

Strengthening Information Support for Management of District Health Systems

Report of an Interregional Meeting

Surabaya, Indonesia

30 October – 3 November 1989



World Health Organization

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1. BACKGROUND AND INTRODUCTION TO THE MEETING

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A decade after Alma Ata the principles of Primary Health Care remain valid. Indeed, they have recently been strongly reaffirmed at events such as the WHO meeting of experts in Riga in March 1988, and the subsequent 42nd World Health Assembly.

In spite of the severe economic recession of the past 10 years, many countries have achieved progress in health development. Infant, under-five, and maternal mortality rates have decreased, while increases have been obtained in the numbers of fully immunized children and improvement made in access to health care services.

Nevertheless, progress towards achieving the goal of Health for All has not been sufficient. The health sector must find ways to work more effectively and efficiently, particularly when resources are limited. The primary health care approach is acknowledged as the best means to achieve Health for All. What is needed is to make the approach work more effectively.

Against this background the WHO Interregional Meeting on Strengthening Information Support for Management of District Health Systems was held in Surabaya, Indonesia, from 30 October to 3 November 1989.

Primary health care cannot work well without a strong system for support at the local level. It is for this reason that WHO is promoting the concept of "District Health Systems". The idea is not new but it is highly relevant to the situation in many countries today. This is typified by poorly developed skills in planning, organizing and managing Primary Health Care, and by the lack of motivation and ability to provide leadership for health development.

A key element in making primary health care work well is the availability of up-to-date, relevant information to guide the variety of actions which are needed, whether within communities or in the network of health centres and hospitals in the district. Obtaining such information is not as straightforward as it may seem. It tends to become an end in itself, to the extent that health workers may spend too much of their precious time filling in forms and registers. Furthermore, it is an ironic fact that the rapid advances in information technology which have taken place during the last ten years, have largely bypassed the health system.

What information is really needed? How can it be obtained, analyzed and used so that better health care results? How can the attitude of health workers towards information be changed? These are the vital and extremely practical questions which the participants addressed at the Surabaya meeting.

The meeting was the first of a series supported by the WHO programme on Strengthening District Health Systems. Their purpose is to promote the exchange of experiences and practical information about how the primary health care approach can work more effectively.

Participants were drawn from seven countries of WHO's South-East Asia and Western Pacific Regions, namely Fiji, Indonesia, Republic of Korea, Nepal, Papua New Guinea, Philippines and Thailand. They were supported by staff from SEARO, WPRO, WHO Headquarters, and an observer from UNDP Headquarters.

OBJECTIVES

1. To review experiences in strengthening information support for management of district health systems.
2. Based on country experiences, to identify:
 - a. the information needed;
 - b. appropriate methods and technologies for obtaining, analysing and applying the formation
 - c. the steps required to implement effective information support in districts.
3. Based on the above, to make recommendations, for use by other countries, on the strengthening of information support for the management of district health systems.

OPENING CEREMONY

The meeting was opened by the Honourable Dr Adhyatma, Minister of Health of the Republic of Indonesia, at a ceremony in the State Building 'GRAHADI' of the province of East Java.

On behalf of the Organizing Committee, Dr Sutarto, Kanwil, presented a report on the work of the Committee and outlined the programme of the meeting.

Dr Sumedha Khanna, WHO Representative to Indonesia, welcomed the participants on behalf of the Director-General of the World Health Organization.

Pointing to the need to make Primary Health Care work more effectively, she emphasized the importance of a strong system of support at local level. It is in this context that WHO is promoting the concept of District Health Systems.

Up-to-date, relevant information is a key element in making PHC work well. It is needed in order to guide the wide range of activities which contribute to health development. Furthermore, without information there cannot be sound and efficient management of resources.

She called on participants to share their experiences openly - their successes and their failures, their concerns and their aspirations. Only in this way can useful lessons be learned and exchanged with others.

The Governor of East Java, Mr Soelarso, welcomed the participants to Surabaya. He noted that the issue of strengthening district health systems is an important component of health development, and one of the nine developmental priorities of the province of East Java.

Quite simply, a society with a low level of health will have difficulty in improving its overall socioeconomic well-being and prosperity.

In his official opening address, the Minister of Health, Dr Adhyatma, noted that a number of countries have progressed well beyond mere endorsement of the Declaration of Alma Ata. However, implementation of health services within the context of primary health care is not easy, and countries face a variety of social, economic and cultural settings for which they must formulate appropriate strategies. Undoubtedly a common problem is the weak managerial and leadership capabilities of health programme managers, particularly at the district level. The current emphasis on strengthening district health systems is well placed to tackle this problem. However, success will also depend on adequate decentralization of both responsibility and resources to districts.

Turning to the specific issue of information support, Dr Adhyatma cited Indonesia's past experiences when the health information system was organized vertically to support the needs of the special programmes. The intermediate levels were left out of the process of data analysis and, therefore, were slow to respond to decisions taken at central level. The present policy of decentralization is designed to address this problem but, to be really effective, will need the development of a health information system in districts to support managerial decision-making. He further indicated that training of personnel in using the locally available information must be an integral part of the development of such a system.

2. COUNTRY PRESENTATIONS

2.1. Introduction

The countries represented at the meeting provided a broad spectrum of geophysical features, population size, political systems and stages of socioeconomic development. Consequently the variety of approaches to information support in health districts is considerable.

2.2. Thailand

Thailand has routine administrative health information systems similar to those of other countries, but has given priority to a nationwide Rural Development Information System (NRD), since 1985. Since 1987 this system has been integrated with the Community Development Information System, (based on the Basic Minimum Needs (BMN) approach).

A common feature of these is the integration of data collection from different sectors, facilitating a broad-based approach to development (including PHC). This contrasts with the experience of many countries where even the sharing of data collection systems and information is difficult to achieve within the health sector.

The success of Thailand in this approach is partly due to the fact that while there is emphasis on community involvement, the BMN/NRD systems are strongly promoted and controlled from the central level (by the National Economic and Social Board). In addition, communities and officials must demonstrate, from their BMN/NRD information systems, that they are complying with specific national criteria to become eligible for programme funds covering a wide range of activities.

Considerable progress has been made in utilizing micro-computers within Changwats (Districts) to facilitate a variety of rural development activities. The Health Management Information Systems which have been on trial during the past few years include:

- epidemiological surveillance of communicable diseases
- pharmaceutical control
- finances.

2.3. Fiji

Fiji has achieved considerable success in social and economic development. It has a conventional manual routine reporting system for its health activities, but this has proved cumbersome with excessive data collection and reporting. As a result, little use has been made of it at any level for management or planning.

At the point of service delivery in Fiji the public health nurse is responsible for a specified area with a known population size, and has intimate knowledge of individual needs. However, this knowledge cannot be taken into account by managers and planners in setting priorities and allocating funds as they have no means of accessing it. If this were possible it would become feasible to target services for particularly vulnerable population groups and/or families.

The lack of relevant information has made it difficult to argue effectively for re-allocation of resources from curative care to preventive action against prevalent diseases such as diabetes.

The Health Information System is now being revised and computerized. This is being undertaken as part of a wider process of decentralization of the health services to three geographical divisions. It will be implemented in a progressive fashion. One particular constraint is lack of computing skills and familiarity with computers among health workers.

An area of particular success in Fiji has been the system of recording births and deaths by health workers. This system achieves nearly 100 percent coverage. With regard to maternal mortality, the universal reporting of these deaths to and by health workers enables effective investigative procedures for maternal deaths to be implemented.

2.4. Korea

Rapidly improving living standards have lead to increased demand for both health care services and health care information. In the early 1980's the Ministry of Health and Social Welfare decided to develop a medical care information system in order to meet the expanding demand of medical insurance programmes, to support PHC, and to increase the public health sector's role in health care.

Subsequently the Ministry of Health and Social Affairs has been preoccupied with establishing a universal social health insurance system. This has an extensive information support base but there has not been an equivalent investment in health information systems (HIS) development in the public health sector. Some pilot projects have been undertaken to initiate such development.

The computer culture of Korea is quite advanced, and the three computerized HIS projects reported upon were developed for use with little or no paper recording. DBase III software was used and the design used a topdown approach for development, but one which was very congruent with government organization, structure and management.

Partly due to the topdown approach, users and developers had a number of problems:

Users

- Poor communication between developers and users
- Lack of understanding of computer operation
- Inconsistency in paper forms and formats
- Lack of determination to improve work environment

Developers

- Limitation in manpower resources

- Insufficient time for system development
- No previous work experience in health sector.

The system mainly produces administrative reports, and does not yield information to monitor performance with regard to target achievement.

Targets are centrally set in Korea and passed down to the local level. Because they are developed on national averages they are not very useful and can be counterproductive at local level.

As the system was developed from dBase III, which is used in many health programmes, it may be possible for its development to be shared with other countries.

2.5. Papua New Guinea

Over the past few years, the Department of Health has recognized a number of weaknesses in its PHC implementation. These include:

- lack of involvement of communities in local health care initiatives and interventions;
- inequitable distribution of resources among population groups and within geographical areas;
- lack of supervision by programme managers based at provincial health offices.

When the government committed itself to a policy of decentralization, the Department of Health recognized the importance of strengthening the management capacity of provincial health offices. A strategy for this was devised for implementation by a small technical group at the central level - the MSP (Management Support to Provinces) group. A core component of MSP was developing the Provincial Health Management Information System (PHIS).

A health information policy to guide the development of the PHIS was determined in advance and included in the National Health Development Plan.

The provinces already had a manual data recording and reporting system. The major innovation of the PHIS was to computerize the data processing at the provincial level, with only minor alterations of data collection forms. The main output of the PHIS in the initial stages of development were summarized data on a number of health service indicators for provincial level health managers. The MSP group provided training for this level in the use of the reports of the PHIS. The most important report helps managers monitor progress towards reaching a range of service delivery targets which are population-based. Over the past 3 years the PHIS has been computerized in 11 of the 19 provinces, using specially developed dBase III-plus software.

The development of the system within provinces, and its extension to other provinces, continues. However, the following problems remain to be resolved:

- outputs of systems are not sufficiently used by management for monitoring, or for providing improved supervision and feedback to health providers;

- PHIS does not include provincial hospital data;
- technical difficulties in integrating PHIS with the software used at national level.

2.6. Philippines

The strong support of the office of the Secretary for Health enabled an overall redesign to be carried out, and a much modified and strengthened system to be developed.

From the outset priority was given to reducing the burden of the most peripheral health worker in data handling. Nevertheless the information requirements of national and intermediate programme managers were also given due attention. Through a process of consultation and negotiation a consensus was reached with regard to data items and the channels for reporting.

There was recognition of the potential and inherent limitation of a routine reporting system, and accommodation was made for surveys and sentinel site reporting.

Emphasis was placed upon initial training of health workers in the use of the data collection forms. Future training will develop skills in information use. This emphasis was achieved by including a human resource development specialist on the project team.

The system has some capacity to help identify families at risk, by identifying children who are repeatedly seen at the clinic. But the health system has difficulty in responding to high-risk groups in a special way due to inadequate decentralization of authority (The "district level" of health administration is not well developed in the Philippines.)

Implementation of the system is in its early stages, but an initial evaluation indicates that health workers appreciate the new system's advantages. However, some provincial and national health managers have misgivings as to whether the system will yield the information they want.

2.7. Nepal

Organizationally, Nepal is moving towards an integrated district health system, but the function of the system is hampered by the interplay of difficult terrain, inadequate infrastructure development and an insufficient number of trained personnel.

At present data-processing for the reporting and collecting system is carried out at the national level, but a new information policy aims to strengthen the districts to coordinate the HIS. This will involve computerization over the next five years, during which it will be important to maintain the correct balance between investment in the HIS and investment in the general development of the health system. Of particular concern is the necessity of training a sufficient number of health workers in computerization.

At present the high maternal mortality rate is a major concern. The HIS needs to become a tool to initiate action for investigating these deaths, and for guiding appropriate action to overcome the problem. Currently, mothers' groups are being established as a means of providing information on problems at the village level.

2.8. Indonesia

The overall HIS comprises numerous components which require more adequate means of integration. For example, there is a National Centre for Health Data, but, at the same time, each Directorate of the Ministry of Health has its own Health Information Division.

Formerly, data passed from the periphery of the system to the centre with little analysis at district level. At present, data sent to the district health office from the periphery is distributed to respective programme managers at district level for them to process, analyse and utilize. In the future, at district and provincial levels, there will be information management units to deal with essential information from various institutions, including the hospital.

There have been many innovations to encourage local use of information, particularly in health centres (Puskesmas), and more recently at the Integrated Village Health Post (Posyandu). The system designed for use at the Puskesmas level enables intersectoral matters to be addressed, local target-setting (in some areas), and monitoring. In future, the heads of local villages will be provided with the data collected at Posyandus. Puskesmas will collect the data from the Village Resilience League.

Other innovations, such as local area monitoring (LAM) and area-specific planning (ASP), are being studied in relation to EPI/MCH. These aim to equip local managers with skills in using existing data sources to identify needs, and design actions to address them. Each district also has a sentinel Puskesmas, which functions as a model for other Puskesmas.

A broader range of useful indicators needs to be identified, as well as the subsets of district data which are required at provincial and national levels.

2.9 Conclusions

- Countries are exploring innovative ways of meeting the information needs of contemporary health workers and managers. The approaches adopted in Papua New Guinea and the Philippines to develop their HIS provide two examples. The method of recording births, deaths and investigating maternal deaths in Fiji is another; Indonesia is exploring a variety of methods of information collection and use.
- Up to now, most efforts have been directed at developing techniques and improving reporting systems. What has been relatively neglected is examination of the processes by which these approaches can be incorporated within districts health systems.
- More attention is needed to encourage processes whereby information can be used locally to change patterns of care; for example, to direct resources and activities to vulnerable families or population groups.

- National information managers remain more concerned with the information requirements at the national level, rather than promoting effective information support in districts.
- Clear policy guidelines and central support seem important prerequisites to enable districts to be innovative in developing information support for themselves.
- Micro-computer technology has been introduced in the information systems in every country present. Already many countries have experiences of the potential and drawbacks of computerization. These experiences need to be widely shared.

3. WORKING GROUP REPORTS

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3.1. Group A considered the question : "Within a district health system what information is really needed to implement PHC effectively?"

At the outset it is important to remember that a district is not an independent unit. It is part of the national health system. Clearly, therefore, district health managers must be aware of national and intermediate level health policy, general programme objectives and so on, in order that the district system can be developed and managed within the overall national context.

There are certain categories of vitally important information which managers need for control of the service for which they are accountable. However, in many situations these categories of information remain underdeveloped and/or under-used. They are:

- Population size and characteristics of districts
- Resource information:
 - facilities
 - health manpower
 - financial
- Routine reporting of levels of service activity
- Vital statistics

They are essential, and need to be specific to district health systems based on PHC.

Focus on the district brings more clearly to light issues such as equity, intersectoral action, community involvement, decentralization and health programme integration. Although it may not always be possible, and often not necessary, to quantify these issues, it is possible to obtain information about them all. Obtaining this information need not (and should not) add to the data-handling burden of health workers. Most of the information required to monitor progress on these issues can be derived from already existing, or routinely collected, information. Much of it is acquired by health workers, supervisors and managers in the course of their work, if they are doing it properly.

A district health system's success in reducing inequities requires, for example, health information on population and vulnerable groups, service availability and accessibility (including costs such as those of transport and time), coverage, with particular attention to those least likely to use services.

Information on progress in delegating authority, in line with stated national policy on decentralization, will be reflected in procedures for budget disbursement and local government organization and autonomy.

From their direct contacts with community members and leaders, individual health workers are aware of the extent to which these communities are involved in health activities, and the resources the community provides. This knowledge is available to supervisors and, through them, to district managers. District managers can readily inform themselves of the orientation of their staff to support community involvement in health.

The quality of care given to individuals and the standards of health prevention and promotion programmes, can be improved and monitored by consistent and supportive supervision. Managers can assess this by reviewing with supervisors the frequency, content, findings and actions of supervisory visits to health facilities and communities. This can be supplemented by small and informal studies to discover why achievement is particularly good or disappointing in particular circumstances.

The degree to which health programmes are integrated within a district is reflected in such matters as the availability of training modules and courses serving the needs of several programmes. Health centre work schedules demonstrate the extent to which a policy on integration is put into practice. Data collection and reporting formats illustrate whether health workers are obliged to duplicate data collection or complete separate summary forms for different health programmes.

Intersectoral action can be monitored by reviewing the nature and frequency of meetings to plan joint action. Are these meetings merely to talk, or are there integrated development activities within communities for which they have responsibility? The extent and depth of discussion on health matters by the overall district authority can be gauged directly by the district health officer in attendance at such meetings.

Being aware of the details outlined above is of little value in itself. It is necessary for the health managers to include such information when giving formal reports to other levels of the health system, and to other sectors. It is even more important that such knowledge is used within the health district, to initiate and support actions which will reduce inequities, and improve integration of health programmes, etc.

3.2. Group B considered the question: "What methods and technologies are available to meet the information needs of health districts?"

Routine data collection and reporting.

Routine data systems are, and will remain, an important part of the overall information resource of a health district. Once the personnel have become familiar with the procedure, it is easy for them to comply. However, the inherent characteristic of routine systems carries a number of dangers - health workers become bored by the routine; the system is resistant to change, and so on. This being so, it is the responsibility of those who manage such systems to encourage local use of data, to provide interesting and useful feedback of information and to regularly review the system to remove redundant data. Experience in the Philippines has demonstrated that health workers have considerable insight into the usefulness of routinely collected data, and of defects in data collection and reporting procedures. Their opinion is valuable for improving routine data systems.

The usefulness of recording and reporting all diseases from primary health units is very doubtful. Both coverage and diagnostic accuracy are very variable, and attributing ICD codes and incidence to such diagnoses is misleading. A more useful approach may be to monitor one or two 'tracer' diseases, for example measles and anaemia, as indicators of programme effectiveness.

In using routinely collected facility-based data, health managers need to be constantly alert to the fact that it only provides information about those who use the service. However, where target population size is known (from census or other means) good quality records and reporting can be used to calculate coverage.

Indonesia provides examples of a number of tools to maximize the use of routinely collected data for improved health district management - namely local area monitoring (LAM) and area specific planning (ASP). Making information on these approaches widely available will be useful.

Where microcomputers are available in health districts, they greatly enhance the feasibility of linking different data bases such as health activity reporting and drug inventories, thereby opening up new possibilities in the use of routine data systems.

Intermittent Data Collection Systems

A number of countries only collect data on an annual or biannual basis. In some countries an annual census is carried out by health workers to enable more accurate targets to be set. This has proved practical and useful in a number of places, and will be used in the Philippines.

Thailand has based its Basic Minimum Needs approach in annual data collection by communities. Likewise, the National Rural Development Programme uses biannual village data. In Indonesia the method of health centre stratification, health centre resource surveillance and microplanning by health centre staff, is based on an annual data collection procedure.

These approaches have proved useful for district management, but they increase the overall data collected with overlap and duplication of the routine system. Thus, without due care they may become a burden and be carried out in a mechanical fashion, thereby missing the opportunity to introduce change, for example in the deployment of resources and in work patterns.

Informal Investigations

Routine systems can alert health personnel to things going wrong - but they may not indicate "why?". To answer this question within a district will require health managers to investigate problems at the local level by examining original records, interviewing health workers and perhaps undertaking small-scale community studies. Such problem-oriented action research is an important strategy for overcoming the weaknesses of management systems and for improving the performance of managers. In this way the district health team will develop a wider range of information skills which can be used to complement routinely collected data.

Sample Surveys

There is now fairly widespread experience of applying standardized sample survey techniques, particularly the cluster sampling method developed by the EPI programme. This technique can be applied to a range of subjects for achieving an overall assessment of PHC. These approaches are important as a means of drawing more objective conclusions than is possible from other data collection methods. They can also provide information about subjects such as disease prevalence. Thus, in districts with the skills and resources to implement such surveys, they have an important role to play in obtaining information. Other districts will require assistance from outside when such investigations are required.

Large scale sample surveys will not be a concern within the health district. However, the results of such surveys may be very useful to districts, in addition to their importance in influencing national health policy.

Microcomputers

Microcomputers offer many advantages, but they are not without problems. They should not be introduced to a district health information system without careful consideration of a variety of factors. These include the familiarity of health staff with computers, the availability of computing skills, the reliability of electricity. However, where their introduction has been carefully planned they have considerable potential for improving information support in health districts.

3.3. Group C considered the question : "What steps can be taken to implement information support efficiently within health districts?"

The development of a coherent, formal information system, nationally and within a district, requires a clear policy on health management information by the Ministry of Health. Some countries lack policy statements by the Ministry of Health, while in others broad policy objectives have not been sufficiently operationalized by senior officials. The absence of the policy framework contributes to a lack of direction in developing information support within districts.

However, stated policy alone is unlikely to be adequate in giving impetus to local efforts for improving the information resource and its use. A strong commitment at provincial and national levels will be essential, especially when the development of the information system cuts across vested interests such as those of individual programme managers or non-governmental and private health care providers.

Health managers can contribute to the formulation of policy by adopting a strategy of advocacy, and by using seminars and consultative meetings to promote policy development, as well as individual and organizational commitment to policy implementation.

Once progress has begun at this level, the standard approach of project planning (situational analysis and problem identification, establishment of objectives and strategy, etc.) is likely to be an effective approach for overcoming inertia and achieving change. Experiences in the Philippines and PNG, for example, illustrate the value of this approach.

- In a programme to develop information systems, emphasis should be placed on:
- consultation, and willingness to negotiate at community, district, provincial and national levels;
 - developing training material and providing adequate training and ongoing support to health workers and end-users of information;
 - recognizing that the information resource within a district, in common with other resources, requires to be managed, monitored and evaluated.

It is important to note that even in the absence of national policy guidelines, much can be achieved within a district to improve information support. Formal information systems are an essential, but perhaps not the most important, part of the information resource as a whole. While the national or provincial level may impose certain reporting procedures on districts, this is unlikely to prevent a district management team from using the data already at their disposal for improving their own effectiveness and that of their staff. Such initiatives can be encouraged by provincial and national health managers provided they recognize that an important part of their responsibility is to help health districts do their work better.

4. RECOMMENDATIONS FOR ACTION

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Based on their own experiences and the discussions which took place in Surabaya, the participants recommended the following actions to be taken by countries working to strengthen information support for management of District Health Systems. It should be noted that these are not comprehensive since it is clear that further country experience is needed as well as further opportunities to analyse and exchange experiences.

4.1. IDENTIFY INFORMATION NEEDS

- Apply the District Health Systems concept in your specific country context, with emphasis on identifying information needed for monitoring the reduction of inequities.
- Identify the implications of national health development policies for action in districts and, thereby, the implications for information support. This is in recognition of the place of the district within the entire national health system, and the role of the national and intermediate levels in providing guidance and resources.
- Consult health personnel, personnel from other sectors and communities in districts as a means for refining information needs and appropriate indicators, as well as preparing them for participation in improving information support.

4.2. IDENTIFY APPROPRIATE METHODS AND TECHNOLOGIES

- Supplement routine data collection and reporting with other appropriate methods such as small-scale studies, local area monitoring and action research. In this way flexibility can be maintained and overload of the routine system avoided.
- Consolidate recording into the minimum number of forms and records which are printed in the language of preference of the staff.
- Avoid duplication of data collection and data which is irrelevant to districts. This may entail setting of strategies to cope with present demands by national programme managers and funding agencies.

4.3. IDENTIFY STEPS FOR IMPLEMENTATION

- Assess the need for a national policy on strengthening information support to district health systems. In some situations the existence of such a policy may greatly enhance national support by clarifying the objectives, defining the roles of national, provincial and district levels and helping to alleviate the fears of those who may feel threatened by change. It can also serve to establish standards for acquisition of equipment and data standards for computerized health information.
- Identify the financial requirements at all levels for strengthening information support and preparing a realistic budget.

- Prepare personnel to accept and utilize information. Workshops and in-service training courses will be needed in the short-term, whilst changes in basic training will be necessary to ensure long-term acceptability and utilization. The appointment of someone in each district to be responsible for implementation will be an important strategy.
- Establish mechanisms for sharing information between different programmes and sectors. In this way the use of information will be maximized and awareness of its utility will be gradually increased.

5. FIVE CRITICAL CONSIDERATIONS

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In order to facilitate the development of information support to district health systems management, there are five critical considerations which need to be taken into account. They are important not only for countries, but also for the external agencies who provide them with financial and technical support. These are:

5.1. Applying the concept of District Health Systems based on PHC.

In many countries the health information system is overly concerned with the activities and performance of separate health programmes. In addition, the activities of non-governmental and private sectors are often omitted.

Information is needed to analyze and monitor the use of all the human and financial resources in a district for meeting the health needs which exist. Of critical importance is information to determine how well the district is applying the following basic principles of PHC:

- reducing inequities
- increasing accessibility to care
- emphasizing prevention and promotion
- working with other sectors
- involving communities, and supporting community action
- acquiring and accepting greater responsibilities through decentralization
- integrating separate health programmes.

5.2. Adopting a new information perspective.

Information is relevant to the extent that it is used for decision-making in relation to actions which influence health. In far too many countries information is used by very few health personnel in comparison with the numbers involved in its collection.

If information support is to achieve its potential in improving managerial decision-making in districts, then a new, positive attitude needs to be encouraged. This requirement has far-reaching consequences for activities such as the basic training of health personnel. Many medical students and nurses emerge from training strongly aware of their responsibility to individual patients, but unaware of their wider responsibilities for the health of a defined population around their health centre, hospital or in their district. This, in turn, leads to an attitude by which information about populations is undervalued and under-utilized.

The process through which information support to districts is strengthened needs to include in-service training, and workshops which enable personnel to better appreciate and accept the importance of information in improving their own performance and in giving them job satisfaction.

5.3. Accountability and management.

Districts are accountable for what they do and the resources they use. This means that they are required to report routinely to national authorities on a wide range of disease-related activities. Improving the management of district health systems, on the other hand, requires an additional set of data. Moreover, the principal client is the district itself. Whilst accountability must be maintained, countries will need to review the data requirements in terms of quantity and frequency, and study how information obtained primarily for district management, might be used by national authorities.

5.4. Information support as a component of management.

All too often health information systems become separate vertical programmes, with the purpose of supplying national authorities with material for routine reports and for identifying outbreaks of communicable diseases. The district health systems approach implies that information recording, analysis and utilization must be an integral part of the management process. Two important obstacles must be overcome if this is to become a reality. First of all ways must be found to encourage adjustments of the present system in order to better meet the needs of districts. Secondly, district managers need to be encouraged to recognize the value of information in improving their decision-making. Many will need training in methods for obtaining, analyzing and using information as part of their day-to-day responsibilities.

5.5. Integration of programmes in accordance with local needs.

National programme managers and many funding agencies often require detailed information from districts about separate disease programmes. There are examples where such information is required from all levels, starting in the community itself. The workload on personnel may be unduly heavy, diverting them from providing health care services.

Moreover, the diseases about which such information is demanded may not be of great importance in a given district, so that over-concentration on one may lead to neglect of another. Malaria is a good example of the latter in many countries today.

Improvements in methods and technologies for strengthening information support to district health systems offer an important opportunity to encourage greater integration of separate programmes, including hospital information, so that the resulting mix of activities and allocation of resources better reflect the health needs of each individual district.

ANNEXES

1. Programme

2. List of participants

3. Members of Organizing Committee

ANNEX 1: PROGRAMME

Monday, 30 October 1989

- 10:00 - 11:30 Departure for official Opening Ceremony
- Report by Chairman Local Organizing Committee
 - Remarks by WHO Representative to Indonesia
 - Welcome by Governor of East Java
 - Keynote Address and formal opening of the meeting
by His Excellency, Minister of Health, Republic of
Indonesia
- 11:30 - 12:15 Introduction to the meeting by WHO Secretariat
12:15 - 12:30 Election of Chairman and Rapporteur
- 12:30 - 13:30 LUNCH BREAK
- 13:30 - 14:30 Country Presentation Thailand
14:30 - 15:30 Country Presentation Fiji
- 15:30 - 15:45 COFFEE BREAK
- 15:45 - 16:45 Country Presentation Korea

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- 08:00 - 09:00 Country Presentation Papua New Guinea
09:00 - 10:00 Country Presentation the Philippines
- 10:00 - 10:15 COFFEE BREAK
- 10:15 - 11:15 Country Presentation Nepal
11:15 - 12:15 Country Presentation Indonesia
- 12:15 - 13:15 LUNCH BREAK
- 13:15 - 13:30 Introduction to Group Discussion
13:30 - 15:30 Group Discussion
- 15:30 - 15:45 COFFEE BREAK
- 15:45 - 16:30 Group Discussion continued
20:00 - 22:00 Computer software demonstration

ANNEX 2: LIST OF PARTICIPANTS

COUNTRY PARTICIPANTS

FIJI

Dr Salik Ram Govind, Chief Medical Officer, Central Eastern Division, Ministry of Health, Fiji

Mr S.N. Reddy, Administrative Officer, Ministry of Health, Fiji

INDONESIA

Mrs Horry Fanggidae, Division of Information, Chief Directorate Community of Health, Ministry of Health, Jakarta

Dr Suriadi Hadiprodjo, National Consultant for WHO INO PHC 101, Jakarta

Dr Nyoman Kandun, EPI Manager, Ministry of Health, Jakarta

Mr Khin Maung Lwin, WHO Health Information System Specialist, Jakarta

Mr A.M. Meliala, Chief Centre for Health Data, Ministry of Health, Jakarta

Dr Arief Muljahardja, Chief, Secretariat of Directorate of Academic and General Hospital, Ministry of Health, Jakarta

Dr Toeti Soelistiowati, Staff of District Health Office, Sidoarjo, East Java

Dr Haryadi Soeparto, Researcher, Health Services and Development Centre, Ministry of Health, Surabaya

Dr Tarbinu, Provincial Health Office Staff, Surabaya, East Java

Dr I.G.P. Wiadnyana, Director, Health Centre Development, Ministry of Health, Jakarta

Dr Widiharto, District Health Medical Officer, Jember, East Java

Dr U Than Win, Senior Public Health Administrator, WHO INO PHC 101, Jakarta

KOREA

Dr Myeng-Ki Kim, Director Division of Medical Information System Engineering, Seoul National University Hospital, Seoul

NEPAL

Mr A. Prasad Gautam, Section Officer, Antirabies Clinic, Epidemiology Division, Ministry of Health, Kathmandu

Mr Vijaya Kumar Khanal, Health Assistant, Epidemiology Division, Ministry of Health, Kathmandu

Mr Hari Gopal Shakya, District Public Officer, Ministry of Health, Kathmandu

PAPUA NEW GUINEA

Mr P. Coleman Moni, Officer in Charge, Policy Planning and Coordination Unit, Department of Health, Boroko, Port Moresby

Dr Levi Sialis, First Assistant Secretary, Primary Health Services, Department of Health, Boroko, Port Moresby

PHILIPPINES

Dr N.E. Fernando, Medical Specialist, Department of Health, Manila

Dr Jose Rodriguez, Chief, Health Manpower Development and Training Division, Regional Health Office N. 7, Cebu City

THAILAND

Mr Noparat Leungvititkoon, Health Statistician, Health Statistics Division, Ministry of Public Health, Bangkok

Dr Wiput Phoolcharoen, Deputy of Medical Chief Officer, Office of Public Health, Suratthani

Dr Weerawat Punkrut, Soonghern Hospital Director, Soonghern District, Nakornrachasima

OTHER ORGANIZATIONS

Dr Julia Walsh, UNDP, New York

REGIONAL OFFICES

Dr S. Khanna, WHO Representative to Indonesia, Jakarta

Dr Sun-Hee Lee, Management Officer, MCH/FP, WPRO, Manila

Dr James M. Robey, Regional Adviser, Health Information Network, WPRO, Manila

Dr Sonja Roesma, Regional Adviser in Primary Health Care, SEARO, New Delhi

WHO/HQ SECRETARIAT

Dr E. Tarimo, Director, Division of Strengthening of Health Services

Dr John Martin, Responsible Officer, District Health Systems, Division of Strengthening of Health Services

Dr F. Siem Tjam, District Health Systems, Division of Strengthening of Health Services

Dr Hugh Annett, Liverpool School of Tropical Medicine, Consultant, WHO/HQ

Ms G. Dubouloz, Secretary, District Health Systems Unit (SHS)

ANNEX 3: MEMBERS OF THE ORGANIZING COMMITTEE

Dr K. Halim, Provincial Health Office, East Java, Surabaya

Dr Haryoko, Chief, Division of Health Centre and Family Health, Provincial Health Office, East Java, Surabaya

Dr Ismuhadi, Chief, Division of Community Health Services, Ministry of Health, Surabaya

Dr S.L. Leimena, Director-General Community Health, Ministry of Health, Jakarta

Mr I. Rifai, Bureau of Foreign Affairs, Ministry of Health, Jakarta

Dr Soebagyo Oetomo, Directorate of Health Centre Development, Ministry of Health, Jakarta

Mr Soehardjono, Chief, Division of Data Collection and Processing, Ministry of Health, Surabaya

Dr E. Sutarto, Chief, Provincial Health Office, East Java, Surabaya

Dr Suwarna, Secretary to the Director-General Community Health, Ministry of Health, Jakarta