How should the Malawi Health Sector Indicators be Revised to Align with Current Monitoring and Evaluation Needs?

Mwayi Kachapila

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Policy Brief

Introduction

An indicator is a measurable variable used as a representation of an associated factor or quantity[1]. It provides evidence of the quality or standard of service. To monitor performance of the Health Sector in Malawi, Ministry of Health (MoH) formulated a Handbook of Heath Indicators in 2003[2]. The Handbook had 110 Health Management Information System (HMIS) indicators. The Handbook was formulated on the basis that it will be revised every five years to reflect emerging health problems, priorities, goals and targets of the health sector. However, 13 years later, the indicators have never been evaluated or revised.

In 2009 the MoH with support from the Health Metrics Network conducted an assessment of the Malawi HMIS. Among others, the assessment established that:

a) Some subsystems are not yet fully developed and therefore are unable to provide the required data in appropriate formats, leading to some vertical programmes continuing to collect and use their own data sets and indicators.

b) Donor-driven vertical programmes continue to establish and support parallel/independent reporting systems, putting pressure on already overburdened health workers and drawing resources away from the Health Information System (HIS).

The results of the assessment were used to choose 10 priorities that are being addressed by the Health Information Strategic Plan 2011-2016[3], some of which are to: strengthen monitoring and evaluation within the health sector, design and implement an integrated national HMIS that includes health sector data from all sources.

Challenges

According to the 2015 Malawi National Health Information System Policy[4], the current HMIS indicators formulated in 2003 can no longer sufficiently measure health sector performance because of changes that have happened in the country's health profile and also the HMIS indicators are not aligned to the Health Sector Strategic Plan (HSSP)5 indicators.

Over the years, a number of changes have happened both in Malawi and at the global level that have increased the reporting requirements of the health sector and created multiple reporting systems. Between 2011 and 2016, Malawi health sector programmes have been guided by the HSSP. The HSSP has 38 indicators for monitoring progress especially on the delivery of the Essential Health Package (EHP) (i.e., agreed upon diseases and conditions affecting majority of the population especially the poor). However, most of the HSSP indicators are not part of the HMIS indicators, hence they are not reported regularly. During the same period, the Malawi Government has been implementing the Malawi Growth and Development Strategy II (MGDSII)[6]. As with the HSSP, the MGDSII has indicators on health which are not part of the HMIS. Also, the HMIS indicators were formulated during the implementation of Millennium Development Goals (MDGs). With the phasing out of the MDGs, it implies that the indicators may not be aligned with the new Sustainable Development Goals (SDGs).

The scenario above has created a burden for reporting for the MoH since it is required to submit various indicators to various institutions, government departments and international organisations. This has, in turn, led to a situation where programmes and departments of the Ministry have created parallel data collection systems, hence the need to revise the HMIS indicators to harmonise reporting.

Key Messages

- The 110 Health Management Information System (HMIS) indicators formulated in 2003 can no longer adequately and efficiently measure performance of the health sector in Malawi due to policy and other changes at the country and international levels.
- There is need for consultative process to revise the Malawi Health Indicators. The revision process should categorise the new indicators into core and programme categories and ensure they are aligned with national and international policies like the Health Sector Strategic Plan and the Sustainable Development Goals (SDGs).
- Also, the Ministry of Health's data collection and aggregation tool, the DHIS2, should be re-customised to calculate values of the revised indicators. This will remove the current burden of manually calculating the values of the indicators and reduce errors.

Methodology

This policy brief is based on a comprehensive review of existing literature. The literature reviewed included scientific papers, research reports and government policy documents.

Discussion of Policy Options

In 2014, the World Health Organization (WHO) released a report following A Rapid Assessment of the Burden of Indicators and Reporting Requirements for Health Monitoring (here after, Rapid Assessment). The purpose of the assessment was to: give a brief overview of the global perspective on reporting requirements, assess the current indicators of reporting disease burden for countries, and identify areas where efforts can be made to both strengthen and reduce reporting burden[7]. The assessment found that in most countries, there were a lot of indicators, fragmented data collection, uncoordinated efforts to strengthen country institutional capacity, causing unnecessary reporting burden to countries and inefficiencies, thereby hampering overall analysis and decision-making.

Priority actions identified by the Rapid Assessment included: global agencies to bring greater alignment and efficiency in investments, to rationalise existing reporting demands and to reduce the reporting burden and reporting requirements on countries6. To achieve this end, WHO collaborated with international, multi-lateral partners and countries to move towards agreement on a global reference list of core health indicators and compiled the Global Reference List of Core Health Indicators[8]. Among others, the purpose of Reference List is to: improve alignment between global reporting needs and country processes for monitoring of progress and performance; and to improve the quality of results-based monitoring by focusing on better data for fewer indicators.

In an effort to strengthen HMIS in Nepal, the Management Division in the MoH revised the HMIS system in 2014[9]. The revised HMIS addressed the information needs of Nepal Health Sector II Plan (NHSPII) at policy level as well as the data needs of various programmes. In the course of the HMIS revision, the Ministry in consultation with its partners reviewed and revised the HMIS indicators. The revised indicators are expected to address the needs of the NHSPII and specific needs of different programmes. Among others, the indicators were also revised to bring HMIS in line with the Health Sector Information System (HSIS), ensure indicators and tools meet the needs of all programmes, integrate vertical reporting systems and improve data.

In Afghanistan, the first HMIS indicators were developed in 2003[10]. The indicators were based on the 2003 version of the Basic Package of Health Services for Afghanistan (BPHS). At that time, the Ministry of Public Health determined that after at least six months of implementation, the HMIS would be evaluated and revised. However, the evaluation took place late in 2004. The HMIS Task Force also incorporated the changes made to the BPHS 2005 and, based on the Essential Package of Hospital Services 2005, added the indicators to forms and guidelines on data reporting.

Fragmentation and lack of coordination of health programmes and inconsistences by international agencies on maintaining their own vertical systems has made improvement of health information systems difficult[11]. In 2012, Braa et al., after assessing the Zanzibar HMIS, established that if reporting forms are simplified on the basis of revised indicator and data-sets, it reduces the number of data elements collected and the workload of facility staff. Also, an integrated framework for HMIS, using a national data warehouse framework, provides an enabling environment in which actors, health programmes and systems can speak to each other, which is the foundation for improving health systems[12].

In Tanzania, an indicator set has existed since the 1990s13. Between 2007 and 2008, it was noted that the indicators were out of date, fragmented, and inadequate, and therefore needed to be reviewed in conjunction with all relevant stakeholders. This was due to the fact that numerous additional programme-specific data collection tools were in use with vertical programmes independently operating their own datasets and tools[13]. In 2009, analysis was conducted for data collection tools of different health programmes comparing data sets and tools. The analysis identified, corrected duplicates and inconsistencies. Then information requirements of different stakeholders at district, regional, national (HSSPIII), and international levels were also identified, documented and presented for implementation. Then a team of four people was formed, which then

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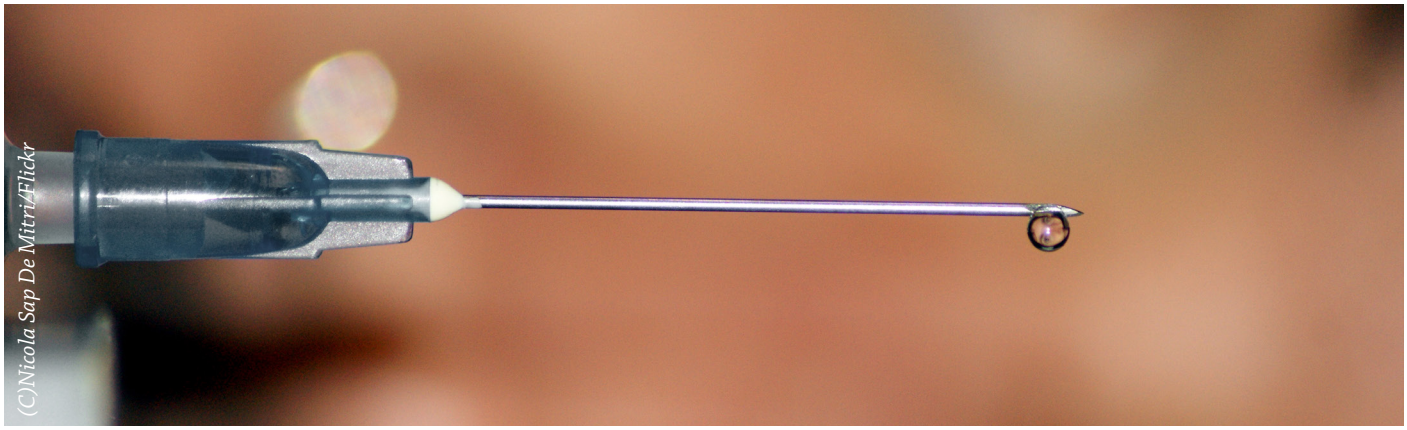

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revised the datasets[14]. However, after the revision, there were dissatisfactions from some programmes who wanted more of their data included and some duplications were also reported.

For Malawi, given the situation above, the current set of indicators seem not to be aligned with the recent local and international reporting requirements. In this regard, it is essential that the HMIS indicators be revised and aligned with indicators that will come out of the HSSPII, and other emerging local reporting requirements like the: programme and department needs, MGDSII, and global reporting requirements especially WHO's Global Reference List of Core Health Indicators.

Building on the preceding point, the current version of the Ministry's monitoring and evaluation tool, District Health Information Software 2 (DHIS2) only captures data elements and not final values of the indicators. This gives the burden to the officers at Planning Directorate to calculate the 110 indicators. However, the software can be re-customised to calculate final indicator values. In Uganda, for example, the DHIS2 is linked to the Reproductive, Maternal New born and Child Health (RMNCH) Score card. The DHIS2 generates and updates the Score card with indicators giving real time data[15].

The purpose of revising the indicators in Malawi will be to:

a) Reduce the burden of reporting,
b) Improve monitoring of programmes by harmonising M&E tools,
c) Re-customise the DHIS2 to calculate real time values of the indicators.

> *"There is need for consultative process to revise the Malawi Health Indicators. The revision process should categorise the new indicators into core and programme categories and ensure they are aligned with national and international policies like the Health Sector Strategic Plan and the Sustainable Development Goals"*

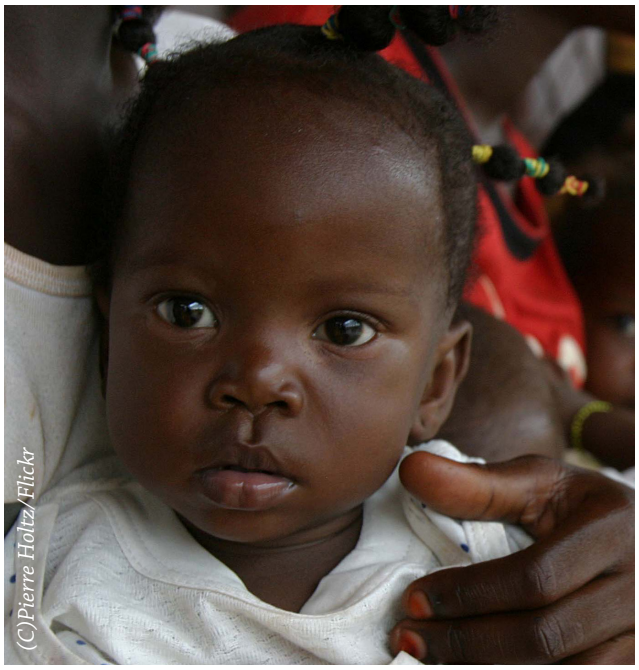
Recommendations

Based on the discussions above, the following recommendations are put forward:

i. Revise the HMIS indicators, starting with consulting programmes and departments - Considering the situation described above and the increasing pressure from programmes and departments to incorporate more of their indicators into the HMIS indicators list, it is imperative that HMIS indicators be revised. To avoid overlooking programmes/ departments' needs, the revision process should start with consultations. The Central Monitoring and Evaluation Division (CMED) of the MoH should conduct consultative meetings with every programme/ department, consulting each programme/department separately. Partners of those programmes should be part of the meetings to achieve a broader consensus. Then, a smaller group of monitoring and evaluation (M&E) experts be formed to do a critical synthesis of the first draft to remove possible duplicates, indicators that might be suggested by more than one programme and clean out the indicators list. The group would also ensure that all indicators are specific, measurable, achievable, relevant and time bound.

ii. Align the national indicators to the national and global indicators to reduce the burden of reporting - The processes described in "a" above must take into cognizance that not all indicators needs of programmes can be taken into the core HMIS list. Some indicators will have to be monitored at the national level using the DHIS2, but by programmes/departments. Therefore, the group of M&E experts ought to categorize the indicators into two sets; Core HMIS and Programme-Level Indicators. Hence, to be part of the Core HMIS indicator list, an indicator must be of prominence in the national programmes as outlined in the HSSPII and the MDGSII and be part of international reporting requirements such as WHO's Global Reference List of 100 Core Health Indicators. Otherwise, it has to be monitored as programme-level indicator. Then, after this categorization, the indicators be submitted to senior management of the MoH for endorsement.

iii. Re-customise the DHIS2 to calculate the values of the revised indicators - Once the list of indicators is endorsed, CMED should customise the indicators in DHIS2 to generate final values of the indicators. This will remove the burden of manually calculating the values of the indicators as well as reduce errors from the manual calculations.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