Online Forum on Participation of Private sector in health information development and Use: Key Findings from Developing Countries

Bolaji Fapohunda, PhD.

&

Theo Lippeveld, MD, MPH

24 October 2012

Acknowledgement

Several people contributed to the success of this historic online Forum on Private Sector Participation in Health Information Development and Use in Countries. First and foremost, great appreciation goes to Theo Lippeveld, JSI, for supporting the exploratory work which informed the development of the concept paper used to frame the questions discussed at the Forum. The outcomes of this early exploration have also informed the development of country level assessment protocol for the evaluation of commercial private sector HIS practice in countries. Theo's visionary leadership is a blessing for all of us who work with him. It was this approach to leadership that inspired this online Forum.

Also key to the success of this forum are Natasha Kanagat and Evis Haake, two women who teamed up to provide logistics for the Forum and advertise the event in several high profile media outlets. The advert enabled the news of the Forum to percolate the main media and be viewed all over the world, allowing the Forum to draw on the best minds in the Field. Stephanie Mullen facilitated the environment for the Forum. The Team is grateful to Stephanie for her inputs and leadership. Bolaji Fapohunda moderated the Forum and provided the intellectual work that went into the Discussions.

Special thanks also go to **all** Forum participants and, in particular, those who worked tirelessly to provide inputs and country case studies to this high quality Forum. These great colleagues gave the forum the good sense and elegance it had.

Funding was provided by USAID through MEASURE Evaluation. Special thanks go to the Agency for the resources and for leading at the fore front efforts to make the world a healthier place for all us. The views expressed in this report are the author's.

Online Forum on Participation of Private sector in health information development and Use: Key Findings from Developing Countries

Bolaji Fapohunda, PhD. and Theo Lippeveld, MD, MPH

24 October 2012

Introduction

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

Evidence suggests that substantial component of formal sector health services in developing countries are provided by the private sector institutions and for-profit practitioners. Yet, the national health management information system's (HMIS) architecture in these countries appears to be dominated largely by data from the public sector information. In many countries, the role of the private sector and the way they link with the public sector is not even known. To reach the MDG health sector goals, not only is the effective monitoring of the utilization of private-sector services critical, but knowing how the sector links with the public sector through the national HMIS is important for service delivery. Furthermore, triangulating private- and public sectors service data is a key for learning about the contributions of both sectors to the performance of the overall health system. Recognizing the role of the private sector in health systems strengthening, the 63rd World Health Assembly passed the Resolution "Strengthening the Capacity of Governments to Constructively Engage with the Private Sector in Providing Essential Health-Care Services (WHO 2010). A robust routine health information system (HIS) that incorporates the private sector is pivotal to the implementation of this resolution.

An online forum was conducted from October 9 to 17, 2012, to provide opportunity for exchange and learning about private sector involvement in HMIS. Insights from the discussion were to (1) inform strategies for engaging developing country governments to strengthen information collection and use by private sector practitioners in their countries; and (2) to sharpen tools and approaches for monitoring and evaluating routine information collection and use in the private sector. The forum was based on the premise that unless service data development and reporting improves in the private sector, developing countries cannot gain the vitality they need to meet their health sector goals because, in the absence of the private sector data, any health system is basically working half-strength.

Forum Objectives

The specific objectives are to:

- Contribute to an increased knowledge and understanding of the current HIS data development practice and process in the private sector, discuss quality of information

collected and the organizational, human and infrastructural capacity readiness for fulfilling this function.

- Describe health systems policy, legislative and regulatory environment and assess whether this has enhanced or debilitated the participation of the private sector in NHMIS and the implication of this for performance.

- Based on the study findings, recommend steps for sustaining or strengthening the private sector participation in NHMIS.

Specific Questions Discussed at the Forum

The key questions that were addressed are the following:

Routine Health Data Development Process & Practice

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

Policy, Legislative & Regulatory Environment

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

Key Recommendation for Improving HIS in the Private Sector

7. What are the key challenges limiting data development in the private sector?
8. What are the recommendations for addressing them?
9. What key messages should we sending to the developing countries on this important topic?

Methodology

The Forum utilized the community-based focus group discussion (FGD) approach. The main difference between this FGD and the one used in communities is group size; group size is much bigger in the virtual focus groups than in the community context. Nonetheless, they are easier to organize because they are a virtual group. The discussions are, however, no less credible, intense or interactional as in the community context. To give participants the appropriate context to frame their facts and opinions, a concept paper and other reading materials on RHIS Framework and HMIS in the private arena were circulated several days ahead of the Forum[1]. An annotated summary of these materials is presented in Appendix C. During the Forum, questions were presented ahead of time with clear guidance on how participants can present their comments. A copy of the guidance issued is presented as part of the opening statement in Appendix A. To read more about the program agenda and participants rule of engagement, see Appendix B. The final remarks are presented in Appendix D.

Results

We received a total of 29 postings of which 28 are country level case studies. The data have been collated and synthesized and the key findings are presented below under each question that was discussed. In the final section, we articulated the key actions that low income countries, particularly, sub-Saharan Africa, can take in the short (immediately) to medium-term (1-2 years) for strengthening data development and use in the private heath sector. As a next step, we will be working with our partners to see which countries would be ready to uptake some of these actions in the nearest future.

I. Routine Health Data Development Process & Practice

Discussions of the status of routine health information system development and practice in countries focused on four important domains:

a) Whether data are being collected
b) Types of data being collected
c) Processes & infrastructure in place for data collection
d) What is being done with the data collected? (a) Where are the data sent? (b) How is it utilized?
e) Impressions regarding linkages between development in the private and public sectors.

The findings are summarized below for each question

Are data being collected?

In **Nepal and Nigeria**, data are being collected from the commercial private sector (CPS) but the reporting coverage is difficult to assess due to lack of denominator data. In **Kenya**, data are collected from the CPS. Overall reporting by the CPS is roughly 50% and about 80% for

[1] To read more, see **Fapohunda B, Lippeveld T**. 2012. Learning about the Process and Practice of Health Information Systems in the Private Sector: Concept Note. MEASURE Evaluation / JSI, Arlington, VA., USA (contact: bfapohunda@jsi.com)

immunization data (Wanjala, 10/11/12). Kamau/Kolongei stated that reporting coverage is likely to get better with the use of master facility list (MFL), which allow coverage to be estimated and the drop outs/left outs identified for follow up. In **Tanzania**, CPS data are collected monthly during supervisory visits. In **Zambia**, data are collected; reporting rate is about 24%. In **Pakistan**, no data is collected from CPS. In **Namibia**, data are also not collected. Some informal arrangements exists between the public, NGO, and CPS facilities at the District and regional levels; formal processes are currently being developed, including the establishment of a directorate to oversee data collection and coordination of HIS reporting across all HF. This new strategy will also include the development of policy to mandate data collection & reporting by CPS.

Types of data collected

Surveillance data is gathered on communicable disease outbreaks s and HIV testing are collected in most countries (*Rodriquez, comments posted on 10/10/12*). In addition, service statistics are collected in Kenya/Nepal/ Nigeria/Tanzania/Zambia. Data collected depend on types of services provided by the CPS. Specific data domains includes immunization, FP, safe motherhood (e.g. pregnancies, births, deaths), HIV/AIDS (Kenya), morbidity and mortality statistics. *Kamau of Kenya* noted that immunization is the most completely reported data area by the CPS. Other data tends to be reported with varying degrees of completeness and correctness.

Processes in place for data collection

Data collection in most countries are usually informal, much depends on the amount of regulation and oversight by the central government (MOH). Evidence from Nepal and Nigeria indicates that oversight is weak or non-existent. Dr. Lekhak stated that there is no uniform or standard process adopted to collect data from the private sector. Reporting schedules are discretionary; it can be annual or periodic, when the CPS are renewing their licenses, which can be every 3 years. In **Kenya**, the processes include the annual target setting and work planning exercises, which enable the public sector to monitor the private facilities. In **Namibia** there is no formal processes in place as of now but the government has initiated a HIS strengthening strategy that will create a directorate to oversee HIS collection and reporting, and a policy that will mandate data collection from the private sector. In **Tanzania**, health facility registry (database of all HF in Tanzania) exists at the Ministry of Health and Social Welfare (MOHSW). Reporting schedules have also been established for the CPS and reporting forms and registers are in place at each facility. Using these registers, HFs record the services they give routinely. The information is transferred into the reporting forms and collated summaries are collected monthly during supervisory visits by the District Health Offices. However such visits are not regular and many HF end up not reporting at all, which probably accounts for the low reporting rate by CPS in the country (*Daudi, on 10/11/12*).

Citing Kenya, Mrs Kamau noted that the establishment of "*soft justification*" via the use of incentive that enables health facilities to see "whats-in-it-for-them" of collecting and reporting service statistics and the demerits of not doing so is a major element of the process for encouraging HIS in the private sector. For routine immunization (RI), the incentive consists of making vaccine supply and replenishment contingent on data reporting (*Kamau,10/11/12*). For

the administration of the master facility list (MFL), that consists of including the regulatory bodies/stakeholders in the management of the registry. In both of these examples, performance is notably higher (80% coverage for RI *versus* 50% for other services) than for services in which no incentives were utilized. In the future, Kenya plans to make private HF license renewal and registration contingent on HIS data reporting.

Infrastructure in place for data collection in the private sector: forms, hardware, capacity

In many countries (e.g. Kenya, Nepal, Nigeria, Pakistan, Tanzania, and Zambia), data collection form are the main infrastructure. In Kenya, CPS have access to District Health Information System tool version 2 (DHIS 2) and can report to this system directly if they have internet connectivity and computer (***Wanjala, 10/11/10***). In Nepal, the **no commitment** stance to CPS data development on the part of government, evidenced by the **no provision** of inputs is a major problem. CPS purchases all items of data collection, forms, computers, software from their own resources. In Tanzania, computerized HIS is available at the District level but paper-based at the lower levels. In Namibia, there is no infrastructure in place for CPS reporting. But once the new Directorate and policy goes into effect, CPS will be able to access existing reporting structures.

What is done with the data collected| where the are data sent| how data are used

a) Where data are sent

Data are sent to the District Health Office (DHO) in Nepal, where the data compiled along with data from the public sector. The collated data are forwarded to the Regional HIS Office. Compilation of CPS at the District Office occurs only if the data arrives at the point the monthly data for all health facilities (HF) are being compiled, otherwise, CPS data are not included in the summary sent to the Regional Office.

In Nigeria, data from the primary and secondary level CPS are reported to the State MOH monthly. The data are collated with the public sector data and reported to the National HMIS office quarterly. Data from the tertiary CPS facilities are reported directly to the NHMIS. In Kenya, data are sent to the District HIS Office (DHISO), where they are collated and entered into the DHIS tool. Once in the DHIS tool, the data is available nationally. Immunization data are reported directly to the Ministry of Health in Nairobi, Kenya (*Kamau, 10/11/12*).

In Tanzania, data are collected directly from the CPS facilities during supervisory visits and reported to the Ministry of Health and Social Welfare (MOHSW) quarterly and annually. But supervisory visits are irregular and, as such, data are not collected/reported some of the time. In Zambia, CPS send their data to the District Health Office (DHO) monthly. At the DHO, data are collated, entered into the DHIS software and transmitted to District and Provincial Offices.

b) How data are utilized

In Nigeria, CPS data are included in the bi-annual reports produced by NHMIS. The reports are ideally used by the federal government to assess population health status (*Chukwuemeka,10/10/12*). In Nepal, the data are included in semi-annual and annual reviews.

But the lack of disaggregation by public/private sector limits the utility of the data for planning (*Lekhak; Ban, 10/10/12*). In Kenya, the immunization data from the CPS are collated with those from the public sector and used to calculate regional coverage estimates, forecast vaccines supplies; and estimate uptake of services. All HIS data are fed into the annual reports and a copy of this report is given to each facility. Quarterly bulletins are planned to support data use at the District and facility levels. Kenya is planning to use the M&E Framework it is currently developing to formalize these products so that they become essential elements of HIS (*Wanjala, 10/11/12*). In Zambia, data are used to inform planning and service delivery at the District level. In Tanzania, data are not used. The annual review intended to provide a forum for data to inform planning is not active. In every country, use of data at the point of service does not exist. The non availability of data in useable quantities is highlighted as a key hindrance. Participants agree that disaggregating data by private and public ownership, sharing these data with data collection points, and incentivizing as appropriate, can encourage data use at the district and facility level. Given the challenges in enforcing more formal regulations, Kamau stated the provision of regular feedback to data collection points and using this process to name and shame performance will, encourage more positive response to data collection and use not only by CPS, but by everyone (public/private).

The table below presents the country scores on the qualitative rating scale of participants' impressions of how well public private sectors HIS are integrated in countries. These scores range from 1-5, with 1 representing loosely, not integrated at all to 5, representing tightly integrated. As seen below most countries were rated as 1 or 2, meaning that the private public sectors are loosely integrated in these countries:

Quantitative impression of Public/Private Sector Integration in HIS in Countries

Respondent	**Score**				
	1	**2**	**3**	**4**	**5**
Kenya (Kamau)		2			
Kenya 2 (Kolongei)	X				
Namibia	X				
Nigeria (Chukwuemeka)		X			
Nepal 1 (Lekhak)		X			
Nepal 2 (Ban)		X			
Pakistan	na				
Multiple (Rodriguez)		X			
Zambia		X			
Tanzania	X				
For the illustrative information on what the scores mean, see Appendix E; na: no score provided					

II Policy, Legislative & Regulatory Environment

In this section, participants discussed three questions:

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

b) Do these legislation, regulations, and policies offer sufficient guidance and basis for data collection in the private sector? If not, what improvements are needed?
c) Who are the key stakeholders and what are their roles and responsibilities in private-sector participation in HMIS? Key findings are illustrative.

Table 1presents a list of legislations, policies and regulations for four countries, the purpose of this legal & regulatory framework and whether or not they offer sufficient mandate for data collection in the private health sector. As shown the legal/regulatory Framework in Ethiopia, Kenya, Nepal and Tanzania include, Standards of Licensing for private sector practice, Public Health Bills/Acts, the Constitution, Health Information Policy, Health Sector Strategy, Public Health Acts. Except for the Constitution, which is an umbrella rule, none of the legislations/regulations/policies reviewed offer sufficient grounds for data development and use by the private health sector.

Table 1: Illustrative Legislations, Policies and regulations in place for CPS HMIS in Countries

Legislation/Policies/Regulations	Purpose	Does it offer sufficient guidance	Country
Regulatory Standards: (1) The Standards for licensing	Specifies clinical processes and practices as key area of regulation, linkages with professional associations, focus on quality, of which HIS will be key	Not yet fully implemented	Ethiopia
Policy and regulation for data collection	Specifies collection of data on notifiable diseases	Not inclusive of all diseases, does not specify collection of routine data	Ethiopia
The Public Health Act Cap 242 of the Laws of Kenya (Kenya)	Outlines reporting to the Director of Medical Services	Does not address issues of data collection, analysis, use & dissemination	Kenya
Constitution	Defines access to information as a human right	Necessary as specified *but not* Sufficient	Kenya
Health Bill (being developed)	Mandates the collection and reporting of health information and punitive measures for defaulters	Not known until fully developed	Kenya
Health Information Policy	Specifies the roles and responsibilities all players in health service delivery, private and public	Does not address issues of data collection, analysis, use & dissemination	Kenya
Health Sector Strategy (built on the Policy Framework 2012-2030	Outlines government strategy per vision 2030	??	Kenya
HMIS clause in	Data collection and reporting by the	No, not enforced;	Nepal

Private Sector health services establishment and approval contract	private sector	absence of systematic effort to encourage and maintain record and reporting schedules	
Public Health Act	Requires all facilities including private sector to report notifiable diseases to the MOH.	No, does not cover routine service data reporting	Tanzania

Improvements Needed, the Nepali Example

Improvement to evolving a functional legal framework for private sector HIS is illustrated with Nepal example. Nepal does not at present have any legislation, policies or regulations that support date development in the private sector. Per Susheel Lekhak (10/12/12), improvements will include:

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

Stakeholders, their roles and responsibilities

[2] In Nepal, HMIS is managed by a MIS Section located under the Ministry of Health and Population, Department of Health Services Management Division. This is considered *under-location* compared to the amount of authority and visibility needs in order to perform statutory functions. As such, other departments perceive HMIS' section as not having oversight responsibilities for them since a section is below a department in the Ministry's administrative hierarchy. **Recommendation -** Either keep HMIS at the ministry level or give it all the power and authorities to manage health information from community to Ministry.

[3] Information management is a challenging job, particularly in developing countries, but is still paper-based with data manually entered into Forms from month to month. This system has serious data quality issues. ***To overcome such situation Lekhak suggested that HMIS would require a strategic plan that systematically outlines human, financial, physical, infrastructure resources necessary to manage public and private health information***.

The Stakeholders important for CPS HMIS and their role and responsibilities are summarized in for three countries as illustrative examples (Table 2). Country context and information systems vary in both structure and complexity, and as such, the challenges presented and the method of address will differ from place to place.

Table 2: HMIS Stakeholder for the Private Health Sector

Name of Stakeholder	Roles and Responsibilities	Country where found
• Kenya Medical Laboratory Technicians and Technologists Board (KMLTTB) • Kenya Medical Practitioners and Dentist Board (KMPDB) • Nursing Council of Kenya (NCK) • Clinical Officers council (COC) • Pharmacy and Poisons Board (PPB) • Kenya private sector alliance (KEPSA)	Regulatory private sector players by specific professions	Kenya
Community leaders, members of parliament and influential groups	Assist with develop a strong business case for data development in the private sector	Pakistan
Association of Private health facilities in Tanzania.	Coordination of private health facility owners with government	Tanzania

III. Key Recommendation for Improving HIS in the Private Sector

Participants brainstormed two questions in order to identify key challenges to data development and use in the private sector and recommend interventions for removing/downgrading these challenges and orchestrating sustainable data collection in the CPS in countries. The following questions framed the discussion:

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

Key Challenges to data work in the CPS

A number of key constraints to data collection and use in the private sector are summarized below:

1. Reporting coverage is difficult to assess because of lack of denominator information in many countries. Therefore HMIS strengthening efforts in countries are weak because they are not tailored to areas with greatest need. For instance, given the lack of denominator data, countries are not able to tell where and which HF(s) is left out or dropping out for action. Participants recommended that a HF registry be developed under the HMIS office as a first step to addressing this problem in countries. The example of the Kenya **Master Facility List (MFL) was presented** as a good model for solving the denominator problem. To read more about MFL, visit **www.ehealth.or.ke**.[4]

2. Legal framework for service data collection and reporting, e.g. Health Act, Health Information Act, does not exist and/ or is not enforced (*Lippeveld, 10/10/12; Lekhak, 10/17/12; Memon, 10/7/12*; *Kamau, 10/11/12*). Such mandate is needed to authorize the national HIS office to manage the CPS HIS participation and to support them with resources (Kolongei, Kenya, 10/11/12).

3. Poor information culture, that is poor valuation of formal data for decision making, hinders data use in countries and holds grave consequences for population health outcomes (*Lippeveld, 10/10/12*). Illustrating this complex in Kenya, Kologei noted (paraphrased): *many senior managers manning the private sector do not value use of information. … many are more grounded in clinical work; to these colleagues, data use is of limited or secondary importance.*

4. Lack of resources: human (size, skill, training), money, materials (infrastructure, equipment, Forms) and technical assistance, is a key constraint to data use. This problem is fueld by poor commitment by national governments to data collection and use (Memon/Wanjala) and a dwindling donor support. **Mahmood Memon,** Pakistan, noted that governments should provide data collection Forms and technology to the private sector, otherwise, they should stop requesting data in specialized formats at the expense of the CPS (*see comments of 10/17/12*).

5. Limited skills for data collection, for analysis and reporting fueled by shortage of skilled staff and high staff turn out rates is a major problem across countries In a regime of high health worker turn out, the better trained health worker are the first to leave, leaving the system with less competent hands (*Ban, 10/10/12*; *Kolongei, Kenya, 10/11/12*).

6. Complex, cumbersome, unfriendly overlapping reporting forms are the bane of data development, including data collection, management, comparability; and use in countries (Lekhak/Nepal; Ban/Pakistan; Chukwuemeka/Nigeria). *Illustrating this complex for Nigeria, Chukwuemeka stated that "HMIS has been operational in Nigeria since 1999, but data are still inaccurate, incomplete; HIS officers are not getting it right because of the complexity of*

[4] AfyaInfo supports the MOH to strengthen the functionality and use of MFL/HF registry; coordinate its updates to reflect changed circumstances such as increase of districts, change of users, etc. and identify areas for further development.

the Forms." Lekhak (2012) noted that the lack of formal provision of forms, hardware and capacity building activities for private sector recording and reporting is the root cause of the proliferation of Forms in Nepal.

7. The public sector mindset of "*the private sector is not my business*" is harmful not only to data collection in the private sector but also to CPS involvement in/HMIS and in the overall management of the Health system (Lekhak, 10/17/12). In Nepal, this posture has isolated the private sector from the public sector being perceived and perceiving themselves as the main/only machine of service data collection. This isolation and the lack of clarity and guidance regarding the purpose and use of data have led the CPS to cocoon than participate in HMIS, even at the government's behest. **Bharrat Ban** (2012) illustrates what this isolation looks like for the CPS in Nepal (paraphrased): they (CPS) are rarely supervised; included in training programs, or invited for program planning or tools development, with the result that tools developed are not culturally competent or user friendly.

8. Data are not available in usable quantities or aggregates, e.g. by facility ownership, or some other useful categories.

9. Separation between the locus of decision making and locus of data collation and administration. For example in Nepal, as with many countries, health program decision are made at the District level but data are compiled at the *Ilaka* level in (a level between the district and the facility), which has no functional autonomy or decision-making power.

Recommendations

To address the challenges above, the participants recommended the following solutions:

- Develop/enforce strong regulatory frameworks – Health Act, Health Information Act, Guidelines etc.; develop strategic plans to articulate CPS participation.
- Countries to develop and maintain health facility registry with oversight by MIS at the MOH
- Fight inertia in public sector regarding CPS participation; Governments to use ongoing existing fora and activities to orchestrate the participation of CPS in health sector programs and HMIS development and administration .
- Promote periodic assessment of participation of CPS in HMIS or systematic open dialogue in order to identify the existing barriers and recommend the improvements for strengthening HMIS in general and CPS HMIS in particular. Results are used to inform the development of a strong business base for data collection and use in the private sector (*Mursalim, Pakistan, 10/17/12*).
- Provide the required inputs for data collection and reporting by CPS: forms, funds, trained capacity, and technical assistance. Participants noted that data collection tools are expensive and cannot be left solely to the Private sector as is currently done in many countries.

- The HMIS Office needs to develop an analysis plan/dashboard/synthesis model to guide the extraction of useable information from data collected at the private/public sectors at regular intervals. This use of this plan will ensure the availability of relevant information in usable quantities and enhance/engender utilization.

- Encourage use of information at all levels, particularly at the health facility level (Lippeveld, 10/17/12), emphasizing that information use for decision making in health facilities should become part of the standard of health care delivery practices the same way as clinical standards are". To ensure that skilled manpower is available to work the system, Lippeveld recommended that design and implementation of [routine] health information system should be taught at all medical and nursing schools as part of the pre-service curriculum.
- Institutionalize regular ***feedback*** to District and lower data collection points, end the **regime of "data goes up but nothing comes down'.**

- Incentives, incentives, incentives! Countries need to design incentive mechanisms for compliance and punitive actions for non-compliant private facilities. With incentives, CPS are able to see what's-in-it-for-them of collecting and reporting data. Per the participants, potential incentive and concessions usable by countries include income tax relief, reduction in import duties on hospital equipments, concession in electricity tariff and supply of data collection and reporting tools etc., OR free drugs (such as malaria or TB) and/or vaccines (Memon/Lippeveld, 10/17/12; Kamau, 10/11/12).

Key messages to Countries

The participants were asked to suggest key messages the HMIS field should be sending to the world on this important topic of private sector HMIS. The results are summarized below:

- Participation of CPS is the completion of HMIS and is essential for measuring progress towards MDG, understanding failures in national programs; understanding Private Partnership (PPP) health, and mapping national goals and response to problems confronting the health sector. Data collection, reporting and use is therefore mandatory for both public and private health sectors (*Lekhak, 10/17/12; Bharrat Ban, 10/17/12).*
- CPS needs input, guidance and support from government for data development and use
- Knowing the status of your CPS HIS is critical to more robust and integrated HMIS. As such **Countries are to systematically assess their private sector HIS practice periodically to find out what is working, what are the gaps**, and what actions are needed to strengthen the system (*Tariq Azim, Ethiopia; Chukwuemeka, Nigeria)*. Any intervention on the health information system that is not based on systematic (re)searching or assessment, or moderated "open dialogue" to understand perspectives' is fickle, neither reliable nor sustainable. However, Countries have to be selective in order to avoid assessment overload.
- CPS HIS cannot function in the absence of a functional public sector HMIS; **the public sector should set HMIS goals but must carry the private sector along**.
- Countries must develop adequate regulatory frameworks to govern and drive data development in the private sector and forge public/private coordination/collaboration around data. CPS HIS will be strengthened by this facility (*Lekhak, Nepal; Mahmood Memon, Daudi **Simba**; Kelvin Chukwuemeka, 10/17/12*).

Conclusion

The following key actions emerged from the discussion for implementation in the short- to medium-term:

- Countries to assess their CPS HIS situation, develop, and implement action plans. Assessment here does not have be a huge exercise; even systematically documenting the current data collection practice in the Private sector and the available support system for data development and use will yield tremendous benefit to the entire HMIS.
- Countries to build complete HF registry/Master facility/list of all health facilities in their domain and assign unique IDs to them.
- Countries to develop analyses plan/dashboard/synthesis model to guide data extraction and analysis in countries where this does not already exist.
- Countries to simplify/harmonize data collection tools
- Countries to institutionalize the regular ***feedback*** to districts & facilities, both public and private
- Countries to add *design and implementation of (routine) health information systems* to the medical and nursing schools' pre-service curriculum.

Appendix A: *Forum Program*

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

Objectives

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

Daily Program:

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

Routine Health Data Development Process & Practice

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

Day 3 & 4: Monday & Tuesday, 11-12 October 2012

Policy, Legislative & Regulatory Environment

8. In your country, what legislations, policies, and regulations are in place for private health sector service delivery and are they working? How is HMIS development captured in these legislations? Do the existing legal framework offers sufficient guidance for data collection in the private sector? If not, what improvements are needed?

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

Day 5 & 6: Monday & Tuesday, 15-16 October 2012

Key Recommendations for Improving the Private Sector role in HIS Development & use

10. What are the key challenges limiting data development & use in the private sector?
11. What are the recommendations for addressing them?
12. What key messages should we be sending to the world on this important topic?

Forum Organizers

- Thoe Lippeveld, MD, MPH, RHINO President
- Stephanie Mullen, PhD., Team Lead, MEASURE Evaluation /JSI Group
- **Bolaji Fapohunda, PhD., MEASURE Evaluation/JSI, Forum Moderator**
- Evis Haake, RHINO Coordinator & M&E Advisor
- Natasha Kanagat, M&E Advisor, MEASURE Evaluation/JSI

Forum Country Case Study Presenters and Discussants by Day Postings received

Day 1

1. **Susheel C. Lekhak**, WHO & NHSSP M&E Consultant, Director, South Asian Institute for Policy Analysis and Leadership (SAIPAL), Kathmandu, Nepal (lekhak@saipal.com; susillekhak@gmail.com) (2 postings- 1 in day 2)
2. **Michael P. Rodriguez**, Director, Health Information Systems Strengthening, Abt Associates, USA
3. **Kelvin Chukwuemeka**, Engender Health (KChukwuemeka@engenderhealth.org) (2 postings, 1 in day 2)
4. **Theo Lippeveld**, HIS Advisor & Vice President, JSI, USA.
5. **Bharat Ban**, Team Leader, Nepal Family Health Program II, JSI, Nepal

Day 2

6. **Titus Kolongei**, **BSc, HIM (KU),** M&E(UON), Senior Health Information Officer Ministry of Public Health & Sanitation; Division Disease Surveillance & Response, MOH&S, Nairobi, **Kenya**
7. **Erwin Nakafingo,** Programme Officer, HIS**,** Epidemiology Division, Primary Health Care Directorate, Ministry of Health and Social Services|**NAMIBIA**; Email: his@healthnet.org.na
8. **Wanjala Pepela**, Senior HIS Officer, Min of Public Health & Sanitation, Nairobi, Kenya, wanjala2p@yahoo.com
9. **Maria Kamau;** HIS Development (Output1) Coordinator, **USAID AfyaInfo/**Abt Associates, Inc., Kenya, Maria_Kamau@AfyaInfo.org

10. **Brivine M. Sikapande, Senior** M&E Officer, **Ministry of Health,** Ndeke House**,** Lusaka, Zambia

Day 3 & 4

11. **Susheel C. Lekhak**, WHO & NHSSP M&E Consultant, **Director**, South Asian Institute for Policy Analysis and Leadership (SAIPAL), Kathmandu, Nepal (lekhak@saipal.com; susillekhak@gmail.com)
12. **Wanjala Pepela**, Senior HIS Officer, Min of Public Health & Sanitation, Nairobi, Kenya, wanjala2p@yahoo.com
13. **Daudi O. Simba**, MD, PhD., Associate Professor. Muhimbili University of Health and Allied Sciences (MUHAS), Dar es Salaam, Tanzania (daudisimba@yahoo.com)
14. Hussein Faris, MD, MPH, Health Systems Advisor / Private Health Sector, USAID Ethiopica (FHussein@usaid.gov)
15. **Maria Kamau;** HIS Development (Output1) Coordinator, **USAID AfyaInfo/**Abt Associates, Inc., Kenya, Maria_Kamau@AfyaInfo.org

Day 5 & 6

16. **Daudi O. Simba**, MD, PhD., Associate Professor. Muhimbili University of Health and Allied Sciences (MUHAS), Dar es Salaam, Tanzania (daudisimba@yahoo.com)
17. **Susheel C. Lekhak**, WHO & NHSSP M&E Consultant, Director, South Asian Institute for Policy Analysis and Leadership (SAIPAL), Kathmandu, Nepal (lekhak@saipal.com; susillekhak@gmail.com)
18. Mahmood Igbal Memon, MBBS, MPH, MBA (HRM), Public Health Consultant, Health Departmenr, Government of Sindh, Pakistan (miqbalmemon@yahoo.com)
19. **Kelvin Chukwuemeka**, BSc., MPH, Research Assistant, Engender Health (KChukwuemeka@engenderhealth.org) (*2 postings*)
20. **Theo Lippeveld**, HIS Advisor & Vice President, JSI, USA.
21. Tariq Azim, Country Lead, HMIS Scale-up Project, Ethiopia
22. **Bharat Ban**, Specialist and Team Leader for M&E, Nepal Family Health Program II, JSI, Nepal
23. **Wanjala Pepela**, Senior HIS Officer, Min of Public Health & Sanitation, Nairobi, Kenya, wanjala2p@yahoo.com (2 postings)
24. **Titus Kolongei**, M&E(UON), Senior Health Information Officer
    Ministry of Public Health & Sanitation; Division Disease Surveillance & Response
25. **Dr. S.M. Mursalim, National Advisor, HIS/eHealth, National Institute of Health, Isalamabad, Pakistan**
26. James C. Setzer, MPH, Principal Associate, Deputy Chief of Party – Technical, AfyaInfo Prohect, Abt Associates, Nairobi, Kenya

Appendix B: *Opening Address*

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

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

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

Here are the main objectives of this Forum:

- Contribute to an increased knowledge and understanding of the current HIS data development practice and process in the private sector, discuss quality of information collected and the organizational, human and infrastructural capacity readiness for fulfilling this function.

- Describe health systems policy, legislative and regulatory environment and assess whether these have enhanced or debilitated the participation of the private sector in NHMIS and the implication of this for performance.

- Based on the Forum findings, recommend steps for sustaining or strengthening the private sector participation in NHMIS.

Under each objective, we have outlined key questions to focus our discussions (see the attached Program). We are sending you the key questions ahead of time for your review and reflections and to enable you prepare your comments in your spare time. However, we only want you to respond to the questions posted for each day. In other words, if we post question 1 for day 1, we

do not want you to send comments on question 2. We only want you to send your answers to question 1.

Program

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

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

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

Rules of Engagement

Here are the guidelines for our discussion:

1. Let your voice be heard. The Yoruba of Nigeria have an adage: "ipolongo l'agunmu owo". Translated, *telling it, speaking it, advertising it, is the medicine of business*. In this Forum, therefore, lets us all speak out and be as participatory as possible. There are 140 of us in this Forum. Can you imagine the wealth of knowledge we will create if we can have at least one comment per person per question? We can do it! So, let's go ☺.

2. While sharing your opinions, let us be respectful of one another by being lively and succinct in our comments – taking care to refrain from ethnic or offensive grammar, jargon or felicitations. Make your contributions clear and straight to the point.

3. Every comment counts. Do not judge what others are saying. Lets us be builders in our comments, getting the best out of our colleagues.

4. If you use findings/quotations from articles you have read, please give the citation/source document. This will enable our team to do more reviews if need be and to use your comments in the most optimum way.

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

Here are the questions for our discussion today and tomorrow:

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

Routine Health Data Development Process & Practice

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

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

Bolaji Fapohunda, PhD.
Senior Technical Officer, M&E
MEASURE Evaluation /JSI
1616 N. Fort Myer Drive, 15th FL
Arlington, VA 22209
www.cpc.unc.edu/measure; www.jsi.com

Appendix C: *Background Reading*

1. Learning about the process and practice of RHIS in the private sector: Concept Note, Bolaji Fapohunda, MEASUE Evaluation / JSI & Theo Lippeveld, JSI
   --Background issues and Forum objectives

2. Approaches to Strengthening health information systems, by Theo Lippeveld & Steve Sapirie. Ch. 14 in Design and Implementation of Health Information Systems, edited by Lippeveld T. et al., 2000.
   --A summary of one, if not the most, widely read text on Designing and Implementing Health Information Systems anywhere.

3. Health information system in the private sector, by Patrick Matchidze and Lyn Hanmer. Ch. 6 in South African Health Review, 2007. [http://www.hst.org.za/uploads/files/chap6_07.pdf]
   --A specific country case study of the process and practice of Routine Health Information Systems in the Private Sector

4. PRISM framework: a paradigm shift for designing, strengthening and evaluating routine health information systems , Aqil A, Lippeveld T, Hozumi D, Health Pol Plann 2009;24:217-228 [http://heapol.oxfordjournals.org/content/24/3/217.full.pdf+html]

--An overview of RHIS theory and practice and tool for assessing performance

5. The World Bank: Health in African Initiative—Fact Sheet [https://www.wbginvestmentclimate.org/advisory-services/health/upload/FINAL-HiA-factsheet.pdf].
   --Most authoritative initiative in bringing the Private and Public sector together for health

6. Regional Conference on Engaging with the Private Sector, Speech of the Honorable Minister of State—Prime Minister's Office investment and Empowerment [http://healthpartnershipafrica.com/links/ conference-documents].
   --Country perspective on private- public sector collaboration for health and issues in involving the private sector sustainably, by a high ranking Senior Government official

7. Strengthening Engagement with the Private Sector in Health Systems in Africa, Khama Rogo, Director, IFC, Kenya. [http://healthpartnershipafrica.com/links/conference-documents]
   --Overview of private sector contributions to health care delivery and financing and a look at how to strengthen public-private sector engagement.

8. Regional Conference on Engaging with the Private Sector: *Conference Findings and Key Messages* [http://healthpartnershipafrica.com/wp-content/uploads/2012/05/Dar_es_Salaam_Health_Conference_Findings_1605121.pdf] ***--Key messages and recommendations from the ground breaking Regional Conference on "Engaging with the Private Sector.***

Appendix D: *Closing Statement*

Online Forum on Private Sector Participation on Health Information Development and Use: 17 October 2012

Esteemed Colleagues:

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

Key Challenges to CPS data development and use

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

A few of the recommendations

- Incentives, inventives, incentives! Countries need to design incentive mechanisms for compliance and punitive actions for non-compliant private facilities that will allow CPS to see what's-in-it-for-them of collecting and reporting data. Incentive could include income tax relief, reduction in import duties on hospital equipments, concession in electricity tariff and supply of data collection and reporting tools etc., OR free drugs (such as malaria or TB) and/or vaccines (Memon/Lippeveld, 10/17/12; Kamau, 10/11/12)
- Promote regular assessment of participation of CPS in HMIS to identify the existing barriers and to recommend improvements to HMIS.
- Provide the required inputs for data collection & reporting by CPS; data collection tools are expensive and cannot be left as the solely responsibility of the Private sector.
- Develop an analysis plan/dashboard/synthesis model to guide the extraction of useable information from data collected at the private/public sectors at regular intervals. This use of

this plan will ensure the availability of relevant information in usable quantities and can kick-start data use.

- Encourage use of information at all levels, particularly at the data collection points (Lippeveld, 10/17/12). Information use for decision making at this level, Lippeveld added, "…should become part of the standard health care delivery practices the same way as clinical standards are". To ensure that skilled manpower is available to work the system, Lippeveld recommended that design and implementation of (routine) health information systems should be taught at all medical and nursing schools as part of the pre-service curriculum .
- Institutionalize the provision of regular ***feedback*** to District and lower levels & the CPS, the data collectors.

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

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

Talking about feedback, in the coming days, we will be sending you a short evaluation questionnaire to find out your impressions on how we have conducted this Forum. Your impressions will help to tailor future RHINO fora. We ask that you please respond to us.

In addition, as Theo Lippeveld noted, we will be sending send you and updated synthesis of the Forum discussion and next steps.

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

I thank, most especially, those who have sent comments, opinions and insights. We are grateful to USAID for making the monies available to run this Forum and for all their efforts in being at the fore front of efforts to make the world a healthier place for all us.

From all the Team at JSI, its good bye for now!

The Forum is now officially closed.

Warm regards,

Bolaji Fapohunda, PhD.
Senior Technical Officer, M&E
MEASURE Evaluation /JSI
1616 N. Fort Myer Drive, 15th FL
Arlington, VA 22209

www.cpc.unc.edu/measure; www.jsi.com

Appendix E: *What the rating scale means*

In Nepal, per comments by Shusheel Lekhak (10/11/12), a rating of 2 on the scale of 1-5, will mean the following: **Strengths:** (1) Exists provision of regular reporting from private health facilities in routine HMIS; (2) District Health Offices (HMIS Unit) compiles reported figure in the monthly reports and forwards a compiled copy to central HMIS; (3) Health Sector Information System Strategy (HSISS) which is a guiding strategy for health sector information system suggests to develop a complete health facility database and collected health facility information in the three piloting districts. (3) A separate reporting format is designed during the Health Sector Information System piloting in three districts.

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

In ZAMBIA, per Brivine Sikapande, a rating of 2 will mean:

Strengths (1) Training of private health facilities on the use of HMIS reporting tools is underway; this training will ensure integration of private health facility reporting into the routine HMIS; (2) Availability of a health facility listing that is update every two years to include all newly created facilities; this includes all health facilities regardless of ownership, (3) The sector is bringing on board all key stakeholders including the private health facilities into the sector reviews.

Weaknesses: Very low reporting rate, rate is 24%