GROUP WORK PART A: DEFINING PRINCIPLES FOR SCALING UP ICCM IN COMMUNITY HEALTH SYSTEMS

TUESDAY, 23 July 2019

System Component: Monitoring and Evaluation and HMIS

Members: Chair – Kate Gilroy; Co-chair – Tanya Guenther; Rapporteur – Guilhem Labadie

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What are the enablers for iCCM M&E and HMIS?

National and district level enablers:

- Strong national HMIS & capacity to manage private sector
- DHIS2 functionality and strong national capacity to update (ICT backend support)
- Capacity for data visualization within DHIS2
- Digitized systems for data collection and reporting at scale
- Strong coordination and ownership of HMIS system by MOH (e.g. Uganda)
- Systemic and institutionalized feedback loops throughout the system and reaching to CHW level
- Global guidance/harmonization of indicators and data elements – and buy-in from all stakeholders (e.g HDC consensus)

What are the enablers for iCCM M&E and HMIS?

Health facility and CHW level enablers:

- Proper training and ongoing follow-up to ensure well-trained and supported CHWs who understand what data they are collecting and why
- Strong CHW supervisors trained in data management and use who are able to support CHWs
- Harmonized data collection forms (e.g. simple register so don't have to fill in sick child form and sick child register)
- Harmonized CHW reporting form that captures iCCM plus the other programs CHWs deliver
- Data use champions at multiple levels, encouraging a culture around data use (applies at district and national level as well)

What are the bottlenecks /challenges pertaining to M&E and HMIS?

1. **Parallel systems (e.g. three different systems in Madagascar; iCCM not integrated into C-HIS)**

   Drivers/root causes:

   - Donor driven reporting systems with their own reporting requirements
   - Weak coordination and government oversight/leadership
   - Gaps in national systems M&E/HMIS – community reporting system not integrated within national HMIS– should be interoperable but doesn't always function
   - Data quality issues drive partners to develop parallel systems

2. **Data quality (incomplete, not timely)**

   Drivers/root causes:

   - Data entry not prioritized
   - CHWs may not understand what they are filling and how it will be used;
   - limited capacity of CHWs – poor literacy and numeracy
   - Weak supervision and limited data use (o one is checking/using the data in real time)
   - Sometimes community reports not included in data cleaning exercises;
   - **Heavy reporting burden on CHWs**
     - Complex/poorly designed forms
     - Lack of prioritized data
     - No incentive for reporting (use of data/feedback can be an incentive)
     - Duplication/lack of digitization and lack of forms
     - Lack of accountability, data flow back to CHW

What are the bottlenecks /challenges pertaining to M&E and HMIS?

3. Weak data use/lack of evaluation

Drivers/root causes:

- Limited understanding of how to use data at all levels
- Few evaluations conducted because: expensive, people think they should just come at the ‘end’, limited capacity for evaluation, fear of failure/repercussions
- Denominator issues, (can try to focus on trends)
- Lack of approaches for valuing societal benefits, missed impacts of iCCM on family (focus on mortality impact)

What are the bottlenecks /challenges pertaining to M&E and HMIS?

5. Lack of harmonization/standardization of data elements and indicators

Drivers/root causes:

- Donors driven systems, weak MoH leadership, differences in packages
- Inconsistent terminology (e.g. ARI at facility versus pneumonia at community level)
- Need to maintain flexibility and maintain relevance - consensus building process is necessary but takes time, effort and resources

6. Lack of private-for-profit sector data on iCCM

Drivers/root causes:

- Lack of regulation of private sector, operate outside the system
- In some models where donated commodities need to be given, it may not fit within the private sector model so how can you expect reports
- No incentives for private providers to submit data; reluctance to report on their services
- Not often included in trainings or invited to be part of the system

Community data aggregated with facility level *- Progress has been made in this area - not so much an issue anymore as many countries have addressed*

GROUP WORK PART B: DEFINING GUIDING PRINCIPLES AND BENCHMARKS FOR ICCM

WEDNESDAY, 24 July 2019

System Component: Monitoring and Evaluation and HMIS

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Problem: Parallel systems

- **Global level**
  - Develop guidance on harmonized and prioritized indicators for iCCM within the Community Health Management Information System (CHIS)
  - Support harmonized health information systems (HIS) that include CHIS, LMIS, HRIS, Financial data, private sector, etc
  - Ensure these various components are interoperable

- **National level**
  - Foster strong government leadership to build consensus on indicators and data elements with all partners, as well as end users
  - Develop/implement digital strategy / eGovernance policies to reduce fragmentation

Problem: Data quality and data use (1)

- **Cross-cutting**
  - Expand and adopt digitization at national scale for data collection, reporting, data use at all levels. Platforms should also include:
    - Decision support
    - Embedded quality checks
    - Dashboards at all levels
  - Develop and test sustainable models for different contexts for digitization and data use that can be scaled-up to the national level
  - Ensure monitoring and evaluation indicators and analyses address health systems supports, such as supervision frequency and quality and logistics, for decision-making
  - Ensure all partners should be at the table, including the end users
- **Global level**
  - Promote learning culture and data use to drive improvements in data quality
  - Streamline global recommendation and expectations to limit the reporting burden on CHWs and the health workforce
  - Share best practices and learning on ways to improve data quality and data systems (especially for digitization) across countries and regions

Problem: Data quality and data use (2)

- **National level**
  - Prioritize M&E and data quality during training and supervision (i.e. incorporate data quality into entirety of training – practicing recording after case management)
  - Ensure facility of use: server, connectivity, consider partnership with mobile providers

- **Sub-national level**
  - Promote and support data use
  - Support and focus on data verification at all levels, including community level (with timeliness)
  - Harmonize/improve forms to reduce duplicative recording and reporting (All partners should be at the table, including the end users)
  - Introduce incentives for CHWs overall and for good data reporting and use, such as recognition, in-kind incentives,
  - Strengthen feedback loops and use of data and results with communities and CHWs (can be paper or digital dashboards, scorecards or the like [examples from Ghana, Malawi, etc]) that can foster engagement with and accountability to the community

Problem: Private sector data

- **Cross-cutting**

  ANYONE FROM THE PRIVATE SECTOR HERE?

  - Acknowledge that the private sector exists and accounts for much service delivery and engage private sector partners in global dialogue
- **Global level**
  - Develop guidance for engaging the private sector in child health and community-based services
- **National level**
  - Develop private sector strategy (e.g. Uganda)
  - Develop policies and regulations to link certification and regulation to data reporting (or strengthen in places where this exists)
  - Formalize the informal private sector and introduce reporting mechanisms
- **Sub-national level**
  - Engage private sector in standardized trainings, etc that can foster engagement and willingness to report data

Overarching Statement

Government led, harmonized, streamlined M&E systems that produce high quality information to optimize learning and data use for action and accountability for sustained improvement in iCCM programming.