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MINISTRY OF HEALTH - ETHIOPIA

Information Use Standard Operating Procedure (SOP)

Strategic Affairs Executive Office

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Contents

Section 1: Introduction

1.1. Background

Encouraging results were registered over the past few years in terms of improving data quality, data use for evidence-based decision-making, and digitalization of priority health information systems. The mid-term evaluation of HSTP II indicates that the reporting completeness of service data has improved, the ratio of data gap between routine HMIS and survey has been narrowed down for selected indicators and more than 90% of health facilities and WoHOs are conducting performance monitoring team (PMT) monthly. Among the efforts made to bring about improvements in data quality and information use are investments in various HIS related infrastructures mainly of digitization, capacity building of various forms and strengthening the HIS governance structures. Even though, some improvements have been observed with regards to information use for evidence-based decision making at all levels of the system, the culture of data use practice is far from the expectations and the desired vision.

The HMIS related trainings were guided by Information Use Training Manual. As the manual is reference document which provide detailed information on wider areas of information use concepts, a document that is aimed at providing a step-by-step process of key practices is found to be essential to bridge the gaps in the practices and overall outcomes of the health information system. Therefore, this SOP is prepared to serve this purpose and guide health care workers in health facilities managers and supervisors at health administrative levels.

1.2. About the Standard Operating Procedure

This is information use standard operating procure meant to give a step-by-step processes of key information use platforms and practice in the health sector. The content of this document is primarily driven from the Information Use facilitator's manuals that were prepared and release in 2018 by the Ministry of health. The document is intended to guide both health administrative units and health facilities including Health Posts. It contains description, frequency, procedure, examples and supporting tools/templates about the commonest information use practices and platforms, (i.e. department/desk/ case team level data review forums and organizational performance monitoring team meetings, quality improvement projects). The SOP is open for revision when the need arise following change in the national level relevant guideline.

1.3. Objectives of the SOP

The overall objective of this SOP is to support the improvement of information use practices and outcomes that are able to improve quality of health services.

The specific objectives:

- To provide a step- by- step guidance on key information use practices at a health facility and health administration unit levels
- To improve practices of information use related national standard tools/templates
- To reiterate and emphasis steps and points that are often overlooked, under performed and wrongly skipped based on current practice of data quality and information use

1.4. Intended users of the SOP

The intended users of this SOP are:

- All health care providers and public health experts at all health facilities (Public and private) and health administrative units
- Health Extension workers
- Heads of institutions and departments/units, coordinators/focal persons of case teams/desk units, PMT members who are actively engaged in executing and overseeing data use practices
- Trainers, Mentors, supervisors, advisors that provide technical support to health facilities and health administrative units
- Anybody who is interested in understanding and engaging in key data use practices

1.5. Scope of the SOP

This SOP is about information use practices that are more expected to be employed more regularly and frequently in the health sector. It is not the intention of this SOP to provide theoretical and conceptual knowledge which are readily accessible in the national information use manuals (Facilitator and participant's). For any such details, the user is expected to consult the reference stated in this document and others as applicable. The SOP is rather almost entirely aimed at providing a step-by-step processes of key information use practices. It tries to illustrate the detailed steps, frequency, timing, responsible person, tool and formats of the practices under consideration. The SOP has included practices expected at health facilities including health posts and health administrative units. Although most of the practices contained here use manual or paper-based tools in the process, it also tries to elaborate practices that uses digital platforms such as creation and use of DHIS 2 dashboards.

Section 2: Process of common Data Use platforms and practices

There are various types of platforms, forums and practices in the health sector which use quantitative or qualitative health information for evidence-based decision making either systematically or in a less organized and structured manner. The most important and common ones are described below.

2.1. Performance Monitoring Team (PMT) meetings

PMT is expected to take three levels with a given institution as applicable: Institutional level (All levels), Departmental/Directorate/unit (All levels except health posts) and case team/desk/ level (MOH, RHBs and hospitals as applicable). The purpose, frequency and process/procedure are the same for all levels of PMT while there is slight difference in the "where, when /timing and who" part.

2.1.1 Institutional level PMT

1. Purpose

PMT is a team of multidisciplinary health workforce that is primarily responsible to improve data quality, use information regularly, monitor progress and improve performance at all levels. It is considered as the major data use platform of the health sector and must be established and maintained functional at all levels of the health system.

2. Where:

At all levels, both at health facility and health administration units

3. When/timing

Generally, it is expected to happen before sending the monthly reports to next levels except for MOH. It should be done after reviewing the data quality.

4. Frequency:

Monthly

5. Who: Depends on the type of institution

MOH: Strategic Affairs, all program wing executive offices, nutrition, HIV Prevention and Control LEOs, operation wing executive offices as needed

Health administrative units: Management committee members

Hospitals: Head of the Hospitals, unit coordinators and HITs.

Health centers: Head of the Hospitals, unit coordinators and HITs.

Health posts: Health extension workers along with existing governance structures (Kebele cabinet, health committee members)

6. Process/Procedure

6.1 Problem Identification –IDENTIFY PERFORMANCE GAP

- Use template under annex 1 to list the prioritized indicators, track performance and identify performance gaps

6.2 Prioritization of Problems – PRIORITIZE

- Prioritize indicators with performance gap; use prioritization matrix written under annex 2; the most priority problem is the one that scored higher. Score is the sum of rating given by each team independently

6.3 Investigate underlying and root Causes – INVESTIGATE

- Conduct Root cause analysis using one or combination of tools such as Fishbone diagram, tree diagram, pareto diagram and/or others

6.4 Develop action plan/solution-INTERVENTION

- Prioritize intervention using the criteria stated in annexes 3 and prepare action plan using annex 4 and select the most appropriate interventions
- The high scoring intervention is selected for implementation

6.5 Implementation and follow up – IMPLEMENT and follow up

- Follow up of action plan is made using the template found in annex 5

7. Tool/Template: See annex 1-5

2.1.2 Department/unit and case team level description

Description	Department/directorate level	Case team level
Where	All levels, both at health administrative units and health facilities except health posts	Mostly expected at MOH, RHB and hospitals where case teams are supposed to exist. It can be done anywhere as applicable.
When/timing	It should be done at least a day before the institutional level PMT meeting. It should be preceded by data quality review	It should be done at least a day before the departmental/unit level PMT meeting. At health facilities, it should be preceded by data quality check
Frequency	Monthly	Monthly
Who	Head of the unit and all subunit coordinators/focal persons	All members of the case teams/ sub-units
Process/ Procedure	Same as institutional level above	Same as institutional level above
Tools/template	Same as institutional level (Annex 1-5) with minor possible customization tailored to unit/sub-unit	

2.2. Performance Monitoring Chart

1. Purpose: Performance monitoring charts are tables, which are used to display the performance status of key data elements or indicators of an institution or a given unit of an institution. It ensures easy access and tracking of a performance by the unit members, by supervisors of different levels and other stakeholders who happen to visit the units for supportive supervisions or other purposes.

2. Where: At all levels (at health facility and health administrative units): institutional, dep't and case team levels

3. When/timing: Updating of the data elements/indicators displayed in the chart should happen monthly within a week of submission of reportable data elements to next levels. MOH departments and desks/teams in the 3rd week of the next reporting period

4. Frequency: The chart should be updatable monthly, following the monthly reports. Some charts my be updated annually (Example: Catchment population profile, staffing...)

5. Who: Regular updating of institution level charts should be led by the HMIS /M&E unit focal person and/or the head of the institution with active engagement of PMT members.

Updating of department and team level charts should be led by the respective heads/ coordinators with active engagement of PMT members

6. Process/Procedure

6.1 Define the data elements/indicators to be displayed and get ready the blank chart with a list of selected indicators at least a month ahead of the first month report of a given fiscal year

6.2 Review the data elements or indicators by the institutional, respective departmental/ unit and case team/sub-unit level PMTs before updating into the chart to be displayed

6.3 Update the data elements/indicators displayed in the chart within a week of submission of reportable data elements to next levels

Use a marker with following color options or conventions when filling out the chart (performance against target). This gives at a glance understanding of the performance without much strain.

- » Black: The list of data elements/indicators and the table headings
- » Green: >= 85% performance
- » Yellow: 60-84%
- » Red: < 60%

6.4 Discuss issues emanating from the review during the next immediate PMT meetings of the institutional, departmental/unit and case team levels

7. Tool/Template: See annex 6

8. Minimum set of display charts: See annex

2.3 Dashboards

1. Purpose: Dashboard is a data display tool (mostly in an electronic format) that helps in displaying information in interactive intuitive and visual way. The Ethiopian customized DHIS2 visualizer module enables to generate dynamic data analysis and visualization through charts, tables and maps. DHIS2's Dashboard is a place to post key analysis results.

2. Where: At all levels, at health facility and health administration units

3. When/timing

In most instances, dashboards are automatically updatable. In situations such as in DHIS2. When fixed period is used, dashboards should be updated and prepared ahead of the respective PMT meetings

4. Frequency: Monthly

5. Who:

Dashboard creation and updating should happen in collaborative manner.

The PMT chair should led the development of the dashboard while PMT secretary works the technical activities.

Dashboards of other platforms such as eCHIS, MFR, eHRIS can be led by other health care providers with support from HMIS personnel

6. Process/Procedure

6.1 Define the dashboard development requirement

- Use requirement gathering template under Annex 8
- Head of institution/unit/case team should lead this step

6.2 Run analysis

- Run analysis in the DHIS2 platform and save it as favorite. It is advisable to select the relative period to make it automatically updatable

6.3 Create dashboard

- Click the green + button in the left corner of the control bar. Add a title in the title field, and description in the description field and save it
- Add items you have saved from your analysis to the dashboard
- Customize the layout by moving and resizing the items
- Save the change made
- You can edit the created dashboard later if needed

6.4 Share dashboard

- Share dashboard with users or users group as appropriate

6.5 Monitoring dashboard use and update it

- Monitor groups interaction and interpretation given
- Make sure that dashboard are updated on monthly bases

7. Tool/Template: See annex 8

2.4 Quality Improvement Projects

1. Purpose: Quality improvement is a systems approach that applies the scientific method to the analysis of performance and systematic efforts to improve it. For data quality and use purposes, Quality Improvement Projects (QIP) or initiatives should be considered if problems persist despite efforts to address the problem using the common five step cycle of data use and when deeper analysis of the problem, very tailored interventions and more structured monitoring mechanisms are required.

2. Where: All levels, both health administrative units and health facilities

3. When/timing: When persistent problems are identified following the monthly PMT meetings.

4. Who: By PMT members along with quality team members or focal persons as available

5. Process /Procedure

5.1 Identify persistent data quality and use problems which warrants QIP

5.2 Follow the common outline of QIP

5.2.1 Introduction: (Definition , the problem and efforts being carried out, the duration or span of QIP, the process of QIP...etc)

5.2.2 Define Problem statement: (Where, time frame and magnitude and implication: Should not include Root cause analysis (RCA) and action to be taken (Change ideas)

5.2.3 Aim statement

5.2.4 Do root Cause Analysis

5.2.5 Prepare driver diagram: Links root cause with interventions (Change ideas)

5.2.6 List of change ideas (interventions)

5.2.7 Prioritize solutions using a matrix (refer data use manual)

5.2.8 Prioritize the list of change ideas

5.2.9 Implementation plan (POA): Focuses on change ideas/activities/ interventions with timeline .....etc (Gantt chart)

- Measure improvement using run charts such as trend chart, shift chart, runs, astronomical etc..

5.3 Discuss progress and challenges during PMT meeting

Annexes

Annex 1: Performance monitoring and problem identification template

S.N (1)	Selected indicator (2)	Current Month Performance (3)	Previous month performance (4)	Cumulative to date Performance (5)	Target (6)	Performance against target in percent =5/6) (7)	Previous year the same reporting period performance (8)	Investigation need (Yes, No) (9)	Remark (10)
1									

Annex 2: Priority setting table

Type of problem	Magnitude of the problem	Seriousness/Severity of the problem	Feasibility & cost effectiveness	Community concern	Total	Rank

**Score: 1-Low, 2-midium, 3-high*

Annex 3: Prioritization matrix for intervention selection

Potential Solutions	**Magnitude** Large scale = 4 Medium scale = 3 Low Scale = 2 Very Low Scale = 1	***Feasibility** Highly feasible = 4 Good feasibility = 3 Low feasibility = 2 Not at all feasible = 1	**Cost** Low Cost = 4 Medium Cost = 3 High Cost = 2 Very High = 1	**Time** required to implement the solution Minimal = 4 Few = 3 Several = 2 Significant = 1	****Capacity** Excellent Capacity Exists = 4 Good Capacity Exists = 3 Fair Capacity Exists = 2 Little Capacity Exists = 1	**Total**	**Rank**

* Feasibility (social acceptance, technology, availability of intervention and political acceptance)

** Capacity (human resource, knowledge and skill)

NB: The high scoring intervention is selected for implementation

Annex 4: Action plan matrix

Performance gap to be addressed	Underlying cause	Solutions /action points	Cost (If it incurs)	Time	Responsible Person

Annex 5: Implementation and follow-up Template

Intervention/Solution	Indicator	Target/Expected result	Responsible Person	Progress status*	Reason for partially completed, Delayed and not done

*Progress status: This should be documented and reported during the next PMT meeting. The status includes: Completed, partially completed, delayed, not done, Other (Write

Annex 6: Performance monitoring chart

Name of health institution: _____Department/Unit/team:_____Fiscal year (EC):_____

S.no	Indicator	Annual target	Month 1	Month 2	Month 3	Quarter I			Month 4	Month 5	Month 6	Quarter II			Month 7	Month 8	Month 9	Quarter III			Month 10	Month 11	Month 12	Quarter IV			Annual		
						Q I Perfor-mance	Q1 target	% Perfor-mance				Q II Perfor-mance	QII target	% Perfor-mance				Q III Perfor-mance	QIII target	% Perfor-mance				Q IV Perfor-mance	QIV target	% Perfor-mance	Perfro-mance	Tar-get	% perfor-mance
1																													
2																													

Annex 7: Minimum set of display charts

S. No	Name of Chart	Format	Frequency of update
1	Map of catchment area	Map	Annual
2	Catchment population profile	Table	Annual
3	Staffing	Table	Annual
4	Ten top causes of morbidity (Age, sex)	Table	Bi-annual
5	Ten top causes of mortality (Age, sex)	Table	Bi-annual
6	Reproductive and Maternal Health (CAR, ANC 4+, ANC 8+, SBA, Early PNC)	Graph	Monthly
7	Nutrition chart (Vitamin A supplementation, Deworming, GMP)	Graph	Monthly
8	Immunization chart (BCG, Penta 1, Penta 3, MCV 1, MCV 2, full immunization, Rota 1-3)	Line graph	Monthly
9	Disease Prevention and Control (HIV/AIDS, Tuberculosis, Malaria)	Graph	Monthly
10	Service Utilization (OPD attendance per capita, admission rate, ALOS, BOD)	Graph	Monthly

Annex 8: Dashboard requirement gathering template with an example

SN	Indicator	Formula	Disaggregation	Data Sources	Reporting level	Preferred Chart a. table b. Score card c. league table d. Charts (Specify) e. Map f.. Other (Specify)	Remark
1	Proportion of deliveries assisted with SBA*	Total number of SBA assisted deliveries	None	DHIS2	HC/Hospital/ clinics	Bar chart	
		Total number of expected deliveries					
2							

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