Decision Maker Perceptions in Kenya and Nigeria

An Assessment of Data Use Constraints

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About MEASURE Evaluation

MEASURE Evaluation works to strengthen the capacity of host-country programs to collect and use population and health data.

As a key component of the Monitoring and Evaluation to Assess and Use Results (MEASURE) framework of the United States Agency for International Development (USAID), we work closely with USAID missions to promote a cycle of data demand, collection, analysis and use to measure progress toward addressing and confronting disease, population issues, and poverty.

We help health ministries, district caregivers, and local trainees successfully manage data for better informed program planning and policy-making. Our guidance and technical innovations empower our partners to improve family planning, maternal and child health, and nutrition programs and to confront HIV/AIDS, STDs and other infectious diseases worldwide.

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Introduction

For some time it has been apparent that the use of data for policy and program decision making is constrained in several ways. Some of the better-known forces that hinder the establishment of a self-sustaining cycle of data demand and information utilization (DDIU) include:

- The lack of an enabling environment to reward and foster DDIU;
- The unavailability of information of sufficient quality upon which to base decisions;
- Weak capacity and support systems to translate data that do exist into actionable information;
- Relationships with donors and leaders that send mixed messages about the value and importance of having high quality data and information as inputs into the decision-making process; and
- Delays in releasing data affect the timely use of high quality information once it is available and in demand.

Between August and October, 2005, MEASURE Evaluation engaged in assessments in Kenya and Nigeria to obtain a more thorough understanding of decision makers' use of health-related data in evidence-based decision making and their perceptions of the constraints and barriers to using data. MEASURE Evaluation intended to use findings from these assessments to inform the project's data demand and information use (DDIU) activities, including developing and refining tools to improve information use. The findings were based on key informant interviews with 20 national and district-level public- and private-sector decision makers and program managers in each country. We also wished to explore whether key informants might provide insights into any previously unrecognized issues that hamper the demand for data and the use of information.

Overall, the findings provided strong support for the conventional view of what constrains the use of data and information, and no significantly new barriers were identified. In this instance, the confirmation of existing understandings and the 'negative findings' with regard to any hidden issues has given the project confidence that the strategies and tools being developed to facilitate DDIU are on the right track. Even if the familiar constraints and obstacles cannot easily be overcome, having an approach that takes account of, or exhibits an awareness of, the existing universe of deterrents to DDIU should be advantageous.

Within the broad types of constraints noted above, the following specific issues appeared to put a consistent drag on the uptake and use of information for decision-making, policy formulation, or advocacy.

Lack of Enabling Environment

- There are insufficient financial and human resources available to analyze, disseminate, interpret, and utilize information.
- Political factors, which were seen as important and wide-ranging, influence the availability and use of data.

- Social factors, such as cultural beliefs and values, affected the use and acceptability of data at the community level.

Unavailability of Sufficient Quality Information

- There is an overall lack of information, including service delivery information, for decision making.
- Where data are available, they are often insufficient to support a particular decision.
- The quality of the data and the accessibility to the data were significant constraints to the data being used.

Weak Capacity and Support Systems

- There is a lack of technical skills in data use and analysis.
- External technical assistance is often required to produce reliable information.
- There is a lack of commitment to work and the importance of using data among staff.

Relationships with Donors, Leaders and Others

- External donors and leaders send mixed messages about the importance of using high-quality data in the decision-making process.
- There is a lack of support from key leadership to promote the availability of data, which was considered a driving force behind both structural and organizational processes.
- Sharing of information is limited by the possibility that other groups may misuse the information.

Delays in Releasing Information

- Unnecessary government authorization before final dissemination delays and may limit the usefulness of the data.
- The length of time for the information to be validated among stakeholders negatively affects their ability to use it in a timely manner.

Appropriate and effective generic strategies are available to address the constraints cited above. Some of the strategies that could be used include:

- Train M&E staff in DDIU concepts and strengthen processes to support the use of data, so that more appropriate data are collected and used in compiling decision-relevant information.
- Build the capacity of M&E staff in the areas of data collection, data analysis and data dissemination with the aim of effectively producing high-quality information.
- Advocate for increased funding to support data production and use efforts;
- Obtain increased support and promote demand for data and information from key leadership by demonstrating the usefulness of high quality, relevant information.

- Strengthen linkages between stakeholders to avoid duplication of data production efforts and build trust between them.
- Improve the attitude and commitment of all involved in the data production process to help ensure that quality data are collected.
- Build political and social analyses into the information use process.

While these strategies could be used in many contexts, each solution needs to be tailored to address the constraint and its underlying causes within a specific social and cultural setting.

The following two sections of this report include the actual assessments conducted in Kenya and Nigeria.

Decision Maker Perceptions in Kenya

An Assessment of Data Use Constraints

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Abbreviations

NCAPD	National Coordinating Agency for Population and Development
MOH	Ministry of Health
FHI	Family Health International
PPFI	Planned Parenthood Federation International
KSPA	Kenya Service Provision Assessment
KDHS	Kenya Demographic and Health Survey
KANCO	Kenya AIDS NGOs Consortium
FPAK	Family Planning Association of Kenya
MAP	Men as partners
MOH	Ministry of Health
VCT	Voluntary Counseling and Testing
NASCOP	National AIDS and STDs Control Program
ARVs	Anti-Retroviral drugs
NYS	National Youth Service

Background and Objectives

This is a report of a rapid assessment that was conducted among policy makers and program managers in Kenya between August and October, 2005. The assessment was aimed at collecting information from decision makers in the public and private sectors on their current use of data and on their perceptions of the constraints to the data use. This assessment focuses on the perceptions of decision makers about constraints and barriers to the effective use of data to make evidence-based decisions. For the purposes of this assessment "decision makers" were defined as those individuals in a position to make decisions on policies or operational protocols and guidelines, on project designs and plans, and on resource allocation.

Methodology

Study Design

This was a cross-sectional study that involved 20 key informants purposively selected by virtue of their positions. These public- and private-sector policy makers and program managers were drawn from national and district levels. The selection of key informants included policymakers and program managers in the health sector or a related position in finance or planning. In line with the guidelines provided, 20 key informant interviews were conducted; 12 from the national level and eight from the district level.

Among the 20 informants chosen for interview, two-thirds were to be from the national level; at least one-third should represent the provincial or district level. One-half should be from the public sector, including the Ministry of Health and related parastatal organizations, including National Population Councils or National AIDS Commissions. The other half should include decision makers from the NGO sector (for example, program managers or executive directors from the national family planning NGO, directors of mission hospitals) and from the private sector (private hospitals, industry executives from companies that provide health services to their workers).

Using these criteria, the consultant chose key informants to interview on an opportunistic basis. If the decision makers were known to the interviewer, a level of trust already may have been developed that would facilitate frank and detailed responses to the questions. Provincial and district representatives were approached for an interview when they were in the capital city on another assignment in order to minimize travel costs. This was not intended to be a representative survey; the objective was to locate knowledgeable individuals who could contribute to our understanding of the types of existing barriers and constraints to data use and evidence-based decisions, and to approaches that can be used to overcome these constraints and barriers.

Data collections methods

A short questionnaire was used to collect the information from each respondent. The consultant asked the respondent questions in a conversational manner while taking notes, and immediately after the interview the consultant completed the questionnaire form for each respondent. Most of the respondents objected to tape recording of the interviews. Therefore tape recording was not used in the interviews.

Data analysis

The information obtained was analyzed descriptively theme by theme in line with the report template provided by MEASURE Evaluation.

Limitations and methodological difficulties

One of the main constraints faced by the consultant was the reluctance by the some of the key informants who had initially consented and given appointments for interviews, arguing that their program officers were in a better position to answer questionnaires on data use and constraints. Several senior decision makers in both public and the private sector declined to be interviewed, arguing that they make decisions based on the briefs that they received from their officers whom they expected to use current and relevant data and information. In several organizations, the consultant was referred to the monitoring and evaluation officers and health records and information officers who themselves were reluctant to participate in the interviews since their seniors had skillfully declined to be interviewed.

No provision was made in the contract for upcountry travel to conduct interviews involving provincial and district level personnel. Because of this the consultant had to look for opportunities to interview upcountry provincial and district level officers when they were in the capital for other business. Some of upcountry people identified wanted to be given the questionnaires so that they could fill them themselves and return them later. However, this request was not granted, and all interviews were conducted in person.

The other limitations include the smallness of the sample size and the opportunistic selection of the interviewees. The sample size of 20 is not representative in a statistical sense. The opportunistic selection of informants may have introduced some biases. However, these limitations are not serious since this study is not meant to provide results obtained from a representative sample.

Findings

The following is a profile of the interviewees.

National level

At the national level, 12 key informants were interviewed. These included:

a) A deputy director of a national population agency whose specialization was on policies on population, health and nutrition.
b) A project coordinator from an international NGO whose specialization was HIV/AIDS programs.
c) A project manager from an international NGO whose specialization was population and health programs.
d) A project officer from an international NGO whose specialization was population, health and nutrition programs.

e) A project coordinator from an international NGO whose specialization was programs in population, health, nutrition and HIV/AIDS.
f) A senior program officer from an international family planning organization whose specialization was health and HIV/AIDS programs.
g) A program director from a national family planning organization whose specialization was health, child survival and HIV/AIDS policies.
h) An assistant program director from a national family planning organization whose specialization was population, health and nutrition and HIV/AIDS programs.
i) A program manager from a national HIV/AIDS consortium of NGOs whose specialization was policies and programs in population, health, nutrition and HIV/AIDS.
j) A monitoring and evaluation and data manager from an international NGO whose specialization was in nutrition and HIV/AIDS programs.
k) Two program managers from an international NGO who specialized in population, health, nutrition, child survival and HIV/AIDS programs.

District level

All the key informant interviews at the district level were conducted with the informants in the public sector and include the following:

a) Two district medical officers of health whose specialization were programs in population, health, nutrition, child survival and HIV/AIDS and public health, respectively.
b) Four district public health officers who specialized in programs in population, health, nutrition, child survival and HIV/AIDS.
c) A district health records and information officer who specialized in programs in health, child survival and HIV/AIDS.
d) A district statistical officer whose specialization was programs regarding the statistics of population, health, nutrition, child survival and HIV/AIDS.

Decision Making by Respondents

The results clearly indicate that that the key informants made a wide range of decisions in which they used data. These decisions included policies, operational protocols and guidelines, project designs, scaling up projects, project activities, and resource allocation.

For example, one key informant from a population agency used data drawn from the 1998 and 2003 Kenya Demographic and Health Surveys (KDHS), 1999 census, preliminary results of the 2004 Kenya Service Provision Assessment (KSPA), and program reports to make decisions regarding repositioning of family planning and reproductive health programs in the country. On the basis of the data on the trends in the key indicators of fertility and reproductive health, he was able to make the decision. However, he lacked information on the number of community-based family planning workers who would facilitate the programs. The information he lacked could not be found from their key partners, the ministry of health and major NGOs such as FPAK. The health information system of the ministry of health did not collect such information and the data collected on family planning service providers were incomplete and hence only give a broad view of the health situation.

The M&E and data manager of an international NGO made a decision regarding creation of new databases for health information systems, antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT), and voluntary counseling and testing (VCT). He used information from periodic, terminal, and evaluation reports. From the reports he was able to obtain data for three years only although he required cumulative figures for six years. The information systems serve the interests of the management, clinicians and medical personnel, the NGO headquarters, and that of its donors such as USAID. The information systems help the program officers to monitor the patients for follow-up services, to allocate resources, and to facilitate the sharing of information among the staff and other users.

Using the NGO's own statistics and information from the ministry of health, which revealed that many women underwent unsafe abortions resulting in physiological and psychological complications, a project officer from an international NGO decided to introduce post abortion care for patients at home. There was, however, inadequate information from the hospitals since abortions are illegal in Kenya. The management, counselors and field officer are the main users of the health system information in the NGO. However, the health information system does not meet all the organization's needs for information.

The program manager of an international NGO with a program focusing on men used the data obtained from health information system of the ministry of health, training reports, and their own surveys to make decisions to involve the youth from the national youth service (NYS) in their project. From the statistics, it was apparent that most of the youth from NYS were sexually active and had some understanding of reproductive health issues. Furthermore, the NYS had the capacity to reach out to the community and provide further training. The organization is the primary stakeholder in the use of their information. The health information system helps in meeting the organization's interests; it assists the program formulators and implementers in making decisions easily and also helps the organization to know the progress of its programs on the ground. The health information systems do not provide all the data they require, however.

The program director of a national family planning organization used the information shared by their international affiliates to decide to introduce anti-retroviral drugs (ARVs) in their program activities and to their health staff. However, information on the cost of provision of ARVs was missing. Project managers, researchers, policy makers, international NGOs, and the government are the primary stakeholders in the use of the information that the NGO collects and stores in their health information system. The system serves the interests of project implementers and the other users of the information; for example, NASCOP requires records of VCT, and the National Aids Control Council relies on NASCOP. However, the information is not readily available in the formats required by most users.

Some decision makers had adequate information in making their decisions. One was the project coordinator of an international NGO who had adequate information from the Kenya Human Development Report. From that report, he was able to get information on the poverty levels in the country, and then changed the geographical focus of the NGO's activities to the most marginalized communities. The primary stakeholders in the use of their information are the communities in which the NGO works. They only carry out the needs assessment and on the basis of the results mobilize the communities to take action on the problems identified. The health information system should benefit the community but this is not always the case.

In the decision to involve the community in the management of an HIV/AIDS project, the project coordinator at an international NGO had adequate information. Using data on the trends in HIV/AIDS infection rates obtained from NASCOP, the ministry of health, and VCT programs, it became apparent that people infected with the virus were being shunned by the society. Therefore, there was a need to eliminate the stigma associated with HIV/AIDS and encourage the community members to play an active role in caring for those infected, thereby improving their lives. The management of the NGO, especially its program officers, are the main users of the information. Health information systems meet their need for information adequately, and it mainly serves the interests of counselors, programs designers and its field staff.

Technical Constraints

Several technical constraints and barriers to the use of data in decision making were mentioned and discussed by the majority of the interviewees. While technical constraints were minimal in most organizations in the private sector, several constraints were experienced by the key informants in the public sector and made it necessary for them to rely on external assistance.

Poor quality of information was reported by several informants as affecting the used of data. In some cases, data was scanty or incomplete or the information was missing completely, hence affecting the data quality. Those dealing with HIV/AIDS programs reported that accurate data on HIV/AIDS is especially difficult to obtain: people give deflated figures so as to give an impression that the situation was not so bad, while in other cases the information was being withheld because of stigmatization.

Incompleteness of information and missing information also affected the quality of data. This caused some organizations to rely on estimates that are sometimes not reliable and that end up giving false information.

Poor quality of information also resulted from lack of timeliness in data collection. In one example of a district public health officer, data collected in the health facilities in the district usually was delayed in reaching the district health records office for almost two months, so decisions had to be made on the basis of the data collected the previous months. This gave false information on the current health situation in the district.

Unclear geographical boundaries also affected the quality of information. In one case, the actual population of a certain area could not be obtained with certainty because of unclear boundaries.

Inadequacy of staff – especially in the district health facilities – affects the quality of information. In one district, the medical officer reported that some of the facilities in the district were so understaffed that reports were not completed on time. In cases where there is staff, other setbacks, such as poor training in computer technology, exist. Lack of computers and other equipment, transport facilities, and funds were some of the factors that caused some organizations to depend on external technical assistance.

Poor communication between facilities, especially in the public sector, also affects the quality of information. For example, hospitals in two neighboring districts may not communicate patient information when the patient is treated at a hospital in a district that is not his/her home. This leads to having false information about the prevalence of diseases in either district.

Multiplicity of the sources of information was also a technical constraint to some decision makers. For example, one medical officer of health reported that she at times had various sources of information regarding mortality caused by certain diseases. The number of deaths could be obtained from the data in the health facilities and also from the vital registration department. In most cases the two figures would be merged to obtain an estimate that would be different from those obtained from using either of the sources.

Dishonesty of the data collectors also affects the quality of information. In addition, handling of data by various people sometimes leads to inaccuracy of data.

Informants suggested several ways to overcome some of the above constraints and barriers. One suggestion was for adequate staffing, where staff with the required skills would be involved in the use of data, from data collection, analysis, dissemination, and decision making. Another suggestion was that training on the accuracy and timeliness of information should particularly be emphasized.

Some informants felt that it would take more than training in the cases of HIV/AIDS and abortion. In the former, there was a lot of stigmatization concerning the disease hence there was need for mobilization and educating the public about the disease. For the latter case, the difficulty of obtaining abortion-related information was attributed to the country’s strict laws on the issue.

Provision of transport facilities and equipment such as computers would also help in solving the problems encountered, especially in the public health facilities.

Individual constraints

A number of individual constraints that are related to the capacity of staff to collect, analyze and interpret the data were also reported by some decision makers. Most of the constraints were experienced in the public sector at the district level.

The main challenges experienced among staff in using data were the non-use of the data in decision making. This was attributed to the lack of knowledge of the benefits to using data and of the sources of data and how to use it. Some staff simply lacked the commitment in using the data while some were said to find the use of data cumbersome (they did not want to be involved in filling forms, writing reports, and so on).

Inadequacy of equipment and the inability to use some equipment, such as computers, was also a challenge. In one district, the public health officer cited an example where the public health technicians worked without calculators even though calculators are essential in their work. In another district, the statistical officer had to purchase a computer, printer and internet access using his own money. Lack of computers made storage, analysis, and retrieval of data problematic.

Poor staff training was cited as a challenge that resulted in staff with inadequate data collection, analysis and reporting skills and technology training.

Low motivation and morale among the staff was mentioned as a key problem in data collection and use. This was due to poor pay, poor working conditions, and lack of feedback on the collected information. Time constraints were reported by many decision makers as hindering data use among their staff.

The use of technical terms also hindered use of data among staff. For example, terminology such as the MMR and CPR were not easy to comprehend among some staff.

Organizational constraints

Most organizations supported information in decision making through various means, including enhancing data collection by providing the funds and necessary tools such as forms, and providing transport to the data collection points. Data analysis, compilation, and dissemination of information are also done; various reports and publications are made available and well-equipped libraries exist in some organizations. Some organizations update their staff regularly on various skills related to data collection, analysis and compilation.

Examples of ways in which prioritization is undertaken include strict adherence to record keeping, making decisions based on the available data, setting objectives using the available data, implementing set plans using the existing data, organizing surveys and making information available to various stakeholders. While some organizations support the prioritization and use of information in decision making, other organizations do not see data as a priority and seem to practice management by crisis. In these cases the organizations operate without necessarily referring to available data but instead depend on the information on the ground.

Efforts are made by most organizations, especially those in the private sector, to train staff in skills for using information for decision making. For some organizations, it is either an individual's effort to acquire any skills required or the training is done at a higher level (e.g., the headquarters). The efforts made in training staff are varied.

Workshops and seminars are organized to train staff on any new information. Some organizations help in identifying the groups of their staff that require training depending on the need for skills and recommending them for training. Some do support the headquarters's effort of providing training by providing the logistics (finances, transport and materials such as stationery).

While in some organizations the process through which research or survey data is reviewed before approval for dissemination favored the use of data in decision making, in others it posed a constraint. In the latter case all the stakeholders have to be assembled. They then scrutinize the data and deliberate on it. From this deliberation an agreement is reached whether or not to disseminate the information. Most decision makers described this process as being bureaucratic and causing problems in the implementation of urgent recommendations by causing unnecessary delays both in waiting for all the stakeholders to assemble and waiting for a consensus to be reached. It is also an expensive process to assemble all the stakeholders. In some cases data had to be authorized by the headquarters before dissemination and this process was found to slow down the decision-making process.

Various constraints are experienced in sharing survey or research data. Lack of funds to disseminate the findings was one of the challenges. Arranging an appropriate forum to disseminate information is a constraint, especially if the information is meant for a large population. Cultural challenges also exist in sharing information; for instance, disseminating information that required some behavior or attitude change is sometimes difficult if there is resistance to change. Another challenge is the misinterpretation of information especially if it is shared with the media.

Inadequate resources for disseminating information are also another challenge. In one district, the statistical officer said that they have only two copies of the 2003 Kenya Demographic and Health Survey Report. All the staff that require the information use those same two copies – be it the health department, the population department, researchers, or any other government department. The lack of resources leads to ineffectiveness in information sharing.

Differences in priorities, background, training, concepts and terminologies used, and information systems and poor record keeping in some agencies make sharing of survey and research data difficult. Some agencies also find the process of sharing information time consuming. An example is taking time to share some information on a certain disease to tea pickers in tea plantations. The company might find the process time consuming and see it in terms of lost productivity for the company. Convincing agencies to share information, and convincing people to attend a dissemination workshop and to adopt the recommendations is problematic and was reported by some decision makers to hinder data use.

Disclosing confidential information about the patient may lead to conflicts between the health providers and the patients. Lack of acknowledgement of the source of information was also cited as a challenge in information sharing.

In some agencies, restrictive policies prevent some people from accessing some information, which makes the sharing of data across some agencies difficult. Reluctance of some organizations to disclose that they have information also makes data sharing difficult.

The most common problem about sharing information mentioned by the respondents was the misinterpretation of information and using the information against the person who provided the information, especially if it is confidential information. The issue of some organizations questioning the credibility of the research findings and hence not taking the information seriously also posed a barrier to sharing information. Time constraints, remoteness and inaccessibility affect the use of information, especially in the rural areas.

The political, social and economic environments were found to affect the use of information in making decisions. Political interference was reported in some areas in resource allocation, staffing and area of focus where politicians wanted issues to be done in their way regardless of the existing data and the immediate needs. This would obviously hinder decision making. A particular example of political interference was reported in the case of the Constituency AIDS Control Committees (CACC) whose work plans may differ with certain organization's programs. The work plans of such Committees are in most cases made without reference to existing data. This may therefore lead to altering the organization's work plan to be consistent with the CACC work plan so as to avoid confusing people.

The social environment affected decision making mainly through cultural values and practices. For instance, disseminating information about HIV/AIDS and sexuality is difficult in some areas because the cultural practices and values do not allow open discussion on issues dealing with sexuality, e.g. the term sexual intercourse is a taboo in some societies. Another example is on reporting of deaths, especially neonatal deaths. For some communities it is a bad omen to talk about the dead because it reminds them of the sad event and it is equated to inviting death to come again. Such cases therefore end up being misreported. In other cases there is resistance to change, for example, water sanitation programs that encourage the boiling of water for drinking are often met with resistance.

Economic constraints are manifested through lack of funding for implementing various decisions, for instance, the purchase of various materials for data collection or drugs, the construction of boreholes to improve sanitation, and others. In a disease-stricken community with high levels of poverty, it would be difficult to implement some decisions concerning the people's health because the individuals might have competing priorities. Lack of funding has also led to over-reliance on donors, which sometimes leads to decision makers being forced to work towards the donors' priorities. Plans, and even information, might therefore end up being altered in order to suit the donor's priorities and to ensure continued funding. Economic constraints are also felt in the field of HIV/AIDS and reproductive health where there are so many NGOs, and hence where there is stiff competition for funding.

Discussion

It is apparent from the information collected in this survey that the majority of the decision makers interviewed used some data to make decisions about their program activities. Most organizations relied on their own monitoring data and information to make decisions or carried out surveys when they needed information that they did not already have. This means there could be a lot of duplication in the information and data collected, as there is no central way of knowing which data is available.

Concerns about the quality of data are prevalent in almost all the organizations interviewed. The main reasons for this were poor data collection methods and use of staff that have no technical skills to collect data. Multiple sources of information often led to conflict in the information available and in this case most organizations relied on the most recent data, or in some cases they went to the field to verify why the discrepancies existed.

The majority of the key informants observed that needs for information and data were numerous and varied and that no single organization would be able to produce all they need without external assistance. But while the private organizations were able to produce most of the data and information they needed without external assistance the public institutions needed external support due to lack of staff and lack of qualified staff in the area of data and information, and general lack of appreciation of the need of information and data for decision making.

The differences between the public and private sectors in terms of access and use of data were also evident. Most private organizations had unlimited internet access, resource centers or libraries where staff members could access all the information they need, data from their headquarters, and networking to gain access to data, while the public relied on what the ministries provided.

Technical constraints mentioned include lack of understanding of the importance of data, low morale, high workload and inadequate technical skills. In some of the private organizations generation and use of data was part of their job descriptions and as such they did not have many problems in his area.

Some organizations supported the training of staff in using information for decision making. Some sponsored staff for specialized training, while others carry out in-house training after doing a training needs assessment. One organization has a data analysis department that does all the technical work and provides data to the staff in an easy to use/easy to understand format thereby eliminating the need for training.

It was mentioned by nearly all the respondents that the mechanisms put in place for approving research or survey data for dissemination, though they vary from organization to organization, enhanced the quality of information being disseminated. The general process among the private institutions was internal peer review, and then review by stakeholders, with comments incorporated before dissemination. There was an interesting case where findings are shared with the community where the data was collected so as to agree on the conclusions before dissemination. This proved important, as the community was party to the recommendations as well as their implementation. However for the public institutions the process was more laborious as only the ministries were allowed to release or disseminate data/information. Data or information from the public institutions had to work its way through the hierarchy before it could be disseminated.

The challenges experienced in sharing information ranged from misinterpretation of the information particularly by the print media, thereby giving a different picture all together, to the data/information being questioned which puts the credibility of the institution under scrutiny, to time to write or translate the data/information into something consumable by the general public, and to costs involved in disseminating information and not being to reach all the targeted consumers of the data/information. The challenges were greater in the sharing of survey and research data publicly as opposed to sharing within organizations or agencies.

Generally, the political, social and economic environment did not greatly affect the use of information in making decisions. However this did appear to have greater affect in some cases especially donor-funded projects whereby they required specific data collected. One organization mentioned that in one case they had to say no to a funding partner because what they wanted implemented was not in line with the data the organization was using to make decisions.

One main constraint was the lack of a central place that has all the information on data available and where one can get directions on where to find which information. Some of the decision makers complained they had to make decisions based only on the information they knew available while there could be some relevant information somewhere but they are not aware about it. Another constraint that was mainly identified by the public institutions is the lack of qualified personnel to collect data or the use of casual labor and people who do not appreciate data in collecting it and thereby compromising the quality.

Summary

This study was carried out to collect information on the use of data in decision making in the field of population and health. A total of 20 respondents were interviewed as key informants comprising public- and private-sector policy and/or program decision makers.

The results indicate that that the key informants made a wide range of decisions in which they used data/information that had been obtained from a variety of sources. These decisions included policies, operational protocols and guidelines, project designs, scaling up of projects, project activities, and resource allocation.

Several constraints and barriers – individual, technical, and organizational – to data utilization were identified, including inadequate resources (especially computers), poorly trained staff, poor transport and communication, cultural challenges, and political interference. The constraints appeared to be more severe in the public sector than in the private sector.

Recommendations

Recommendations derived from these key informant interviews are as follows:

a) Efforts should be made to develop national health and population databases that are routinely updated and easily accessible to all users. The Ministry of Health should be responsible for the national database(s) on health information. The National Coordination Agency for Population and Development could be responsible for the population databases, in collaboration with the Central Bureau of Statistics. These information systems should have links to both local and international databases and information systems.

b) There is a need to document the available health and population databases in the country and to disseminate this information as widely as possible so that users can know where to look for the information they need. The documentation should include research findings.

c) There is a need to strengthen the District Information and Documentation Centers in the country so that they can have updated district-specific and national health and population data and information.

d) The problems of inadequate staff, heavy workloads, and low moral among staff in the public sector should be addressed urgently. These problems came out clearly as data use constraints.

e) In the majority of the organizations included in this assessment, particularly those in the public sector, data collection and use seemed to receive a relatively low rating in their priorities and in budgetary allocation. Similarly, some of the top managers were not very concerned about data and information and their role in decision making. There is a need to change this culture. All top decision makers in major population and health organizations in Kenya should have training on the use of information in decision making so that they can begin to appreciate the importance of data and information in decision making.

f) In order to minimize the difficulties in sharing of information between and across organizations, there is a need to clearly define the concepts and terminologies used in the various sources of data /information. For example, the terms such as MMR, CPR, CMR, IMR and TFR should be described clearly defined and comprehensively explained as to how each indicator is computed. This is particularly useful for users of data in other fields where the terms are not common.

g) There is a need to educate users of data in the field of population and health on various issues.

- i. This should start from education about the importance of data in decision making, the various data sources, data collection techniques, data analysis, data compilation, and reporting of findings. There is also a need to train staff on the use of various data collection equipment and in the use of computers to process, store and retreive data.

- ii. Emphasis should also be put on the accuracy of data since data inaccuracy is a common problem. Honesty in data should also be emphasized so as to reduce errors and hence improve accuracy.

- iii. Education and training should also explore how to obtain certain estimates from given data. Some decision makers reported an inability to correctly use existing data to obtain various parameters because of a lack of knowledge on how to calculate the parameters.

- iv. Education should include behavior change, especially regarding the cultural practices that hinder the use of information. For instance, people should be educated on water sanitation practices, openness in discussing sexuality, and change of attitude towards reporting the number of children or the death of children.

h) In order to facilitate access to good information, communication facilities and internet connectivity should also be improved, particularly in the remote areas of the country where the inaccessibility impedes the use of data in decision making.

i) Equipping various organizations with equipment and materials should also be given priority as a way of facilitating the use of data. These should include data collection tools such as stationery, projectors, computers, printers, and fax machines.

Decision Maker Perceptions in Nigeria

An Assessment of Data Use Constraints

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Abbreviations

ART	Anti-Retroviral Treatment
COMPASS	Community Participation for Action in the Social Sector
HOD	Head of Department
DPH	Department of Public Health
FCT	Federal Capital Territory
FMH	Federal Ministry of Health
IMCI	Integrated Management of Childhood Illnesses
LGA	Local Government Area
M&E	Monitoring and Evaluation
NACA	National Action Committee on AIDS
NASCP	National AIDS and Sexually Transmitted Diseases Control Programme
NEPAD	New Partnership for African Development
NHMIS	National Health Management and Information Systems
NPI	National Program on Immunization
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission (of HIV/AIDS)
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization
NGO	Non-Governmental Organization

Executive Summary

This study is an assessment of the perceptions of decision makers on the use of data and the obstacles to data use. Respondents were drawn from the health sector and included 20 federal, state and local officials who were involved in decision making or program management in three main areas: (i) population, health and nutrition, (ii) child survival, and (iii) HIV/AIDS at the national, state or local level.

The study found that many decision makers were unclear as to how policies were formulated at the national level. It was also found that the organizational structures that were in place in these agencies were a constraint on efficient data management processes as it made the lower levels in the administrative hierarchy (local and state agencies) almost entirely dependent on the officers at the national level for analysis and interpretation of the information that they collect. Most of the lower level staff were poorly trained and unable to interpret data. The training, where provided, was often ad hoc and could not be sustained. Moreover, those that were trained do not always have the environment to put into use whatever training they might have been given due to a lack of necessary facilities in their offices. The lack of technical capacity to generate and use data is thought to be an important constraint on the availability of current national data in the country and an obvious impediment to efficient policy making. The study also highlighted poor funding and socio-cultural/political interference as factors hindering data generation, policy formulation and program implementation in Nigeria.

The study team recommends a re-orientation of both the decision makers and the staff of these agencies. The study team also recommends training decision makers at both state and national levels on the skills necessary to use information for decision making, and on the significance of good data management to efficient policy making and program management. Finally, the government is urged to accelerate the development of the country’s National Health Management Information System (NHMIS) into a credible and readily accessible databank as a way of avoiding duplication of data generation by various agencies, thereby reducing cost and time spent on acquiring data for policy formulation.

Background and Objectives

Purpose of the Study

This study is concerned about the tendency by policy and decision makers to underrate the use of data in the course of making decisions that affect health policies and programs. Decision makers make various policy and program related decisions on a regular basis. Such decisions that have far reaching effects on health policies and programs are in many cases not based on sound data. Data collection and analysis is of vital importance in the decision-making process, especially in the health sector. This study is thus undertaken to understand the demand for data and the constraints to data use among decision makers in Nigeria.

Methodology

To accomplish the objectives of the study, 20 national and district level public and private sector policy makers and program managers were interviewed. All the respondents were senior officials working in one of three main areas: (i) population, health and nutrition, (ii) child survival, and (iii) HIV/AIDS at the national, state or local level. At the national level, five respondents were interviewed while six respondents were interviewed at the state level. At the local level, a total of nine respondents were also interviewed, three of whom were decision makers and program managers of local NGOs.

Information was collected from the respondents using an unstructured interview guide. The respondents were selected from various units and parastatals of the national and state level ministries of health. Other respondents were selected from one of the parastatals under the Health and Human Services Department of the FCT[1], as well as from the Health Department of a Local Government Area.

The main problem encountered during the fieldwork was the unwillingness of many federal and state level officials to grant an interview. For some of those who consented to be interviewed, approval had to be obtained from their superior officers and this resulted in some delays as such approvals sometimes took days to process through the bureaucratic civil service system. Many were not available for interview even after appointments were booked in advance. Thus, it took a longer time than expected to carry out the interviews.

Presentation of Findings

Decision Making by Respondents

The types of decisions made by the respondents vary widely. The Federal Civil Servants claim to implement decisions made by various committees set up at the national level, e.g. health policy, reproductive health policy, immunization policy, policy on HIV/AIDS, and the roll back malaria policy are products of committees set up by the national government. Officials at the state and local government levels in turn reported that they mostly implemented the decisions that were handed down from the national level.

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[1] The political and administrative structure of the Federal Capital Territory (FCT) is a replica of that at the state government level in the country.

Nevertheless, the few decisions reported to have been made include some policy formulation and program implementation decisions.

The reported decisions include decisions on implementation of immunization programs and addressing reproductive health matters within the NEPAD framework. Other reported decisions include the development of a child and infant feeding policy, decisions to retrain facility-based health workers in a state, and the development of a new national strategy to combat HIV/AIDS in the country.

Some of these decisions were based on data collected by their field officers at the local level while some others based their decisions on data obtained from surveys conducted by different organizations like WHO, MEASURE Evaluation, University Consultants, etc. A number of officials also reported that they reviewed some of the programs executed by their respective agencies, examined the strengths and weakness of such programs and the outcomes of these evaluations were used to re-focus or redesign such programs to make them more effective.

On the timeliness of information, it was found that for most of the reported decisions made by respondents, information was not readily available. Some vital information that would have enabled the decision makers to budget for their programs, make projections on what can be accomplished by the programs and the level of resources needed to accomplish their objectives were lacking. Sometimes the policy makers reported that they have to base decisions on assumptions in the absence of reliable information:

> … (if) the data is not readily available, there is tendency to resort to "empiricism"…… the frustration of not having access to information needed to meet certain deadlines can lead one to make recommendations based on assumptions (rather than on data).
>
> *– A national level policy maker on HIV/AIDS*

> … we have to reach a compromise. Sometimes the data might be obsolete, but you need to back up your decision with data and as such, you have to use what you have (the obsolete data).
>
> *– A national level program officer on Nutrition*

In another instance, available data for just one geographic region was used to generalize for all the other areas:

> … (information) was available for only (one local government area) out of 30 LGAs in the state. We were forced to use the only available information to extrapolate for all the other LGAs.
>
> *– A state level program officer on Nutrition*

Only a few of the respondents reported that health information systems have been meeting their needs for data; some others believed it is just being developed, that it is yet to become functional. Several respondents were of the opinion that the NHMIS is not yet functional in the country. It was found that some decision makers were either not aware of the existence of a health information system within each federal and state ministry of health or believe that it is not readily accessible as the extracts below show:

> A health information system is presently not in place. The NHMIS has just started the process of data collection from all the LGAs. Health workers are currently undergoing training on the use of the NHMIS forms in gathering data, this training is yet to be completed in all the LGAs.
>
> *– A state level decision maker on Population, Health and Child Survival*

> Unfortunately, there is no functional health information system in the country. I think for the past years that I have been here, I should know. I should put it this way. There is no integrated health information system in the country, but there are vertical health information systems. By integrated health information system, I mean a system where you log on at your unit and easily access health information from other units, but in terms of vertical health information system, that is available to some extent. For example, if you need information on immunization, you go to NPI – you will find it there. If you need information on HIV/AIDS, you have to go to NACA. But the fragmented health data is not the ideal thing, there should be a databank containing all necessary health information nationwide.
>
> *– A national level program officer on HIV/AIDS*

The veracity of some of these claims however remains to be authenticated. This is in view of the fact that other respondents reported that they have been obtaining data from the NHMIS in their respective department/ministry:

> There is a health information system in the FCT and I have been there a number of times to collect certain information. We supply data to them as well. To some extent, it has been meeting my needs.
>
> *– A state level program coordinator on Child Health*

> Well, we have NHMIS set up by the Federal Ministry of Health – that is our source of data. It is presently undergoing some modernization to make it user friendly.
>
> *– A senior national level policy maker on Population and Health*

In the instances where data had been used to make decisions, the decision makers were asked to explain how they have used data to make such decisions. It was reported that in making the decision to scale up the programs for Anti-Retroviral Treatment (ART) of people living with HIV/AIDS and the Prevention of Mother-to-Child Transmission (PMTCT) of HIV/AIDS, information was obtained on the HIV sero-prevalence rate across the country, through sentinel surveys that were conducted nationwide. Information was also obtained on the attendance rate at ART centers and on the number of people requiring treatment but are still on the waiting list; as well as on the estimate of HIV positive persons that need ART nationwide. This information guided their decision making on the issue.

Similarly, in developing the new national strategy for combating HIV/AIDS in the country, the policy makers involved in formulating this strategy used data on the number of HIV-positive persons treated in the last four years in the country and on the number of HIV-positive persons that currently require treatment. This was compared with the target set by the agency four years earlier to determine how well they have fared. This evaluation prompted the need to develop a new national strategy for combating the disease. Another example of the use of data was in the development of an HIV/AIDS and gender-equity policy within a university. The center involved in developing the policy used data obtained from the university's health facilities, the Health Center (which attends primarily to the health needs of staff and students of the university), and the Teaching Hospital (which is in a major health referral facility in the country). Data obtained from these sources included the number of cases of STIs and HIV/AIDS among staff and students treated at these facilities. The center also considered information on enrollment by sex and employment practices by various faculties as it relates to female applicants for academic positions.

To make a decision on the retraining of health workers in the area of nutrition, a decision maker examined data on growth monitoring and promotion supplied by the LGAs, and found that there were mis-applications of the formats used in sending data to the state headquarters. This informed the decision to re-train the facility-based health workers in all the LGAs in the state since these officials are responsible for generating the primary data used at both the state and national levels.

When asked to identify the primary stakeholders in the use of information, a reasonable proportion of the respondents identified the government at the various levels (national, state and local) as primary stakeholders. In addition, respondents also identified donors such as WHO, UNICEF, USAID, and UNFPA as primary stakeholders. Others mentioned by some respondents as primary stakeholders include researchers from academia and the public.

Technical Constraints

The study also examined the technical constraints to the use of data by decision makers and the findings are presented in this section of the report.

Most of the decision makers interviewed reported that their respective agencies do not have adequate technical capacity to produce reliable information without significant external assistance:

> To the best of my knowledge, we have no technical capacity, especially in the analysis of data. Unless the information is straightforward, that is, requiring no expert knowledge to understand its implications, we might be unable to do further processing.
>
> *– A senior state-level health officer*

Nevertheless, it was found that a number of international agencies, notably COMPASS and MEASURE Evaluation, had been offering technical help to some of the agencies in the area of data collection and processing, and in training their staff.

In terms of the quality of data, almost all the officials interviewed have reservations about this. They expressed concern that the data supplied from the various LGAs were not properly collected. Some of the local level officials were accused of carelessness in the discharge of their duties as this extract clearly suggests:

> There was an occasion when a report was sent from an LGA and I saw an incidence of smallpox. A serious matter like that requires urgent attention because the disease was thought to have been eradicated. I summoned the HOD in charge of health in the LGA (who is a medical doctor) to go and confirm the reported case. By the time he returned to brief me, he found that the doctor had actually diagnosed chickenpox, but the local officer responsible for sending data to the state headquarters recorded smallpox. … I have to warn that if anyone does not understand the handwriting of any health officer who made a diagnosis, clarification should be sought from the officer rather than assuming and recording just anything.
>
> *– A state level Director in charge of Health and Child Survival*

Some decision makers even expressed fear that some of these data (forwarded from the LGAs) might have been fabricated:

> … most staff don’t know the benefit of using data, they think it is a waste of time going to the field to ask questions when questionnaires can be completed in the comfort of their offices. These are serious challenges!
>
> I have had an instance when the information supplied was at variance with the reality on ground. Many times, you are very sure that the data supplied had been cooked, probably out of the wrongful notion that “fantastic” data will impress the supervisors.

Suggestions made on how to address these lapses include the need to train the various categories of officials involved in data management. These include the program officers, disease surveillance and notification officers, M&E officers, as well as others involved in the data management process.

Individual Constraints

The study showed that there were serious limitations to the use of data because of individual staff inadequacies.

A common complaint in virtually all the agencies was about the capabilities of the junior staff responsible for data collection at the health facilities (local level). Many of these staff were poorly educated and therefore have problems coping with the responsibilities that come with their duties. Some of them have only a primary school level of education and have to use quite sophisticated formats to report data to their superiors; the result of this has been the misapplication of formats, the return of incomplete or wrongly coded forms, etc.

Another problem noted on individual constraints was the staff's lack of understanding of the importance of data. Some of the junior staff believe that data reporting is merely a routine function; they do not appreciate just how important the data they supply are in the process of policy formulation and program decision making. The comments made by some of the officials interviewed suggest that these junior staff thought that the information they forward are merely kept in the archives, not analyzed and used in decision making, hence, they are quite careless with what they report:

> A problem we are still grappling with is educating the workers on the reason why they are collecting the data. They should not be collecting the data without first knowing the reason or how vital the job is. I think I once discussed this with COMPASS that our M&E officers have to be trained on data management. … people need to know why we are collecting data and why we must have correct data.
>
> *– A state level Director in charge of Health and Child Survival*

Another problem is that staff are not communicating data regularly to the headquarters. This was a comment received from a senior national-level program officer in the area of nutrition:

> … since we relocated to Abuja[2], we've not been receiving returns from any state or LGA. The last time we received information was when we were still in Lagos and were able to monitor some LGAs one-on-one.

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[2] The national government relocated the federal capital from Lagos to Abuja (Federal Capital Territory [FCT]) on December 12, 1991.

The main suggestion made on how to overcome these shortcomings was that all the staff (both senior and junior level officers) should be trained (or re-trained) on data management.

Organizational Constraints

The study also examined the challenges faced by decision makers in their use of data, which are due to how their organizations function. The study examined the type of support which the organizations have put in place to ensure that decision makers have the necessary information and the skills to use such information for decision making.

Almost all the officials reported that their organizations have been supporting the use of information in decision making. The types of support reported include provision of infrastructure to make data readily accessible like the setting up of the NHMIS, purchase of computers[3], provision of funds for M&E activities, and provision of logistics for the collection of primary data like motorbikes for field officers. The only respondent that reported little or very limited organizational support was of the view that funding for data collection and processing was very inadequate. According to this state-level Deputy Director in the area of Population and Health matters:

> There has not been much support as limited funding is committed to data collection and processing. The state relies primarily on the routine procedures through which the LGAs collect and forward data to the state while the state in turn collates all information from all LGAs and forwards it to the FMH for analysis and interpretation.

The support provided by some organizations includes training their officials on the use of computers. These training programs are generally inadequate as some of the trainings were mere computer appreciation courses and did not include training on analysis and interpretation of data. The respondents were of the view that their respective organizations supported the prioritization and use of information in decision making. However, when prompted for further elaboration, many could not give specific practices or policies within an organization that justify the claim.

In terms of organizational structure, this was found to be inadequate. The structure in place was such that the LGAs only collect data and forward it to the state headquarters, the state in turn appears to be a collation center for data submitted by the various LGAs, after which the data is forwarded to the national level for analysis and interpretation. The results then follow the same route back to the states and LGAs for implementation, where necessary. The administrative structure made the lower levels too dependent on the national levels. This largely explains why many of the officials at the state and local levels lack the skills for data analysis. It also partly explains why no major policy

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[3] The interviewer was not convinced about some of these claims of organizational support. At a state office, the offices that he visited included those of deputy directors and senior program officers in charge of key units such as M&E, HIV/AIDS, Nutrition and Environmental Health and none of these officials had a computer in the office.

decision was reported at the state and local levels, as they are largely dependent on the national level for policies and programs.

The study also examined the social, economic and political environments in which the organizations operate and how these influence their use of information. Though some of the respondents mentioned that donor organizations do set priorities and dictate how the funds they provide should be administered, none considered this as a negative influence and none reported that donors impact negatively on their use of information. However, socio-cultural, political and often religious challenges were reported to have influenced the use of information. There were reported instances where decision makers were unable to act immediately on the basis of information at their disposal about the outbreak of certain diseases due to religious-motivated, political interference. Two such instances were mentioned. One was the politicization of the immunization program in the northern part of the country. The immunization exercise was halted because of political interference, despite available information on the spread of the disease in the country. A separate instance of political interference was cited by another respondent:

> Some years back, I remember on the issue (outbreak) of cerebrospinal meningitis, it was just before the airlift of pilgrims to Saudi Arabia for that year's Hajj. The (political) leadership did not want the world to know then that the disease had broken out in the country so that Muslims will not be prevented from making the Hajj trip. That was about the only incidence that I can recall where political interference prevented the disclosure of information at a point when it should have been made public so that all stakeholders can take immediate action to combat the outbreak.

Another instance cited was the socio-cultural inhibitions that made it difficult to immediately adopt the promotion of condoms as a tool for controlling the spread of HIV/AIDS. According to one of the policy makers interviewed, despite all available evidence that condoms can help to check the rate of the spread of HIV/AIDS, policy makers found it difficult to recommend its adoption as a strategy to check the spread of the epidemic due to cultural and religious opposition.

Discussion

There is clear evidence that in Nigeria data collection and use are not given due priority in the formulation and implementation of health related policies and programs. The reaction of officers to the request to grant interviews and their responses demonstrate weak concern for data collection and use in the country. It took an unusually long time to get those officials in relevant positions to respond to the current exercise.

Many decision makers have no clear-cut process on how policies are formulated. Some of the respondents feel that decisions are made based on policies instituted by various sub-committees set up by the government.

One major problem that is highlighted by the findings is the inadequacy of the organizational structure that is in place in these agencies which makes the lower levels in the administrative hierarchy (local and state agencies) almost entirely dependent on the officers at the national level for analysis and interpretation of the information that they collect. Responses from officials at each of the three levels of government clearly suggest that the local government level is responsible for merely collecting data, the state government level is responsible for collating data from the various local governments, and it is the responsibility of the federal level officers to analyse and interpret the information, after which the results are sent back to the local levels, if considered necessary. The decisions these officials make are in some cases passed down to them as directives and they in turn enforce the implementation within their various units and departments. Therefore, the issue of timeliness in policy formulation and implementation has not been an area of concern for decision makers. Decisions are made anytime and implementation could even come much later. Examples abound with various population and health policies in the country. Policies are made and accepted but decisions to implement may await a "convenient time."

It is also a widely held view that most of the time, decisions are made not based on empirical evidence but on mere rationalization. The health information system in place is poorly managed and accessed. The various government units fail to make available necessary data on a timely basis. Therefore, there is no one source that could be found in which needed data could be obtained. There are scattered sources of data in various units, but they are largely uncontrolled for use to make any decision that could be of national interest. The situation is worse at the state and local government levels.

A process of generating data begins at the LGA level. The data are sent to the state for onward transmission to the national coordinating unit. As simple as this process is, it achieves very little. Many LGAs fail to send any data; those received at the national level are poorly collated. It appears the coordinating officials at the national and state levels are not monitoring the activities of the LGAs responsible for data collection. As a result of the lack of adequate supervision, the junior officials no longer supply data and are not held accountable. The comment by a national official that no data on nutrition has been supplied by any state or LGA since relocating to the new federal capital (in 1991) was quite revealing. This raises the question of how much of the decision making at the national level is influenced by data supplied from the grassroots.

National current data are lacking in the country because most units lack the technical capacity to generate and use data. The staff are poorly trained and unable to interpret data. The training in some cases is ad hoc and could not be sustained. Those that are trained do not always have the environment necessary to put into use whatever training they might have been given due to a lack of essential facilities in their offices. In many of the agencies, the technical manpower was either not there or inadequate. The M&E officers in these agencies are largely responsible for information gathering and processing. Some of these officers are not computer literate, some M&E officers who were interviewed said they have no computers to work with and others admitted that they cannot use any data processing software. This suggests that many of these agencies are seriously hampered. The M&E officer is the official saddled with the technical responsibility of making quality data accessible to each unit, and with such limited knowledge and few facilities to work with, it is inevitable that information will not be readily available in many of those organizations for decision making. On the other hand, at the local level, many of those charged with data collection and collation do not have adequate knowledge in the areas of population, health, nutrition, child health, and HIV/AIDS. The implications, in many cases, are that records are not properly kept due to a lack of technical knowledge on the subject matter. In some units, unqualified staff are placed in charge of data collection and collation. Even when trained, they lack the basic educational background to report data correctly. Since available data are of low quality, there is usually nothing to disseminate. Therefore, many are not aware of the existence of any data that could be used in making decisions.

That data are not available in the way expected could be attributed to poor funding. In most of the units, the monitoring and evaluation units are poorly funded and therefore, those units cannot boast of any data that could be used. The staff also are handicapped because they lack the necessary hardware and software to manage data collected. They have little appreciation for data entry, data cleaning and analysis. Only a few are trained in statistics.

One other major constraint has been the socio-cultural and political factors that are hindering data generation to assess policy formulation and program implementation. For example, immunization was vehemently resisted in some northern states. Therefore, to attempt data collection on immunization in these states might be a problem. Also, condom use has received poor reception and has not been nationally adopted as a measure to check the spread of the HIV/AIDS epidemic in the country.

Conclusions and Recommendations

This study, which is an assessment of the perceptions of decision makers on the use of data, has shown that serious reorientation of both the decision makers and the entire staff of these agencies needs to be undertaken.

The data collection machinery in these organizations needs to be correctly repositioned. Every staff member involved in the data collection exercise must be adequately trained on the skills necessary to collect data and on the importance of their work, i.e. the junior workers must understand the reasons why they should take adequate precautions to ensure that such information is accurate. The staff are not likely to approach their data collection duties with the seriousness deserved unless they appreciate the role played by the data that they send to the state and national levels in shaping the future of policies and programs in the country. Policy makers and program planners are not likely to rely on data for decision making if they do not trust the sources or quality of the information. This ultimately will have a negative impact on policies and programs in the country.

Another area that should be immediately addressed is the training of decision makers at both the state and national levels, especially on the skills necessary to use information for decision making. Officials involved in the data management process should be equipped with the relevant skills, and the necessary facilities should be provided in all offices.

Finally, the government should accelerate the development of the NHMIS into a creditable databank. This databank should be readily accessible, through proper networking facilities, to all government agencies as well as other stakeholders in the health sector. This will significantly improve the decision-making process and eliminate the need for every government department or agency to hire consultants to collect primary data every time a major policy decision needs to be formulated. The cost of acquiring information for decision making could be significantly reduced if information generated by one agency is readily accessible to the other agencies.