SUMMARY RHIS EVALUATION REPORT FOR THE PUNJAB NATIONAL HEALTH MISSION USING THE PRISM FRAMEWORK

May 2014

This publication was produced for review by the United States Agency for International Development and Punjab National Health Mission. It was prepared by Nehal Jain, Vunnava Janardhan Rao and Michael P. Rodriguez of the Health Finance and Governance Project, while Gajinder Singh provided support with data collection.

The Health Finance and Governance Project

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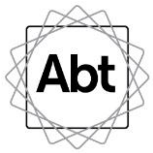

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SUMMARY RHIS EVALUATION REPORT FOR THE PUNJAB NATIONAL HEALTH MISSION USING THE PRISM FRAMEWORK

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ACRONYMS

ANM	Auxiliary Nurse-Midwife
BCG	Bacillus Calmett Guerin
CHC	Community Health Centre
DEAT	Data Entry and Analysis Tool
DHIS 2	District Health Information System version 2
DQA	Data Quality Audit
GOI	Government of India
HPD	High Priority Districts
HFG	Health Finance and Governance project
HMIS	Health Management Information System
M&E	Monitoring and Evaluation
MCTS	Mother and Child Tracking System
MOHFW	Ministry of Health and Family Welfare
NHSRC	National Health Systems Resource Centre
NHM	National Health Mission (*formerly National Rural Health Mission*)
OBAT	Organizational and Behavioral Assessment Tool
PRISM	Performance of Routine Health Information Systems Management
PHC	Primary Health Centre
RHIS	Routine Health Information System
RMNCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health
SC	Sub-centre
USAID	United States Agency for International Development

ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

The Health Finance and Governance project has worked with the National Health Mission in Punjab to conduct an assessment of the routine health information systems across three districts in the state. The assessment team utilized the Performance of Routine Information Systems (PRISM) Framework to conduct the exercise, including the Performance Diagnostic Tool, the Overview and Facility/Office Checklist, the Management Assessment Tool and the Organizational and Behavioral Assessment Tool (OBAT). Site visits for data collection and interviews were conducted over a six-week period from mid-June 2014 to late-July 2014. Based on the data collected and analyzed from 24 health facilities across the three districts of Barnala, Mansa and Patiala, the following are the key findings and recommendations from the PRISM assessment:

Performance Diagnostic Tool

- Data transmission follows the designated protocol for the Punjab NHM M&E teams, with routine reporting by Information Assistants and Block Assistants at the health facilities and Monitoring and Evaluation Officers at the district level. The standard reporting formats (paper forms) and tools (DHIS 2.0 web-based system) are routinely and effectively used by all sites visited.
- Based on a review of four key indicators from the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) initiative, most indicators were being reported with over 85% accuracy for both months of data reviewed when comparing the recounted data with those of the monthly reports submitted. There was wider variation for one indicator (Outpatient Total Attendance), which was still found to be within a reasonable range of accuracy.
- Across all health facilities visited, the time and effort required for routine data reporting was reported to the assessment team as being a significant burden. Moving closer to real-time reporting or direct data entry at the facility level during patient visits would spread out the burden of reporting over a more manageable period for staff.

Overview and Facility/Office Checklist

- The tools and reporting forms were identified by most staff interviewed as being easy to understand and user-friendly. Availability of reporting forms, access to the DHIS reporting system and internet access all facilitated routine and consistent reporting of data.
- There was a significant amount of data collection and reporting redundancy noted across the health information system. Staff interviewed reported numerous information systems that they were required to report into, while there was little electronic interaction between different information systems, again increasing the burden on staff to routinely report.
- The use of information for decision making, advocacy and monitoring was very low at the facilities, with most decisions referred to the district offices. There seems to be a much more active culture of information between the state and district levels, as shown by the higher levels of discussion about data, the feedback reports, and decisions taken based on information available from the RHIS.

Management Assessment Tool

- The level of management functions were found to be relatively low at both the facility and district level, with neither scoring higher than a 50% rating on governance, planning, quality, training, finance or supervision measures.
- There was an average of 2.7 supervisory visits by higher level staff made to the health facilities in the

three months prior to the PRISM assessment, with some facilities reporting having received more than three visits during that time. The quality of those visits varied widely with regard to promoting an information culture, as less than 10 percent of facilities visited reporting having data quality checks performed as part of the supervisory visits.

Organizational and Behavioral Assessment Tool (OBAT)

- The most notable finding in the OBAT section of the PRISM assessment was the stark contrast between staff perceptions of their capacity to perform specific RHIS tasks and their measured competence on these tasks. In four out of the five skill areas measured at the facility level, the actual staff competence was less than half of their own perceptions of their skills.
- The district level showed greater consistency between staff's perceived and measured competencies in RHIS skills, with only one domain (data interpretation) showing a significant divergence between the two.
- Among the RHIS skills measured with the OBAT, competency in problem solving at both the district and facility levels was found to be lowest. For the districts, they scored the highest in the demonstrating their knowledge of data quality and competency in problem definition.

RECOMMENDED WAY FORWARD

- Increasing the level of information use at the district and facility levels should be prioritized for action. Specifically, creating programs that encourage and reward the use of information in a variety of ways (e.g., presenting data on the walls of the district offices and facilities, sharing recent disease pattern data with local stakeholders, advocating for resources based on findings from the data) need to be developed and supported by the NHM in Punjab, particularly with regard to district interactions and support to facilities.
- Establishment of a routine data feedback mechanism by the Punjab NHM from district and block levels to all facility staff involved in the collection, recording, and compilation of facility data can improve the likelihood that data will be used by the health facilities. As part of the supervisory visits, district M&E teams should also be documenting the quality of data through routine accuracy checks.
- Modify reporting requirements at health facilities to eliminate the need to report on services not provided. For example, if they do not provide sterilizations at their facility, they would not see that component on their reporting form. Likewise at the data entry to DHIS level, there would no longer be zeroes for services not provided.

1. INTRODUCTION AND CONTEXT

There are numerous, distinct sources of health information across multiple program domains in India and in Punjab State. The Government of India has implemented a web-based portal (National Health Management Information System) to capture the primary information for health statistics under the Ministry of Health and Family Welfare (MoHFW) Nation Health Mission (NHM) programs. The MoHFW and National Informatics Centre launched the electronic Mother and Child Tracking System (MCTS) in 2009 as way to monitor individual pregnant mothers, newborns and children across communities. In addition, the State of Punjab has implemented separate electronic data reporting systems which they use to capture state-specific data sets but which also overlap with the MoHFW reporting requirements of the national HMIS portal and the MCTS.

The District Health Information System 2.0 (DHIS 2) is used by health facilities in Punjab to report their data electronically up to the state level; district-level information (i.e., all health facilities within a district) is automatically aggregated within the DHIS 2 based on the data reported by the health facilities. At the state level, the NHM Monitoring and Evaluation team is using monthly DHIS 2 data to create the Reproductive, Maternal, Newborn, Child Health and Adolescent Health (RMNCH+A) dashboard, which tracks progress on key indicators for that GoI priority initiative. However, the Information Assistants at the facilities are also required to export their DHIS 2 data into a Microsoft Excel format and then upload it into the national HMIS web portal in order to meet the national NHM reporting requirements. None of the electronic health information systems identified here share information electronically, resulting in much duplication of data entry and reporting.

1.1 PRISM Methodology

The GoI and individual state governments have invested heavily in the implementation and promotion of electronic reporting systems for health in the past five years. One goal of this investment is to provide high quality data for monitoring and evaluating high-priority programs such as the RMNCH+A initiative. In order for these efforts to be successful, a number of factors have to be effective and coordinated. The Performance of Routine Information Systems Management (PRISM) Framework and the PRISM Tools are based on a holistic approach to health program interventions and systems evaluation. This approach acknowledges that:

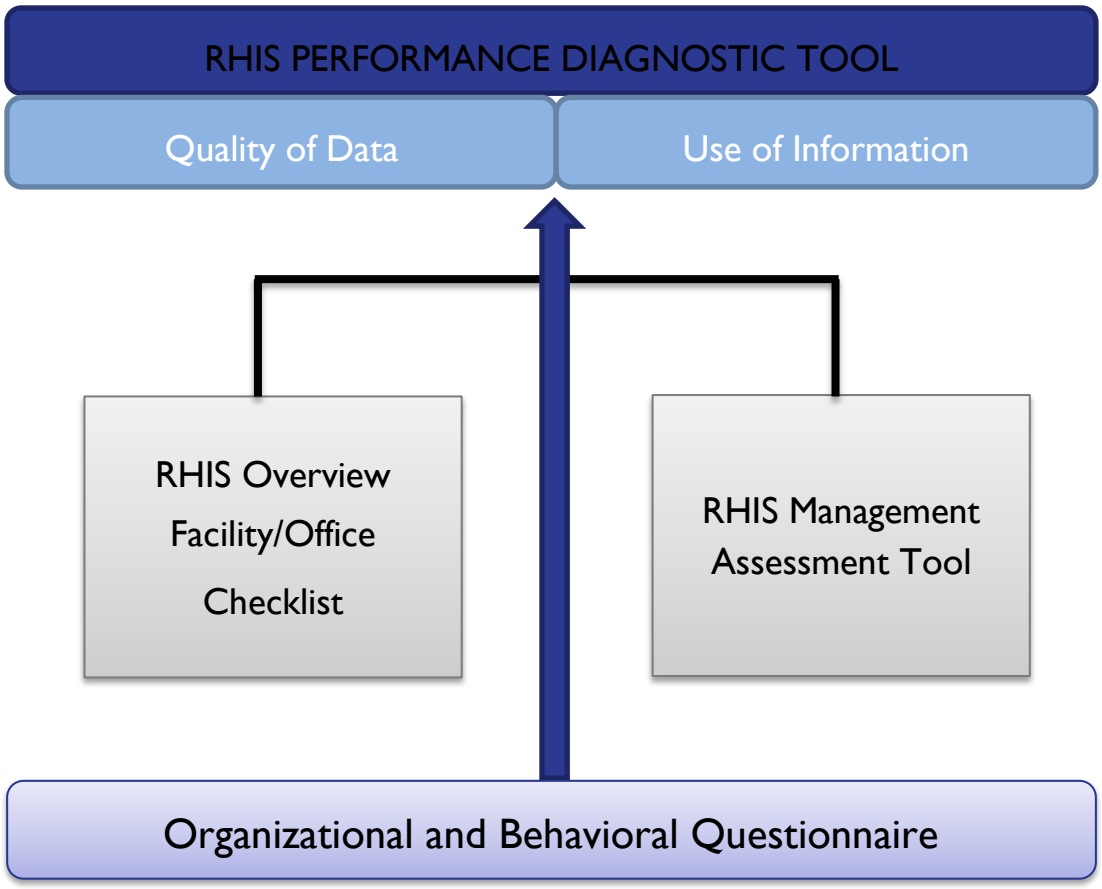
- The performance of routine HMIS depends on a **combination of technical, organizational and behavioral factors.**
- Each component and contributor in the system contributes to the ***whole system*** and the whole combines to be greater than the sum of its parts.
- The underlying causal influences (rather than the symptoms on the surface) in each of the three domains must be understood before an effective path toward addressing the issues can be developed.[1]

[1] *Tools for Data Demand and Use in the Health Sector: Performance of Routine Information Systems Management (PRISM) Tools*, MEASURE Evaluation Manual, 2011, p. 30.

The HFG India team is working with the National Health Mission (NHM) of Punjab to ensure that a holistic understanding is gained of the causal issues impacting the use of quality data across the state, particularly at the district and health facility level. From that level of understanding and with the objective of identifying priority areas for data quality improvement that Punjab NHM and HFG India can jointly address, the HFG India team conducted data gathering exercises across three Punjab districts from 9th of June to 18th of July 2014 using the PRISM Tools.

The PRISM Tools focus on the organizational and behavioral determinants of effective data reporting and usage and how these issues are related to the technical determinants. The following diagram illustrates the relationship between the assessment tools and the domains which they evaluate:

Figure 1: Relationship of PRISM Tools



The PRISM Tools consist of the following components:

- **Performance Diagnostic Tool** – This is the central component in the PRISM toolkit and is used to determine the overall strengths and weaknesses of the routine health information system (RHIS) performance. The tool is comprised of questionnaires that evaluate data transmission, data accuracy, data processing and data analysis.
- **Overview and Facility/Office Checklist** –This tool examines technical determinants of performance, such as the structure and design of existing information systems in the health sector, information flows and interaction between different information systems. It was applied

to evaluate the *use of information* at district offices and at health facilities.

- **Management Assessment Tool** – This tool is designed to take rapid stock of the RHIS management practices and aid in developing recommendations for better management. Supervision and feedback structures are key components evaluated using this tool.
- **Organizational and Behavioral Assessment Tool (OBAT)** – This tool identifies behavioral and organizational factors that affect RHIS performance, including such areas as data demand (from multiple sources), motivation of staff to collect and use information, the confidence level of staff in performing their jobs, task competence (compared to their perceptions of competence), and problem-solving skills. The OBAT provides a critical link between job functions, job performance and information use at multiple levels.

The PRISM Tools, which were originally developed and piloted by the USAID-funded MEASURE Evaluation project, were applied at 24 health facilities and three district and block offices in Punjab. Data were collected for the assessment using multiple methods, including the following:

- Reviews of documents, office records and RHIS feedback reports
- Information technology review
- Observations and interviews by the evaluation team (Performance Diagnostic Tool/MAT)
- Self-administered questionnaires (part of the OBAT)

1.2 Site Selection

Districts

The GoI has prioritized 184 poor performing districts in the country based on a composite set of indicators across the entire spectrum of maternal and child health for focused interventions to improve health outcomes in these domains. These poor performing districts were designated High Priority Districts (HPD) for providing technical support and resources to promote the improvement of health outcomes within the maternal and child health domains. The RMNCH+A initiative is a central component of this effort in the designated HPDs and key objectives are to accelerate the progress towards attaining Millennium Development Goals 4 and 5 (reduction of maternal and infant mortality rates) and health based targets outlined in the GoI's 12th Five-Year Plan. In the State of Punjab, the designated HPDs are Sangrur, Barnala, Mansa, Sri Muktsar Sahib, Gurdaspur and Pathankot.

In consultation with the M&E team from Punjab NHM, the HFG India PRISM assessment team selected a mix of HPDs and non-HPDs to review in order to gain a broad understanding of the RHIS components working well and where there may be common challenges across both types of districts. Hence, two HPDs and one non-HPD district were purposively selected for the PRISM assessment in Punjab and site visits for data collection were coordinated to not conflict with times that staff were focused on data capture and reporting for NHM purposes. The following are the three districts selected for the PRISM assessment:

- Barnala – HPD
- Mansa – HPD
- Patiala – Non-HPD

Blocks

As discussed above, each district in Punjab is further subdivided into block level administrative units. Mansa comprises five blocks, Barnala three blocks, and Patiala eight blocks. The PRISM assessment team attempted to cover 75 percent of the blocks (with a minimum 12 blocks) within the three districts in order to provide a wide spectrum of understanding of the data quality and information use issues in these districts.

Facilities

Each block contains multiple types of facilities including Sub-Centres (SC), Primary Health Centres (PHC), PHCs operating 24 hours per day (24x7 PHC), Community Health Centres (CHC), Sub-Divisional Hospitals (SDH), and District Hospitals. For the PRISM assessment, stratified samples of health facilities from all types were utilized to ensure a broad, but purposeful, pool of respondents to the multiple questionnaires and assessment tools utilized by the team. The sample of facilities for the PRISM assessment in Punjab breaks down as shown in Table 1.

Table 1: Site Visit Facility Summary

District	Facility Name	District	Facility Name
Barnala	CHC Dhaunala	Mansa	Joga Subcentre
Barnala	CHC Mehal Kalan	Mansa	PHC Boha
Barnala	PCH Bathlan	Mansa	SDH Budlada
Barnala	PHC Chananwal	Mansa	SDH Sardulgarh
Barnala	PHC Dhilwan	Patiala	CHC Dudhan
Barnala	PHC Rure-Ke-Kalan	Patiala	CHC Shutrana
Barnala	PHC Tallewal	Patiala	PCH Sauja
Barnala	SDH Tapa	Patiala	PHC Bhadson
Mansa	CHC Bhikhi	Patiala	PHC Harpalpur
Mansa	CHC Jhunir	Patiala	PHC Jogipur
Mansa	CHC Khyala Kalan	Patiala	SDH Nabha
Mansa	DH Mansa	Patiala	SDH Rajpura

1.3 Indicator Selection

In consultation with Punjab NHM, the PRISM assessment team selected four data elements to review for accuracy in reporting at the facility and district levels that are drawn from those used to monitor the RMNCH+A initiative. The data elements selected for accuracy checks were a) Number of first doses of Bacillus Calmett Guerin (BCG1) given to infants (to immunize against tuberculosis), b) Number of live births recorded and reported at the health facility (Live Birth), c) Number of newborn children with a weight less than 2.5 kilograms (Low Birth Weight), and d) Total number of outpatient department (OPD) cases registered at the health facility (OPD Attendance, All). These data elements were selected for review in part because they are drawn from a variety of registers maintained by the health facilities, thus providing a broader view of data accuracy at the health facilities.

2. PRISM ASSESSMENT FINDINGS

The PRISM assessment in Punjab was conducted using the set of four tools described in Chapter 1. Assessment findings have been compiled here, following the order of the tools used.

2.1 Performance Diagnostic Tool

The diagnostic tool measures strengths and weaknesses in different dimensions of data quality, information use, and RHIS processes. The tool provides information about technical determinants such as perceived user friendliness of forms, software, and RHIS design, and quality of supervisory visits.

The tool consists of four forms on data quality and information use: two for the district level or higher and two for the facility level. The questions related to RHIS design and information technology are more relevant for the district or higher level. However, the information use section has similar questions for both levels, except for the addition of a section on the quality of supervision at the facility level. The data for this tool is analyzed using a data entry and analysis tool (DEAT).

Data Collection and Transmission

The compilation of data takes place in the State of Punjab at three levels within each district, two of which are primarily administrative levels (Figure 2). The first takes place at the level of the health facility, the second is at the block level, and the third at the district level. In principle, data at the health facilities in Punjab are to be initially recorded by hand in the relevant registers at the time that services are provided to a patient, then compiled into a paper summary monthly report in the required formats that is sent to the block level on a monthly basis. In a number of cases during the PRISM site visits, staff noted that the first recording of services provided to patients is sometimes informally recorded on slips of paper or case sheets before being transcribed later to the registers, increasing the opportunity for transcription errors along the way. The registers are organized by service delivery units, including Outpatient, Maternal Care, Labor and Delivery, Child Health, and Family Planning. The data of all the facilities falling under the jurisdiction of the block are then entered into an electronic format using the DHIS 2, Punjab's designated reporting system for NHM data.

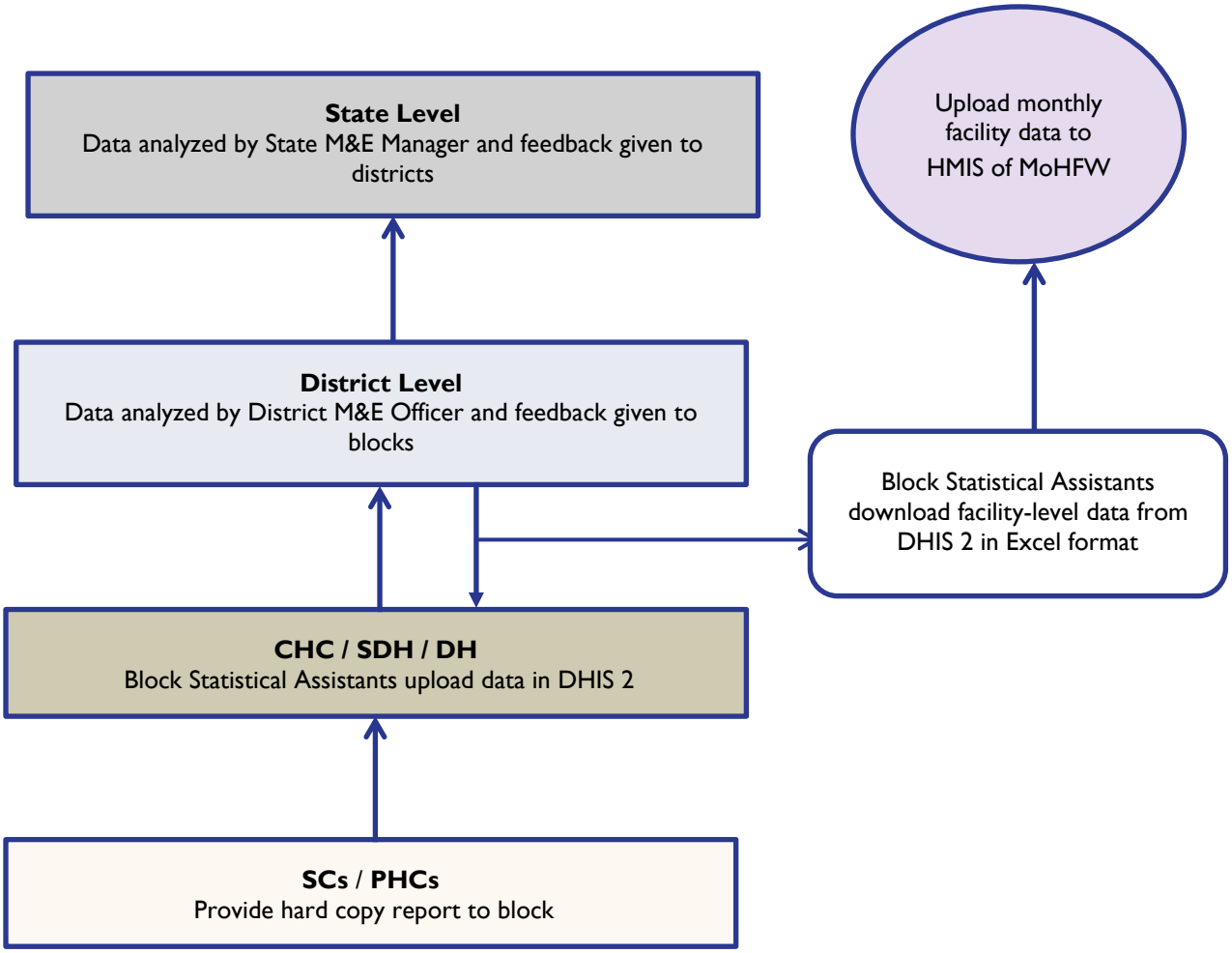
The DHIS 2 is a web-based data collection system (built on an Open Source database platform) that maintains a single centralized electronic database for each health facility and that aggregates pre-defined groups of health facilities according to the Punjab NHM organization of facilities, blocks, and districts. From the DHIS 2 database, Punjab NHM M&E staff exports a subset of data that is then used to fulfill the national-level reporting requirements of the MoHFW-designated reporting system, the web-based HMIS portal.

The DHIS 2 captures all of the required state-level and national summary health statistics for the following domains: Reproductive and Child Health, Health Facility Services, and Mortality Details. The DHIS 2 as implemented in Punjab does not, however, capture patient-level data nor allow tracking of individual patients across health facilities. The number of data items to be reported by each health facility on a monthly basis into the DHIS 2 ranges from five to 386, depending on the type of health facility and range of services provided. The majority of the reporting burden falls within a few days, either from the 1st to the 5th for health facility staff or the 6th to 10th of the month for district level staff, increasing the time pressure to report. The state-level data set for DHIS 2 is larger than that of the national data set required for reporting on the HMIS portal of the MoHFW.

In Punjab, data are captured in the DHIS 2 at the block PHC level by the Block Statistical Assistant and reviewed by the District M&E Officer at the district level and the State M&E Manager at the state level.

As of now, there are no computers or Internet facility or manpower at the facility level to enable the State of Punjab to roll out the data captured from the facility level (CHC or PHC) onwards. For those facilities (CHC or PHC), the data are uploaded at the block level for all health facilities within their section. Based on interviews with the field teams, the block- and district-level M&E officials are under tremendous pressure to upload the data in the DHIS 2 web portal within the prescribed reporting deadlines (5th of the month for the block and 10th of the month for the district).

Figure 2: Flow of HMIS Data in Punjab



The State of Punjab has a number of distinct health data systems operating in addition to the DHIS and National HMIS Portal. Following are brief descriptions of two of the data systems:

- MCTS – The national MoHFW introduced MCTS as a name-based tracking system to ensure that pregnant women and newborn children get the appropriate type of services for their situation. MCTS is intended to be used to register pregnant women to ensure that their ante- and postnatal checkup schedules are monitored and adhered to. For newborns, there is an emphasis on ensuring that they receive the appropriate childhood immunizations on schedule. While the MCTS is a web-based system, much of the data are initially captured on paper records by auxiliary nurse-midwives (ANMs) working in the community; the data are later

captured electronically when the ANMs return to their health facilities. In addition, there is currently no electronic interface between MCTS and any of the other HIS operating in Punjab, which frequently results in duplicate data entry.

- Integrated HMIS (under development) – The Integrated HMIS was conceived as a single source of reporting of all health service-related reports from the facility level upward. In a comprehensive process of rationalization of the reporting formats, about 242 monthly reports were rationalized and merged in to a single reporting system. The Integrated HMIS is being rolled out using the DHIS 2 platform. As the Integrated HMIS is still in its infancy and not been rolled out in the entire state, it is too early to comment on its performance. As in the case of the DHIS 2, the Integrated HMIS is planned to be operated at the Block PHC level by the block Statistical Assistant, the District M&E Officer at the district level, and the State M&E Manager at the state level.

Based on the review of systems by the assessment team during the PRISM site visits, most of the data management work was found to be handled by the block-, district-, and state-level M&E officials. There is no electronic data exchange mechanism available at the state or national level to facilitate the flow of data directly from one system to another. As observed by the PRISM assessment team, the state- and national-level web portals are being managed by different agencies with little coordination between them leading to several software and design-related issues that could affect data quality. The PRISM review focused solely on the flow of data from the health facilities in Punjab to the state-level NHM.

The health facilities of a single type such as PHC, CHC, or Civil Hospital are required to fill out the same routine forms and data elements for monthly reporting. However, based on the observations and data gathering by the PRISM assessment team, while distinct facilities may have the same designation in Punjab, the health services provided vary widely from facility to facility. The data elements expected to be filled in on the monthly HMIS reporting forms are based on the services that are supposed to be provided by the health facility based on their designation. What was observed during PRISM site visits, however, is that actual elements filled in on the monthly reporting forms vary widely even across facilities with the same designation (e.g., both operating as a PHC). Interviews with staff at the health facilities indicate this is frequently caused by human resource issues, such as a specialist being transferred from one health facility to another, which impacts the types of care provided at each facility and thus the data elements reported on a monthly basis. For one of the factors reviewed during the PRISM assessment – the level of data completeness at facilities as measured by the number of elements actually filled (numerator) divided by those data elements actually filled in (denominator) – there was significant variation in the completion percentage. At the low end of the spectrum of the facilities reviewed, some had filled in only 13 percent of the expected data elements, while at top end, one actually filled in more than 100 percent of the expected data elements, as shown in Table 2 (a full summary of the national HMIS reporting formats is provided in the Annex). This reflects not so much a reporting issue as a variation in services provided.

Table 2: Completeness of monthly reporting forms

Count of Health Facilities	Elements Expected to be Filled In	Actual Elements Filled In	Completion Percentage
1	45	6	13%
2	63	10	16%
3	65	14	22%

4	94	22	23%
5	128	32	25%
6	386	102	26%
7	34	9	26%
8	104	28	27%
9	36	10	28%
10	104	30	29%
11	127	37	29%
12	20	6	30%
13	68	22	32%
14	24	8	33%
15	105	36	34%
16	34	12	35%
17	104	38	37%
18	55	22	40%
19	52	22	42%
20	62	33	53%
21	6	6	100%
22	16	16	100%
23	5	5	100%
24	12	16	133%

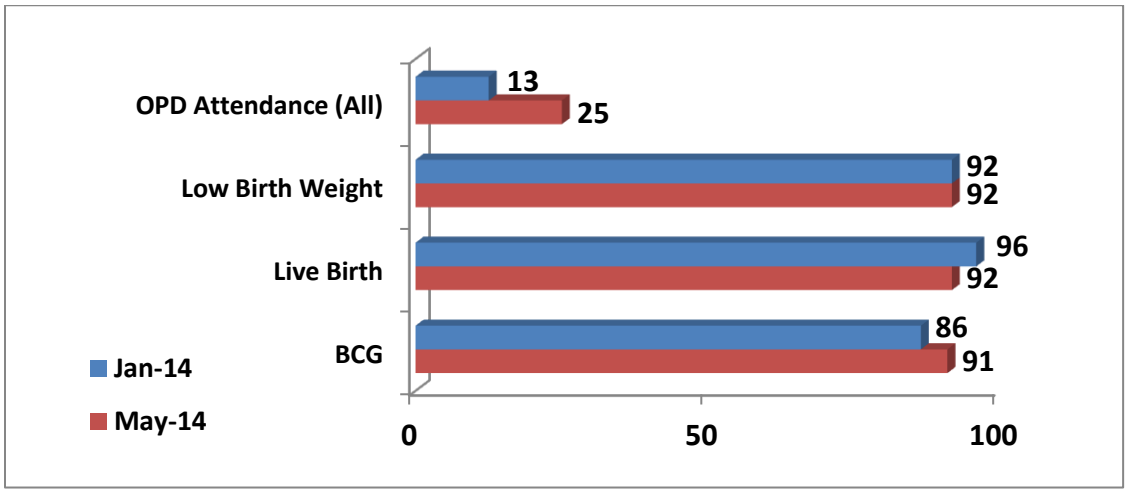
During the PRISM assessment, some of the staff interviewed across the districts expressed concerns that the DHIS 2 gathers information that is also gathered by other information systems, such as the MCTS, which capture patient-level information. Duplication of data collection and reporting can lead to increased workloads on the already burdened health facility staff. It was noted by the PRISM assessment team that this concern might be resolved after the Punjab NHM M&E team completes implementation of its integrated HMIS across the state, which was expected to be completed by December 2014.

While the required reporting deadline for monthly reporting of data from facility to block or district level is well known by health facility staff, it was noted by the PRISM assessment team that the date on which the monthly reports are sent to the block level is not recorded at the facility level nor is the date of receipt recorded at the block level. The absence of these records made it difficult to assess the timeliness of reporting by health facilities or district teams visited during the PRISM assessment.

Data accuracy

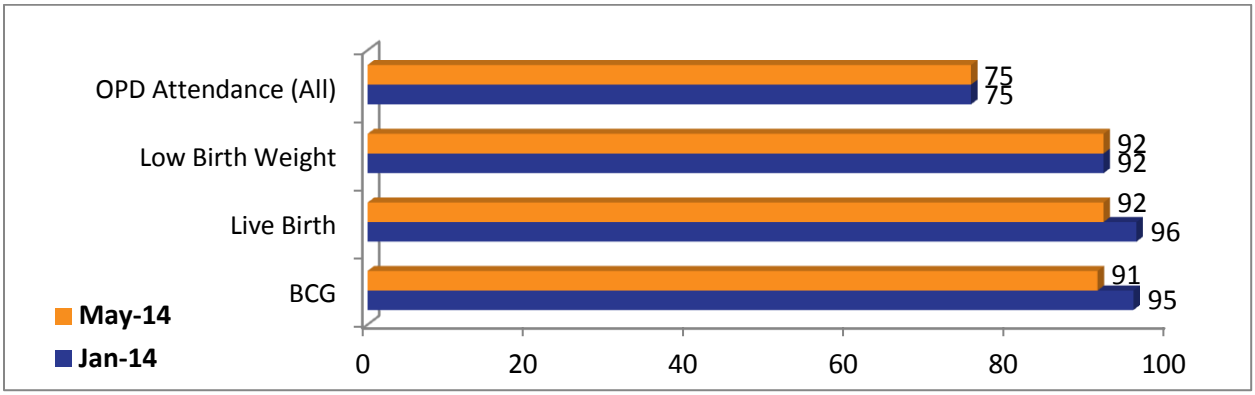
A key function and measure of any routine reporting system is the level of accuracy with which the information is collected and reported. As noted above, the PRISM assessment team selected four indicators from the RMNCH+A initiative to review at the health facility level and district level to evaluate the level of accuracy being achieved with the NHM reporting processes in the three Punjab districts visited. The data elements selected were a) Number of first BCG doses given to infants (to immunize against tuberculosis), b) Number of live births recorded and reported at the health facility (Live Birth), c) Number of newborn children with a weight less than 2.5 kilograms (Low Birth Weight), and d) Total number of outpatient cases registered at the health facility (OPD Attendance, All). The data elements selected for review came from a variety of registers maintained by the health facilities, thus providing a broad view of data accuracy at the health facilities. The PRISM assessment team reviewed the monthly reports for two separate periods (January 2014 and May 2014) at each of the health facilities visited to confirm whether the amounts recorded on the monthly reports matched with the original data sources for each data element. The PRISM assessment teams recounted the data elements directly from the registers to compare with the reports submitted to the block or district levels. OPD Attendance scored the lowest in matching between the two, with 13 percent and 25 percent for January and May 2014, respectively. Live Births matched the most frequently, with 96 percent and 92 percent accuracy between counted and reported for January and May, respectively. Figure 3 provides the summary of accuracy (i.e., recounted versus reported totals) for the 24 health facilities across the four indicators reviewed.

Figure 3: Facility Level Data Accuracy Measured by Report to Source Matching (%)



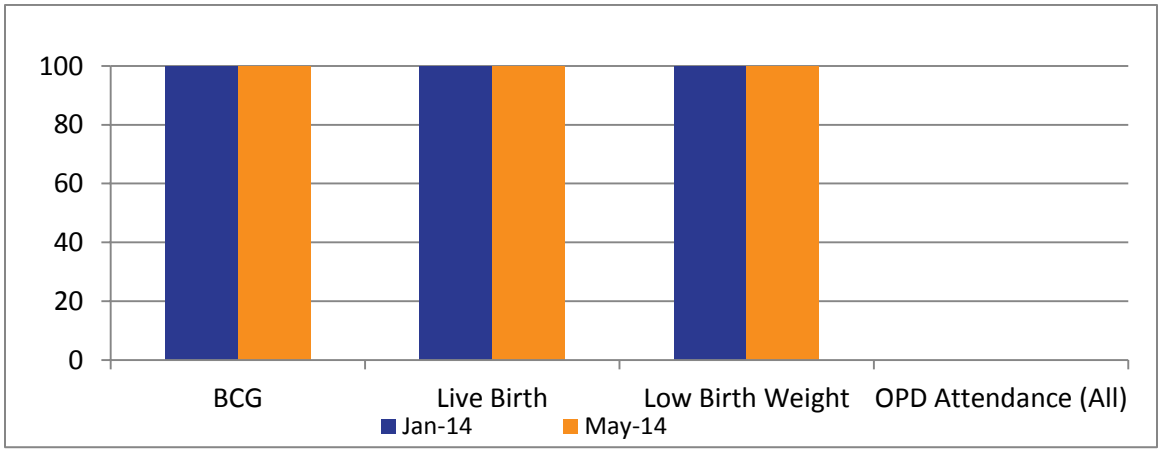
Given the volume of data being compared and level of staffing resources available, it is perhaps reasonable to expect a certain amount of variation between the totals counted by the PRISM assessment team and the totals reported by the facility staff. In some facilities visited during the PRISM assessment, the monthly totals for OPD Attendance were over 22,000. When a tolerance range of 5 percent (i.e., from 95 percent below to 105 percent over the actual figure as calculated by the PRISM team) is considered to be 'accurate,' the accuracy of the OPD Attendance shifts. Using this framework, 75 percent of the monthly reports for OPD Attendance for the 24 facilities visited during the PRISM assessment were within 95 percent and105 percent of the figure recounted by the team. In essence, there were numerous mistakes in counting, but they were relatively small mistakes, as highlighted in Figure 4.

Figure 4: Facility Level Data Accuracy Measured by Report to Source Matching with 5% Tolerance Range (%)



A similar exercise was conducted at the district level to review the data accuracy at the district level. The PRISM assessment team selected the same four indicators that were reviewed at the facility level to assess the data quality: BCG1, Live Birth, Low Birth Weight, and OPD Attendance, All. The PRISM assessment team reviewed the monthly reports for two separate periods (January 2014 and May 2014) of each of the health facilities falling under the three sample districts of Punjab visited to confirm whether the amounts recorded on the monthly reports in the DHIS 2 matched with the original reports for all health facilities in the districts. This was done by totaling the counts of the four data elements under review from all the health facilities reports and verifying them against with the total numbers for that particular district as shown in the DHIS 2. For the districts, the PRISM assessment team did not apply a tolerance range above or below the 100 percent accuracy target. As presented in Figure 5, Live Births and Low Birth Weight data accurately matched between monthly reports of the health facilities and district aggregate in the DHIS 2. The OPD Attendance reports, by contrast, did not match for either the January or May 2014 periods when compared with the DHIS 2 totals for the same periods. It should be noted, however, that monthly reports could only be compared for two of the districts as the reports were not available for review by the PRISM assessment team during their visits to the Mansa district office.

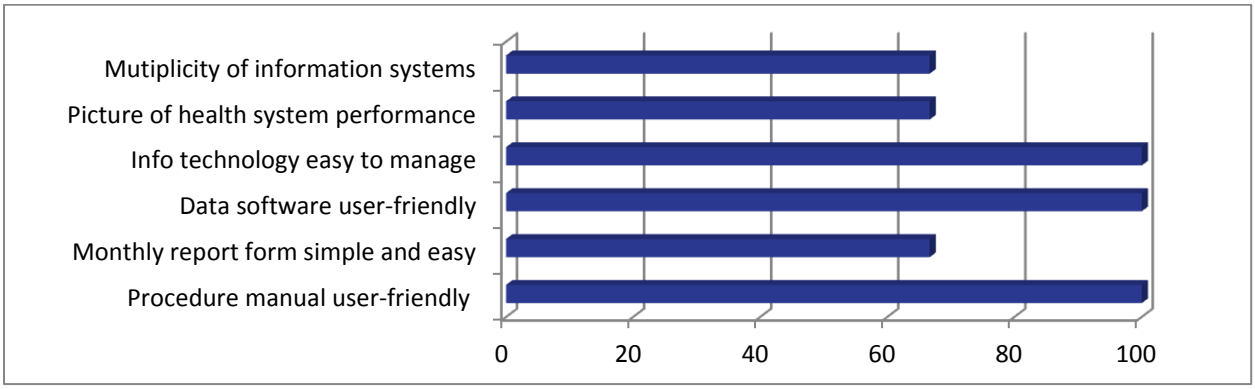
Figure 5: District-Level Data Entry Accuracy (%)



Data processing and data analysis

Beyond merely compiling data and reporting it to the next level, conducting analysis and using the data is a key indicator of a functioning RHIS. The PRISM assessment team queried M&E staff at the district level about their perceptions on the ease of use of the data collection forms, the registers, and the information technology tools (e.g., DHIS 2) used to compile the data. All three district M&E teams interviewed found the information technology (i.e., computers, Internet, etc.) easy to manage, and the DHIS 2 software and procedure manual to be user friendly. Figure 6 summarizes the perceptions of the district-level staff on the accessibility and utility of the reporting tools.

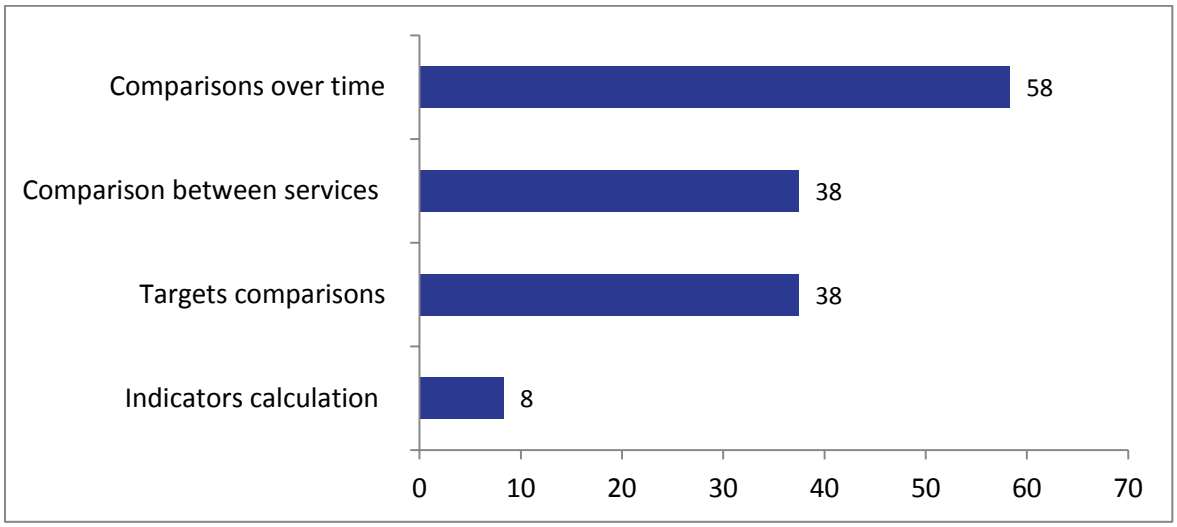
Figure 6: Perceptions of Technical Issues at District Level (%)



The PRISM assessment team assessed the types of analysis being conducted at the facility level across the three districts visited by asking about the production of different indicators. The team found that the following types of data analysis are being compiled by the health facilities, albeit with relatively low frequency: a) calculating indicators for a facility's catchment population, using numerators and denominators that show the level of coverage for a particular service; b) comparing various indicators against the district or national targets; c) measuring comparisons between services to evaluate which is more effectively reaching their targets; and d) comparing data over time to determine whether a certain service is improving, static or declining.

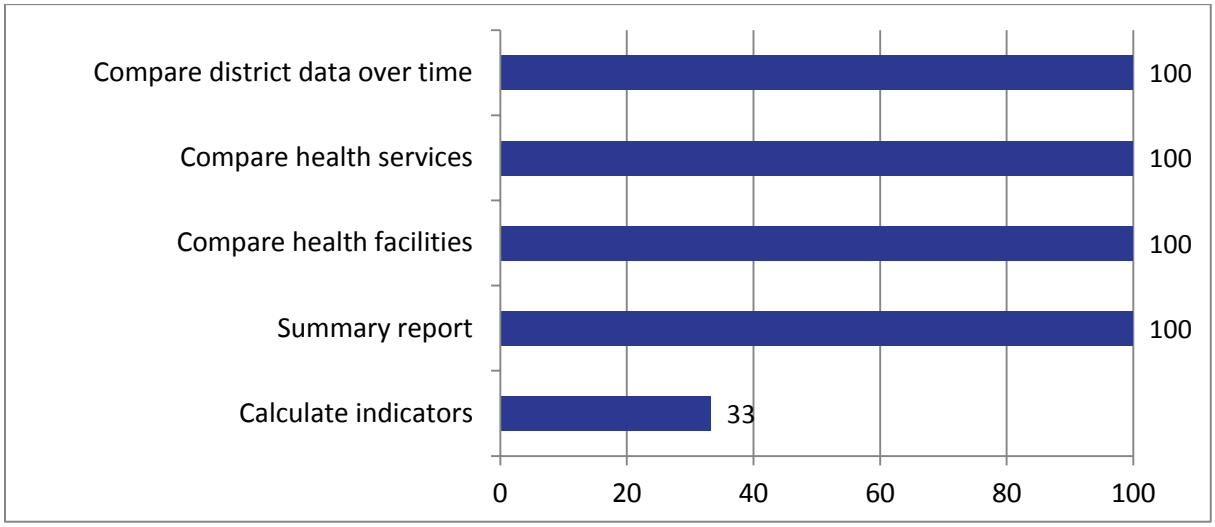
As can be seen in Figure 7, only 8 percent of the health facilities visited for the PRISM assessment were using data to calculate indicators at the facility level. Less than half of the facilities visited use data to compare their performance with district/national targets and compare performance by type of service within the facility. Most frequently observed at the health facilities was the comparison of the indicator performance over time, with more than half (58 percent) of the facilities doing this. One reason that there appears to be low production and analysis of indicators is the absence of tools to support this. The DHIS 2 produces these types of analyses as a routine reporting function. However, the DHIS 2 is not available to sub-centres and PHCs, which means that they would have to produce these analyses with other tools or by hand. Given that only 8 percent of the health facilities were calculating indicators, it is likely that some of the district-level teams were providing the data for tracking indictors over time to the facilities.

Figure 7: Types of Analysis Conducted at the Facility Level (%)



The PRISM assessment team found a broader range of analyses being conducted at the district level. Figure 8 summarizes the range of analyses being conducted at the district level.

Figure 8: Types of Analyses Conducted at District Level (%)

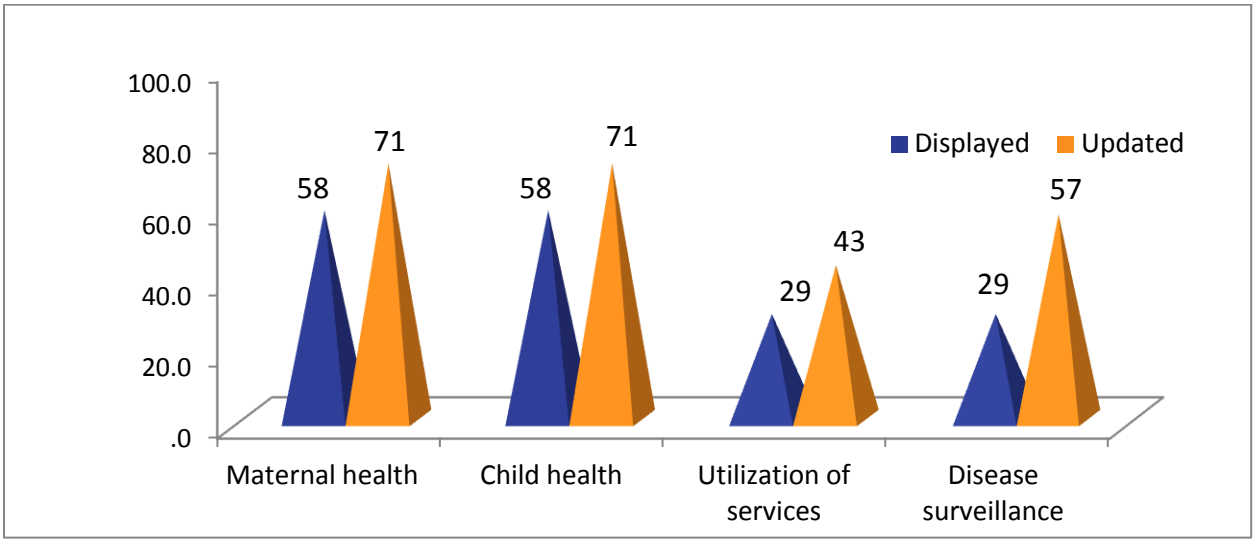


Display of information

During the facility site visits, the PRISM assessment team looked at whether or not the facilities were displaying the information generated at the facility level, thus enabling patients and other visitors to see what is happening at the facility. The assessment team chose to observe the extent to which four broad types of indicators were displayed: a) related to maternal health; b) related to child health; c) facility utilization of services; and d) disease surveillance. The team looked for data displayed in the form of tables, graphs, charts, maps, and similar products. It observed that 58 percent of the health facilities visited displayed maternal and child health indicators, while only 29 percent of health facilities displayed data on facility utilization indicators (e.g., total OPD visits, total inpatient visits, total laboratory test, total number of x-rays conducted) and disease surveillance performance indicators (e.g., number of

vector-borne diseases, number of waterborne diseases, respiratory diseases, and vaccine preventable diseases). In addition, the PRISM assessment team checked to see, in those facilities that did display data, whether the displayed data had been updated since the latest reporting period. The assessment team found that the maternal and child health indicators are the ones most frequently updated: 71 percent of the health facilities visited displayed updated maternal and child health indicators, while only 42 percent of the facilities displayed facility utilization indicators with updated data (Figure 9).

Figure 9: Types of Information Displayed at Facility Level (%)



The PRISM assessment team conducted a similar analysis at the district level. Two of the three district offices displayed data in the four domains observed, and one of the two used updated data in the display.

2.2 Overview and Facility/Office Checklist

The Facility/Office Checklist takes stock of available resources such as equipment, utilities, storage of information, communication capability, and HMIS forms and registers. Each facility visited in Punjab by the PRISM assessment team had been provided with hard copies of the data reporting formats for DHIS 2 and other HMIS systems by their district M&E teams. The facilities enter the data manually from the registers to the hard copy of the formats provided by the districts. The assessment team observed in some cases that the data were not collated at the facility level but instead different departments or groups of departments within the health facility sent their data directly to the block level.

As also observed during the site visits, the data sent by health facilities were sometimes sent on regular paper rather than the required reporting forms, which may indicate an insufficient supply of reporting forms at the health facility level. However, when asked whether the health facilities ever experienced stock-outs of monthly report forms, the vast majority of facilities indicated that they had ample supplies. Table 3 shows the percentage of facilities with available forms at the time of the PRISM assessment site visit and the percentage of facilities that had experienced a forms stock-out within the past 12 months. The availability of forms did not appear to pose a barrier to routine data reporting. It should also be noted that calculations were made by the PRISM assessment team only for relevant forms at each facility; thus, not every facility visited provided emergency or inpatient services, so the absence of these forms did not get recorded as a stockout in the availability data compiled.

Table 3: Review of Data Reporting Forms Availability

Type of Data Reporting Form	Availability During Site Visit	Stock out Within Past 12 Months
Delivery	95.8	8.7
OPD	100.0	8.3
Lab	95.8	4.3
Birth	83.3	5.0
Emergency	62.5	6.7

One of the key elements that impact the ability of health facilities and district-level M&E teams to produce and report timely, accurate data is the level of resources available to the teams. To evaluate this element, the PRISM assessment team used the Facility/Office Checklist to review the level of staffing for HIS and M&E functions, and the availability of required reporting tools and components of technical infrastructure at both the facility and district levels. At the facility level, there appears to be adequate technical infrastructure, with consistent electricity and back-up power, working computers and printers, as well as access to the Internet at more than half of the facilities visited for the assessment (Table 4).

Table 4: Basic RHIS Infrastructure Available at the Facility Level

Hardware / Equipment	Total Quantity	Working Condition
Computer	27	27
Data back-up unit locally (e.g., floppy, CD, zip)	7	7
Printers	29	27
Modems	17	16
UPS	25	18
Generators	23	22
Regular telephone	10	9
Radio telephone/Mobile phone	39	39
Access to Internet	15	15
Calculator	17	17

In terms of human resources, the PRISM assessment team looked at the number and type of staff employed at the health facilities, as well as whether they had received training within the past three years in the areas of data collection, analysis, and/or reporting of information. As seen in Table 5, while not all health facilities had Block Statistical Assistants, Information Assistants, or Computer Operators on staff, 86 percent, 36 percent, and 80 percent of the staff on board in these categories, respectively, had received HMIS-related training.

Table 5: Health Facility Staff Employed and Trained

Human Resources	Average Number per Facility	Trained in HMIS (%)
Senior Medical Officer	1.4	3.0
Staff Nurse	3.7	0
Pharmacist	0.8	0
Block Statistical Assistant	0.5	85.7
Information Assistant	0.6	36.4
Lab Technician	0.8	0
Computer Operator	0.3	80.0
Driver	0.4	0
Lady Health Volunteer	0.6	10.0
Male Health Worker	0.4	16.7
ANM	0.8	26.7

At the district level, the PRISM assessment team also evaluated some of the technical resources commonly required to collect and report health data through the system. There were no limitations with regard to resources found as each of the districts visited had computers, ready access to the internet and back-up power sources available to them.

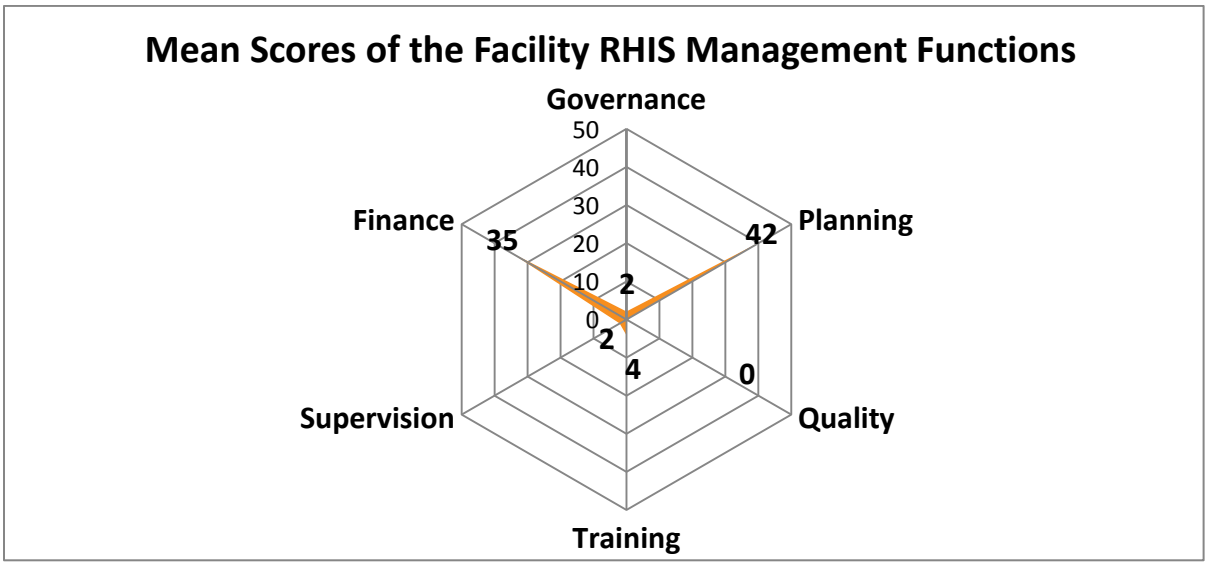
2.3 Management Assessment Tool

Management of a health system is about managing resources and functions to produce better outcomes. RHIS management is no different. For the purposes of the PRISM assessment, RHIS Management is being defined as "the presence of mechanisms for managing RHIS functions and resources effectively for better RHIS performance." RHIS management functions comprise RHIS governance, planning, training, supervision, finances, logistics, and use of performance improvement tools. One objective for the PRISM assessment was to compare the level of management functions with how they are used to set priorities for action within the health system.

In order to measure the existence and, if in place, the strength of management practices at the facility level, the PRISM assessment team asked a series of questions related to governance, planning, quality standards, training, supervision, and finance. At least two questions were used to assess each function and an index percentile score for each function was calculated as a measure. For example, to evaluate the presence of quality standards, health facilities were asked whether there was a written copy of expected quality standards at the facility and whether there were any performance improvement tools (e.g., flowcharts and control charts) in use at the facility. None of the facilities visited by the PRISM assessment team indicated that these quality standards were present. Of the six management functions

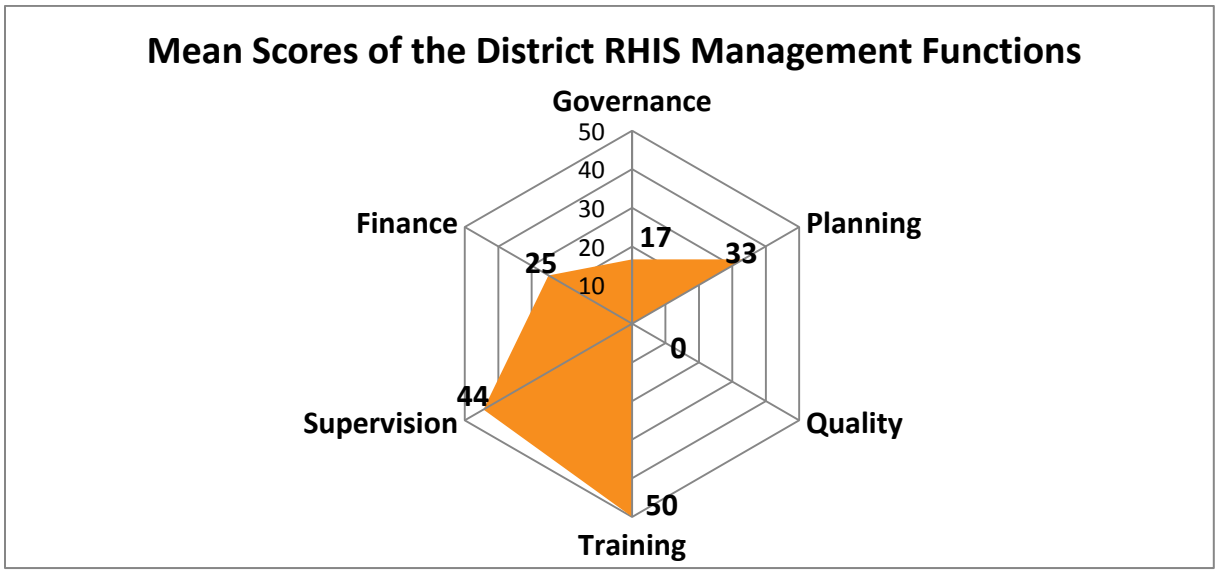
reviewed, planning scored the highest across the facilities (42), as some facilities noted having written targets that are shared across reporting levels and a situation analysis of the RHIS written within the past three years. The mean of the scores for each of the six management functions reviewed during the PRISM assessment is presented in Figure 10.

Figure 10: Mean Scores of the Facility RHIS Management Functions



At the district level, training scored the highest among the management functions reviewed (50), as measured by the presence a schedule for planned trainings and having an RHIS training manual in place. As was found at the health facility level, the existence of quality standards was notably absent at the district level. Figure 11 provides a summary of the overall means for each of the six management functions reviewed at the district level during the PRISM assessment.

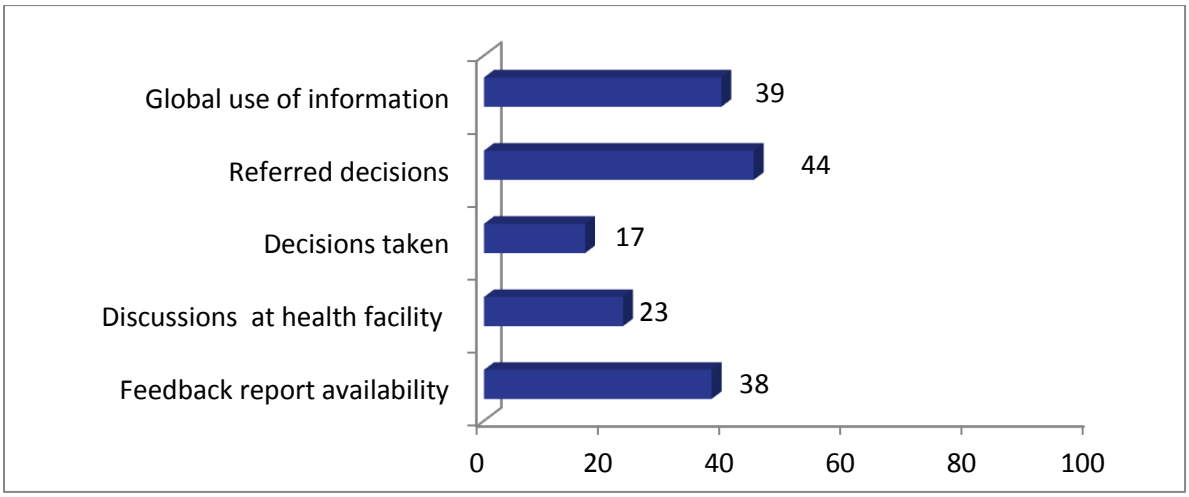
Figure 11: Mean Scores of the District RHIS Management Functions



While reporting accurate and timely information is a central function of an RHIS, equally important is the way that information from the system is (or isn't) used for making decisions related to programs.

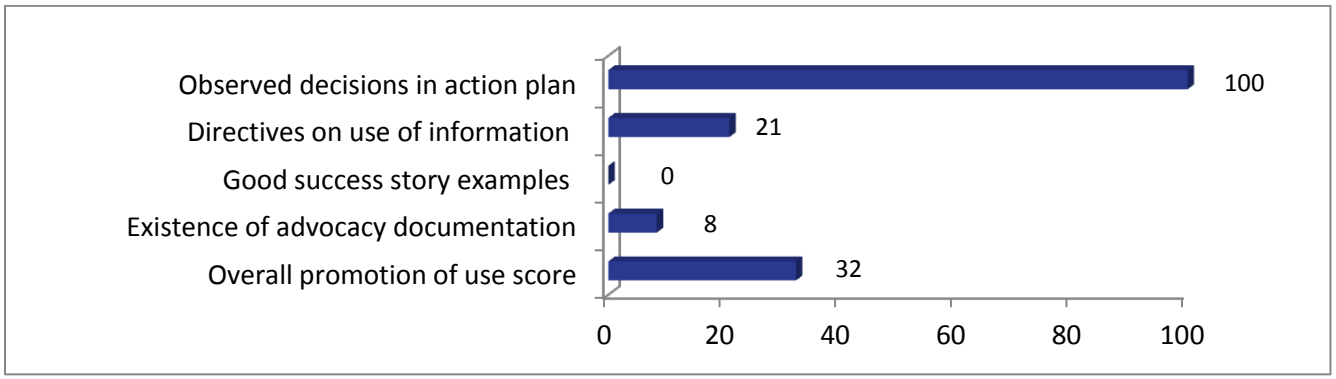
Supervision and feedback structures are key components evaluated using the Management Assessment Tool during the PRISM assessment to begin assessing the use of information across the Punjab health system. At the facility, the PRISM assessment team asked staff about the system of conducting monthly meetings for reviewing managerial and administrative matters and if the health facility maintained official records of the management meetings. The team found that only 38 percent of the health facilities could provide it with the records of the meetings. It reviewed the records of the meeting for the months of March through May 2014 to understand whether the RHIS information was being used for functions such as data quality reviews, timeliness of reporting or patient utilization, disease data, and service coverage. The team found that only 23 percent of the health facilities had used data from the RHIS to discuss management issues at the facility and fewer still (17 percent) had taken a decision based on the data (Figure 12). The PRISM team found that the average global level of information use based on these criteria was very low at 39% across the health facilities visited.

Figure 12: Level of Information Use at the Facility Level (%)



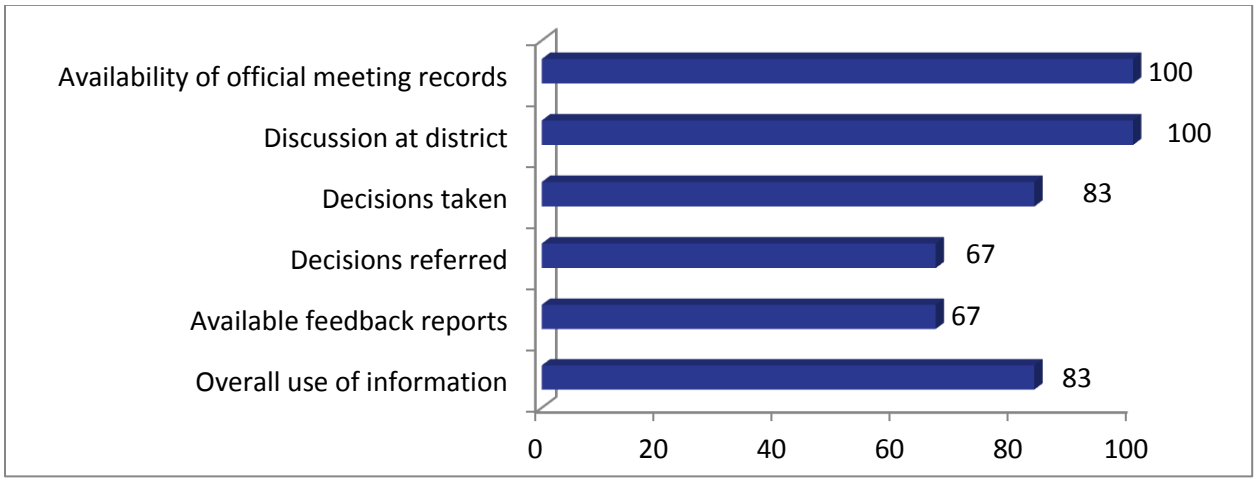
The PRISM assessment team asked facility staff to review their facility action plans and then verified whether RHIS information was used for annual planning. The team found that all 24 health facilities visited had used RHIS information to set monthly/annual targets in their facility action plans. Twenty-one percent had received documents containing directives by the district or a higher level concerning the use of RHIS data within the three months prior to the site visit (March–May 2014), but none of the health facilities had received newsletters or reports in this period providing examples or success stories of how information has been used successfully in the past by facilities within the district. The team found that only 8 percent of the health facilities had used the information for advocacy. As can be seen in Figure 13, the use of information at the facility level is primarily promoted in developing the annual action plans for the facilities.

Figure 13: Promotion of the Use of Information at the Facility Level (%)



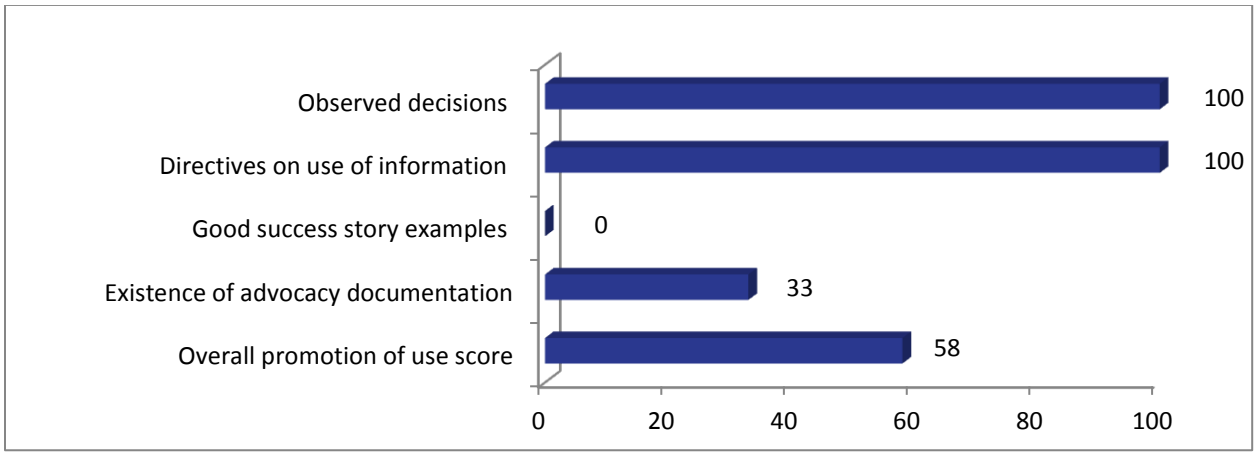
The routine monthly meeting mechanism also exists at the district level and the districts visited for the PRISM assessment all maintain minutes for meetings conducted. The PRISM assessment team reviewed the official records (minutes) of the meeting for the months of March, April, and May 2014 and also looked for available feedback reports from the higher levels to the districts. If found, the assessment team reviewed the feedback reports to assess the level of information use in these for such purposes as acknowledging well-performing facilities, whether resources were mobilized or advocated for based on information in the reports and/or whether any policies were developed as a result of information in the reports. A composite score on scale of 0-100 was compiled for each district to measure the level of information use in the available reports. Figure 14 summarizes the average of the three districts for the level of information use across several categories.

Figure 14: Level of Information use at the District Level (%)



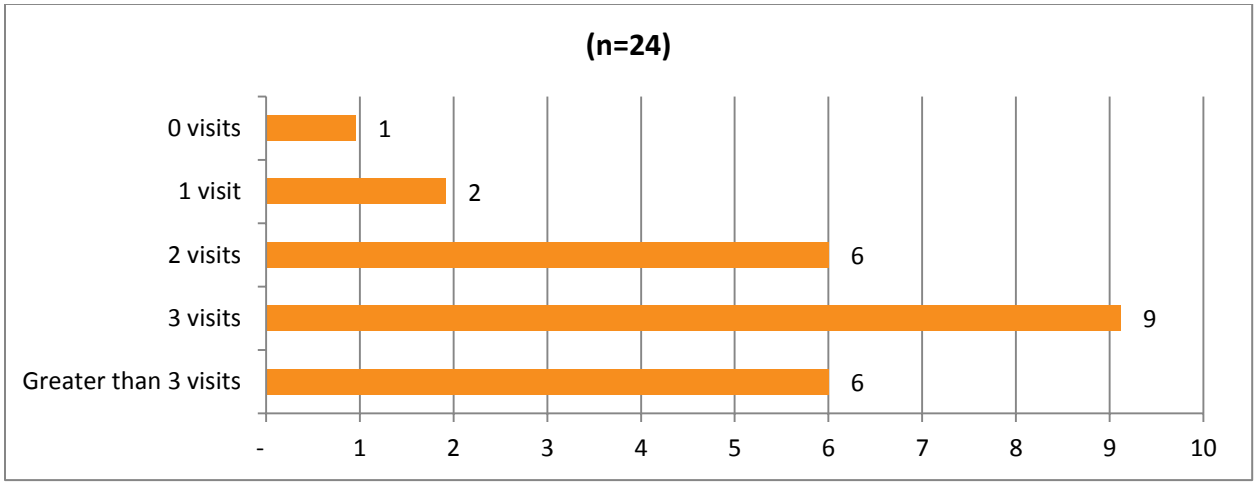
As shown in Figure 14, two of the three districts had feedback reports available from the upper-level teams. It was observed during the PRISM assessment that there appears to be a higher level of engagement between state and district levels than between district and facility levels. The assessment team found that more directives relating to promotion of information use had been received at the district level than the facility level, but that there was no evidence of success stories in promoting the use of information and very little evidence of information having been used for advocacy purposes at the district level (Figure 15).

Figure 15: Promotion of the Use of Information at the District Level (%)



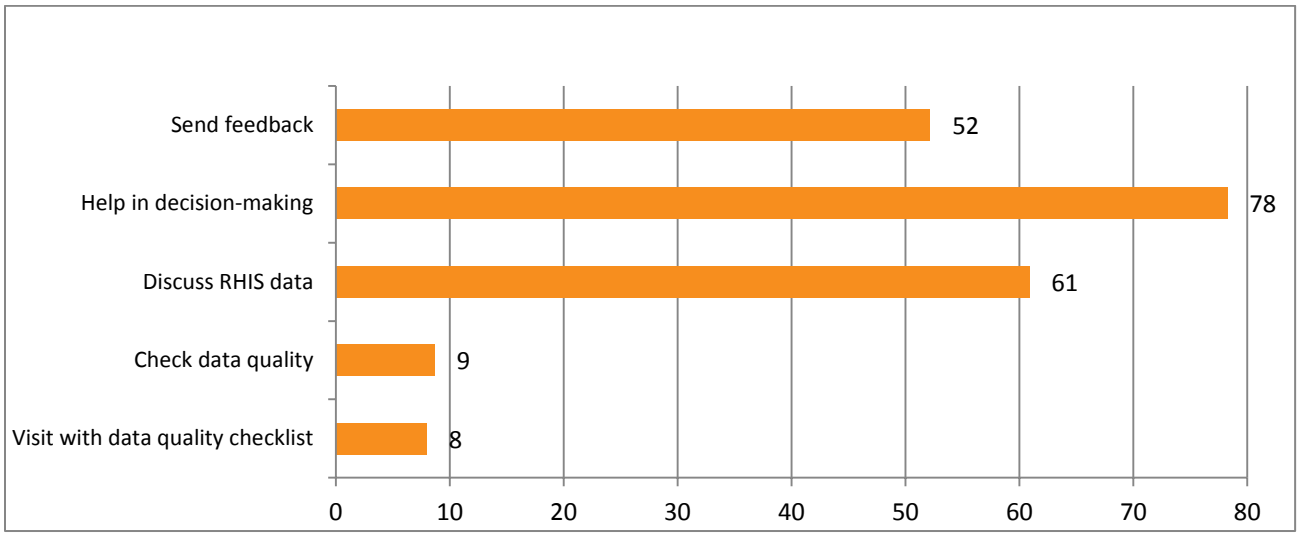
In conjunction with the questions about promotion of information use, the PRISM assessment team asked the health facilities visited about their experiences with supervisory visits. They were asked the number of supervisory visits that had taken place within the past three months (March to May 2014) and certain observations about the supervisory visits. Across the 24 health facilities visited during the PRISM assessment, 65 supervisory visits had taken place in the prior three-month period for an average of 2.7 supervisory visits per health facility. However, there was a wide range in the number of visits at each facility, from zero in one facility (4 percent of sample) to more than three visits in six facilities (25 percent). Figure 16 provides an overview of the number of supervisory visits documented.

Figure 16: Number of Supervisory Visits to Health Facilities



The PRISM assessment team asked additional questions to ascertain the quality of the supervisory visits taking place. Based on the responses from facility staff, there was extensive discussion of RHIS data and help in decision-making and moderate amounts of feedback were sent to the facility. However, staff at the health facilities indicated that there was not much done in the way of checking data quality, as summarized in Figure 17.

Figure 17: Observed Supervisory Quality at Facility (%)



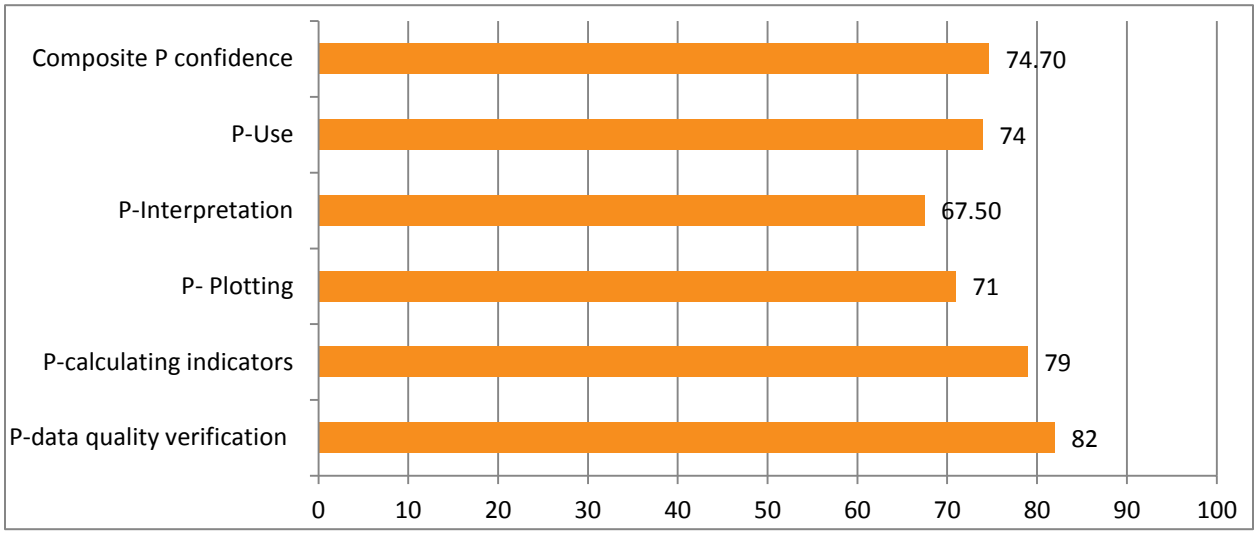
The absence of emphasis on data quality during supervisory visits is consistent with earlier observations from the PRISM assessment with regard to the absence of data quality tools and guidelines available and in use at the health facilities in Punjab.

2.4 Organizational and Behavioral Assessment Tool

The OBAT assesses perceptions about the organization through a rating scale, while task-competency and problem-solving skills are estimated by responses to problems given in a written test. The culture of information is defined as "the capacity and control to promote values and beliefs among members of an organization for collection, analysis, and use of information to accomplish its goals and mission." The OBAT goes beyond perceptions to test actual capacity and knowledge of staff at the facility and district levels. This was done by administering a written test to one individual per health facility to assess their task-competency and problem-solving skills, in addition to reviewing the behavioral factors on RHIS performance, the culture of information, and the effectiveness of reward system through survey instruments. Most of the findings present variables that are composite indices of more than two question items. Thus, they have been converted into percentile score for easy interpretation and comparisons.

The first component evaluated with the OBAT was the perceived confidence of health facility staff across a range of tasks related to RHIS. The self-efficacy or confidence percentile scores for RHIS tasks were calculated for checking data quality, calculating indicators, plotting the given data, and interpretation and information use at facility level. The findings are presented Figure 18. Health facility staff perceived confidence in performing RHIS-related tasks was relatively high and fell within a uniform range across the various RHIS tasks from 66 percent to 76 percent, with the overall perceived confidence level at 66 percent.

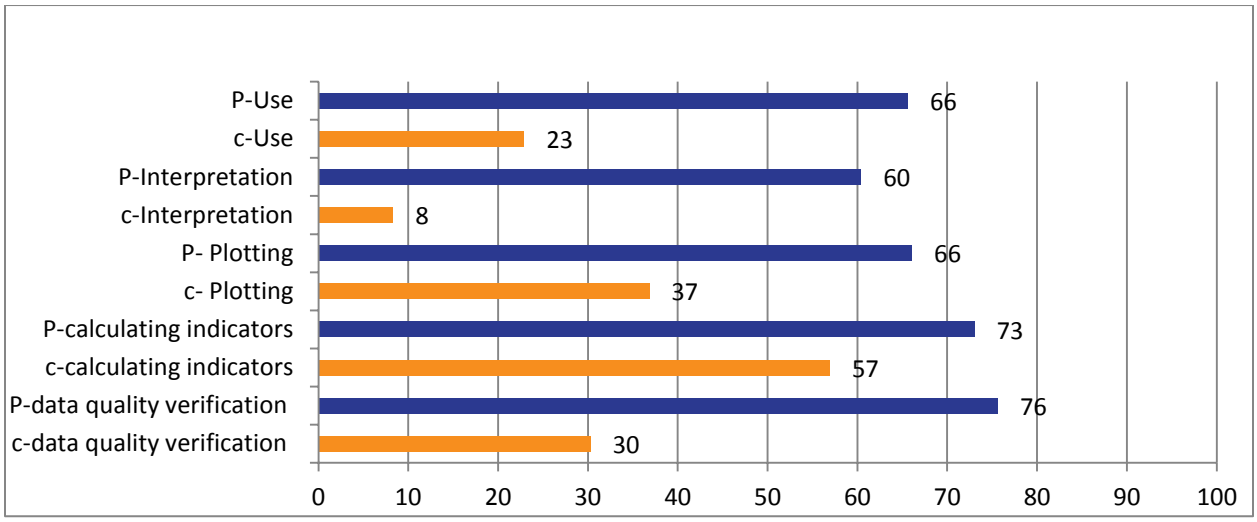
Figure 18: Perceived Confidence Levels for RHIS Tasks at Facility (%)



Note: P=perceived

The health facility staff participating in the OBAT exercise completed a multi-question test that evaluated the same components as those in which they rated their self-efficacy. The results provided a stark contrast, as respondents scored only half as well as they perceived their competence on a number of the RHIS tasks. Figure 19 compares the perceived confidence of the staff on the RHIS tasks to the measured competence using the OBAT tools.

Figure 19: Perceived Confidence vs Competence Levels at Facility (%)



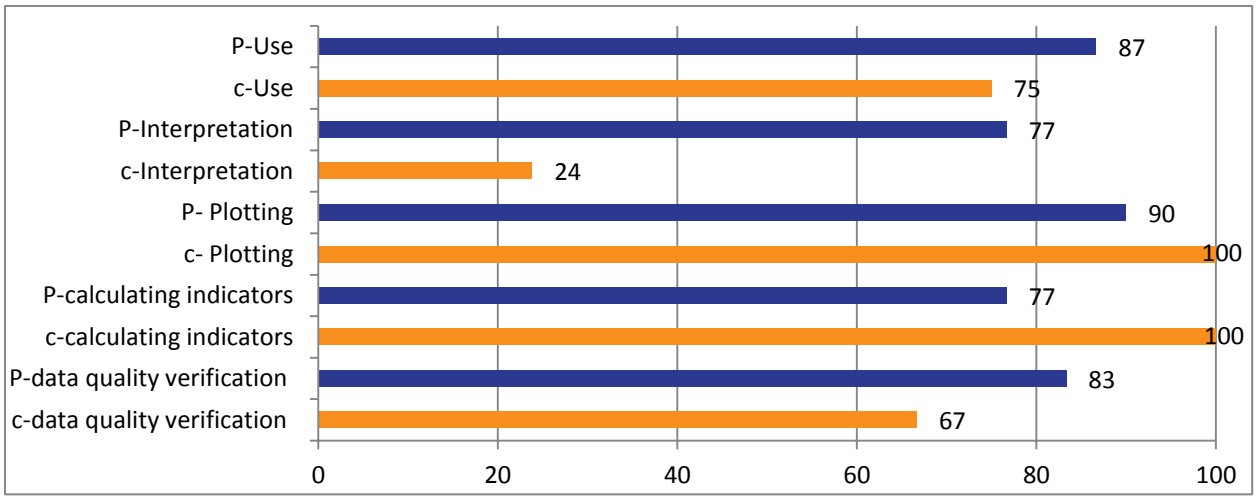
Note: P= perceived confidence; c= measured competence

The greatest gaps between task competence and perceived confidence levels were with data interpretation (8 percent versus 60 percent) and data quality verification (30 percent versus 76 percent), where the gaps were 52 percent and 46 percent, respectively. The smallest gap between task competence and perceived confidence was found in the OBAT assessment for calculating indicators, which reflected a 16 percent gap.

The same approach to measuring the difference between perceived confidence and task competency was taken by the PRISM assessment team at the district level. District-level staff was given the same

OBAT exercises to complete as the facility staff. Overall, both the perceived confidence and actual competence levels across all RHIS tasks were higher. In several cases – with plotting indicators and calculating indicators – district staff actually underestimated their task competence. The largest gap found between perceived confidence and measured competence was with interpretation of data, where there was a discrepancy of more than 50 percent. This is also the component that had the lowest overall competence score at the district level (Figure 20).

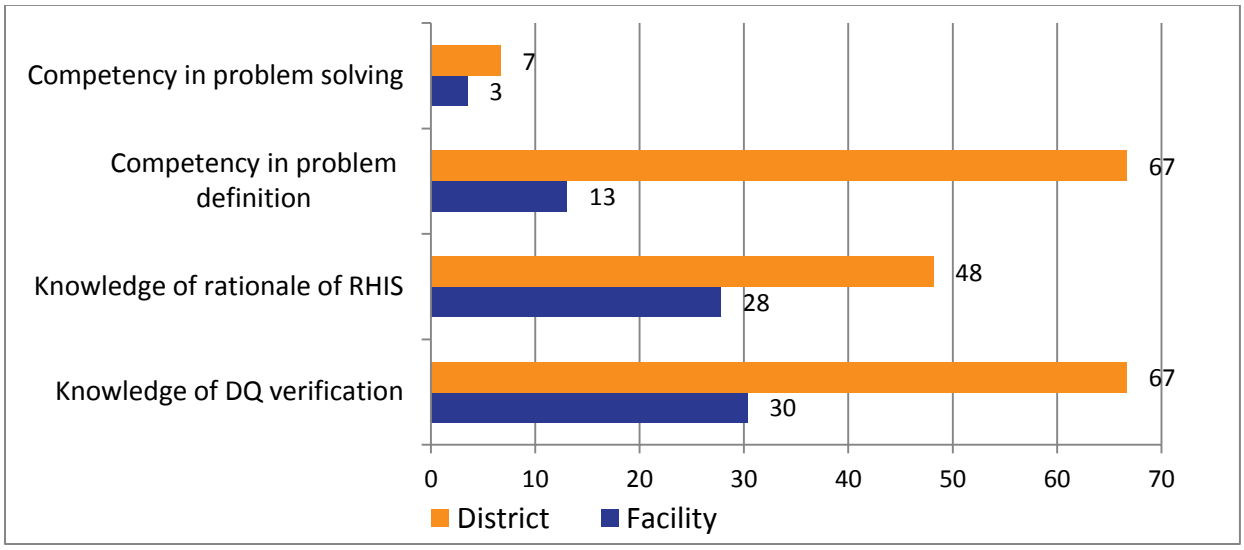
Figure 20 Perceived Confidence vs Competence Levels at District (%)



Note: P= perceived confidence; c= measured competence

The OBAT tool was used to delve deeper into specific RHIS competencies, such as knowledge of how to conduct data quality verifications, the rationale for having an RHIS, and both problem definition and problem solving. District staff scored fairly well on problem definition and data quality verification, but demonstrated lower competencies on the rationale for having an RHIS and in problem solving. Facility staff scored consistently low on this group of competencies, with none higher than 30 percent and with problem-solving competencies registering only 3 percent. Figure 21 compares the measured competencies for selected components at both the district and facility levels.

Figure 21: RHIS Competencies of District and Facility Staff (%)



The further components of the OBAT are intended to evaluate the links between the existing culture of information at facility and district levels and the behavioral determinants. To obtain this information, the PRISM assessment team interviewed staff at the facilities and district offices to evaluate their perceptions of motivations of superiors and colleagues within the RHIS to collect and use information, their perceptions on how decisions within the NHM are made, and how they perceive their roles in that structure. As a first level of comparison, the PRISM assessment team evaluated the differences between the perceived motivation of staff to collect and report high-quality data and the extent to which staff believe they are or will be rewarded for good work. Responses to questions addressing these components showed a relatively high correspondence between the two with perceived motivation across the facilities scoring at 68 percent while perceptions of being rewarded for good work scored 73 percent. At the district level, the correspondence between the two was also similar, but perceived motivation was higher (75 percent) than perceptions of being rewarded for good work (62 percent).

3. RECOMMENDATIONS AND NEXT STEPS

- Across all health facilities visited, the time and effort required for routine data reporting was reported to the assessment team as being a significant burden. Moving closer to real-time reporting or direct data entry at the facility level during patient visits would spread out the burden of reporting over a more manageable period for staff. This can be accomplished over the long term by providing clinical services staff with electronic reporting tools to capture patient level information, which can then feed into the RHIS for aggregation as facility-level reporting.
- There was a significant amount of data collection and reporting redundancy noted across the health information system. Staff interviewed reported numerous information systems that they were required to report into, while there was little electronic interaction between different information systems, again increasing the burden on staff to routinely report. The current efforts of the Punjab NHM to implement the Integrated HMIS may address this specific issue.
- The use of information for decision making, advocacy and monitoring was very low at the facilities, with most decisions referred to the district offices. Increasing the level of information use at the district and facility levels should be prioritized for action. Specifically, Punjab NHM should create programs that encourage and reward the use of information in a variety of ways (e.g., presenting data on the walls of the district offices and facilities, sharing recent disease pattern data with local stakeholders, advocating for resources based on findings from the data). This will also promote more district interactions with and support to health facilities.
- Establishment of a routine data feedback mechanism by the Punjab NHM from district and block levels to all facility staff involved in the collection, recording, and compilation of facility data can improve the likelihood that data will be used by the health facilities. As part of the supervisory visits, district M&E teams should also be documenting the quality of data through routine accuracy checks.
- Modify reporting requirements at health facilities to eliminate the need to report on services not provided. For example, if they do not provide sterilizations at their facility, this component can be removed from their reporting form. Likewise at the data entry to DHIS level, there would no longer be zeroes for services not provided as that element can be removed from the data entry screen.
- Punjab NHM should expand HMIS-related training to cadres beyond the information team (i.e., to nurses, ANMs, etc.). This will expand the knowledge of why data reporting is important and help the clinical staff to understand their role in the RHIS, thus giving them a larger stake in the work. Additionally, if they too are rewarded as part of a team incentive structure to improve data quality and use of information, they will additionally be more engaged.

There are many opportunities for Punjab NHM to further promote the use of quality data in the management of health facilities and programs across the state. The first step in this process is for Punjab NHM to engage in an active dialog with all levels about the importance of timely, accurate and complete information reporting.

ANNEX: SUMMARY OF NATIONAL HMIS PORTAL REPORTING FORMS TO MOHFW

The annual consolidated reporting forms primarily consist of data elements related to infrastructure and human resources. These forms need to be submitted by each state once a year. The elements for this format are grouped in the following ways:

- **Part A:** Demographic
- **Part B:** From the Eligible Couple Register (ECR)
- **Part C:** Selected Indicators
- **Part D:** Urban Health Infrastructure
- **Part E:** Status of Health Infrastructure
- **Part F:** Status of Human Resource Availability
- **Part G:** Infrastructure and Accreditation

The quarterly consolidated reporting format consists of data elements related to training elements and needs to be reported by each district in the country every quarter. The elements for this format are grouped in to the following:

- **Part A:** Status of Health Infrastructure
- **Part B:** Trainings Conducted
- **Part C:** Additional NHM Components

The monthly consolidated format consists of performance-related data elements and needs to be reported by each district in the country every month. The elements for this format are grouped into the following:

- **Part A:** Reproductive Health consisting of:
  - Antenatal care services
  - Deliveries
  - Caesarean deliveries
  - Pregnancy outcome and weight of new born
  - Complicated pregnancies
  - Postnatal care
  - Medical termination of pregnancy (MTP)
  - RTI/STI cases
  - Family planning
  - Child immunization
  - Number of Vitamin A doses

- Number of cases of childhood diseases reported during the month (0-5 years)

- **Part B**: Other Programmes consisting of:
  - Blindness Control Programme
- **Part C:** Health Facility Services consisting of:
  - Patient services
  - Laboratory testing
- **Part D:** Inventory Status consisting of:
  - Monthly inventory status
- **Part E:** Mortality Details consisting of:
  - Details of deaths reported during the month with probable causes

Table 6: Forms to be submitted by States/Union Territories to the GoI

S. No	Form No.	Form Name	Periodicity	Version	Submission Date
1.	NHM/GOI/1/A	Annual Consolidated	Annual	1.1	30th April
2.	NHM/GOI/2/Q	Quarterly Consolidated	Quarterly	1.1	20th of Month following respective Quarter
3.	NHM/GOI/3/M	Monthly Consolidated	Monthly	2.0	20th of following Month

Table 7: Facility-level forms for internal reporting

S. No	Form No.	Form Name	Periodicity	Version	Submission Date
1.	NHM/GOI/1/A	Annual Consolidated	Annual	1.1	30th April
1.	NHM/DH/3/M	Monthly format for District Hospitals and equivalent hospitals	Monthly	2.0	5th of following Month
2.	NHM/SDH/3/M	Monthly format for Sub-District Hospitals and equivalent hospitals	Monthly	2.0	5th of following Month
3.	NHM/CHC/3/M	Monthly format for CHCs and equivalent hospitals	Monthly	2.0	5th of following Month
4.	NHM/PHC/3/M	Monthly format for PHCs and equivalent facilities	Monthly	2.0	5th of following Month
5.	NHM/HSC/3/M	Monthly format for SCs and equivalent facilities	Monthly	2.0	5th of following Month

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