



Information System & Governance & Leadership



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ADDIS ABABA, ETHIOPIA

OUTLINE

- Findings:
 - Information System
 - Governance and Leadership
- Conclusion
- Recommendation
 - Maintain
 - Modify
 - Add
 - Drop

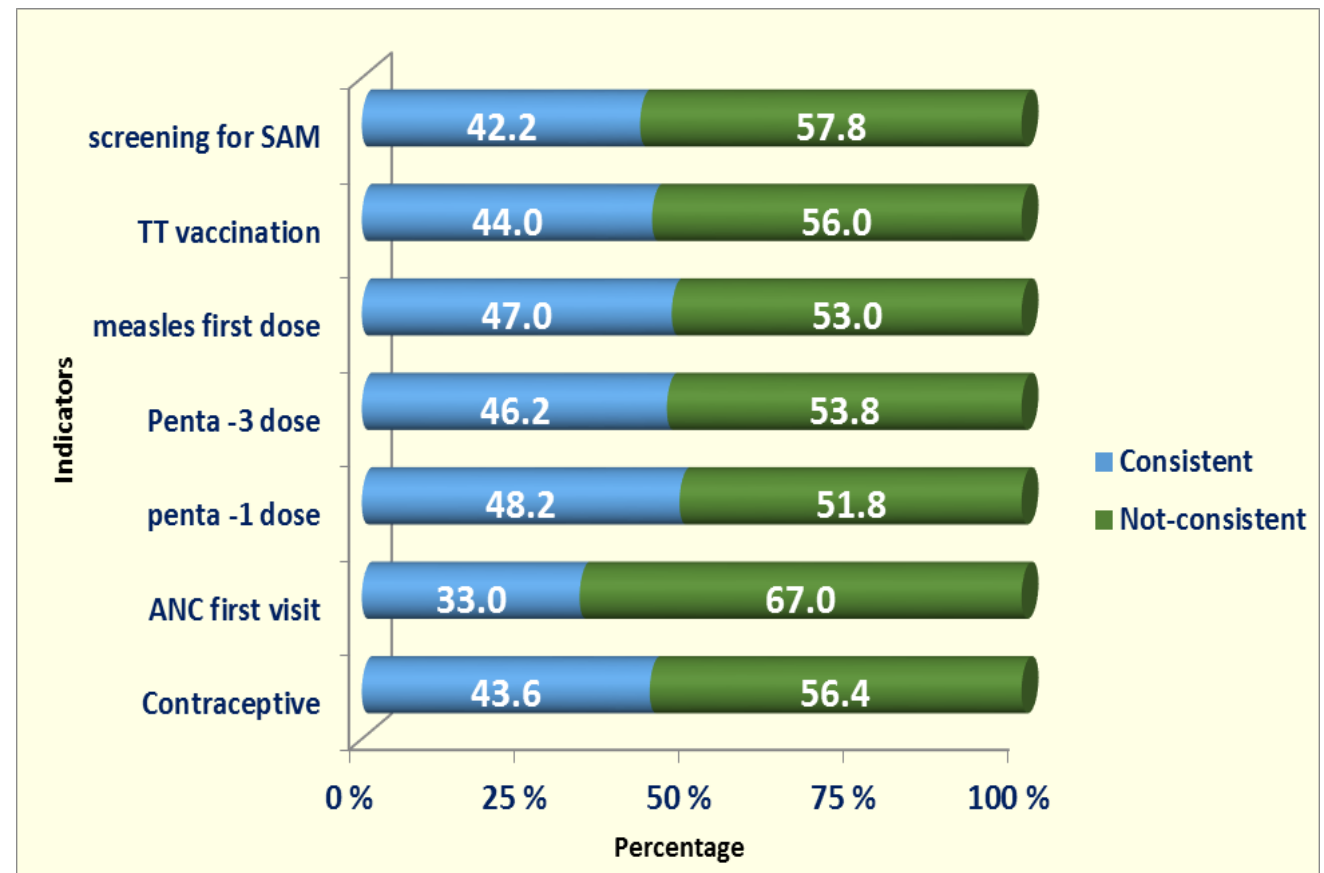
Information System

HIS - Design

- Indicators of the health information system
 - Focus only on outputs of specific programs reportable to higher levels
 - Limited attention to the process of HEP
 - Definitions involving unrealistic targets (HDF, ODF, 100% CBHI enrollment)
 - Poorly defined data sources/method of measurement leading to unreliable reports

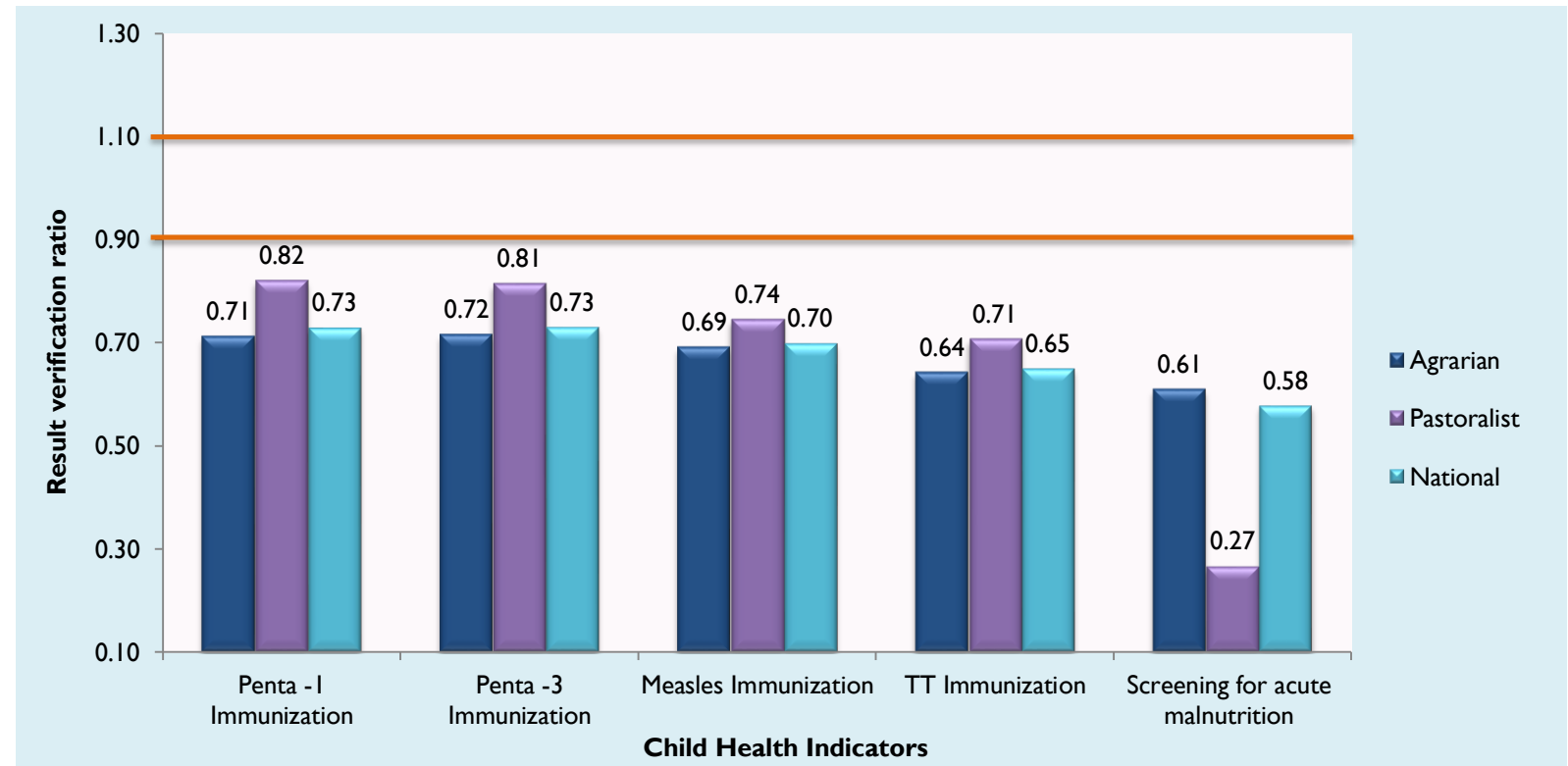
Inconsistency of Data

- Records from the tally sheets were compared with records in the cards and registers
- More than half of the data were inconsistent for all indicators



Over Reporting

- Data accuracy was calculated as recounted values from available data source divided by the reported value.
- For example, over reporting was common among child health indicators



Over Reporting ...

Proportion of Health Posts by their level of accuracy by indicators

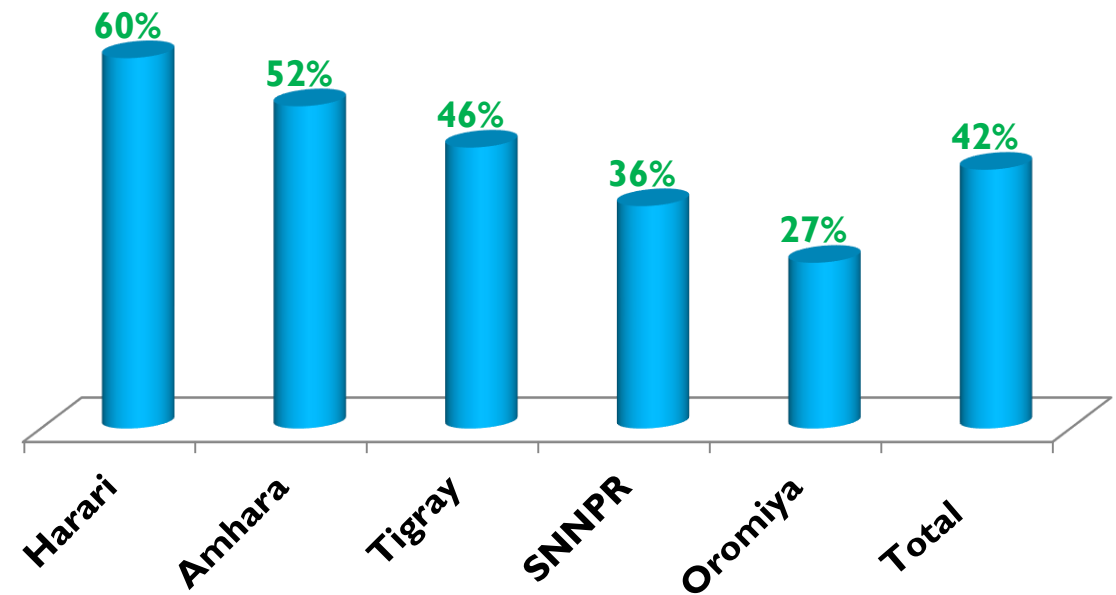
Variables	% of HPs		
	Accurate Report	Over Report	Under Report
Indicators			
# of women that received contraceptives	52.8%	37.2%	10.0%
# of women that received ANC first visit	59.7%	30.9%	9.4%
# of women that received four ANC visits	62.7%	29.0%	8.2%
# of children <1 yrs of age that received Penta 1 dose	60.1%	30.2%	9.6%
# of children <1 yrs of age that received Penta 3 dose	60.1%	32.4%	7.5%
# of children <1 yrs of age that received measles 1 st dose	58.8%	35.5%	5.7%
# of women who received TT vaccination	56.5%	35.9%	7.6%
# of children <5 yrs of age screened for acute malnutrition	54.2%	39.0%	6.9%

Reasons for Low Data Accuracy

- Data manipulation to meet un realistic targets
- Delay in update of CHIS along with the emergence of new indicators;
- The belief of HEWs that CHIS is not simple and it is time consuming;
- Lack of commitment and limited knowledge of HEWs and supervisors on CHIS
- In adequate level of supervision and support on CHIS
- Additional data demand by HCs and WorHOs
- High work load of HEWs to update CHIS cards

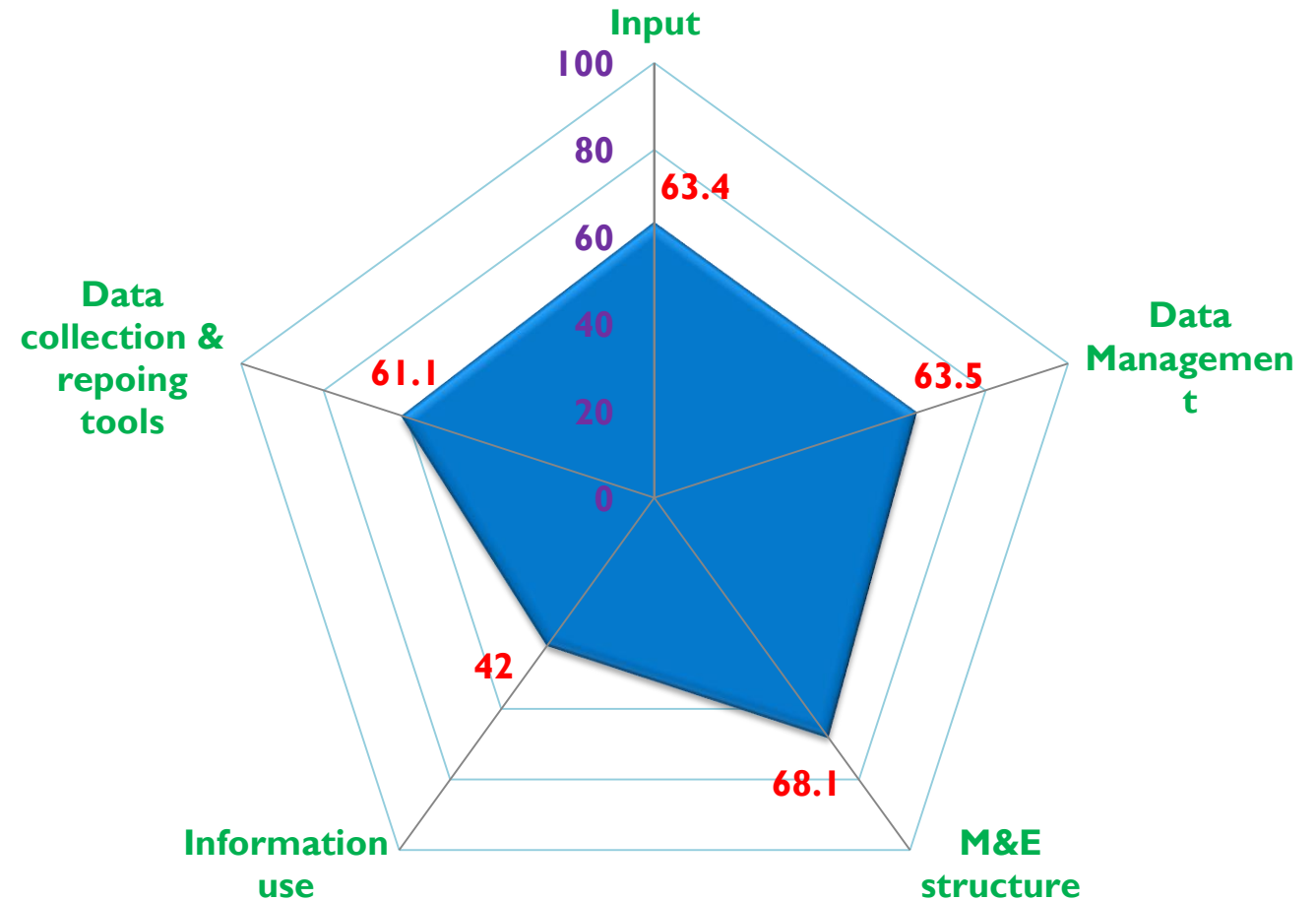
Limited information use

- Information use is found to be low across regions
- It ranges from 27% in Oromiya to 60% in Harari regions.
- The national index was 42%



Partial Implementation of Five CHIS Functional Areas in HEP

- Only 63% of the required inputs, 61% data collection and reporting tools were available
- Information use was only 42%



Governance & Leadership

Governance and Leadership

- There has been limited guidance on how HEP should evolve in the future.
- Major decisions on HEP didn't take advantage of opportunities created to generate and use evidences on effectiveness of HEP and its effectiveness
- Single standard of HP didn't fit the realities of populations at the kebele level.
 - Services provided, staffing patterns, supplies and equipment, and infrastructure needs of HEP in kebeles with a health center are different from those located far from a health center.
 - The current standard of health posts didn't acknowledge this difference leading to Inefficient use of available resources.

Governance and Leadership ...

- Supervisory support from health centers hasn't been adequate. Whenever provided, team-based supervision of health posts has been more supportive than individual HEP supervisors.
- Accountability is limited at health post level, leading to high rate of absenteeism and closure of health posts
- Multiple chain of command and parallel reporting are common among health posts.
- There is less integration and multi-sectorial approach to HEP activities at Kebele and Woreda levels that is still a great challenge to the HEP implementation.
- HEWs are assigned to “non-health” related activities (E.g. tax collection), which affected their routine HEP service, acceptance by community, etc

Conclusion

- The current health information/M&E system that captures data for measurement of indicators reportable up to the federal level focuses only on outputs of specific programs implemented through HEP with very limited attention to monitoring the process of HEP at lower levels.
- Kebele level indicators directly linked to the performance of HEP involve definitions with unrealistic targets resulting in lack of sensitivity to intermediate progress of health posts.
- Data recorded and reported by health posts is largely inconsistent with source documents mostly resulting in over reporting of performance. And, the information use is limited at health post and higher levels.
- The HEP structure that extends from Federal to Community levels is well designed and accepted. However, governance and leadership roles, particularly at Woreda and Kebele levels, are not functioning well

Recommendations - Information System/M&E

■ **Maintain**

- High coverage of reporting among health posts
- Data disaggregation by level of service provision (HP, HC)

■ **Modify**

- Include process indicators of HEP reportable to at least at health post, health center, and woreda levels.
- Revise definitions of indicators with unrealistic targets.
- Expand electronic CHIS with dashboard features facilitating information use.
- Enforce the use of family folders to record any encounter between HEWs and household members.

Recommendations - Information system/ M&E ...

■ Add

- Regular data verification system involving a component to do community level verification on a random sample of service users in order to minimize deliberate over reporting
- Performance management system relying on auditable progress in coverage as well as quality of services
- Initiating incentive mechanisms to encourage improved data quality and use
- Encourage WoHOs, HCs, and HPs to reset baselines to real current values

■ Drop

- Eliminate formal and informal incentives to over reporting

Recommendations - Governance and Leadership

■ **Maintain**

- Health Center – Health Post linkage for technical support and administrative oversight.

■ **Modify**

- Clarify and enforce lines of accountability of HEWs/HPs
- Ensure alignment of priorities and targets of different health programs with those of HEP.
- Strengthen intersectoral collaboration at all levels guided by collaborative frameworks enforced at higher levels.
- Ensure that HEP plays vital role in facilitating Kebele level intersectoral collaboration with the intention of addressing social determinants of health.

Recommendations - Governance and Leadership ...

■ Add

- Develop a roadmap showing clear path on how HEP and its components should evolve in the future.
- Introduce service and input standards for multiple categories of HEP implementers:
 - HEP unit in a health center (for kebeles with HCs)
 - HPs implementing basic set of packages
 - HPs implementing comprehensive set of packages
- Rebrand health posts along with changes in their function and structure. Consider changing names from health post to one that reflects upgrading to a facility with more comprehensive services in order to boost demand for both existing and newly added services.
- Consider administrative board for HPs to involve communities in overall oversight of HPs.

Recommendations - Governance and Leadership ...

- **Add ...**
 - Provide clear guidelines on involvement of HEWs in “non-health” activities with the purpose of keeping their involvement to activities that:
 - Create opportunities for health promotion and disease prevention activities and addressing social determinants of health
 - Do not create negative co-notation for HEWs by any member of the society
 - Can be pre-planned to avoid too much compromise in routines of HEP
 - Increase the power and acceptance of HEWs
 - Are planned in a framework facilitating intersectoral collaboration
 - Introduce a standard decision making procedure that requires generation and use of adequate evidences before making decisions on major investments in HEP

Thank You!



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GROUP DISCUSSION



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GROUP DISCUSSION POINTS

- Our successes: Which recommendations of the thematic areas should be kept “as is” for the implementation of HEP?
- Our limitations: Which recommendations of the thematic areas should be revisited and improved? Why?
- Our priorities: Which recommendations of the thematic areas should be prioritized while others are dropped? Why?
- Our missed opportunities: What other pressing recommendations would have been included in this study? why?