Community Health Information Systems and Data Use: Learning from Africa and Resources for Practitioners

Webinar – July 30, 2019

Additional Questions & Responses from Webinar

Question	Response
Is the Resource Package available on the MCSP website?	*MCSP:* Yes, the link of the presentation can be found here: https://www.mcsprogram.org/resource/supporting-communities-to-use-health-data/?_sfm_resource_topic=community-health
What's being or can be done to reinforce compliance with privacy regulations, i.e. protection of personal identifiable information, in CHIS that use DHIS2 technology? Are there options/controls available in the DHIS2 technology to support this?	*Scott Russpatrick (University of Oslo):* Privacy is our primary concern in developing patient centric data capture tools. There is a detailed response to this question here: https://community.dhis2.org/t/how-does-dhis2-protect-personal-information-the-tech-details/5335 In summary data in DHIS2 is encrypted end-to-end and all applications are password protected. DHIS2 has the ability for administrators to define robust user authorities that define what each user can see, add, edit, and search for. Essentially this means users can be restricted to only being able to see the patients and health programs that they need to have access to. DHIS2 can be configured to be GDPR compliant as well as adhere to all patient electronic data transmission laws and regulations that we have seen. When we are directly involved in implementation, we push countries and implementers to adhere to global standards for patient privacy even when the country or donor does not require it.
Thanks for the lovely presentation, when will the smartphone dashboard be deployed?	*Scott Russpatrick (University of Oslo):* The dashboard application will be available by the end of the year.
I'm wondering if the "choose two" directive for the Venn diagram you showed would be	*Scott Russpatrick (University of Oslo):* I think it is very important to define the complexity spectrum, and I am very happy to have an ongoing conversation with anyone

different if one replaces the “low cost” circle with “cost-effectiveness”? Is it possible that increased complexity increases cost-effectiveness, and that scale is necessary for cost-effectiveness? Would be interested in your take on this as we consider the complexity spectrum.	who is trying to figure out what is appropriate from a technical perspective. Yes, you do see many economies of scale both in terms of number of users, geographic and programmatic coverage, and complexity, but there are diminishing returns at some point. I hesitate to add cost-effectiveness to the same model, but certainly a new model could be made that shows how cost-effectiveness increases as these various other dimensions increase.
Scott, you identified a lot of challenges in the evaluation -- what did you see as the bright spots and where should we be looking for positive examples to learn from?	*Scott Russpatrick (University of Oslo):* Yes there were many. In the assessment process itself, bringing together users and admin across the entire health system had many profound and unexpected positive results. We also found many examples of strong data use, innovative system design, and government ownership and sustainability. Many of these are highlighted in use-case descriptions in the guidelines itself which can be found at dhis2.org/academies
Great to hear about progress on community DHIS2 progress. You mentioned Ghana using an instance of DHIS2 for its community HMIS. Do you have a sense of how many countries are institutionalizing DHIS2 in this way? Are there others that are building community health modules right into the National DHIS2?	*Scott Russpatrick (University of Oslo):* We have directly communicated with or assisted 27, but there could be more because we are not in direct communication with the majority of countries or dhis2 implementations around the world. Some of those countries are building the CHIS directly into their HMIS, but I do not think this approach is very advisable while the CHIS is in early stages of implementation and adoption. Making large architectural changes to the HMIS can potentially disrupt data flow and use across the whole system. I recommend building and implementing the CHIS initially in a separate clone instance of the HMIS. Initially the CHIS can push aggregated data into a CHIS dataset and data elements at the lowest level of the HMIS. After the CHIS has stabilized and has good user adoption then it can be merging in to the HMIS can be first tested and carried out if no technical problems are found. Please feel free to reach out to us or the DHIS2 community (community.dhis2.org) regarding testing protocols to follow when merging instances.
Do you have a sense of the main challenges that are precluding facilities from analyzing and using data?	*Jerome Korvah (Liberia MoH):* Some of those challenges included: • Stock out of standard MOH reporting tool

	• Staff attrition. Training of newly employed staff on reporting and information system often is done during supervision by mentoring which do not take much time with the staff. • Onsite supervision and mentoring often is not held as scheduled
It would be great to hear Jerome discuss the process of engaging private facilities and what successes/challenges there have been getting them to report into the system	*Jerome Korvah (Liberia MoH):* The Ministry has the same processes for engaging both private and public facilities. Government do not have control over the skill set of staff haired at private facilities. Also some of the data use fora like staff meetings and HFDC meetings are not always held at private facilities.
Given the limitation of skilled human resource in remote rural areas, and the high demands for skills in multitasking in the available health personnel, how would you ensure an effective uptake of the Resource Package for supporting communities to use health data. Especially given that several of such tools exist but the uptake is usually low.	*Jennifer Yourkavitch (MCSP/ICF):* The intended audience for the Resource Package is program managers and organizations that may be working on health programs in communities. This audience, as a start, can help build community capacity to use the data their programs generate, as well as health data in the community. It may take some effort and advocacy to make this a priority. *Melanie Morrow (MCSP/ICF):* When prioritized, there are opportunities for implementing partners to work with their government counterparts to build capacity in this area.
There seem to be quite a few forms and registers at community level. How many CHAs are completing these forms every month? How do the community data get into the DHIS2? Are community data disaggregated and visible at district, county and national level?	*Jerome Korvah (Liberia MoH):* There are 3166 active CHAs, reporting rate shows 80% - 84% of them report every month. Community data comes as aggregate and summarize into a supervisor (CHSS) report. In the DHIS2 it is the CHSS that is represented as an organizational unit. Data is disaggregated at CHSS, Facility, District & County levels.