information should include all users inside the systems, including clinical people. We should focus on the bottom.

The focus in this presentation was on the promotion of a culture of information. There should be goals, not only at the senior level, but also for any member of the organization, including care providers.

Where senior management is not interested in data (or is threatened by it!), there needs to be a role for advocacy.

Advocacy means mobilizing support from the community to help with data gathering, with problem solving attributes.

All organizations have an information culture. It affects how people communicate and their behavior, but it is very difficult to change.

In Africa, we deal with limited resources. People focus on technical elements, but organizational change and information are not luxuries. They need commitment from the top.

We need to have motivation to inform ourselves. We should gain more from the information that is presented. Managers should be willing to read further and inform themselves.

There are many aspects. There is not a single intervention, but it is rather multipronged and complex, and it does take time.

Priorities and calls to action: Working group reports

Group 1: Namibia

Priority actions going forward:

- Build HIS capacity in staff.
 - Conduct training needs assessment.
 - Plan accordingly (develop training manuals and guidelines involving stakeholders).
 - Implement training in data collection with district and HIS staff.
 - Monitor and evaluate.

- Develop HIS coordinating mechanism.
 - Establish within three months.
 - Set up steering committee with high-level officials.
 - Identify and set up core technical team.
 - Form broad multisectoral stakeholders working group.
- Expand use of information.
 - Define a template for district feedback report.
 - Run example of district HIS meeting.
 - Orient managers to regional and DHIS system.
 - Develop and distribute call to action.

Key messages:

- There is an urgent need to collect, analyze, and act on data we collect in order to improve service delivery.
- We have a fragmented information system in Namibia that needs urgent coordination/integration in order to improve health service delivery.

Discussion:

Are there items that are at no-cost or are costed? Where will the funding come from to actualize these action plans? Fewer action items would give a stronger focus. Prioritizing is important for an effective way forward.

The training strategy will cover all areas, including funding. Donor communities will also be there to ensure funds are available. In-house resources will be used, as well.

Who will be targeted by the key messages? What will the outcomes be? Why are we doing certain things? There must be evidence for, say, an improvement in service delivery. Are you aiming at technical people, high-level ministers, or others? Wording should clearly target a specific audience.

Key messages are aligned to our needs. For instance, the fragmented information systems show the need for the coordination effort. We should ensure that we fine-tune the messages. It is difficult to convey the richness of the discussions in brief presentations. The way the message is presented will depend on the audience, to whom the presentation will be delivered. This presentation will probably be aimed more at the policy makers in the field of health.

Group 2: Zambia, Zimbabwe, and South Africa

Priority actions going forward:

- A high-level multisectoral stakeholder summit will be convened on strengthening national HIS.
 - Form a national working group, which will work on the terms of reference and a code of conduct and on developing a roadmap.
 - This group should also devise the goals, agenda, and timeline, as well as identify and secure funding and resources.

Key messages:

- There is a need for multisectoral engagement for a stronger national HIS and to enable countries to accurately track progress toward achieving Millennium Development Goals 4, 5, and 6.
- Increased economic growth is attributable to a fully functional HIS.
- A strong HIS will enable informed decision making.

Discussion:

The idea of “increased economic growth” was cause for debate in the group. In the United States, health data are used to project market share. The IT sector also depends on this data. The argument is normally one of the strongest to reach planning commissions in each country. If you can give an estimated projection to economists about GDP growth, it can be a strong argument, apart from saving lives, etc.

There was also an effective linkage with existing Millennium Development Goals in this presentation. If one lays a thorough groundwork with the core group (rather than the big group), it can be effective.

Group 3: Mozambique and Angola

Two key messages from Angola:

- HIS strengthening is critical for decision making, research, dissemination of information, and for putting it to good use.
- It is only possible to do this well if multiple sectors are involved, which brings the benefits of diverse perspectives and technical knowledge.

Three Angolan priorities for action:

- Governance and multisectoral coordination – Organize a multisectoral forum.
- Strategic planning and finance – Finish the national strategic plan for HIS.
- Policies and norms – Develop a legal and regulatory framework for HIS.

Two key messages from Mozambique:

- The quality and quantity of human resources constitute a “spinal cord” for a sustainable HIS.
- ITCs need to create a favorable environment for use of information and to develop a culture of information.

Three priorities for Mozambique:

- Create a framework for HIS.
 - Develop framework.
 - Develop aggregate data software.
 - Develop patient tracking system.
 - Develop ITC equipment procurement and maintenance plan.
- Increase human resource capacity (quality and quantity).

- Define career paths, with incentives.
- Develop pre-service and in-service training.
- Recruit and deploy personnel.
- Increase use of information.
 - Reinforce feedback and dissemination.
 - Accelerate use of technology and media for dissemination.
 - Expand Internet connectivity to all district levels.

Discussion:

This group has introduced some new elements and shows the importance of South-South cooperation. They have also been fully engaged throughout, despite the language barrier.

Group 4: Botswana, Lesotho, and Swaziland

Priority actions going forward:

- Lesotho
 - The challenge is the finalization of the HIS policy and a costed strategic plan.
 - Key actions are to identify technical assistance for finalization of these documents, disseminate the policy/plan, and cost the national HIS plan.
 - Actors – Ministry of Health, other ministries, donors.
 - Indicator – Approved HIS policy and strategic plan.
 - Completion – April 2011.
 - Resource – Technical assistance to finalize plan.
 - Responsible – Masebo.
- Botswana
 - Challenge is to develop HIS policy and strategic plan.
 - Key action is to engage key stakeholders.
 - Actors – Division of Policy and Planning, Department of Clinical Services and Public Health, Ministry of Home Affairs.
 - Outcome – Establishment of HIS policy and strategic plan, which will guide all of the processes.
 - Completion – Negotiations in November; monthly meetings starting January, policy/plan to be finalized September 2011.
 - Resources – Technical assistance.
 - Responsible – Diemo and Sam to present to Division of Policy and Planning.
- Swaziland
 - Challenge is the lack of analytical skills.

- Key action is to select one “champion” per region who will train supervisors and data entry clerks.
- Actors – The regional information officers, strategic information department, and the regional team.
- Indicator – The number of staff trained.
- Completion – February 2011.
- Responsible – the HMIS manager.

Key messages:

- Knowledge on the front line determines data quality.
- Planning and budgeting should be based on quality data, which will create a clear picture to help us see trends over time, the impact of interventions, and where best to put resources and where not to.
- A coordinating body will strengthen HIS and produce output to:
 - Justify our existence.
 - Harmonize donor support.
 - Support implementation of an action plan.
 - Standardize reporting requirements.
 - Streamline reporting at the facility level.
 - Ensure quality data for evidence-based planning and decision making.

Discussion:

The cost of doing the exercise is not too much – perhaps three to five days of work for a group of people who arrive at a consensus. The cost is less than US\$40,000. It can be done in bits and pieces, but doing it sooner in one session will be better for the country to attract donors. This will continue the momentum.

Closing session (John Novak, USAID)

- Consensus points
 - There has been a consensus regarding national multisectoral efforts in the nine countries.
 - We have conducted a strengths/gaps analysis, which will be a pivotal point for assessing HIS.
 - We have explored the role of stakeholders at all levels.
 - We have confirmed the importance of collaboration and transparent approaches.
 - Donor discussions: There will be a review of support and responses to specific requests.

Maintaining our momentum is important, and donors and participants have a role to play. Participants can use their personal and positional power to gain buy-in from key stakeholders and implement change: “You yourselves are the change agents.”

We must make personal commitments to model new behaviors, set organizational norms, and act on HIS strengthening agenda whenever and wherever possible.

All our sessions have been meaningful, but more critical is what happens after this forum.

- Next steps:
 - All presentations to be made available.
 - A summary of the forum to be provided.
 - Requests for support to be submitted for donor consideration.
 - Requests to be reviewed, with feedback guaranteed.
 - E-mail network to be used to exchange information, engage in discussions, ask questions, and share experiences.
 - HIS secretariat to be established at the donor level to track communications, receive progress reports, and enable networking.

