

The Politics of HIS Restructuring in Pakistan: The Importance of Policy Analysis

**Issues and Innovations in Routine Health
Information in Developing Countries**
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Presentation Outline

Background & Introduction

Context of HMIS Development

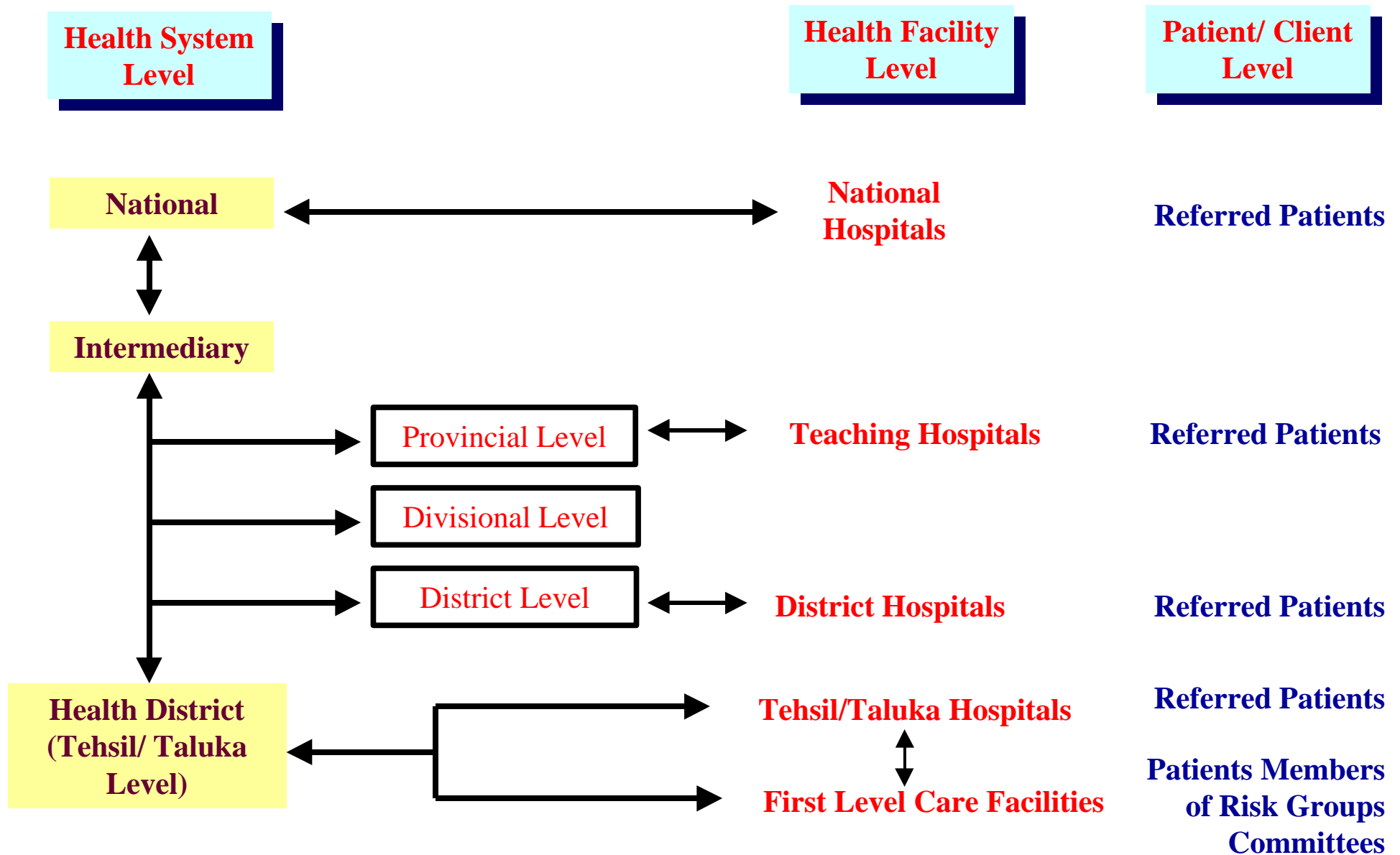
Contents of National HMIS

Development Process

Issues & Challenges

Lessons Learnt

Organizational Model of Health Services



Province wise Distribution of Health Facilities

(December, 2000)

Province	DHQ Hosp.	THQ Hosp.	Disp.	TB Clinic	MCHC	RHCs	BHUs	Total
Punjab	28	57	1006	46	404	307	2494	4342
Sindh	11	44	309	1	41	119	781	1306
*NWFP	15	10	623	24	112	100	1135	2019
Balochistan	18	-	652	9	76	58	432	1227
*AJK	3	6	105	1	10	29	181	335
*Nas	3	21	99	0	1	0	15	139
ICT-Federal	-	-	6	0	1	3	13	23
Grand Total	78	138	2800	81	645	616	5051	9409

**NWFP= North West Frontier Province,
AJK=Azad Jammu & Kashmir,
NA= Northern Areas*

Study of Previous Information Systems (Summary)

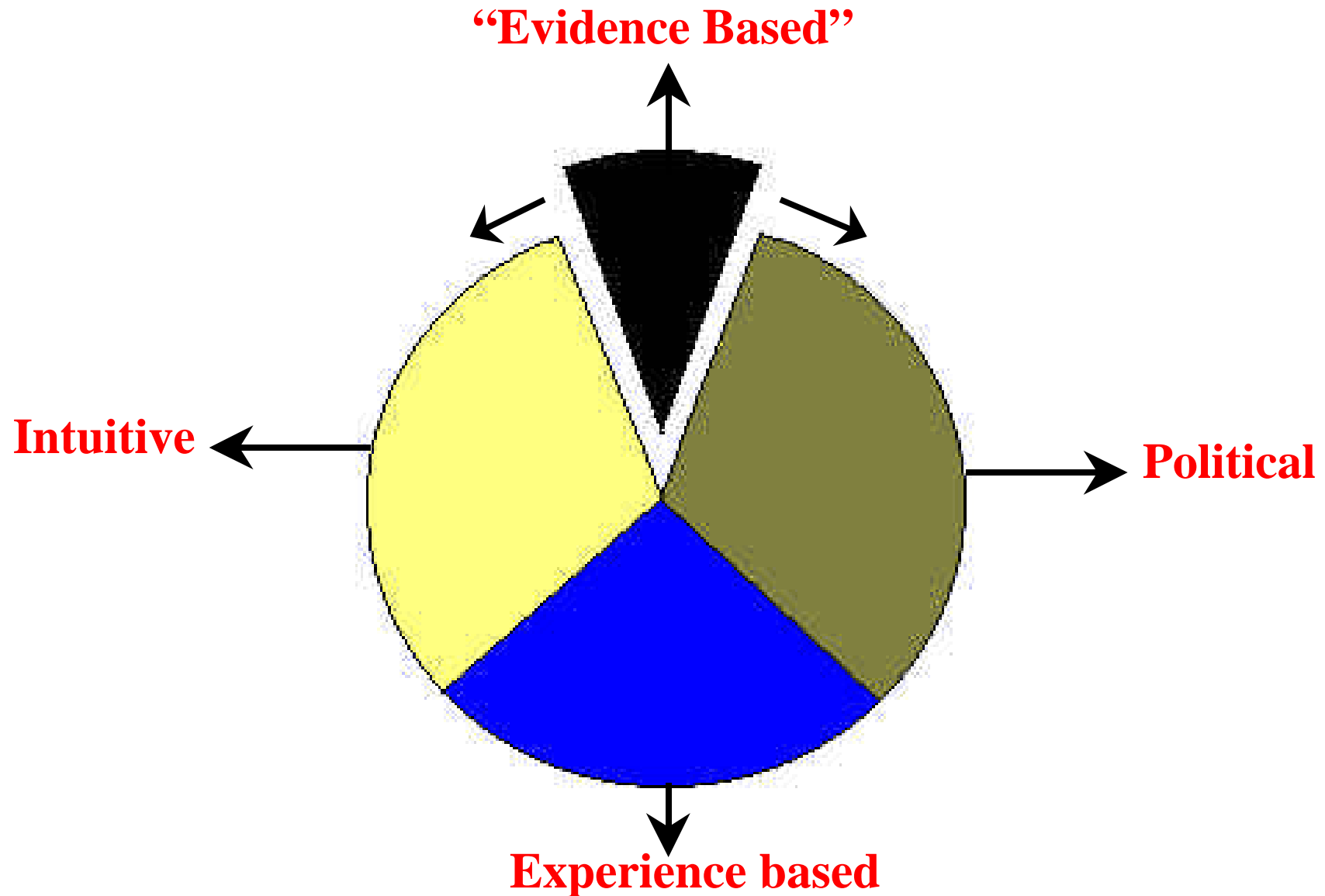
- ◆ **The disease indicators were unfocused.**
- ◆ **System lacked management indicators like those on personnel equipment, supplies drugs etc.**
- ◆ **The data collection methods were improper. There was a general lack of staff motivation, data standardization and printed supplies.**
- ◆ **The data reporting was fragmented, vertical MIS systems & lot of duplication and chaotic transmission.**

- ◆ Data processing was mostly manual and grossly deficient.
- ◆ Most data was accumulated without being analyzed and use of computers is non-existent.
- ◆ Higher level information feedback/guidance, both to the field supervisors and the facility staff was lacking.
- ◆ The Information Management was centralized and very weak, both at the federal and the provincial levels.

Objectives of HMIS

- 1. To provide the information support to the Health Managers at various levels of the health system.**
- 2. To compare performance over time, with other provinces, districts and facilities etc.**
- 3. To identify facilities, districts and provinces in need of support .**
- 4. To monitor trends in disease pattern, coverage, quality and population at risk.**

Decision Making Process



HM S evelo ent Process

Initiated in 1992

**Designed through participatory
development process**

**Creation of National & Provincial
Working Groups**

**Initial funding by USAID, but withdrawal
in 1994**

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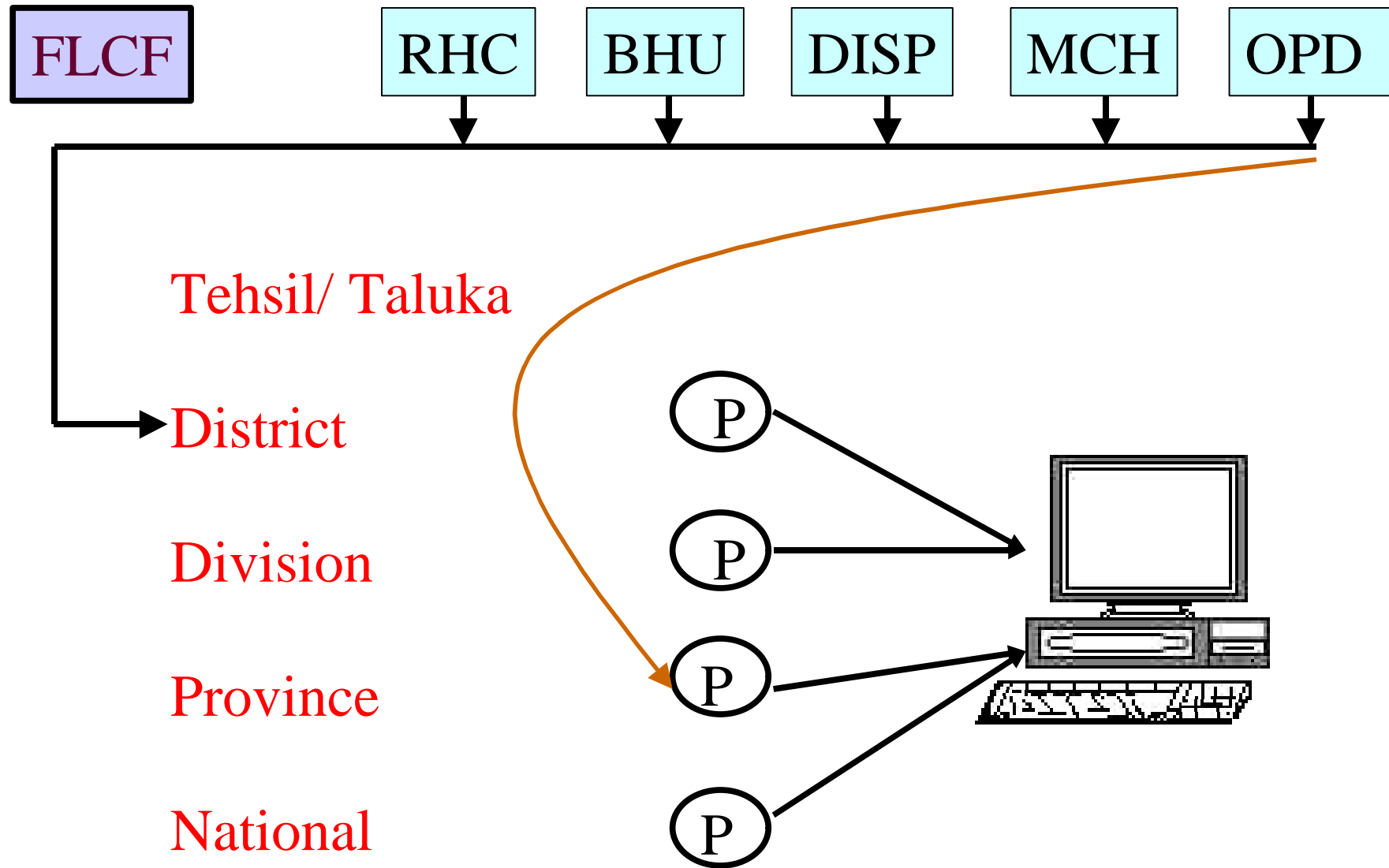
Through Consensus Building: series of workshops on

- **Functions**
- **Indicators and Information Needs**
- **Data Collection**
- **Information Flows**
- **Data Processing**
- **Use of the Information/ Feedback**

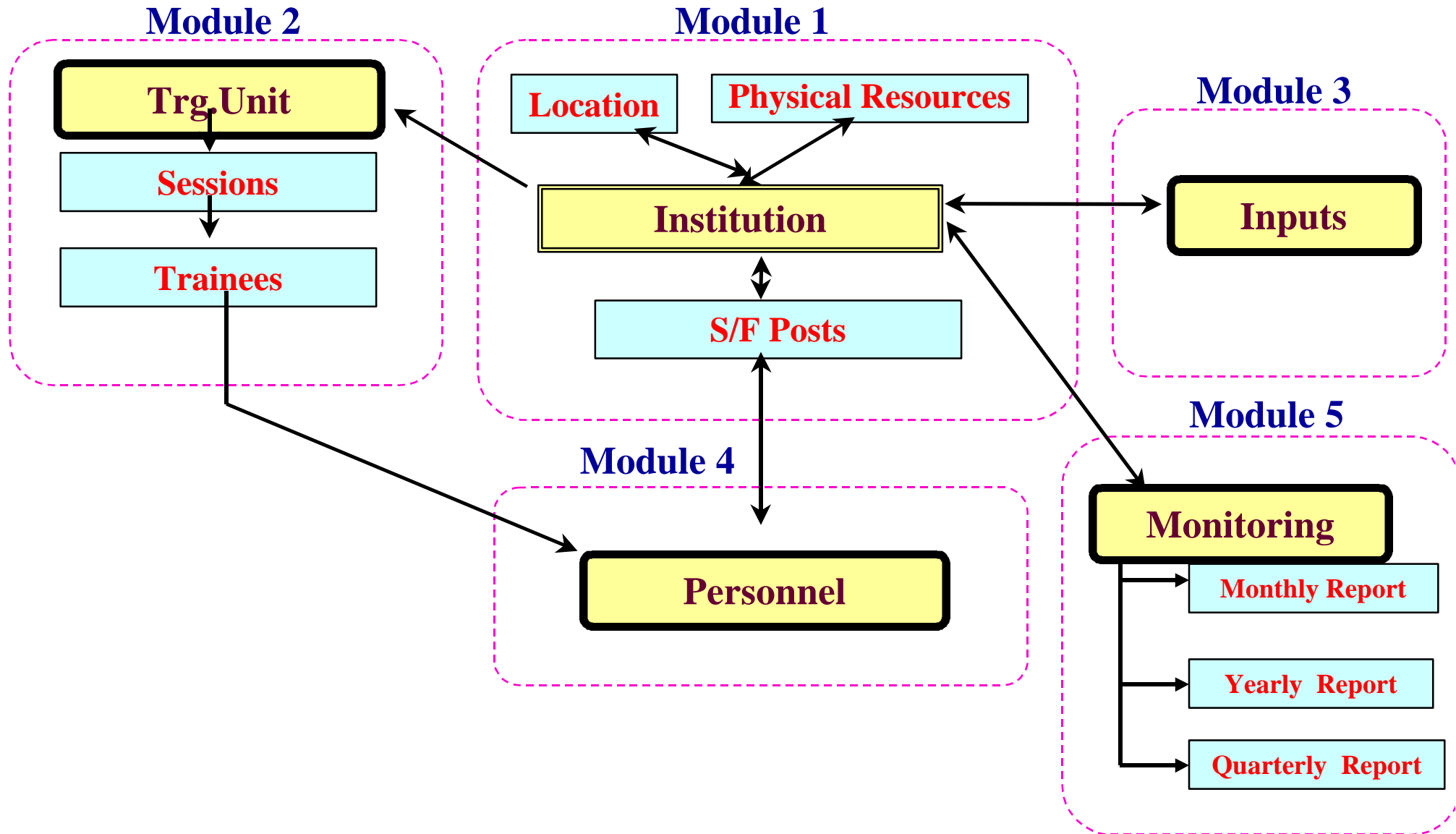
Features of National HMIS

- **Indicators are focused on priority health problems, emphasis on preventive services with management indicators.**
- **Number of data collection instruments reduced.**
- **Creation of national Health Institution Database (HID) (>11000 FLCF's)**
- **Development & Installation of HMIS Software at >100 peripheral HMIS Cells**
- **A distinct feature of higher level feedback included.**
- **System launched through field training (>20,000 health workers trained)**
- **Regular Monitoring through Inter-Provincial Meetings.**

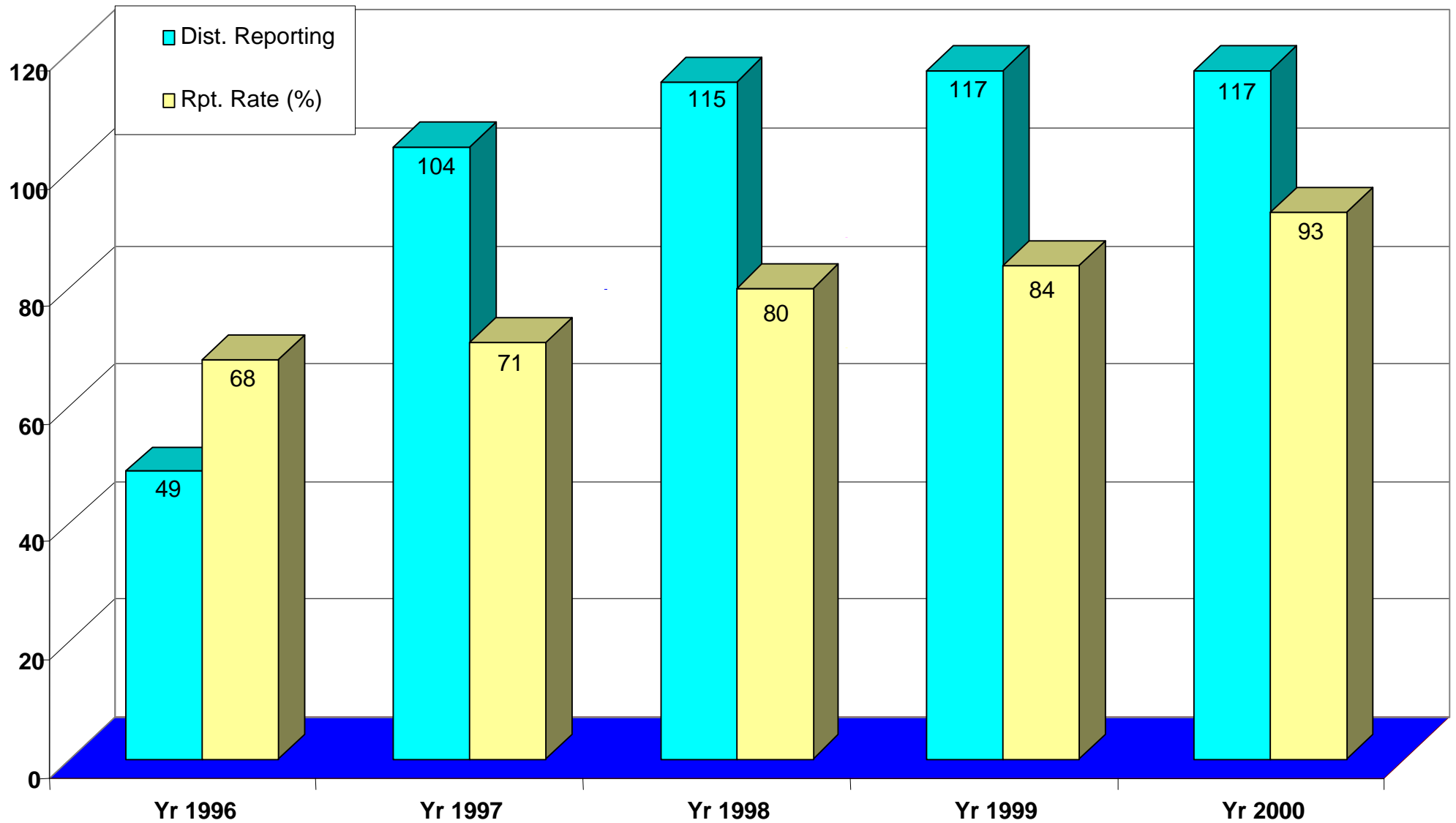
Report Transmission Processing



Structure of HM S



Number of districts reporting HM S e ort ate
HM S ata



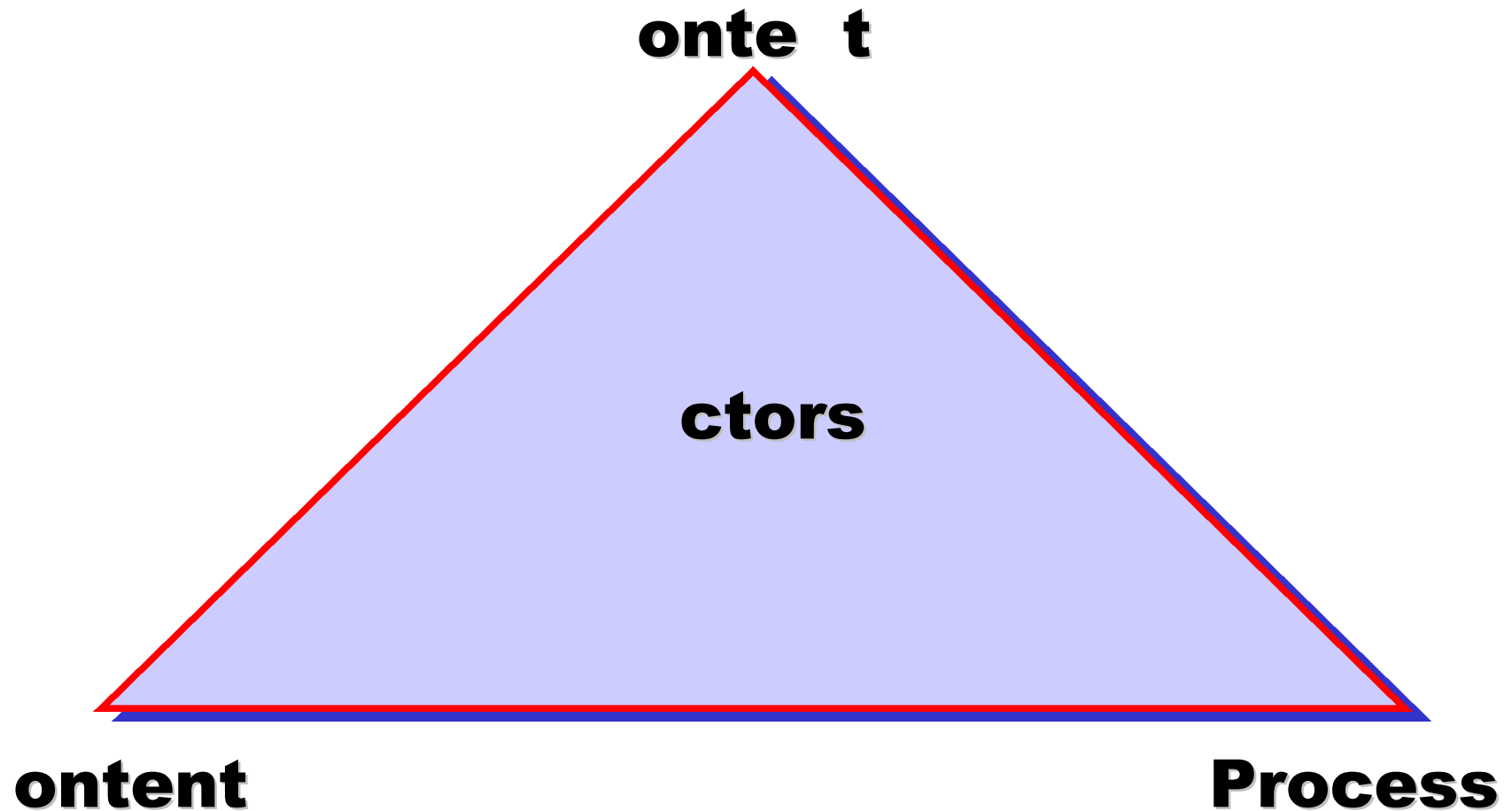
Operational Problems and Constraints

- The scope of present HMIS is limited and needs to be expanded
- Due to a weak Vital Event Registration System, information on mortality and health status indicators are difficult to obtain.
- Persistent multiple information systems organized through public health programs.
- Data is often delayed and is not analysed.

Operational roles and constraints contd

- **Evidence based decision making not in practice. Therefore less demand for HMIS Data.**
- **Special efforts are required to improve data quality and promote information use.**
- **There is a general lack of motivation to collect, analyse and use information appropriately.**
- **The current information system is increasingly difficult to sustain given the available level of financial and human resources**

Lessons learned: based on policy analysis



Lessons Learned

HMIS in Pakistan a Success Story **Reported but**
information use remains poor

Main reasons for success were

The content: HMIS/ FLCF responds better to the information needs of all users of the system.

The process: Consensus-building resulted in solid ownership of the system by most MOH managers.

Lessons Learned

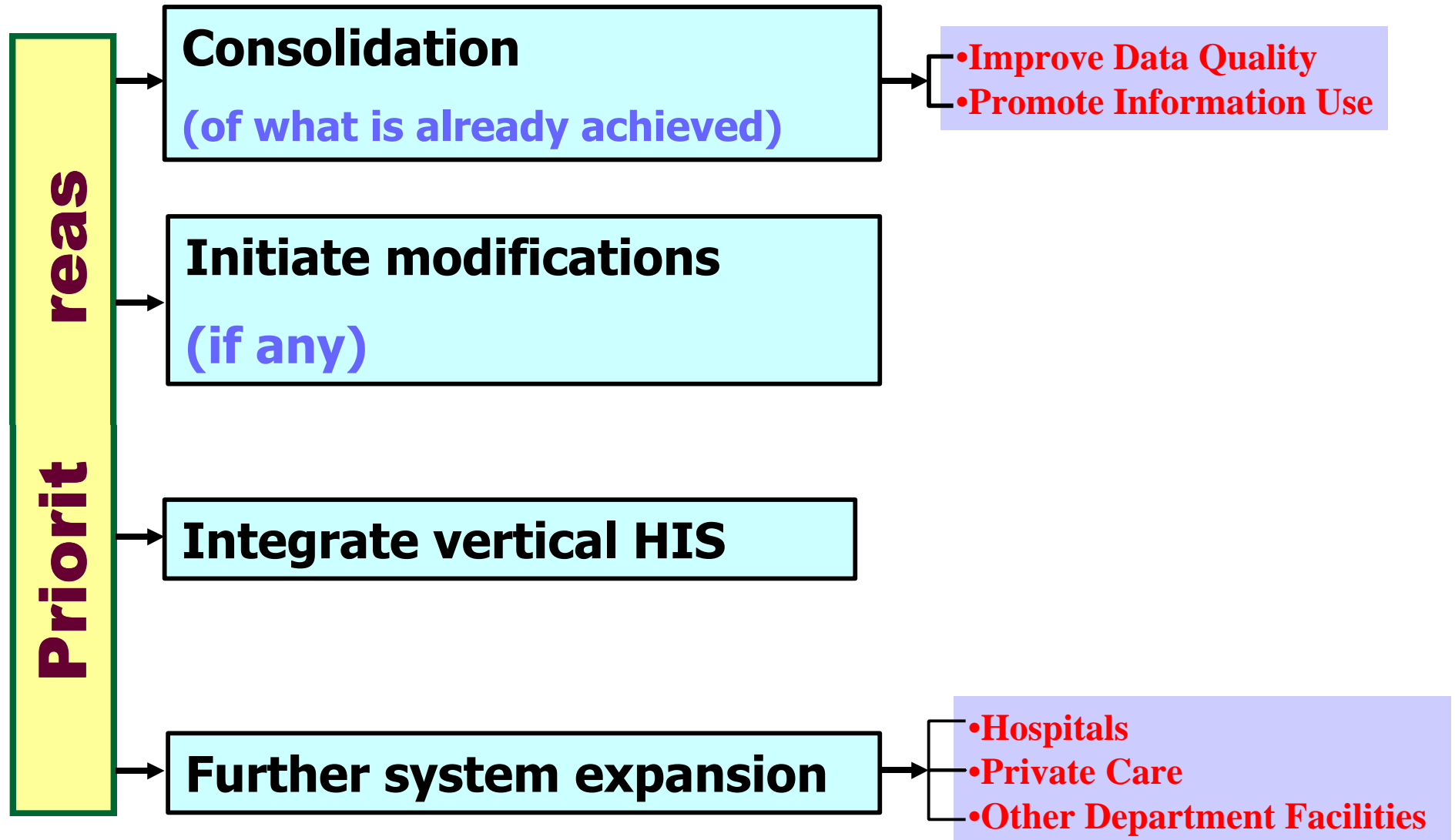
Main constraint as the context in which it has implemented and that is still prevailing

Non-flexible administrative setup with top-down bureaucratic approach and weak management practices.

Absence of information culture throughout the health services.

Dependency upon the donor funding and the poor resource environment in Pakistan.

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Recommendations:

- Participatory Development Approach be adopted for system design and for subsequent modification.
- Need for ownership by the Policy makers from the very onset of the restructuring process.
- Financial commitment from major donor agencies and government be ensured till consolidation.
- Ensure Capacity Building for data analysis, supportive supervision and use of information.
- Clear understanding has to be reached among the users as to what information may be expected from HMIS and what from other data sources.