IMPROVING DATA QUALITY AND INFORMATION USE IN HEALTH DEPARTMENT - MANAFWA DISTRICT

BY

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MEDIUM-TERM FELLOW

2013
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MEDIUM –TERM FELLOW

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Table of Contents

List of Table .................................................................................................................. iii
List of Figures ................................................................................................................ iv
Declaration ...................................................................................................................... v
Roles of the Fellow ......................................................................................................... vi
Acknowledgement .......................................................................................................... ix
List of Acronyms ............................................................................................................. x
Operational Definition of terms .................................................................................... xii
Executive summary ......................................................................................................... xiii
CHAPTER ONE ............................................................................................................. 1
1.0 Introduction .............................................................................................................. 1
  1.1 General Background ................................................................................................. 1
  1.2 Background to Manafwa District Health Department ............................................. 2
  1.3 Project Description .................................................................................................. 4
CHAPTER TWO ............................................................................................................. 6
  2.0 Literature review .................................................................................................... 6
CHAPTER THREE ......................................................................................................... 8
  3.0 Statement of the Problem and Justification ............................................................. 8
    3.1 Problem statement ................................................................................................. 8
    Justification ................................................................................................................ 9
    3.3 Conceptual Frame work ....................................................................................... 10
CHAPTER FOUR ......................................................................................................... 11
  4.0 Objectives .............................................................................................................. 11
    4.1 General objective ................................................................................................. 11
    3.2 Specific Objectives ............................................................................................. 11
CHAPTER FIVE ............................................................................................................ 12
5.0 Methodology ............................................................................................................. 12
5.1 Introduction ............................................................................................................... 12
5.2 Target population (stakeholders) for project .......................................................... 12
5.3 Approaches for achievement of project objectives .................................................. 12
5.4 Sustainability of Project Activities ......................................................................... 17
5.5 Dissemination of findings ......................................................................................... 17
5.6 Limitations ................................................................................................................ 17
5.7 Table: 2 Result Framework for Improving Data Quality and Information Use in Manafwa District Health Department ................................................................. 18

CHAPTER SIX ................................................................................................................. 21

6.1 Objective One: To strengthen knowledge and skills of key stakeholders on data management by May, 2013 .................................................................................... 21

6.2 Objective Two: To improve timely submission of reports from 85% to 100% by September, 2013 ................................................................................................. 21

6.3 Objective Three: To increase information use from 13% to at least 50% of health facilities demonstrating its use. .................................................................................. 22

CHAPTER SEVEN .......................................................................................................... 24

7.0 Challenges, Lessons Learnt and Way Forward ......................................................... 24

7.1 Challenges ................................................................................................................ 24

7.2 Lessons Learnt .......................................................................................................... 24

7.3 Way forward ............................................................................................................. 24

REFERENCES ................................................................................................................. 25

APPENDIX 1 ..................................................................................................................... 26
List of table
Table 1 Result Frame work
List of Figures

Figure 1 Conceptual Frame work
Figure 2 Training Session
Figure 2 In-charges Orientation
Figure 4 Mentorship
Figure 5 Training on Target Setting
Figure 6 Project Outcomes
Declaration
I Makanya David Fred Kisolo hereby declare that, to the best of my knowledge, this end
of-project report titled ‘Improving Data Quality and Information Use in Health
Department- Manafwa ’ is my original work and has never been submitted to Makerere
University School of Public Health HIV and AIDS Fellowship Program or any other
institution of learning for any academic/and fellowship award or publication. Therefore I
hereby submit it in partial fulfillment of the requirement of completion of the medium-
term fellowship programme of Makerere University School of Public Health

Signed………………………….. Date……………………………..
Makanya David, medium term fellow

Signed………………………….. Date……………………………..
Dr Wamasebu Gideon
Institution Mentor

Signed………………………….. Date……………………………..
Ms Mary Dutki
Academic Mentor
Roles of the Fellow

The fellow identified the problem in the monitoring and evaluation system in the health department

In consultation with the members of the DHT designed the project proposal to address the problem

Identified the key stake holders to work with

Organized meetings, trainings, and workshops

Participated in the training of Health Information Assistants Health Assistants and Records Assistants

Participated in the orientation workshop for in-charges

Bought and Installed 3 modems at the HSDs

Led the team in support supervision and mentorship of the staff

Monitored and evaluated the project activities

Wrote a report and disseminated to stake holders
Acknowledgement

I would like to acknowledge my institutional mentors namely; Dr Wamasebu Gideon for the support and guidance that he gave me in carrying out this project activity. In the same way, I would also like to extend my special thanks to Madam Mary Dutki (academic mentor) for the valuable efforts and time she spent in guiding and supporting me in designing and executing this project activity. My mentors (both academic and institutional mentors) have read this project activity report and cleared it for submission. I thank them for that. Special thanks also go to my colleagues, Kurima Steven and Wanga Ruth for the commitment and cooperation exhibited during execution of this project.

In a very special way, I would like to extend my sincere thanks to the management and entire staff of the MakSPH-CDC Fellowship program for the support of every kind that was rendered to me during the development and implementation of this project. I would also like to convey my sincere thanks to my Fellow-Fellows for the words of encouragement that we have shared in this period of proposal development as well as implementation of the project activities.

I would like to thank the almighty God for the blessings that enabled me accomplish the fellowship program. Lastly but not least, my special appreciation goes to my family especially my dear wife Barbara Makanya for the words of encouragement and prayers that she offered during the entire period of the fellowship.
**List of Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>DHT</td>
<td>District Health Team</td>
</tr>
<tr>
<td>HSD</td>
<td>Health Sub-District</td>
</tr>
<tr>
<td>HCIV</td>
<td>Health Centre IV</td>
</tr>
<tr>
<td>TASO</td>
<td>The AIDS Support Organisation</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>C&amp;T</td>
<td>Counseling and Testing</td>
</tr>
<tr>
<td>CDC</td>
<td>Centre for Disease Control and Prevention</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>PREFA</td>
<td>Protecting Families Against HIV/AIDS</td>
</tr>
<tr>
<td>RTC</td>
<td>Routine HIV Testing and Counseling</td>
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**Institutional Acronyms**

<table>
<thead>
<tr>
<th>Institution</th>
<th>Acronym</th>
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<tbody>
<tr>
<td>Makerere University School of Public Health</td>
<td>MakSPH</td>
</tr>
<tr>
<td>Millennium Development Goals</td>
<td>MDG</td>
</tr>
</tbody>
</table>
PMTCT Prevention of Mother to Child Transmission of HIV

TB Tuberculosis

VHT Village Health Team

WHO World Health Organization

PHC Primary Health Care

HIAs Health Information Assistants

HAs Health Assistants
**Operational Definition of terms**

**Effectiveness:** A measure of the extent to which a project attains its objectives at the goal or purpose level.

**Efficiency:** A measure of how economically inputs (funds, expertise, time, etc.) are converted into outputs.

**Monitoring:** The regular collection and analysis of information to assist timely decision making, ensure accountability and provide the basis for evaluation and learning.

**Evaluation:** A systematic (and as objective as possible) examination of a planned, ongoing or completed project.

**Monitoring and Evaluation System:** The set of planning, information gathering, synthesis, reflection and reporting processes, along with the necessary supporting conditions and capacities required for making a valuable contribution towards decision-making and learning.

**Indicator:** Quantitative or qualitative factor or variable that provides a simple and reliable basis for assessing achievement, change or performance.

**Input:** The financial, human and material resources necessary to produce the intended output of the project.

**Output:** The tangible (easily measurable, practicable), immediate and intended results to be produced through sound management of the agreed input.

**Impact:** The long term achievement or contribution of the project in change in the behavior or environment of the intended beneficiaries as perceived by them at the time of evaluation.
Executive summary

Introduction: A strong and functional M&E system is essential in providing data for monitoring and evaluation as well as improving decision making in health services delivery. Following the creation of Manafwa District, there has been an increasing need to ensure effective and efficient services delivery and accountability of health interventions and resources. However, this had been curtailed by poor quality of data and failure to appropriately utilize available data. This project therefore was aimed at improving data quality and enhancing information use at all levels of the district health system. This would strengthen the capacity and ability of mid level managers and the department to make informed decision based on evidence.

The objectives of the project were: to strengthen knowledge and skills of key stakeholders on data management, to increase timeliness submission of reports by introducing on line reporting from HC IV to district, increase data completeness and consistency, improve data storage by introducing 5s principle, and finally promote data utilization by the managers at different levels.

The project therefore targeted staffs who directly handle data at different levels of the district health system. Key activities included training of key staff to improve on knowledge, skills and competencies. The anticipated outcomes were improved data quality and information use. The project ran for four months and it cost 6,500,000/= Ugandan shillings.

This report therefore shows the gaps in the quality of data for health department, conceptualization of proposed interventions, and processes that were undertaken to address the identified gaps. It also shows the achievements registered, challenges encountered, lessons learnt and the way forward as registered in the implementation of the project: “Improving data Quality and Information Use”

Problem statement and Justification: Prior to project implementation, Manafwa district health department and especially the lower health facilities hardly planned basing on the indicator performance. At times the process of planning was hijacked by implementing partners such as PREFA, BAYLOR and TASO contrary to the National policy. This had been largely attributed to poor quality of data, and lack of M&E plan in the department. The monitoring and evaluation system was weak and needed strengthening notably through improvement of data quality and enhancement of information use. Most notably; some set indicators by the ministry were not reported on yet tools were in place! Some tools for collecting some health facility data, as well as community generated data lied pillared at the district office. Some data was not routinely collected,
compiled, and or analyzed by relevant stakeholders. Quite often data was incomplete, inconsistent, reported late, stored poorly and therefore hardly used. As such the district found it difficult to plan, monitor and evaluate health programmes, projects, activities and events. It should be noted that data is a very vital component in any Monitoring and Evaluation System. However, a number of gaps pertaining to its quality and use did exist in Manafwa as evidenced during the rapid assessed conducted. This project therefore aimed at improving data quality and enhancing information use at all levels of the district health system. This in turn would strengthen the capacity and ability of mid level managers and the department to make informed decision based on evidence.

**Objectives:** The specific objectives which guided the project included: 1) to strengthen knowledge and skills of key stakeholders on data management by May, 2013, To increase timeliness submission of reports from 85% to 100% by September, 2013, To increase information use from 13% to more than 50% of facilities demonstrating application by July 2013

**Methodology:** The project was implemented in the health department of Manafwa District. The MakSPH medium-term Fellow led in the management and day to day running of this project implementation.

To achieve the specific objectives, a series of activities were conducted which included: stakeholder consultative meeting, training of Health Information Assistants and Health Assistants and records Assistants on quality data management and use, and orientation of all health facility in-charges on the importance of quality data in planning. Three modems were also procured and installed to ease transmission of data from HCIVs to the district. Supervision and on site mentorship were also conducted to ensure quality. The 5s principle for storage of data and other deliverables was also introduced.

**Achievements/ Results:** The achievements registered in the implementation of the project included: 13 HIAs and 22 in-charges trained in data quality, Baseline coverage established at all facilities, 100% of facilities have performance targets set for 2013/2014, 22 out of 23 health facilities are currently reporting on time since July, 2013, 100% of Reports received and submitted are now complete and consistent, Three modems in place and functional, Data and other deliverables are now stored according to 5s principle, Information use is now evident at all levels as decisions and resolutions are arrived at based on available data.
Challenges Implementing the project alongside the busy schedule of other departmental activities was a challenge but this was mitigated by having a number of stakeholders on board. The Institutional supervisor – a very busy person, Streamlining the MOH M&E plan with the department M&E plan, and Poor internet network

Lessons Learnt: Involving different stakeholders from the design stage to implementation ensured full participation, ownership and sustainability of the project. Introducing monthly meetings promoted timely reporting. Integrating some activities into the routine PHC activities ensures sustainability.

Way forward: The health department and its implementing partners to support the electronic transmission of reports from HCIVs to the district. Monthly meetings within the first week of every month to continue as routine because it promotes timely reporting. Support supervision to ensure quality data and information use be integrated into the routine supervision activities.
CHAPTER ONE

1.0 Introduction

1.1 General Background
Monitoring and Evaluation (M&E) system of Manafwa district Health department is weak and therefore requires some necessary and practicable interventions to strengthen it.

Globally, there have been deliberate efforts to put strong and proper mechanisms of monitoring and evaluation by organisations at different levels so as to track performance and make informed decisions based on evidence. There are constant and growing pressures on organizations around the world to be more responsive to demands from internal and external stakeholders for good accountability and transparency, greater development effectiveness and delivery of tangible results (Görgens and Kusek, 2010). Government agencies, Non-Governmental organizations, civil societies, international organizations, and donors are all stakeholders interested in better performance. As demands for greater accountability and results have grown, there is an accompanying need for useful and usable results-based monitoring and evaluation systems to support the management of programs and policies (Görgens and Kusek, 2010).

International Fund for Agricultural Development (IFAD), (2007) defined a monitoring and evaluation system as the set of planning, information gathering, synthesis, reflection and reporting processes, along with the necessary supporting conditions and capacities required for the M&E outputs to make a valuable contribution to project decision-making and learning (IFAD, 2007).

According to UNAIDS a complete and functional monitoring and evaluation system consists of 12 components which include; 1) Organisational structures 2) Human capacity for M&E 3) M&E partnerships 4) M&E plan 5) Costed M&E work plan 6) Advocacy, communications and culture for M&E 7) Surveys and surveillance 8) Routine programme monitoring data 9) Supportive supervision and data auditing 10) database 11) evaluation, research and learning and 12) Using data for decision making (UNAIDS, 2009).

WHO states that accurately measuring the success of health initiatives and improving program performance is predicated on functional and strong M&E systems that produce quality data
(WHO, 2007). The Joint United Nations Program on HIV/AIDS (UNAIDS) also states that a functional M&E system is important for it provides essential data for monitoring and evaluating the epidemic and improving the response. Specifically, M&E data in this case are vital for: guiding the planning, coordination, and implementation of any health response, assessing the effectiveness of health programmes and identifying areas for programme improvement, ensuring accountability to those affected by the disease or catastrophe, as well as to those providing resources (UNAIDS, 2009).

The Government of Uganda in an effort to embrace this has come up with a number of tools developed by line Ministries or agencies. However, despite these efforts, monitoring and evaluation mechanisms to measure progress and successes are still weak at the districts (Health Sector Annual Review Performance Report 2011/2012). Up to date the centre continues receiving partial reports from districts as evidenced from the national league tables and weekly surveillance reports that run in every Wednesday New vision press. Monitoring and evaluation are essential in ensuring efficiency and effectiveness of any intervention project, program, or policy. Monitoring and evaluation are pivotal in improving performance, accountability, quality of service and promoting learning. It is therefore important to appreciate the relevancy of quality data at all levels of planning and service delivery.

In Manafwa per se, Planning at different levels has not always been evidence based. This to some extent was attributed to poor quality of data. Quality data is a precursor to effective monitoring and evaluation and as such it should be emphasized. The district continued receiving and submitting poor quality reports due to inaccuracy, inconsistency, and incompleteness. At times reports were received and submitted beyond the dead line. It is upon this background that Manafwa District opted to strength the monitoring and evaluation through improving quality of data and information use.

1.2 Background to Manafwa District Health Department
Manafwa district is one of the new and rural districts in Uganda created with the aim of bringing services closer to the people. Manafwa District is located in the Eastern Region of Uganda, bordering the Republic of Kenya in the East; District of Bududa in the North; Mbale to the West and Tororo in the Southwest. It lies between the longitudes of 34° E, 35° E and latitudes 00°45'N The District has the land area of about 451sq km.
District vision

“A knowledgeable Citizenry, health populace and harmonious people by 2035”

Demography

Up to 98% of the District populations live in rural areas. The remaining 2% live in trading centers scattered across the District. The number of females almost equals that of males. The indigenous population comprises the Bamasaba (92%) of the total population of 399,300 people [2012 Projection]. The population of Manafwa has been steadily increasing over the years with a growth rate of 3.3% (2002 census). This is attributed to high fertility rates and emigrations.

Health services in Manafwa district

The district offers curative, preventive, rehabilitative, and promotive services.

Health facilities

The district is served by twenty three (23) health units, 3HC IVs, 12 HC IIIs and 8 HC IIs. The district has 2 Health Sub Districts (HSD) i.e. Bubulo East HSD and Bubulo West HSD with headquarters at Magale HC IV and Bugobero HC IV respectively.

Human resource handling data

1 Biostatistician, 3 Records Assistants, 13 Health Information Assistants, 28 Health Assistants, 1430 VHTs, 2 Stores assistant, 4 Cold chain Assistants, and 1 Accountant.

The health department is the custodian for health programmes in the district. It is therefore responsible for planning, implementing, and monitoring and evaluation.

However, the district was faced with the problem of poor quality data and underutilization of the available data. As such, the managers at the district and lower levels hardly planned based on evidence generated. Quite often data was incomplete, inconsistent, reported late, stored poorly and therefore hardly used. As such the district found it difficult to plan, monitor and evaluate health programmes, projects, activities and events
1.3 Project Description

1.3.1 Methodology:
The project was implemented at Manafwa District Health department. The MakSPH-CDC fellow led the implementation and management of the day to day running of the project and finally compiled and submitted this report at completion. The fellow was supervised by two mentors; one from MakSPH while the other from the Host institution.

To achieve the specific objectives, a series of activities were conducted which included:

1.3.2 Stakeholders’ meeting
Stakeholders’ consultative planning meeting was held first. Documents were reviewed, and standardization of project outputs, outcomes and indicators done. The meeting came up with the list of key individuals to be trained on data management and use. This meeting also enhanced appreciation of quality data by the DHT and therefore increased its demand.

1.3.3 Trainings and workshops
A 2-days hands-on training on data management and use was conducted and it targeting Health Information Assistants and Records Assistants. This meeting empowered trainees with knowledge and skills which translated into proper management of data and ultimately improved on data quality.

A one day in-charges’ orientation workshop was conducted. The aim was to ensure that they staff appreciate the relevancy of quality data in an organization. They were also equipped with knowledge and skills in supervising and monitoring project activities.

1.3.4 Improving timely reporting
Three modems were bought and installed on the current three HCIV computers. This has eased the transmission of data from the HCIV to the district and therefore improved on timely reporting. Monthly meetings with HIAs within the first week of every month were introduced.

1.3.5 Support Supervision
A team of supervisors were facilitated to mentor, support and or supervise the execution of the project activities to ensure quality.
1.3.6 Monitoring and Evaluation
M&E of the project was done according to the M&E plan developed. This M&E plan was specific to the four-month project.
CHAPTER TWO

2.0 Literature review
Programmes for the prevention of infections in infants and young children are gaining increased commitment and support (WHO, 2004). Many countries are expanding their programmes in response to the growing HIV/AIDS pandemic. Such programmes are expensive and represent a major commitment of funds and energy in the countries concerned. It is clearly necessary to set standards for monitoring and evaluating these programmes at different levels and for ensuring that the investments are yielding the greatest possible benefit (WHO, 2005).

According to WHO (2009), a recent substantial increase in international funding for health has been accompanied by increased demand for statistics to accurately track health progress and performance, evaluate impact, and ensure accountability at country and global levels. The use of results-based financing mechanisms by major global donors has created further demand for timely and reliable data for decision-making (WHO, 2009). The purpose of measuring program success is to help determine which service areas are working well and should be continued and which operations need to be improved (Judice, 2007).

With the dramatic expansion of HIV programs in resource-limited settings, the need for monitoring and evaluation initiatives has also increased (Nash, et al, 2009). A monitoring and evaluation system has been as a set of planning, information gathering, synthesis, reflection and reporting processes, along with the necessary supporting conditions and capacities required for the M&E outputs to make a valuable contribution to project decision-making and learning (IFAD, 2007). M&E systems are ideally a cornerstone of HIV and AIDS services, providing aggregate data to inform national programs and priorities while guiding the delivery of high-quality prevention, care, and treatment (Nash, et al, 2009).

WHO states that an increasing number of stakeholders, including global health partnerships, bilateral donors, UN agencies, and academic institutions are involved in health-related monitoring and evaluation (M&E). Activities include the financing of monitoring and evaluation systems strengthening, and the development of frameworks, standards, tools and methods for data generation, collection, compilation, analysis, and dissemination.
Data are used to enable monitoring of progress towards targets, results-based funding, and evaluation of large-scale programmes (WHO, 2009).

In its strategic planning process, Manafwa identified M&E and lack of documentation as some of the weak areas programming (Manafwa District HIV/AIDS strategic plan, 2010).

Study findings by Nash et al (2009) further revealed that the common weak link of M&E systems is their failure to provide timely and useful feedback to site-level staff, district managers, program implementers, and other stakeholders in the form of information that enables the continuous improvement of quality, scale, access, equity, and impact. They further stated that with HIV programmatic scale-up still in its early stages, it is especially important for routinely collected M&E data to be used for epidemiologic analysis and operations research aimed at improving programs. Rapid analyses are particularly useful to ensure that program design and service delivery are evidence informed (Nash et al, 2009). There are major gaps in data availability and quality. Many developing countries face challenges in producing data of sufficient quality to permit the regular tracking of progress in scaling-up health interventions and strengthening health systems. Data gaps span the range of input, process, output, outcome and impact indicators (WHO, 2009). WHO on the other hand notes that harmonizing indicators and methods for M&E programmes as much as possible, duplicated reporting can be avoided and more time can therefore be spent on the delivery of vital services (WHO, 2005).
CHAPTER THREE

3.0 Statement of the Problem and Justification

3.1 Problem statement
Manafwa district health department especially lower health facilities hardly planned basing on the indicator performance. At times the process of planning was hijacked by implementing partners such as PREFA, BAYLOR and TASO contrary to the National policy. This had been largely attributed to poor quality of data, and in adequate use of information in the department. The monitoring and evaluation system is weak and needs strengthening. Most notably; some set indicators by the ministry were not being reported on yet tools are in place! Some tools for collecting some health facility data, as well as community generated data liedpilled at the district office. Some data was not routinely collected, compiled, and or analyzed by relevant stakeholders. Quite often data was incomplete, inconsistent, reported late, stored poorly and therefore hardly used. As such the department found it difficult to plan, monitor and evaluate health programmes, projects, activities and events.

According to the rapid assessment done to establish readiness, the outcome indicators of completeness, timeliness, consistence, usage and storage were used and the following were revealed; Completeness was at 26%, that is 6/23 health facilities submitted forms that were completely filled. Timeliness was at 85% according to the surveillance reports. Consistence was at 67% that is 10 out of 23 monthly reports had inconsistencies Usage only 3 facilities had evidence of utilization of data for planning at health facilities save for drug orders. Storage of data and other deliverables was poor as no facility was implementing the 5s principal of sorting, setting, shining, standardization and sustainability.
In terms of data collection and management, it was usually captured at the health facilities and transmitted directly to the district HMIS focal person without any analysis. The HMIS focal person or biostatistician would process it and transmits the same to the Ministry of Health and a soft copy kept for the district without interpretation. Data from the Health Assistants and Village Health Teams was never captured yet there was provision for its input on the tools. Data from the CCTs, Accountant and Store’s Assistant was captured by the respective section heads and never used make meaningful decision because of its poor quality. Data processing was only done at the district but no interpretation was done; graphs and charts were never drawn.

Data analysis was hardly done by the biostatistician and HMIS focal person as a number of anomalies were often detected by the DHT.

No dissemination at all as the feedback from the district was never taken to the health facilities.

**Justification**

Data is very vital component in any Monitoring and Evaluation System. However, a number of gaps pertaining to its quality and use did exist in Manafwa health department as evidenced during the rapid assessment conducted. This project therefore aimed at improving data quality and enhancing information use at all levels of the district health system. This would strengthen the capacity and ability of mid level managers and the department to make informed decision based on evidence.
3.3 Conceptual Frame work

**CAUSE**
- Knowledge gap
- Unskilled staff
- Low interest in data use
- Poor storage of data
- Low commitment

**PROBLEM**
- Poor quality of data
- Limited use of data

**EFFECTS**
- Poor planning
- Inefficiency
- Wrong decisions
- Wastage of resources

*Fig. 1*
CHAPTER FOUR

4.0 Objectives

4.1 General objective
To improve quality of data and information use of Manafwa health department so as to promote efficiency, effectiveness and accountability in health service delivery.

3.2 Specific Objectives
1. To strengthen knowledge and skills of key stake holders on data management by May, 2013.

2. To improve timely submission of reports from 85% to 100% by September, 2013

3. To increase information use from 13% to more than 50% of facilities demonstrating application by July 2013
CHAPTER FIVE

5.0 Methodology

5.1 Introduction
This chapter describes the methods which were used and the key steps taken to implement and hence achieve objectives of the project. This chapter has been presented according to objectives of the project and other relevant sub-sections.

5.2 Target population (stakeholders) for project
The following stakeholders were targeted or involved at various stages of project implementation;
- Members of the District Health Team (DHT)
- Biostatistician
- HMIS focal person
- Health facility in-charges
- Health Information Assistants
- Records Assistants

5.3 Approaches for achievement of project objectives

5.3.1 Objective One: To strengthen knowledge and skills of key stakeholders on data management by May, 2013.
To achieve this objective, three activities were conducted. First was the stakeholders’ consultative planning meeting. Documents were reviewed, and standardization of project outputs, outcomes and indicators done. The meeting came up with the list of key individuals to be trained on data management and use. This meeting also enhanced appreciation of quality data by the DHT which eventually increased its demand.

The second activity was a 2-days hands-on training on data management and use. The target audience comprised the Health Information Assistants and Records Assistants. This meeting empowered trainees with knowledge and skills which translated into proper management of data and ultimately improved data quality.
Finally, a one day in-charges’ orientation workshop was conducted. The aim was to ensure that Facility in-charges appreciate the relevancy of quality data in an a health facility. They were also equipped with knowledge and skills in supervising and monitoring project activities and enhance its sustainability.
5.3.2 Objective Two: To improve timely submission of reports from 85% to 100% by September, 2013

Three modems were bought and installed on the current three HCIV computers. The aim of this activity was to ease the transmission of data from the HCIV to the district and therefore improved on timely reporting. Monthly meetings with HIAs within the first week of every month were introduced. The aim of this activity was to provide opportunity for collection and correction of monthly reports prior to submission to the centre.
5.3.3 Objective Three: To increase information use from 13% to at least 50% of health facilities demonstrating its use.

A team of 5 members from the district health team (DHT) were selected and facilitated to conduct supervision and mentorship on data and information use. All the 23 facilities were visited fortnightly for six times. The area of focus was immunization data and the purpose was to mentor the target group on data compilation, analysis and interpretation. During this activity facilities compiled baseline data for immunization. That is, Immunisation coverages and drop-out rates for 22 facilities for 2012/2013 were determined. Health Unit Management Committees used this baseline data to set new targets for 2013/2014.
Demonstrating to HIAs how to set targets

Fig.5
5.4 Sustainability of Project Activities
Implementation of this project contributes to the strengthening of M&E system. Therefore efforts were undertaken to ensure that it is integrated into the routine Primary Health Care activities. This ensures continuity (sustainability).

5.5 Dissemination of findings
The project findings (report) will be presented to Makerere University School of Public Health-CDC Fellowship Program in partial fulfillment of the requirement for the award of a certificate of completion of the Medium-term Fellowship training. The findings (report) will also be presented to Manafwa District Local Government and her other implementing partners like TASO. A manuscript will also be written out of these findings and published in a peer reviewed journal as means of disseminating to the wider audience.

5.6 Limitations
This was mainly due to other competing priorities. This was however countered by clearly explaining the importance of the project to all key stakeholders as well as involving them in various stages of the project implementation.

The time for implementation of the project activities by the Fellow was inadequate given that the funds were released late. The Fellow however addressed this by developing and adhering to proper plans with clear timelines. The Fellow also involved others stakeholders especially the DHT members to support the implementation process.
### 5.7 Table 2 Result Framework for Improving Data Quality and Information Use in Manafwa District Health Department

<table>
<thead>
<tr>
<th>Input</th>
<th>Process</th>
<th>Output</th>
<th>Outcome</th>
<th>Impact</th>
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<tbody>
<tr>
<td>Funds</td>
<td>→ Hold a consultive meeting with DHT.</td>
<td>→ DHT aware of the project &amp; list of trainees for quality data generated by DHT planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&amp; personnel</td>
<td>→ increased demand</td>
<td>→ increased demand</td>
<td>→ Evidence based</td>
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#### 5.7.1 Description of Result Framework

The M&E system strengthening through improving data quality and information use took place at various stages. At input and activity level the project activities had a direct control leading to achievement of outputs. Efficient utilization of resources in implementing these activities led to
high achievement at output level. While the project activities significantly contributed to the achievement of set outcomes. The various areas on Framework are explained below:

**Inputs**

In order to achieve set targets, the project required inputs which include but not necessarily limited to;

**Human resources:** these included key stake holders, staff trainers as well as staff involved in various activities data management and information use.

**Materials:** these included items like computer, hard and software, revised/ standardized HMIS data collection tools, cameras as well as stationary and vehicles. The district and Makerere University School of Public Health provided these resources.

**Time:** This was very important for the accomplishment of the project activities. Time was set and allotted according to Gantt chart developed

**Finances:** Finances were required for all the inputs necessary for the accomplishment of project activities. Financial support was obtained from MakSPH-CDC Medium-term Fellowship program.

**Processes**

These were the activities conducted in order to realize the outputs. They included; conducting consultative meeting with members of DHT, training key staff on quality data management, orienting all health facility in-charges on data management and information use, procurement and installation of three modems, supportive supervision and mentorship, and conducting review meetings.

**Outputs**

These are the immediate results of the activities conducted. They included; increased knowledge and skills on data handling, appreciation for quality data, and electronic transfer of data from HCIVs to district,

**Outcomes**

These were the results of the outputs and they included; improved competency in data management, improved demand for quality data, improved data quality, timely submission of data and reports, and improved information use.
Impact

This is measured at the beneficiary level and it includes; improved planning at difference levels, improved accountability and improved health service delivery.
CHAPTER SIX

6.0 Results (Project Outcomes)
This chapter presents achievements of the project. The results are presented according to the objectives. They are therefore presented in the chronological order of the objectives.

6.1 Objective One: To strengthen knowledge and skills of key stakeholders on data management by May, 2013.
One stakeholders’ consultative planning meeting was held and 8 members of DHT attended. During this meeting, documents were reviewed, and standardization of project outputs, outcomes and indicators done. The meeting came up with the list of key individuals to be trained on data management and use. This meeting also enhanced appreciation of quality data by the DHT which eventually increased its demand.

A 2-days hands-on training on data management and use was conducted. The target audience comprised the Health Information Assistants, Health Assistants, and Records Assistants. 30 people attended this training. The training empowered trainees with knowledge and skills which translated into competency in proper management of data and ultimately improved data quality.

Finally, a one day in-charges’ orientation workshop was conducted and all the 23 attended. The aim was to ensure that Facility in-charges appreciate the relevancy of quality data in a health facility. They were also equipped with knowledge and skills in supervising and monitoring project activities and enhance its sustainability.

6.2 Objective Two: To improve timely submission of reports from 85% to 100% by September, 2013
Three modems bought and installed on the current three HCIV computers. Magale and Bubulo are now sending data electronically. The aim of this activity was to ease the transmission of data from the HCIV to the district and therefore improved on timely reporting. Monthly meetings with HIAs within the first week of every month were introduced and so far 4 meetings have been held. The aim of this activity is to provide opportunity for collection and correction of monthly reports prior to submission to the centre. All facilities (100%) submitted monthly reports for July, August, September, and October on time.
6.3 Objective Three: To increase information use from 13% to at least 50% of health facilities demonstrating its use.

A team of 5 members from the district health team (DHT) were selected and facilitated to conduct supervision and mentorship on data and information use. All the 23 facilities were visited fortnightly for six times. The area of focus was immunization data and the purpose was to mentor the target group on data compilation, analysis and interpretation. During this activity facilities compiled baseline data for immunization. That is, Immunisation coverages and drop-out rates for 22 facilities for 2012/2013 were determined. Health Unit Management Committees used this baseline data to set new targets for 2013/2014. 22 out of 23 facilities now can demonstrate use of data and information. That is 96% from 13%. 

Project Outcomes

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<th>Before</th>
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<tr>
<td>Timeliness</td>
<td>85%</td>
<td>96%</td>
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<tr>
<td>Completeness</td>
<td>26%</td>
<td>100%</td>
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<tr>
<td>Consistency</td>
<td>67%</td>
<td>100%</td>
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<tr>
<td>Information Use</td>
<td>13%</td>
<td>96%</td>
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CHAPTER SEVEN

7.0 Challenges, Lessons Learnt and Way Forward

7.1 Challenges
Other competing demands, little interest in M&E as well as varying levels of understanding of data management among some stakeholders affected their level of participation and involvement in the project. This was however addressed by involving all key stakeholders right from the design of the project proposal to implementation. Through this, they were able to appreciate the gaps in data quality and information use and therefore the need to address them. This helped improve their interest, and demand for quality data.

The funding for the programmatic activity was limited and therefore could not cater for some of activities. However this was handled by integrating some activities with others. This on the other hand has significantly contributed to the sustainability of the project interventions. This is because these interventions can now continue since they are catered for in the district plan.

7.2 Lessons Learnt
- Involving different stakeholders right from the project proposal stage to implementation ensured full participation, ownership and most importantly the sustainability of the project.
  Proper identification of a problem and appropriately addressing it led to drastic improvement in data quality. Application of the knowledge and skills on data management and utilization of data generated improves on decision making.

7.3 Way forward
The district health department to ensure sustainability of the project interventions. This can be done by among other measures, continued allocation of resources to support these activities.
REFERENCES


APPENDIX 1  Academic mentor and the Fellow at Manafwa during Supervision