Regional Level Review cum Orientation Workshop
on Revised HMIS Format
4th and 5th July 2023

Organized by

REGIONAL RESOURCE CENTRE FOR NORTHEAST STATES

(Branch of NHSRC)

In Collaboration With

STATISTICS DIVISION, MINISTRY OF HEALTH & FAMILY WELFARE, Govt. of India

Proceeding of the two day's "Regional Level Review cum Orientation Workshop on Revised HMIS Format" held during 4h – 5th July 2023

at Hotel Palacio, Guwahati

Day 1:

Inaugural session

The Two (2) days Regional Level Review cum orientation Workshop on Revised HMIS Format began with an opening ceremony led by Sagarika Kalita ,Consultant, HMIS at the Regional Resource Centre for North-Eastern States (RRCNE). She cordially welcomed the esteemed Chief Guest, Dr. Nilmadhav Das, Director of Health Services (DHS) in Assam, along with other dignitaries present both on and off the stage. Her warm welcome set the tone for the inauguration session, expressing gratitude for their presence and acknowledging their valuable contributions to the workshop. Additionally, resource persons from the Statistics Division of the Ministry of Health & Family Welfare (MoHF&W) were present, including Mr. Anindya Saha, Deputy Director, SP Jaiswal, Senior Consultant, Dr. Nidhi Tiwari, Consultant, and Dr. Aditya Kumar, Consultant. Participants from various districts representing all eight North-eastern States were also in attendance.

She emphasized the primary objectives of the workshop, which were to provide orientation to the states on the revised monthly service delivery and infrastructure formats of the Health Management Information System (HMIS). Additionally, the workshop aimed to facilitate discussions on data quality issues, recognizing their significance in improving healthcare services and policymaking.

After the felicitation of the Chief Guest and resource persons, she invited the Chief Guest for addressing the participants. Dr. Nilmadhav Das, extended a warm welcome to all the participants and expressed his gratitude for their presence at the workshop. In his address, he provided a comprehensive overview of the evolution of the HMIS and emphasized the importance of establishing a strong and robust monitoring and evaluation system for the successful implementation of health programs across the country. He concluded by stating that the workshop would serve as a valuable platform to stay updated on the revised HMIS format and assured that the doubts and queries of participants regarding the revised HMIS would be addressed and clarified during the course of the workshop. Thereafter, Mr. Anindya Saha was invited for the keynote address wherein he thanked RRCNE for providing the platform to discuss the changes in the revised HMIS format. He also assured the participants that the reports of HMIS will be available in the portal soon and highlighted that NITI Aayog would be taking specific data elements from HMIS data for the Aspirational District/ BlockProgramme. Following the keynote address, all the participants introduced themselves. A group photograph marked the end of the inaugural session. Following the group photograph, the participants took a break to enjoy a refreshing tea.

Technical session

Post-tea break, Assam presented its process for ensuring the quality of HMIS data. The State highlighted that its data quality review mainly focuses on maternal death, child death and home-delivery pockets. A monthly factsheet is prepared based on HMIS data and a district-wise comparative assessment of all data elements is done using MS Excel and shared with all stakeholders of the State- including the Deputy Commissioner and the Principal Secretary through proper channels. Data quality feedback is provided to each facility in the State monthly. A district-wise validation error file is also maintained monthly. Few of the measures to maintain HMIS data quality include

sharing monthly minutes of district-level HMIS meetings with the State, formation of an HMIS core team committee and the appointment of Nodal officers at the facility level including medical colleges. The line lists of maternal and child death are also compared with HMIS data and shared with each district to maintain the quality of HMIS data. A manual alert system via WhatsApp is in place to line list maternal deaths in Assam. This mechanism may be replicated in other States. Reporting on the indicator on AEFI was found to be problematic in the State.

Following the presentation by Assam, the resource persons presented the features/attributes introduced into the HMIS format. During the discussion, the resource person inquired about the current status of HMIS data entry in the eight North-eastern (8NE) States. In response, RRCNE reported that Assam and Tripura had successfully completed a major part of the data entry work, ensuring substantial progress in their respective states. However, RRCNE also acknowledged that the ongoing circumstances in Manipur had posed challenges, preventing them from completing the HMIS data entry process as desired. Dr Nidhi informed that in the revised version of HMIS, the indicators in the service delivery format have increased whereas the indicators in the infrastructure format of HMIS have been cut down and presently are in line with the IPHS 2022. She further elaborated on the term 'outreach' used in the service delivery format. A query was put up by the State of Manipur that DHS and CMO Office was directly providing health services like immunization (it was not a physical centre) and they were unsure of how to report the same in the HMIS portal. MoHFW informed the State that such cases can be directly entered by creating DHS and CMO Offices as a separate health facility in the HMIS portal and reporting may be done based on the services provided. During the discussions, it was found that there was some ambiguity regarding the total number of outreach services and OPDs. However, the outreach services given by CHO and MO were counted as OPDs in the HWC portal. Further clarity on the issue will be communicated to the States by MoHFW. Several queries on recording the service delivery given at building-less health facilities were also clarified by the resource persons. The resource person enumerated several new indicators added in the HMIS format which included indicators for Anaemia Mukht Bharat, lymphatic filariasis, age-wise bifurcation of pregnant women, institutional births & maternal births, thyroid and TB test for pregnant women, peer educator programme, NACO, NRC indicators, National Viral Hepatitis programme etc. and discussed the status of the creation of Block Headquarters (BHQ) in each State. Bed-wise category has been removed from the infrastructure part of HMIS. Other topics of discussion included facility sub-type, ownership classification, facility category, time stamping, the inclusion of tea garden facilities, FRUs, LaQshya, Mera Aspatal, Kayakalp, NQAS, delivery points, XV-FC, PM-ABHIM, digital bucketing, instances of refusal by medical colleges to provide HMIS data elements to the State and expectations of the Central HMIS team from the State teams. The session ended with a lunch break.

The subsequent session entailed a thorough discussion regarding the inclusion of new and existing data elements within the service delivery framework of the HMIS. Before delving into the discussion, all participants were provided with the revised service delivery matrix for reference. The experts shed light on the definition of ANC services and addressed any queries regarding what should be considered an ANC visit, and what are the presumptive symptoms of TB. Various issues pertaining to the data elements under the ANC section were discussed. These included the total count of newly registered pregnant women for ANC and its distribution according to age groups, as well as the overall ANC footfall (combining both old and new cases) for the month. Additional concerns were raised, such as the possibility of duplicate registrations, the reporting of the number of iron tablets administered instead of the count of pregnant women receiving them, the occurrence of identical figures for the number of pregnant women registered for ANC during the first trimester and the number of women provided with a single albendazole treatment after the first trimester, confusion over OGTT and RBS test of pregnant women, and confusion over eclampsia and preeclampsia case definition while data entry. Furthermore, the feasibility of collecting data for new attributes within the HMIS format was discussed. After these in-depth discussions, the participants took a break for tea.

Post-tea break, the discussions continued on why the outreach section in service delivery was not open for follow-up in sterilization. Furthermore, indicators like the proportion of serious/AEFI deaths among total AEFI cases, treatment of diarrhoea with Zinc, leprosy cases, TB cases, peer educators and mixed tests positive for malaria

were discussed. The participants raised concerns regarding the malaria-related data received from the program during the discussion with respect to the reporting period and quality. The resource persons highlighted the need for clarity regarding whether diagnosed cases of cancer, who visit Health and Wellness Centres (HWCs) solely for refilling their medicines, should be included in the count of cancer Outpatient Department (OPD) cases. Certain issues related to the indicator for death due to dog bites were also discussed. The sessions for day one closed after selecting two volunteers for summarising the sessions on day two of the workshop.

Day 2:

On the second day, the session commenced with a review of the key points covered on the first day. Subsequently, the focus shifted to the disparities observed in infrastructure and manpower data in the Rural Health Statistics and deliberations regarding the infrastructure framework of the updated HMIS format. This was followed by an interactive discussion where representatives from each state shared their respective challenges related to data quality.

During the session, discrepancies in the reported numbers of sub-centres and building positions of PHCs/CHCs across the States between the years 2022 and 2023 were highlighted. The resource persons present at the meeting provided detailed explanations about the criteria for categorizing health facilities as Urban Health Facilities. They clarified that PHCs located in urban areas should be considered urban PHCs in the RHS system, regardless of their funding source, whether it is under the National Urban Health Mission (NUHM) or the XV Finance Commission (XV-FC). The resource persons advised the States to introspect their data figures.

During the session, the states raised a concern that facility wise data on sanctioned positions for human resources was not available. In response, the resource person clarified an important distinction between the HR required as per the Indian Public Health Standards (IPHS) and the sanctioned positions. It was emphasized that the HR requirements specified in the IPHS may differ from the actual sanctioned positions in the health facilities.

When a participant raised a query regarding the inclusion of different types of beds in sanctioned/functional beds, the resource person from RRCNE explained the specific criteria for categorizing beds as sanctioned/functional within the infrastructure format. Additionally, the Nagaland team informed the participants that they have a designated building for a particular facility. However, due to floods in the vicinity of the designated building, the facility is currently operating from an alternate location. They sought guidance on how to consider this situation in the infrastructure format. In response, the resource person informed the Nagaland team to continue to report data into the infrastructure format for that facility as such issues may occur on rare occasions. This would ensure that the HMIS accurately reflects the operational status of the facility despite the temporary relocation due to floods. Thereafter the group dispersed for a tea break.

Post tea break the resource persons explained the term partial availability of diagnostic tests. The resource person highlighted the need for an official administrative document/notification for upgrading/creating/downgrading a health facility irrespective of the source of funding for the upgrade/creation of the facility. The states put forth a suggestion during the discussion, proposing the implementation of an auto-generation system for determining the IPHS compliance status of healthcare facilities using HMIS data. They emphasized that automating this process using the entered IPHS data would be a highly efficient method compared to manual methods currently in place. The States requested to open the master sheet, however, the resource person stated that if time stamping needs to be done the back-end developers need to be present for removing the previously entered data and therefore the States will be notified once developers are available, and the time-stamping option is unlocked and will be made available for three days. He said that comparison of deliveries against ANC will not be accurate unless a correction factor is used to account for 15% duplication of ANC registration.

During the discussion on the infrastructure format of the HMIS, the states provided valuable updates to the resource persons from the ministry regarding necessary modifications in the revised infrastructure format. Few examples of such modifications included:

1. The Assam Team highlighted the existence of New-born Stabilization Units (NBSUs) at the PHC level facilities.
2. Tripura and Nagaland informed the resource persons that private wards are available at the Community Health Centre (CHC) level in their respective states.
3. Furthermore, Tripura mentioned the presence of an isolation ward from the PHC level onwards.
4. Block Public Health Units may be available at the PHC level.
5. An integrated public health laboratory may be available from CHC Level.
6. Multiple options are available for lab tests. Hence multiple selections need to be activated in the HMIS format.
7. Data entry points for blood banks, blood storage units, and dental technicians are repeated in the format.
8. Functional medical oxygen plant at CHC level.
9. A functional dental chair will not be present at the SHC level format.
10. A labour room is a data element, which will be available at the SHC level.

These updates shared by the states played a crucial role in ensuring that the revised infrastructure format of HMIS captures the accurate and comprehensive infrastructure information of the respective states. Thereafter, the group dispersed for a lunch break.

Post lunch break, representatives from each State presented the measures they employ for quality checks and the issues they face in maintaining data quality. The first presentation was by Tripura. Tripura informed that traditional methods like meetings and one-to-one discussions in the form of review meetings are conducted to ensure HMIS data quality. Quality checks are being done by data entry operators and the person analysing data, thereby ensuring data ownership. A data verification committee is also appointed at each level by the State government. To ensure the accuracy and reliability of HMIS data, developmental partners are actively involved in the process of cross-checking the data with facility registers. The next presentation was by Nagaland. They said that an HMIS review is conducted to ensure the timeliness, accuracy and completeness of data. However, such reviews are not conducted very often. A few of the common quality issues from their State were also presented. The next presentation was by Arunachal Pradesh where they stressed the existence of a district validation committee, and State and district-level monitoring committee to ensure data quality. Excel is utilized as a valuable tool to conduct comparisons of HMIS data with data from previous years to ensure quality. The next presentation was by Sikkim wherein they stressed the importance of regular and refresher training to ensure quality while collecting and analysing HMIS data. To ensure the maintenance of high-quality data, it was emphasized that periodic cross-checking of the HMIS data is conducted with the corresponding facility registers. In Meghalaya, monthly comparisons of data were conducted among districts and facilities using scorecards and index scores to rank their performance. They also implemented peer analysis, exchanging data analysers between districts for data analysis. In Mizoram, quarterly review meetings were held at facility and district levels, providing feedback, and conducting monitoring and evaluation. Data validation was done at state and district levels, the superintendent at DH playing a crucial role. To ensure timeliness, correctness, and completeness of data, medical officers from respective areas were involved in the checking process. The Director of Medical Services issued an order for all private hospitals to register themselves under the Clinical Establishment Act and submit the necessary undertakings once the situation in Manipur normalized. Manipur also addressed the issue of incomplete data being submitted by Medical Colleges and the Regional Institute of Medical Sciences (RIMS). Manipur requested the Ministry for a communication may please be made to RIMS, urging them to submit the complete data of HMIS as it had been pending for two years. Additionally, it was observed that while some private hospitals conducted deliveries, immunization services were

primarily provided in public hospitals. As a result, the immunization coverage reported in public facilities was higher than the number of live births recorded. State-level review meetings were conducted on monthly basis, where Manipur presented data indicating an increase in the utilization of public facilities and their services over the past years. This demonstrated the positive impact of their efforts in promoting public healthcare facilities.

The presentations were closely followed by a discussion on discrepancies in data quality, including instances where live births were recorded without any institutional or home deliveries, home-based new-born care provided where no home deliveries were registered, and mismatches in the number of albendazole tablets distributed compared to the registered first-trimester women. Other discrepancies involved a significant difference in the number of haemoglobin tests compared to registered ANC cases and a high number of deliveries recorded without corresponding live births. Tripura and Meghalaya were advised to involve ministry representatives in their HMIS data reviews. Feedback was collected from all states regarding the workshop, focusing on pros, cons, and suggestions for improvements in future workshops.

The Workshop under Lenses

<table>
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<tr><td>Address by Chief Guest: Dr.. Nilmadhav Das,DHS Assam</td><td></td><td>Participants from NE States during Group Works</td></tr>
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Participants List of Regional Level Review cum Orientation Workshop on Revised HMIS Format for NE States

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