Report to the Kaduna State
Ministry of Health

Consultant Organization:

HEALTH MANAGEMENT INFORMATION SYSTEM NEEDS ASSESSMENT

December 2008

SECTION 1

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1.3 Abbreviations and Acronyms

AMRO	Assistant Medical Record Officer
CAFOD	Catholic Foundation for Overseas Development
CHAN	Christian Health Association of Nigeria
CHEW	Community Health Extension Worker
CMRO	Chief Medical Records Officer
DDPRS	Deputy Director of Planning, Research and Statistics
DPRS	Director of Planning, Research and Statistics
DR	Daily Register
DSN	Diseases surveillance and Notification
DSNO	Diseases surveillance and Notification Officer
FMOH	Federal Ministry of Health
GCE	General Certificate of Education
HDCC	Health Data Consultative Committee
HF	Health Facility
HMB	Health Management Board
HMIS	Health Management Information System
HRO	Health Records Officer
JCHEW	Junior Community Health Extension Worker
KADSEEDS	Kaduna State Economic Empowerment Development Strategy
KD	Kaduna State
LGA	Local Government Area
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MHWUN	Medical and Health Workers Union of Nigeria
NCH	National Council of Health
NEPAD	New Partnership for Africa's Development
NHMIS	National Health Management Information System
NHP	National Health Policy
NSHDP	National Strategic Health Development Project
PATHS	Partnership for Transforming Health Systems
PFP	Private For Profit
PNFP	Private Not For Profit
SCHEW	Senior Community Health Extension Worker
SMOH	State Ministry of Health
SNR	Strengthening Nigeria's Response
SPSS	Statistical Package for Social Sciences
STL	State Team Leader
STTA	Short Term Technical Assistance

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WAEC	West African Examination Council
WHO	World Health Organization

1.4 Acknowledgements

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SECTION 2

EXECUTIVE SUMMARY

The National Health Management Information System (NHMIS) policy was adopted by the Federal Government and authorized for use by all tiers of government to enhance the effective management of health care services in Nigeria. The availability of accurate, timely, reliable and relevant health information is the most fundamental step towards informed public health action. Therefore, for effective management of health and health resources, government at all levels have overriding interest in supporting and ensuring the availability of health data and information for public, private and NGO's utilization. The role of government must extend to ensuring standardization and financing of health data infrastructure, procurement and installation of appropriate information technology, staff training and collection, storage, analysis, dissemination and use of health information with respect to strengthening the National Health Management Information System (NHMIS). The goal of NHMIS is to serve as a management tool for informed decision making at all levels of government. There has been lack of smooth functionality of NHMIS, several years after its establishment, due to existing gaps in its execution. This *Needs Assessment* was carried out to identify the nature and extent of the existing gaps in the implementation of the NHMIS so as to strengthen the system.

The Federal Ministry of Health (FMOH) led the assessment team which comprised of the Organization that designed the assessment; HISP NIGERIA and the Kaduna State Ministry of Health (SMOH) officials into the field for data collection. Three Local Government Areas (LGAs) were selected by the team using the three main criteria of geopolitical spread by zones (preferably senatorial zones, LGA accessibility, and facility functionality). In each of the LGAs visited, the Head of Health Department (HOD Health) sent a representative to accompany the assessment team to the facilities within their domain. The assessment team

The Kaduna State assessment was done at State, LGA and health facility levels. At the State level, the HMIS officer, Acting Primary Health Care Monitoring and Evaluation (PHC M&E) Officer and Hospitals Management Board Assistant Medical Record Officer (HMB AMRO) were interviewed using structured tools to obtain information about HMIS/M&E activities in the state. M&E/ HMIS officers from three LGAs (1 urban, 2 rural) were also interviewed. Three main criteria were used for the selection of the 3 LGAs namely; functionality, accessibility and geopolitical zones (senatorial zones). A total of 17 health facilities (HFs) were assessed from the 3 LGAs: 12 of which were public and 5 Private for Profit (PFP). An additional rural LGA, Chikun, was included in the assessment in order to enrol a Private Not for Profit (PNFP) HF which was not available in the formally selected LGAs. The spread of the HFs was as follows; 3 public PHC- urban, 2 public Secondary Health Care (SHC)-urban, 3 PFP- urban, 5 public PHC (rural), 2 public SHC (rural), 2 PFP (rural) and 1 PNFP (rural). Key state level development partners such as World Health Organization (WHO), European Union Prime Project (EU-PRIME), Strengthening Nigeria's Response (SNR) and International Centre for Care of AIDS Patients (ICAP) were also interviewed.

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The Needs Assessment for Health Information System capacity Building was conducted to identify challenges and gaps that existed prior to the inception of PATHS2 project with a view of identifying those that were state specific. Tools for collecting data were used at fours levels - state, LGA, facility and Partners.

Major Findings:

a) Poor implementation of HMIS/M&E activities in the State.
b) Inadequate personnel for HMIS/M&E/ duties at the state and LGAs.
c) Knowledge of HMIS forms and HMIS software and computer literacy is high at the State, low at the LGAs and absolutely lacking at the HFs
d) Inadequate HMIS minimum Packages for a functional HMIS at the state and LGA with none at the HFs.
e) Lack of data collection tools/forms at the LGAs and HFs for effective HMIS activities.
f) Lack of cooperation among HMIS/M&E officers at the State level, more cooperation between the LGA officers and HF record officers.
g) Lack of supervision of LGA M&E activities by the state officials with appreciable supervision of HFs by LGA officers.
h) No knowledge of a functional HDCC in the State and among donor Partners except for EU-PRIME.

Recommendations

- The Federal Government should carry out strong advocacy to attract state/LGA interest towards the full implementation of the HMIS in the state/LGA.
- LGAs in the state should employ trained and qualified staff to handle HMIS/M&E activities.
- More efforts should be made by the SMOH to implement HMIS activities at the LGA and HF levels.
- Adequate funding should be made available by the SMOH for the smooth running of HMIS activities at the State, LGA and HF levels.
- Training of M&E/Health Record officers should be organized especially at the LGAs and HFs. The SMOH should seek support from FMOH to conduct the training on the use of the NHMIS forms and software.
- The SMOH should make available HMIS minimum packages, forms and software as well as other data collection tools at LGAs and HFs.
- Cooperation among HMIS/M&E officers at all tiers, and partners should be encouraged.
- There is a great need for SMOH to revitalize the HDCC in the state.

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SECTION 3:

3.1 BACKGROUND AND INTRODUCTION: (STATE HEALTH PROFILE)

The state of Kaduna has an interesting history, status and health profile which is important to note in the course of this report.

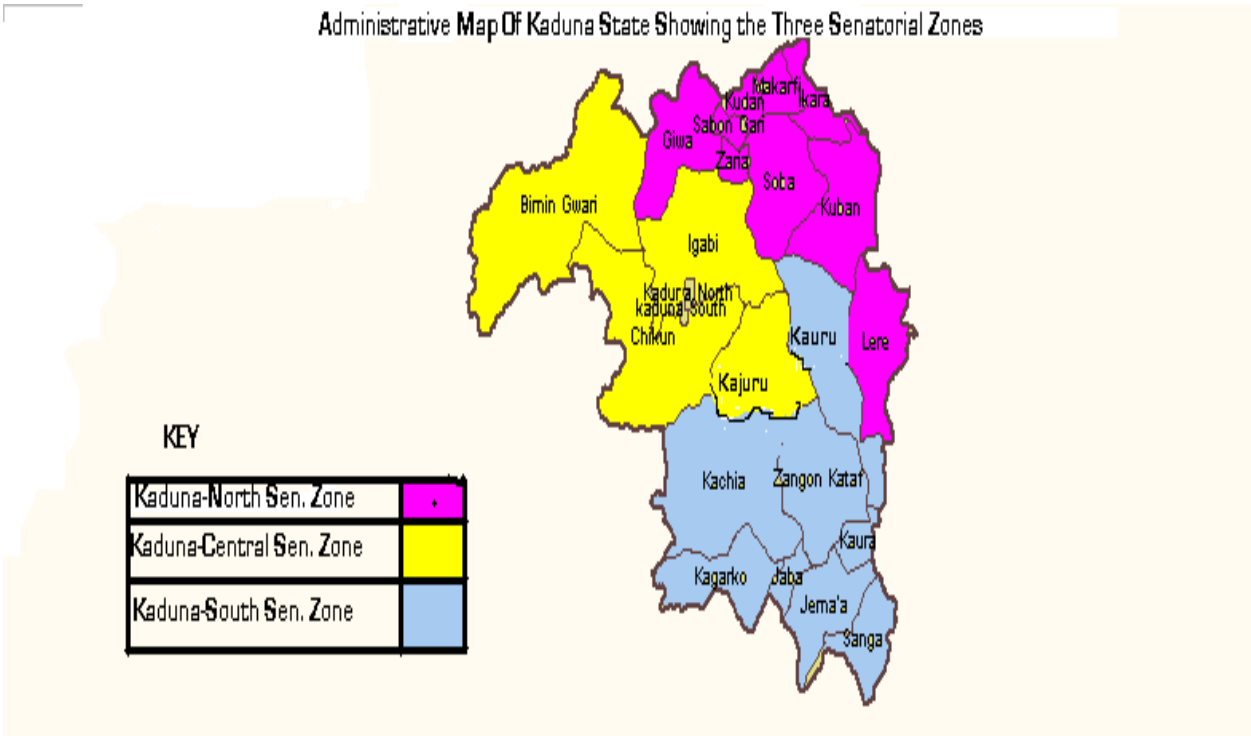
3.1.1 Background to Kaduna State

Kaduna State is in the North West geographical zone of Nigeria. It is the twelfth largest state in the country with 5% of the land mass of 46,000 sq kms. It is culturally diverse with 6 major ethnic groups. The northern part is predominantly Muslim whilst the southern part is predominantly Christian.

Kaduna State has an estimated population of 5.8 million (2005) with an average density of 125 people per sq km and an annual increase rate of around 3 % (in 1991, it was estimated at 3.9 million). This happens to be the third most populous state in Nigeria. Nearly 2 million people live in the two towns of Kaduna and Zaria.

Kaduna state of Nigeria has the city of Kaduna as her Capital. She has 23 LGAs with 261 political wards. The State has a total of 1536 health facilities. Out of these, 46 are faith based, 412 are private while 1078 are public. Because of the high regard for Ahmadu Bello University and other educational institutions situated in Zaria, the state is known as the “Centre of Learning”.

Figure 1: Administrative Map of Kaduna State



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3.1.2 Poverty and health

KADSEEDS clearly highlights the levels of poverty in Kaduna. Around 85% of people in the state live in mud huts; over 70% of households use wood as the major source of energy whilst another 14% use kerosene. Although high levels of poverty are prevalent throughout the state, the northern LGAs are generally worse off and more impoverished than those in the south. There is a clear relationship between individual income and individual health. Poverty leads to lower health status and increased vulnerability. The poor are far more likely to experience social and living conditions that expose them to greater risk, contributing to more ill health and vulnerability to diseases.

3.1.3 Women and Health Equity

In Kaduna women are not empowered to express their health needs and issues. A major barrier for women to achieve good health and well-being is inequality between men and women. Women have different, unequal access to, and use of basic health resources for the prevention and treatment of a range of diseases and for the protection, promotion and maintenance of their health. The lack of effective obstetric services, particularly for emergencies is of particular concern.

KADSEEDS gives key health status figures as follows:
Maternal mortality rate = 980 per 100,000 births
Infant mortality rate = 115 per 1000 births
Under 5 mortality rate = 205 per 1000 births

3.1.4 Background on HMIS: Policy, Structure and Minimum Packages:

The NHMIS is one of the major thrusts of National Health Policy. It is a very essential tool for the ultimate successful implementation of the National Health Policy which requires the availability of accurate, timely, reliable and relevant health information for informed, effective Management and the provision of health services. The origin of the HMIS Policy is based upon the following background information:

3.1.5 HMIS policy

Following the Federal government's reorganization of the civil service in 1988, the Department of Planning, Research and Statistics was created in the FMOH, shortly after which the first comprehensive National Health Policy (NHP) was adopted. It is this policy which called for the mandatory establishment of the National Health Management Information System (NHMIS) by the Federal, State, LGAs and the private health sector of Nigeria. The NHMIS comprises the total of all sources of health information in the country. According to the National Health Policy (1995:37), ***it involves the articulation, establishment and development of the system's constituent parts, including the provision of appropriate infrastructure to make the system function optimally at all levels. The Federal unit tops the NHMIS in the country and provides a focal point for the health information systems nation wide***. This makes it quite necessary for all units to have the NHMIS policy document for reference and guidance.

The resolution which mandated States, LGAs and the private sector to embrace the NHMIS programme was passed at the National Council of Health (NCH) meeting which was held at Port- Harcourt in 1995. In order to ensure the effective

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compliance with this resolution, series of meetings were held with various stake holders in the health development sector from 1995-1999 to that effect so as to create the needed awareness for the importance of this programme. This was also intended to enhance the ownership of the NHMIS programme at all the stages and levels of health information data management.

3.1.6 HMIS structure

The structure of the National Health Management Information System shows the institutional framework of hierarchical levels from which health data and information are to be obtained. At the apex of the structure is the NHMIS Unit. The Unit relates horizontally with the Federal Office of Statistics, the National Population Commission, the National Data Bank, other ministries, international health organizations and other key health data generating agencies in the public health sector, such as the National Primary Health Care Development Agency (NPHCDA), National Agency for Food, Drug Administration and Control (NAFDAC), the National Health Insurance Scheme (NHIS), etc. Vertically, the NHMIS Unit relates and co-ordinates health information related-activities of FMOH departments, parastatals, agencies and professional bodies and interfaces through established protocols with health information related activities of SMOHs and LGAs and other health facilities (public and private).

A functional Health Data Consultative Committee (HDCC) is expected to ensure optimal cooperation, collaboration and co-ordination in Health Data collection, data flow, data custody and release of official Health statistics between the Department of Planning, Research and Statistics on the one hand and other Health data generating departments, agencies and organizations (including International Health agencies).

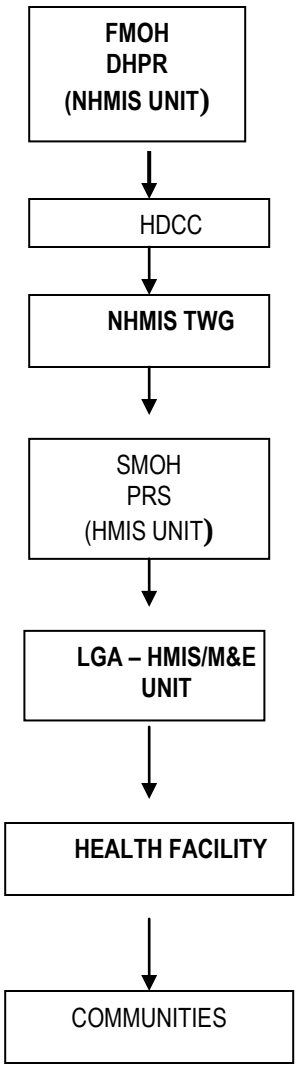

Figure 2: Management Structure of the National Health Management Information System Programme

3.1.7 HMIS Minimum package

The establishment and management of an effective NHMIS, requires substantial investment by federal, state and LGA health authorities in manpower and infrastructural development and in technical assistance within and between the levels. Thus, as part of the overall strategy to improve the quality and quantity of health data and information available for decision-making, HMIS units at all levels are to be provided with a threshold of minimum package to enable them function effectively.

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3.1.7a State HMIS Unit

At the state, HMIS minimum packages required are:

- State HMIS Working Document and NHMIS Operational Manual
- Adequate office space and Office furniture
- Micro-computers for data processing and storage (6), High capacity printers, photocopiers, Full complements of DTP equipment, Binding machines, Power backup and/or Generator, Digital camera, projectors, appropriate software, GIS Software
- **Telematics:** telephone lines (2) with fax network system, internet, and website.
- **Vehicles:** 4-WDR (2), Utility bus(1)
- **HMIS Staff:** HMI Specialist (2) epidemiologist (1), public health specialist (1), Computer Programmer (1), System Manager (1), User- services staff (1), Data Entry and Processing Clerks (3), office assistance (3) Statistician (2), System Administrator (1).
- **Activities:** Data storage, analysis, publication and presentation, Documentation and publication services, User services, Clearing house for health information, State Health Profile, HMIS Forms reproduction, Training.

3.1.7.b LGA HMIS Unit:

Minimum package required at the LGA include:

- LGA HMIS Working Document and NHMIS Operational Manual
- Office space and furniture
- Micro-computer (1), Dot Matrix printer (1), photocopier (1), Binding machines, power backup and/or generator, Geographical Position Machine
- **Telematics:** telephone lines (1) with fax
- **Vehicles:** Motorcycles (2)
- **HMIS Staff:** HMIS Specialist (1) PHC M&E Coordinator (2), Assistant M&E Coordinator (3), System Manager (1).
- **Activities:** Data storage, Analysis, presentation Data forwarding User service, LGA Health Profile, HMIS Forms reproduction, Training

3.1.7.c Health Facility – HMIS

Minimum package requirements are:

- Adequate office space for record keeping with shelves and cabinets etc. and office furniture.
- HMIS facility level summary forms with enough stock to last six months, pencil, erasers, sharpeners, Solar powered calculators.
- **HMIS staff:** Health Record Officers/Assistants (2).
- Activities: Data collection daily in registers and monthly in facility summary forms, Data storage, Data forwarding, Data sharing, Data usage, Training.

3.1.8 Rationale for the needs assessment

A Needs Assessment for Health Information System capacity Building was conducted to elicit challenges and gaps that existed prior to the inception of PATHS II project and efforts of development partners in proffering solutions to such challenges (Dec 2006, Report disseminated Feb 2008; FMOH, WHO, HMN (Health Metrics Network). Following these studies, there have been some interventions from FMOH with the support of development partners. This

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underscores the need for further interventions as can be seen in the call by states for more support to stabilize their NHMIS status which is the basis for the current study being undertaken by the FMOH with support from PATHS II. The result will now help determine the areas that need further strengthening to achieve the much desired culture of health information use at the State, LGA and Facility levels..

An earlier project, PATHSI, had from 2002 – 2008 supported the FMOH and the states to improve NHMIS using basically two strategies i.e. Systems development and capacity building:

Systems Development:

- Development of systems and structures to handle data, based on the information cycle (e.g. registers and tools for collecting data, data flow policy to manage flows of data within the health system).
- Establishment of monitoring systems and structures to manage the information system itself (e.g. systems to ensure the quality of the data produced)

Capacity Development:

- In-service training of local staff from HMIS, management and "vertical" programs to handle data and use information for local management
- Resurrection of a number of work groups to manage the process from SMOH, local government and the faith-based sector
- Training of technical cadres at the state HMIS unit and from local government (M&E officers) to manage the HMIS and ensure sustainability

Institutionalization of feedback to data collectors and provision of regular programme based reports to State and Federal Ministries of Health
The groundwork has been established and the HMIS is basically functional, particularly in states where Health Sector Reform and decentralisation have increased the power of local government and program managers. Data handling processes and infrastructure were strengthened. Strengthening HMIS is a time-consuming and complex process and the transformation of the HMIS cannot be achieved in isolation from major reforms in other systems (e.g. decentralisation, accountability, financial management, performance improvement) and with local level leadership. The HMIS will only fulfill its potential if there is a sustained demand for quality information by managers. In addition, managers need to actively use information to monitor the implementation of plans that are linked to resource allocation and accountability.

The additional challenges now are to build on the foundation of a functioning HMIS by strengthening overall management; and developing meaningful partnerships between government, donors, programs and the faith based organizations that will transform the use of HMIS. The information system must be reproducible and listen to managers, give them faith in the data they collect and provide them with reliable data and information they need for monitoring health programmes and services. The key to this is regular and relevant feedback to reporting units by program managers with skills to interpret and analyze. This process has begun and needs systematic support, through linking information to release of funds and equipment to achieve realistic targets and plans.

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PATHS II project, having realized the need for continuity, sustainability and support for strong local expertise aims to build on the successes of PATHS I by identifying areas of strengths as well as plugging loopholes discovered through areas of weaknesses.. It is expected that previous work would be consolidated and new capacities could emerge that will act as catalysts for a more responsive and effective health system using evidence- based decision making process. In order to sustain the NHMIS, previous decisions must be carried out by all stakeholders by bridging the gap between rhetoric and practice at all levels of the health system. As a re-entry point, PATHS II has commissioned a needs assessment on the current status of HMIS in the states that had been selected as take-off states in 2003 viz; Jigawa, Kaduna, Kano and Enugu. Beginning on the 19th of November 2008, consultants from Health Information Systems Programme, ABT Associates and an independent consultant had been working closely with the Department of Health Planning and Research of the Federal Ministry of Health and PATH II project coordinator to undertake preparatory activities for this needs assessment. This report outlines the methods and findings of the assessment. Based on the findings, some recommendations have been made.

3.2 OBJECTIVES OF THE ASSIGNMENT

The main objectives of the Assessment as outlined in the terms of reference were to:

- Review the process of collecting, collating, analysis and use of health information in the four states.
- Identify the strengths and weaknesses.
- Assess the technical skills of data handlers.
- Assess the availability of basic infrastructure and logistic support for data collection and processing.
- Identify the capacity building needs and other support to be provided to ensure a functional state HMIS.
- Review the functionality and performance of the DHIS system.
- Assess the linkages between the FMOH's NHMIS and the states' systems.
- Explore the complementarities of HMIS and the ongoing NSHDP.
- Assess the functionality of data culture issues in the HMIS.

Some other issues that the assessments sort to cover were;

- Examine the parallel systems that might exist and look for avenues for convergence.
- Identify the residual strengths of the system as it currently is, in order to determine the appropriate re-entry point for the PATHS II Programme.

3.3 APPROACH AND METHODOLOGY

The HMIS Needs Assessment activity has taken a consultative and consensus seeking approach – beginning November 19th – a team of consultants from the Health Information Systems Programme (HISP-NG), Abt Associates and an Independent consultant met with the Deputy Director of Planning from the Federal

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Ministry of Health and PATHS II project coordinator. The meeting reviewed project objectives, deliverables and adopted an outline of plans and activities viz;

- A review of relevant documents.
- Tool adaptation.
- Assessor training.
- Field work.
- Data analysis

Reports of Preceding assessments by the Health Metrics Network (HMN), partnership for transforming health systems (PATHS) and the NHMIS policy document were accessed and made available to the team – a synopsis of these documents was produced and shared within the team – this was intended to provide some background to the inherent issues. Interview tools were adapted after due considerations. From the Federal Ministry of Health HMIS checklist, tools were stratified in order to capture the issues at different tiers (State, LGA, facility), and a separate "discussion list" (all attached in annex) was also designed to be administered to state level development partners. A team of assessors was selected by FMOH officials with technical advice from HISP-NG consultants. At the state level, the teams were to be joined by the State HMIS, M&E officer and Chief Medical Records Officer. The assessors were trained in the use of the tools, expectations and deliverables for the assessment in a one day orientation at PATHS 2 office Abuja. The training was replicated at state level. A fieldwork plan was drawn up with assessors paired off into teams and timelines agreed upon.

3.3.1 Selection of study areas

The selection of LGAs was done in conjunction with SMOH officials while that of health facilities was done at the LGAs in conjunction with the LGAs M&E officers. 3 Local Governments namely Kaduna South, Makarfi and Sanga were selected based on 3 main criteria namely; functionality, accessibility and geopolitical zones (senatorial zones). 17 HF were assessed from the 3 LGAs: 12 of which were public and 5 PFP. An additional rural LGA, Chikun, was included in the assessment in order to enroll a PNFP HF which was not available in the formally selected LGAs, making the total number of assessed HFs to 18. The spread of the HF was as follows; 3 public PHC- urban, 2 public SHC-urban, 3 PFP- urban, 5public PHC- rural, 2 public SHC –rural, 2 PFP- rural and 1PNFP-rural.

3.3.2 Study Respondents

At the state, 6 persons viz: The DPRS/state HMIS officer, PHC M&E officer, CMR,HMB, State Immunization officers, HIV/AIDS M&E officer and DSN officer were the targeted respondents but only 3 of the officers were actually interviewed. The PHC M&E officer, LGA Immunization officer, HIV/AIDS focal Officer, DSN officer and Safe Motherhood officer were the target interviewees at the LGAs and the Health records officers, medical officers, officer in charge at the HFs. 10 officers were interviewed from the three LGAs and 18 from HFs. Additionally, a total of 4 officers, one each, from the four selected State level development partners were also interviewed.

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After completion of the field work, the team re-converged in Abuja for two days to discuss findings and analyze collected data.

3.4 FINDINGS AND ANALYSIS

Findings of the assessment have been presented, analyzed and discussed in three parts, state, LGA and Health Facility, plus the major developments partners.

3.4.1 State Level

Three officers (The State HMIS Officer, Acting State PHC M&E Officer and the Assistant CMRO of the HMB) were interviewed. Their responses have been recorded below under the assessed thematic areas.

3.4.1. a HMIS Management:

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The responses show that there are exclusive office spaces for HMIS/M&E activities at the SMOH. The officers interviewed also said the offices were adequate for their day to day activities. They were seen to operate from three different offices within the SMOH secretariat. They however disagreed over the adequacy of furniture in the HMIS M&E offices. One answered yes while the other said no. However, both offices were seen to be small, choked and un-spacious. Not much of furniture was really seen. The door to one of the offices looked battered. The officer explained that it had been recently burgled.

All three (100%) of the interviewed officers accepted having a vote of charge for HMIS activities. However, there was no common agreement between them as to its funding. One of them did not know if the VOC is funded. One accepted the funding while the other said it is not funded. The true picture of the funding became rather bleak. Yet, they all attributed the delayed training of PHC/M&E officers on the use of HMIS forms to the non release of funds for the printing of HMIS forms. This situation suggests that the VOC may not be well funded at the state level.

It was understood from the responses that most of the officers had no idea of what the Health programme budget amounts to. Only one officer was able to state (35%) as a percentage of the Health programme budget that was released as the VOC for HMIS activities in 2008.

Although the HMIS officer accepted that the amount released was adequate for HMIS activities in the year, the other two said they did not know. By the time of this assessment, the training of LGA PHC M&E officers on the use of the HMIS forms was still awaiting the printing of HMIS forms. It was clear from the pending printing of HMIS forms that the amount released as VOC is not adequate for HMIS activities.

100% of the interviewed officers accepted having an annual work plan for the year ending. The assistant CMRO could not say what percentage of the HMIS work plan was accomplished for the year ending due to his newness in the unit. The

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HMIS officer said 80% while the PHC M&E officer said 60%. Since the work plan itself was not available at interview time, it was difficult to verify.

3.4.1.b Staff Complement:

Three different responses were given by the respondents for number of HMIS staff in the state unit. One Officer said 15 but was able to give the names of only two of the staff. Another said 4 ad-Hoc staff. The third said 5. Despite these disparities, the last two officers were able to give the staff names accordingly. Two of the respondents said the staffs are fairly adequate for the HMIS Unit's activities while one said they are not. It shows a shortfall in the NHMIS policy provision for state level staffing which specifies 16.

All the respondents accepted that all of the State HMIS staff posses the basic computer literacy required for the job at state level. They indicated that the staffs had all been trained on both the HMIS software and forms at the state level. The staff however, did not meet the professional requirement in the NHMIS policy. Only one respondent said the staffs are adequate in skills. The other two answered 'not adequate'.

A question was put to the respondents which demanded to know if they would need additional staff in the face of staff inadequacy. The same officer who said the unit already has 15 staff expressed desire for 30 additional staff! The Acting PHC M&E said 3 as against the 8 desired by the ACMRO. Since, the National HMIS policy stipulates the number of all SMOH HMIS staff as 16, it is not clear if these officers are in the know of this policy requirement.

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3.4.1.c HMIS Minimum Packages:

All the respondents accepted the availability of the HMIS Policy Document. Only 2 accepted the availability of the Instructional manual. Although all of them accepted the availability of Micro computers/PCs for data processing at this level, they showed remarkable differences in the numbers available (10, 3, 5) respectively. While the PHCM&EO said there were no High Capacity printers, the ACMRO said 3 and the HMIS Officer said 5. Both officers said the printers are functional. It was discovered that 1 central power Generator which serves the whole SMOH is available and functional.

Similarly, the HMIS Office said there are internet services for the HMIS unit while the other 2 said there was none. It was later confirmed that the SMOH has a generally functional internet facility. The ACMRO said there were 3 telephone lines in his office for HMIS/Medical Records activities while the other two respondents said they did not have. The ACMRO has HMIS software, just as the HMIS Officer has a non-functional binding machine and a functional projector. Only the PHC M&E Officer has a 4-wheel Drive Vehicle in his office for official activities. HMIS packages not available at the state include fax machines, Digital cameras, utility bus and GIS software. The table below summarizes the findings on the position of minimum packages required for effective HMIS unit at the state level.

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Table 1: HMIS Minimum Packages at State Level

S/N	Requirements	HMIS Officer				PHC M&EO				ACMRO			
		Available	*Functional*	*Not Functional*	*Not available*	*Available*	*Functional*	*Not Functional*	*Not available*	*Available*	*Functional*	*Not Functional*	*Not available*
1	HMIS Policy document	1					1			1			
2	HMIS Instructional Manual	1					1			1			
3	Micro computers /PCs for data processing	10	10				3	3		5	5		
4	High capacity Printers	5	5						✓	3	3		
5	Photocopiers	3	3						✓				✓
6	Telephone line				✓	✓			✓	3	3		
7	Fax Machine				✓	✓			✓				✓
8	Internet Services	✓							✓				✓
9	Websites (website address)				✓	✓			✓				✓
10	HMIS software				✓				✓				✓
11	Binding machine	1							✓				✓
12	Digital camera				✓	✓			✓				✓
13	Projectors	1							✓				✓
14	Generators	1	1						✓				✓
15	GIS Software (Types)								✓				✓
16	4-Wheel Drive Vehicle						1	1					✓
17	Utility Bus								✓				✓

***Source: Derived from interviewee responses*.**

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3.4.1.d HMIS Programme/M&E Data Collection Format:

Almost all data collection tools were unavailable except the House Hold Format which was said to be available in the office of the HMIS Officer, but not enough for 6 months.

The ACMRO was not aware of the availability of any other type of form in use for M&E activities in the state. The respondents said that DHIS forms (which have links with the NHMIS) were printed from the SMOH, used for M&E activities and finally submitted to the FMOH.

Other types of forms for Tracer Diseases, Environmental Health and Family Planning are being used for M&E Programmes and activities at the state level. Their source is not clear. They are submitted to where ever the need for such information arises. There is no data flow chart in the state M&E Office.

3.4.1. e HMIS Processes:

The response indicated that Kaduna state has a functional HDCC which has met twice in the last 6 months. It was gathered that all the 23 LGAs of Kaduna state have been sending HMIS data timely in the last semi annum. The respondent collates data with the computer and gives feed back on received data. He however admitted forwarding the last semi annual summary data to the Federal HMIS unit after June 2008, which is untimely.

From his response, the HMIS Officer conducts monitoring supervision to LGAs on a quarterly basis and also analyses the reports he receives from LGAs. The result of such analysis has been instrumental in the decisions to train other LGAs on the revised HMIS forms. Recommendations have also been made for the continuation of PPRAH trainings. Based on such analyses, decisions have also been taken on FMC, children under the age of 5, and the reduction of child mortality in the state.

3.4.1.f Constraints / Challenges:

The major constraints / Challenges of state unit of HMIS/M&E/PHC towards the performance of health information /M&E activities were found to include inadequate personnel and personnel quality, inadequate working materials and lack of data collection tools, training and shortage of funds. Others are data culture, working environment, transportation, poor staff remuneration and the lack of stationeries.

The respondents called for increased funding of HMIS activities so as to improve the current working conditions. They corroborated the point for increasing workers' remunerations so as to boost their working morale. They also called for more staff training in the relevant areas of the job for greater efficiency in data collection and the maintenance of an acceptable standard of data quality.

3.4.2 LGA Level Findings

Ten respondents were interviewed from three LGAs during the assessment. In Makarfi LGA, the PHC M&E Officer, HIV/AIDS Focal Person, DSN and Safe Motherhood Officers were interviewed. Those interviewed in Sanga and Kaduna South LGAs respectively include the LGA Imunnization Officer, PHC M&E and

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Safe Motherhood Officers. In Their responses have been presented and discussed in this sub-section.

3.4.2. a HMIS /M&E Management

Ninety percent (90%) of those interviewed accepted having a specific office space for HMIS /M&E /PHC activities. The office space is adequate for 2 officers, not adequate for 3 and fairly adequate for 4 of the respondents. This response was not relevant for the Kaduna South LGA immunization officer who had earlier said she had no specific office space for HMIS/M&E/PHC activities. Summarily the office space for HMIS activities at the LGA level is not adequate.

Two of the respondents said their furniture was adequate for the HMIS/M&E/PHC office. 3 said it was fairly adequate. 4 or said it was not adequate. From the summary of responses for this probe, office furniture for the HMIS unit at LGA level is also not adequate.

Concerning a VOC/Budget for HMIS/M&E/PHC activities, 4(40%) of the respondents said they had a vote of charge that is funded, 5(50%) had none and 1(10%) knew nothing about it. With 60% of negative responses to the question of VOC/Budget, it can be cumulatively said that a vote of charge is not adequately maintained at the LGA level for the discharge of HMIS/M&E/PHC activities. The assessments also sort to find out if health facilities have annual work plans for their activities. 50% said they do not have**.**

3.4.2. b Staff Complement

Only 10% of the respondents admitted to have received training on the use of HMIS forms and the software. The respondents took a 50-50 stance on the question of staff adequacy. 50% said their staff strength is adequate as the other 50% said it is not.

There were however, no HMIS specialists or system managers as stipulated by the NHMIS policy for the staff composition of LGAs assessed. The basic qualification of LGA HMIS/M&E unit staff is shown in chart 2 below.

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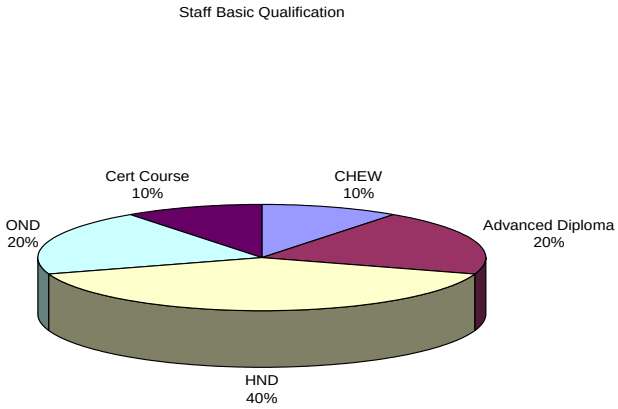
Chart 2:



3.4.2. c HMIS Minimum Packages:

Out of the 14 HMIS minimum packages required by policy for LGA levels, only 10% of LGAs had a functional motorcycle. 70% have 1 non-functional motorcycle each. None of the other packages were present in the 10 LGAs assessed.

The HMIS Programme /M&E Data Collection forms are the basic tools for data capture. They are the primary necessities for the collection of health information. Assessors therefore sought to know if they were available at the LGA level.
It was found during the assessment that the House Hold format forms were not available in all the assessed LGA. 6 respondents (60%) had community tally sheets for ANC and LDR, 70% for tracer diseases, 50% for mortality, and 30% for home activities, community monthly summary sheets and health facility-community outreach services summary forms. Most of the available forms were not enough for a 6 months period. Only one respondent each accepted having a 6 months stock on hand of LDR, mortality and tracer disease forms

50% of responses for the Health Facility Daily Register-ANC showed availability of these forms out of which only10% had enough quantities for 6 months. 70% of respondents do not have the Health Facility Daily Register-LDR. The other 30% had but not enough to last for 6 months.
70% of the respondents have the Health Facility Daily Register-Immunization form out of which only 30% have up to 6 months stock. The Health Facility Daily Register-FPS forms are available to 40% of the respondents with only 10% having enough for 6 months. 60% of respondents had Health Facility Daily Register GMP and OPD but only 10% had 6 months stock on hand. The Health Facility Daily Register IPC forms were available to 20% but not enough to last for 6 months.

Another set of forms not available to 70% of respondents is the LGA Quarterly Forms with only 10% having enough to last 6 months.

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The absence of most of the HMIS forms resulted in the use of various other types of data collection forms such as ANC, LDR, 7LG, BHW, IDSR003, FPS, FIS Routine Immunization , session/outreach and DPT1 &3 dropout monitoring forms These forms do not have any links with the HMIS, and are submitted to the SMOH, WHO and LGAs.. This is contrary to the expectations of the NHMIS policy to have homogeneity of data collection tools for a healthy data quality and culture.

3.4.2. d HMIS Processes

PHC M&E officers in the three LGAs were all found and interviewed on the following HMIS processes;

All three of the PHC/M&E officers (100%) admitted that there is no functional HDCC in their respective LGAs. 2 of the respondents said they received HMIS forms from HFs on a timely basis while10% receive them late. According to the respondent, Kaduna south has a total of 19 public health facilities. Out of these, only 16 were said to be reporting HMIS data to the LGA in the last 6 months. Sanga, with a total of 56 had only 34 (all public) reporting while Makarfi with 34 had only 29 reporting to the LGA. All 100% of the PHC M&E Officers accepted giving feed back to HFs on data received as well as conducting monitoring and supervision on monthly basis. They all accepted to have been collating data manually. Only 2 of them forwarded their last monthly summary reports to the state timely. 1 forwarded late (untimely). 2 of the 3 LGAs said they analyze reports received from HFs. and have used their analysis for the orientation of officers in charge of HFs and to conduct meetings in order to address the observed abnormalities of data collection in the LGA.

3.4.2. e Constraints / Challenges

All respondents (100%) accepted inadequate personnel, inadequate working materials, transportation, training and funds as their major constraints /challenges in the sustenance of HMIS at the LGA level.

60% of the 10 respondents accepted that quality of personnel was a major constraint /challenge for them. 70% accepted that Inadequate and Lack of data collection tools as a major challenge / Constraint and data culture was a major constraint to 80% of the respondents

The working environment was recorded to be a major constraint /Challenge for 90% of the respondents. One of the respondents (10%) mentioned lack of HMIS forms as another constraint while another decried the lack of adequate motivation of PHC M&E officers.

3.4.3 Findings at the Health Facility (HF) Level

The last level of assessment was the HF. The findings are presented below.

3.4.3. a HMIS Management

56% of the HFs was found to have offices for health records purposes.. The office space and furniture were not really adequate for health record purposes as was reported by 33% of respondents. 72% did not have a vote of charge specific funding for health records activities. Even for the two that accepted funding, the amount was not totally released for the year 2008. 78% of the HFs assessed did not have an annual Work plan for health records activities.

Majority of the HFs had adequate M&E staff strength. Computer literacy was however seen as a major challenge.

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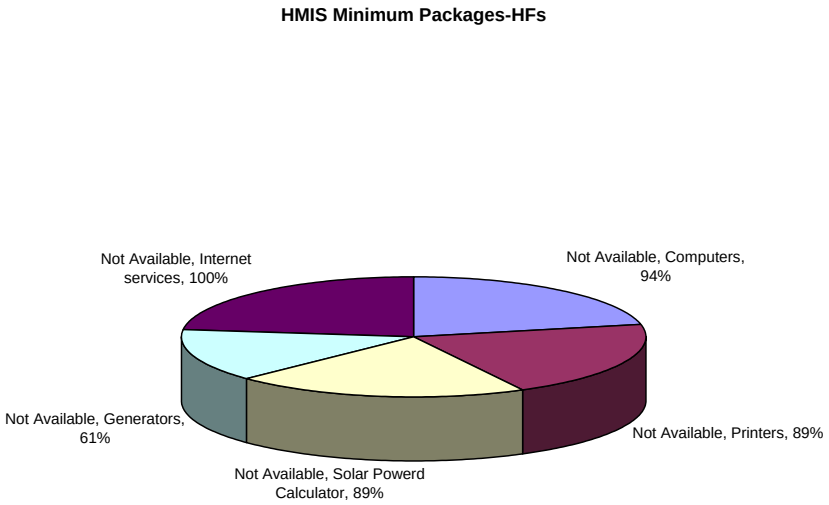
3.4.3. b HMIS Minimum Packages

The required HMIS minimum packages for HFs include micro computers for data processing, printers, solar powered calculators, generators and internet connections. 94% of the HFs had no computers. 89% had no printers. A solar powered calculator was found in only one NGO HF. Also, 61% have no power generators. Only three functional generators were found in the 18 HFs assessed. No internet services were available. See chart below;

Chart 3:



3.4.3.c Data Collection Forms And Formats

Accurate data collection is a basic need for health planning and management in the country and the HF is the primary point for data generation. A carefully planned and articulated data collection format has to be put in place for HFs through the use of specialized forms. The assessors sort to find out if these formats and forms are available for use at the assessed HFs.

Majority of the 18 HFs did not have HMIS forms. The non availability of the proper HMIS forms in the facilities has created a situation whereby other forms for data collection/M&E have taken the centre stage. A collection of such forms used in HFs include DSN Forms, DSN,TD, FP,GMP Monthly forms; Facility immunization Monthly Summary, ANC, FP, GM, DSN forms; FMC HL Reports and Daily Cumulative Records. It was found that 67% of these forms do not have any links with the HMIS. When completed, some of these forms are submitted to the SMOH, General Hospital SACA, LGAs and other bodies like CAFOD and ICAP. This attitude may rather disrupt the information flow channel and also cause a digression in the data flow chart.

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3.4.3. d HMIS Processes

61% of HFs submitted their last monthly summary data to LGA/PHC/M&E units timely.. Monitoring.visits were carried out by LGAs to 61% of the assessed HFs in the last 4 weeks. Most of the LGA visits are carried out on a quarterly basis. Only 50% of the HFs was given feedback on data received. Majority of the HFs (61%) did not analyze the data which they generated.

3.4.3. e Constraints /Challenges

Issues that were identified as major constraints and challenges at the HF level include inadequate personnel and their quality, inadequate working materials, lack of data collection tools, data culture, working environment, transport, training and funding. Others include frustration and lack of encouragement, insecurity and lack of basic equipment for the performance of HMIS functions.

3.4.4 DEVELOPMENT PARTNERS ANALYSIS

Four partners were interviewed. These are The World Health Organization (WHO), The European Union Prime Project (EU-Prime Project), International Centre for Aids Control and Planning (ICAP) and Strengthening Nigeria's Response (SNR).

3.4.4. a Interview with ICAP

This partner whose area of interest is basically HIV/AIDS operates an office at the administrative block of Barau Dikko Specialist Hospital. ICAP's implementation sites include Barau Dikko Specialist Hospital, Yusuf Dantsofo Memorial Hospital, General Hospital Gwamna Awan, Mokafi Gambo and Sowaba hospitals. During the assessment, it was discovered that ICAP collects routine data and accepted following the data flow chart at monthly intervals. It neither used the NHMIS forms nor forms that have any link with the HMIS. However it accepted supporting HMIS activities in the state through the supply of data collection tools, training of data collectors and provision of equipment for data collection. ICAP is not aware of the HDCC meetings as an integral mechanism for health data management in the state. It also has no major challenges with HMIS.

3.4.4. b Interview with the World Health Organization (WHO)

The World Health Organization operates from No.1, Gulf course Road, Ungwan Rimi and has interests in the areas of disease Control, Epidemic out-Break Response, Immunization Surveillance, HIV/AIDS, TB, Malaria, Guinea Worm and Essential Drugs. It implements these programmes through out the state. WHO collects monthly routine data at the community, HF, State and LGA levels. WHO does not use the NHMIS forms for data collection but used forms which have links with HMIS. WHO did not support any HMIS activities in the state and is not aware of the existence of the HDCC as an integrated mechanism for health data management in the state.

The major challenges of WHO with the HMIS in the state include weak coordination, low capacity, irregular training and lack of feed back.

3.4.4. c Interview with EU-PRIME Project

The European Union–Partnership to Reinforce Immunization Efficiency (EU-PRIME) has a project office located at the state epidemiological Unit, Tafawa Balewa Way, Ungwan Rimi. It is primarily interested in Routine Immunization,

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Capacity Building for Immunization Service Providers and Infrastructural Development for 5 Selected LGAs (Igabi, Zaria, Kubau, zangon- Kataf and Kagoro) of the state. The project used forms other than those of the HMIS to collect routine data and observes the monthly and quarterly data flow intervals. Although it admited having links with the HMIS, EU-PRIME does not support any HMIS activities in the state. It is aware of the HDCC meetings in the state as an integrated mechanism for health data management. The major challenge of EU-PRIME with the HMIS lies in the area of incomplete data flow and out dated data.

3.4.4. d Interview with SNR

Strengthening Nigeria's Response to HIV/AIDS (SNR) is a functional development partner with an operational office located at No 20, Katuru Road, Opposite NAF Club, with a primary interest in HIV/AIDS and System Strengthening. The SNR collaborates with the State Action Committee on AIDS (SACA), ISACA, Civil Society Organizations (CSOs) and Local Government Action Committees on AIDS (LACAs). SNR collects routine data using NHMIS forms and empowers LACA M&E officers to follow the data flow interval while submitting data to SACA.

SNR is in support of HMIS activities in the state through the provision of data collection tools, training and funding for some programmes. This partner is however not aware of the HDCC meetings in Kaduna state as an integral part of the data management, Untimely submission of data was their major challenge with the HMIS in the state.

3.5 DISCUSSIONS

The achievement of effective health management services in Nigeria requires the collection of appropriate and reliable health data. This is what informed the establishment of the NHMIS as an aspect of the National Health Policy and Strategy to achieve "health for all" in 1988. The HMIS provides the most comprehensive and systematic methods of data collection and analysis for planning, management and the monitoring of progress in the health sector. Therefore, it has been recognized as a very fundamental step towards modern Public Health practice in the country.

The NHMIS policy document requires each of the three tiers of government to establish a functional HMIS unit with an office space exclusive for HMIS/M&E activities and a clearly defined work plan.

According to the policy document, this office should also be adequate and well furnished for the performance of HMIS activities. Budgets should also be regularly drawn and funded for the maintenance and sustenance of NHMIS units at all the three levels (State, LGA and HF). In 1996, the Federal government approved and directed all tiers of government to allocate "between 0.5% and 1.0%" of their annual capital Health budget for the development, maintenance and strengthening of the HMIS /M&E programme.

At state level, the policy stipulates that there should be 1 HMIS specialist, 2 PHC M&E coordinators, 3 assistant M&E coordinators and 1 systems manager. However, the HMIS programme is still experiencing various challenges which constitute gaps in its full functionality. In Kaduna state, the state unit level has not

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been able to fully comply with the national policy expectations in the areas of staffing, personnel quality, and adequate budget funding and minimum packages. Gaps have also been found to exist in the absence of adequate data collection tools and working materials. The unhealthy data culture is also dependent upon the working environment and transportation support. This situation requires the SMOH to expedite action towards improving the condition of HMIS in the state.

At the LGA level, it was found that the NHMIS policy has not been given the desired attention. The Policy may not be well understood here or it is yet to be fully implemented at the assessed LGAs.

According to the policy document, the NHMIS is imbedded in the provision of appropriate infrastructure, mechanisms and procedures for collecting and analyzing health data to provide the required information. This underlies the FG approval for all tiers of government to set aside 0.5% and 1.0% of their annual budgets for the Development of the HMIS. Much of this has not been seen on the ground in the areas of assessment. The office space and furniture are both inadequate for the performance of HMIS activities at LGA level. The VOC/budget is not adequately maintained, and funded. The absence of most of the data collection materials and minimum packages can be linked to the inadequacy of funding been experienced by the unit at the assessed LGAs.

On matters of staff complements, The National Policy specifies that every LGA should have 1 HMIS specialist, 2 PHC M&E coordinators, 3 M&E coordinators and 1 systems Manager. The number of HMIS staff who should be in an LGA is stipulated by the NHMIS policy document as 7. The situation in the assessed LGAs does not reflect the policy provision for LGA HMIS unit. The existing gap here lies in the need to match the Policy provisions concerning unit staff with the employment pattern of the assessed LGAs in Kaduna State. Care should be taken to employ the quantity and quality of professionals laid down in the policy document.

The funding status of the HFs is not encouraging. The directive from the FG to all tiers of Nigerian government to provide up to 0.5% to 1.0% of their annual health budget for HMIS activities is still on, but not felt in the HFs here. The enforcing circular has for long been in force since 1996.There is no need for the proprietors of HFs to refuse their funding especially where they are public. A situation where only a negligible percentage of the HFs is given the full amount of their HMIS budget is contrary to the National Policy and does not mean well for the systems development in the state.

An annual work plan is very necessary for any meaningful programme to work out. In the case of the HFs, half of those assessed had no annual work plan. This situation suggests that most of the HMIS work in the HFs is done through trial and error. This may explain the absence of HMIS working equipment, data collection forms and format and other complementary materials. The absence or lack of appropriate HMIS forms at the HF levels may be the principal cause of the proliferation of other types of forms. Therefore, the issue of annual work plan should be adequately addressed for every HF to adopt as a basic necessity.

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The NHMIS policy document provides that the HMIS unit of every HF should have only 2 Health Records Officers /Assistants.
Responses during the assessment revealed that the health records units of nearly all the HFs are overstaffed. In most HFs, it seemed like every one was involved in health records duties. An exceptional case was noticed where a private HF had no staff designated for Health Records duties. Such duties are covered by any of the Auxiliary Nurses and clinic attendants. Only 4 HFs (22%) were staffed to NHMIS policy expectations. It is clear from the developments of the assessments that the NHMIS policy document is not well understood or implemented at the HF level. HFs with over staffed health records units also complained of staff inadequacy! Most of them even expressed need for additional staff.

Cumulatively, none of the minimum packages is available in about 40% of the HFs. This does not comply with the NHMIS policy requirement for the facility level. From the findings, there is a need for majority of health records staff to be given training on basic computer skills, HMIS forms and the software in order to strengthen their capacities as data collectors of the unit.

Development partners are seen by the NHMIS policy as specialized health control programmes and expects them to budget properly for HMIS related activities. Partners are expected to collaborate with the NHMIS unit while performing their functions. Towards this end, the policy requires partners to contribute properly for the strengthening of health data processes in their various states of operation. One partner was found who neither used HMIS forms nor had any link with the HMIS. Yet it collects Routine Data and accepted to be observing the data flow chart. Some partners like the WHO are found at all the levels of data collection and management, using forms that are different from the ones recommended by government. This implies that the partners are not complying with the NHMIS policy and are not been checked either. This situation is not really healthy for the sustenance of HMIS in the state.

The HDCC was established by the FMOH in order to ensure "*cooperation, collaboration and co-ordination in Health Data collection, flow, custody and release of official Health statistics between the Department of Planning ,Research and Statistics on the one hand and other Health data generating departments agencies and organizations including international Health agencies*" (Circular No. MH 416,5th March 1996). It has the objectives to;

a. Ensure effective articulation and coordination of inputs from the various data sources with a view to producing relevant, timely, up to date and uniform health data;
b. Facilitate and coordinate the design of appropriate formats for health surveys;
c. Standardize formats for health data returns from all health facilities in the state;
d. Promote inter-departmental and inter-agency cooperation and collaboration in health data related matters with due cognizance given to the statutory responsibility of the DPRS to coordinate public health data and information in the state;
e. Provide inputs to annual reports of progress towards state health goals and targets;

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f. Provide inputs into annual reports of development in state statistics through the state statistical agency;
g. Make recommendations concerning the implementation of the state health information system; and finally, to
h. Address other critical issues in the state health data system.

In addition to this wide spectrum objectives, membership of the HDCC as approved by the National Health Council is widely required to embrace:-

1.	DPRS	Chairman
2.	Director (PHC & Disease control)	Member
3.	Chief Executive HMB	Member
4.	representatives of International health agencies /NGOs active in the state (eg WHO,UNICEF)	Member
5.	representative of Teaching Hospital and /or Federal Medical Centre	Member
6.	Representative of private health Establishments	Member
7.	Chief Medical Records Officer	Member
8.	National Population Commission/FOS	Member
9.	Assistant Director (PRS)	Member/Secretary.

Unfortunately, the HDCC is known to exist only at the state level. Only one of the four partners is aware of the existence of the HDCC. This means that the membership structure is not been adhered to. According to the NHMIS policy, all health development partners are supposed to be represented on the membership of the HDCC. From the responses, it is clear that 90% of the partners have not been intimated with the true position of their membership of the HDCC in the state. With a non functional HDCC, the expected policy aims and the very viable objectives for its establishment may be difficult to achieve.

3.6 CONCLUSION AND RECOMENDATIONS

The HMIS needs assessment exercise was successfully conducted at the State, LGA and HF levels in Kaduna state in order to ascertain the position of HMIS Management, HMIS/M&E Minimum packages, Data Collection Forms And Formats, HMIS Processes, Constraints and Challenges. The findings have revealed a number of gaps in the optimum functionality of the HMIS in the selected areas of assessment. Some recommendations have been made which should be implemented if the philosophy establishing the HMIS is to be achieved. The implementation of these recommendations will help in responding to the urgent needs to strengthen the HMIS in Kaduna State.

Although the importance of the HMIS towards the realization of the National Health Policy cannot be overemphasized, it remains the most appropriate avenue through which the state and LGAs can extend their roles to ensure the standardization and financing of health data infrastructure including relevant organizational structures like the HDCC. They should also stake out for the procurement and installation of

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appropriate minimum packages, staff training, data collection on health information, storage, analysis and dissemination.
At the moment, it is only fair to say that the process of collection, collation analysis and use of health information has been partially curtailed by inadequate funding. The technical skills of data handlers at LGA and HF levels require substantial capacity building and overhaul so as to ensure a functional HMIS.

From the recently concluded needs assessment in Kaduna state, several issues emerged which involve:

- The Financing of the VOC in all the health sectors and Facilities
- The printing of HMIS forms for onward distribution to all necessary offices.
- Strengthening Political interest in the area of health policies and funding
- More attention to the NHMIS policy document and HMIS software
- Strategic timing of projects.

The ***major strength*** of the Kaduna SMOH in the area of HMIS lies in the available health structures on the ground in the state. The state MOH, the LGA Health Departments and the active participation of the private sector in the provision of health services to the people.

Their ***major weaknesses*** include**;**

- ✓ Lack of basic computer skills on the part of data collection staff at LGA and facility levels.
- ✓ Slow action by the SMOH towards the release of funds for the printing of HMIS forms, provision of relevant working equipment and other materials relevant for the training of the LGA and HF level personnel.
- ✓ Absence of relevant HMIS minimum packages at all the levels of assessment.
- ✓ The unclear situation of a functional HDCC in the State.

The ***main threat*** to the HMIS in Kaduna State lies in the non compliance with the NHMIS policy on staffing, funding, and furnishing of HMIS units at LGAs and the health records offices of HFs. The absence of relevant HMIS forms in the state has stalled the training of LGA and HF PHC/M&E officers on the use of both the forms and software.

3.6.1 Recommendations:

Based upon the findings of this assessment exercise, it is hereby strongly recommended that:

- The Federal Government should carry out strong advocacy to attract state interest towards the full implementation of the HMIS in the state.
- LGAs in the state should employ trained and qualified staff to handle HMIS/M&E activities.
- More efforts should be made by the SMOH to implement HMIS activities at the LGA and HF levels.
- Adequate funding should be made available by the SMOH for the smooth running of HMIS activities at the State, LGA and HF levels.

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- Training of M&E/Health Record officers should be organized especially at the LGAs and HFs. The SMOH should seek support from FMOH to conduct the training on the use of the NHMIS forms and software.
- The SMOH should make available HMIS minimum packages, forms and software as well as other data collection tools at LGAs and HFs.
- Cooperation among HMIS/M&E officers at all tiers, and partners should be encouraged.
- There is a great need for SMOH to revitalize the HDCC in the state.

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SECTION 4: ANNEXES

Annex 1 Terms of Reference

TERMS OF REFERENCE FOR SHORT TERM TECHNICAL ASISTANCE TO CONDUCT NEEDS ASSESSMENT IN FOUR STATES

1. BACKGROUND

The partnership for transforming health systems PATHS2 is a six year DFID-Funded programme to strengthen Nigeria's Health system. It is managed by a consortium of partners led by Abt Associates Incorporated, USA in collaboration with OPTIONS UK and Yozu Mannion /New Media Partners. Other partners include John Snow Inc., Axios, Chan and FOMWAN.

The goal of the programme is to ensure that Nigeria's own resources are used efficiently and effectively to achieve the MDGs and its purpose is to improve the planning, financing and delivery of sustainable and replicable pro-poor health services for common health problems in up to six states. The programme has five key out puts as outlined below:

i. Strengthened stewardship role of government (at Federal, state and LGA levels).
ii. Improved systems and regulatory framework for health services management in both.
iii. Improved access by the poor to qualitative and curative services including affordable drugs.
iv. Increased awareness of the public to their entitlement to quality health care.
v. Enhanced capacity of the citizens to prevent and manage priority health conditions themselves.

PATHS II is a government owned -and -led programme and the management partners work in close collaboration with government at all levels, as well as with the civil society including FOMWAN, CHAN, Traditional and Religious Institutions and the media.

2. SPECIFIC CONTEXT

Based on the needs expressed by stake holders at the state level during the initial contacts made by PATHS II, a pre-inception work plan has been elaborated to respond to urgent needs. IN the states, the SMOHs specifically requested PATHS II programme to strengthen its HMIS system and towards this end, PATHS II is supporting the conduct of a HMIS needs assessment of the state.

3. JUSTIFICATION

Health information is an essential component of the health system, since it provides the basis for a sound health planning. PATHS II programme in collaboration with the SMOH in the state is seeking the services of a short term technical assistance (STTA) to conduct a needs assessment for HMIS

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strengthening in Enugu, Kano, Kaduna and Jigawa states to guide HMIS system strengthening activities by the FMOH, SMOH and PATHS II.

4. SPECIFIC/ OBJECTIVE TASKS

Specifically, the consultant will provide the following services:

- Review the process of collection, collation and analysis and use of health information in the four states.
- Identify the strengths and weakness.
- Assess the technical skills of data handlers.
- Assess the availability of basic infrastructure and logistics for data collection and processing.
- Identify the capacity building needs and other support to be provided to ensure a functional HMIS.
- Review the functionality and performance of the DHIS system.
- Assess the linkages between the state systems and the FMOH's NHMIS.
- Explore the complementarities of the state HMIS and the ongoing HMN and NSHDP

5. DELIVERABLES

- A full report containing major findings on the state needs for a state HMIS system, including recommendations for implementing/strengthening a functional HMIS.

6. Performance Period

The consultant will complete his assignment during the period starting from X November2008 to X December 2008.

7. LEVEL OF EFFORT (LOE): 10 Person Days

8. JOB SPECIFICATION

8.1 EDUCATIONAL/PROFESSIONAL QUALIFICATION

Professional qualification in health related discipline as follows:

- Degree with 10 years experience in M&E and / or HMIS or a Masters degree with minimum of five years experience with M&E and/ or HMIS. Specific qualifications related to HMIS and /M&E is an added advantage.
- Experience working with FMOH and /or the SMOH.
- Understanding of Nigeria's Health system and issues around data management.
- Understanding of system requirement necessary for effective HMIS including infrastructure, equipment and personnel.
- Understanding of DHIS is an added advantage.
- Expert user of data base software and Microsoft office application.
- Good interpersonal and report writing skills

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Annex 2: Persons Met / Interviewed

1	Dr. Gyas	DPRS	SMOH, Kaduna
2	Mr. Mathew Sankwei (08028700958)	DDPRS	SMOH, Kaduna
3	Mr. Moses Gankon (08028535403)		SMOH, Kaduna
4	Bashir Yusuf (08028919812)	SHMIS Officer	SMOH, Kaduna
5	Mr. Daniel Ali	PHC/M&E Officer	SMOH, Kaduna
6	Mr. Hosea Jirgi (08030937937)	ACMRO	SMOH, Kaduna
7	Mr. Gambo Abel(08036193384)	Med. Records Office	SMOH, Kaduna
8	Mr Yusuf Ahmed(08038334435)	Admin/Acctg Officer	EU-PRIME
9	Alh. Sani Daba	Executive Chairman	Kaduna South LGA
10	Mr. Mamman S. Kundi (08027055304)	Branch Secretary	MHWUN Kd South Branch
11	Bulus Samaila	ASST.PHC/M&E Officer	Kd South LGA
12	Hajia Hadiza Adamu	Immunization Officer	Kd South LGA
13	Musa Joan	Safe Motherhood Officer	Kd South LGA
14	Shehu Ahmed Abdulahi	ASST.PHC/M&E Officer	Makarfi LGA
15	Angel A. Sheyin	HIV/AIDS Focal Officer & DSNO	Makarfi LGA
16	Tasiu Ahmed	LGA Immunization Officer	Makarfi LGA (Rural)
17	Rebecca Ishaya	Safe Motherhood Officer	Makarfi LGA (Rural)
18	Bala I. Sarkin Noma	LGA Immunization Officer	Sanga LGA (Rural)
19	Joy Bariki	PHC M&E Officer	Sanga LGA (Rural)
20	Mercy Majindadi	Safe Motherhood Officer	Sanga LGA (Rural)
21	Mrs Christiana Musa	HOD Health	Sanga LGA (Rural)
22	DR. E.O. Abba	Officer I/C	Neman Clinic & Maternity
23	Hussaina Isa Ibrahim	Officer I/C	FHC Kakuri 1, KD South
24	DR.A. Ahmed	Officer I/C	Gen. Hospital, Gwamna Awan, KD South
25	Jeremiah Tanko (08082111595	HRO	Yusufu Dantsofo Memorial Hosp, KD South
26	Dauda Medoh	HRO	Bengola Hospital KD South,
27	DR. Chike Okpala	Officer I/C	Delta Clinic &Maternity KD South,
28	Hassan Bitrus	HRO	St. Gerald Hospital, KD South
29	Hajia Hadiza Mohammed	Officer I/C	PHC Makera, KD South
30	Bawa A. Usman	Officer I/C	PHC Gwantu, Sanga LGA
31	Gloria Habu (08063994381)	Officer I/C	Health Clinic Fadan Karshi, Sanga LGA
32	Grace John Pam	Officer I/C	Rilaman Clinic Gwantu
33	Rahab P. Kurmi (0703698328)	Officer I/C	PHC Aboro, Sanga LGA
34	Anthony Bello	HRO	Gen. Hospital Gwantu, Sanga LGA
35	Mansur Dalhatu	Officer I/C	Makarfi Health Clinic, Makarfi LGA
36	Stephen O. Ojo	Officer I/C	Makarfi Clinic & Maternity Centre Makarfi LGA,
37	Yahay Yusufu Tanko	HRO	Gen. Hospital Makarfi, Makarfi LGA
38	Iliyasu Mohammed	Officer I/C	PHC Makarfi, Makarfi LGA
39	Abigail Daser (08035803101)	HRO	Hope for the Village Child Clinic, Chikun LGA

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Annex 3: Facilities visited

	LGA	SHC	PHC	PFP	PNFP
Urban	Kaduna South	General Hospital, Gwamna Awan	FHC, Kakuri 1	Bengola Hospital, television	
		Yusufu Dantsofo Memorial, Hospital, Tudun Nupawa	Neman Clinic and Maternity, Makera	Delta Clinic and maternity, Makera	
			PHC, Makera 1	St Gerald Hospital, Makera	
Rural	Makarfi	General Hospital, Makarfi	Makarfi Health Clinic, Makarfi	Makarfi Clinic and Maternity Center, Tudun Wada	
			PHC Makarfi, Tudun Wada		
	Sanga	General Hospital, Gwantu	PHC, Gwantu		
			Health Clinic, Fadan Karshi		
			PHC, Aboro	Rilaman Clinic, Gwantu	
	Chikun				Hope for the village child,Kujama

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Annexe 4: TOOLS USED:

State Tool

HMIS Needs Assessment in States

2008 FMOH/ PATHS II Collaboration

Questionnaire S/No; S ☐☐

Interviewer's Name; _____

Respondents:

DPRS/STATE HMIS OFFICER ☐ Name; _____

PHC M&E OFFICER ☐ Name; _____

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CMR, HMB ☐ Name;

_____

STATE IMMUNISATION OFFICER ☐ Name;

_____

HIV/AIDS M&E OFFICER ☐ Name;

_____

DSN OFFICER ☐ Name;

_____

STATE LEVEL

STATE IDENTIFICATION DATA

STATE……

HMIS MANAGEMENT	**Yes**	**No**	**Comments if any**
1. Do you have an office space exclusive for HMIS/M&E activities?	☐	☐	

_____

(If no please go to Q4)

	Adequate	Fairly Adequate	Not adequate
2. Is the office space adequate for your day to day activities?	☐	☐	☐
3. Is the furniture in your office adequate?	☐	☐	☐

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		Yes	No	Comments if any
4.	**Do you have a vote of charge (VOC) for HMIS activities?** _____ **(If no please go to Q9)**	☐	☐	
5	**If yes, is the VOC funded?** **(Please verify amount and record under comments)** _____	☐	☐	**Comments if any**

6. **If VOC is funded, what % of health/programme budget is this amount?**
_____ **(Please record under comment)**

7. **Is this amount totally released for your activities this current year?** ☐ ☐
(If no, please go to Q 9)

	Adequate	Fairly Adequate	Not adequate
	☐	☐	☐

8. **If yes, is this amount considered adequate for your activities?** **Yes** ☐ ☐
No ☐

9. **Do you have an annual work plan for these activities?**
(If yes, please see the annual work plan for the current year,
If no, go to Q 11)

10. **What % of the activities on your plan has been carried out so far this year?** **Comments**
(Verify and record under comments)
_____

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STAFF COMPLEMENT IN HMIS/M&E UNIT

11. Total number of staff in HMIS/M&E office _____

12.

Please fill the table below as accurately as possible. Use extra sheet if necessary.

Name Of Staff In HMIS/Program M&E Office	Basic Qualification	Designation	Relevant Training Since Joining Institution	* Basic Computer skills		Training on NHMIS Form		Training On NHMIS Software	
				Yes – List software	No	Yes	No	Yes	No

* List the software conversant with

13. Are the staff adequate in number for your activities? Adequate ☐ Not adequate Fairly Adequate ☐ ☐

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14. Are the staff adequate in skills? Adequate ☐ Fairly Adequate ☐ Not adequate ☐

15. If no, how many additional staff do you need? Fill table below for additional staff.

Basic qualification of Staff	Number needed	Proposed Designation after Joining Organization
Basic qualification of Staff	**Number needed**	**Proposed Designation after Joining Organization**

16. HMIS/M&E MINIMUM PACKAGE

	Requirements	Available	Functionality	Not available (Tick)

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S/N		(Write Number)	(where applicable)		
			No. functional	No. not functional	
1.	HMIS policy document				
2.	HMIS instructional manual				
3.	Microcomputers PC for data processing				
4.	High capacity printers				
5.	Photocopiers				
6.	Telephone line				
7.	Fax machine				
8.	Internet services				
9.	Websites (give website address below)				
10.	HMIS software				
11.	Binding Machine				
12.	Digital Camera				
13.	Projectors				
14.	Generators				
15.	GIS softwares (state types below)				
16.	4 –Wheel Drive vehicle				
17.	Utility Bus				

HMIS/PROGRAMME M&E DATA COLLECTION FORMAT

17. Are the following HMIS forms available? Please fill table for this.

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S/N	Types of Forms	Available	Quantity Enough for 6 months Stock? (Tick)		Not available (Please Tick)
			Yes	No	
1.	Household format				
2.	Community tally sheets for - ANC				
	- LDR				
	- FPS				
	- Tracer diseases				
	- Mortality				
	- Home activities				
3.	Community monthly summary sheet				
4.	Health facility- community outreach services summary form				
5.	Health facility daily register - ANC				
	- LDR				
	- Immunization				
	- FPS				
	- GMP				
	- OPD				
	- IPC				

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6.	**LGA quarterly summary form**				
7.	**State semi-annual summary form**				
S/N	**Other types of Forms (FOR PROGRAM M&E)**	**From where received and intervals of submission**	**Any link with NHMIS?**		**Where submitted and sponsors**
			YES	**NO**	

HMIS PROCESSES (Exclusive for DPRS/HMIS officer) **Yes** **No**

18. **Do you have a functional HDCC** ☐ ☐

19. **If yes, how many times have you met in the last 6 months?** _____

20. **Number of LGAs sending HMIS data to states in the last semi-annum (Jan-Jun)** _____

21. **Do you receive HMIS forms timely from LGAs in the last quarter? (Jun – Aug)** ☐ ☐

22. **Do you collate data?** ☐ ☐

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23. If yes, indicate method of collation? Computer ☐ Manually ☐ Other ☐

Yes **No**

24. Do you give feedback on data received? ☐ ☐

25. When did you forward the last semi-annual summary data to Federal HMIS unit?
(Decide if such submission to Federal HMIS unit is timely or untimely. Circle as appropriate). ☐ **Timely** ☐ **Untimely**

YES **NO**

26. Have you conducted monitoring supervision to LGAs? ☐ ☐

Monthly Quarterly Semi-annually

27. How often have you conducted such monitoring supervision at LGAs in the last 2 quarters**?** ☐ ☐ ☐

YES **NO**

28. Do you analyze reports received from LGAs? ☐ ☐

(If yes, see copies of analysis in form of tables, graphs for data received for the last quarter from LGAs based on at least 3 indicators)

29. If yes, have you taken any decision or action based on analyzed data? (Verify based on evidence and list below)

1. **……**
2. **……**
3. **……**

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30. CONSTRAINTS/CHALLENGES **(All respondents)**
Which of the following do you consider to be major constraints to the performance of health information/M&E activities in this State?

MAJOR CONSTRAINTS	Yes Tick	No Tick
Inadequate personnel		
Quality of personnel		
Inadequate working materials		
Inadequate / lack of data collection tools		
Data culture		
Working environment		
Transport support (Vehicle or allowance)		
Training		
Funds		
Others (Specify)		

31. Please give freely any other comments on the activities of the record unit which may improve its functions.

……..

……..

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LGA Tool

HMIS Needs Assessment in LGAs

2008 FMOH/ PATHS II Collaboration

Questionnaire S/No; L ☐☐

Interviewer's Name; _____

Respondents:

PHC M&E OFFICER ☐ **Name;**

_____

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LGA IMMUNISATION OFFICER ☐ **Name;** _____

HIV/AIDS FOCAL OFFICER ☐ **Name;** _____

DSN OFFICER ☐ **Name;** _____

SAFE MOTHERHOOD OFFICER ☐ **Name;** _____

LGA LEVEL

LGA IDENTIFICATION DATA

LGA Name _____ **Total No of HF** _____ **No Private**____ **No Public**_____

Location (Please tick) (1) Rural (2) Urban

HMIS/M&E MANAGEMENT Comments if any	**Yes**	**No**
1. Do you have an office space exclusive for HMIS/PHC M&E activities?	☐	☐

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(If no please go to Q4)

_____

		Adequate	Fairly Adequate	Not adequate
2.	Is the office space adequate for your day to day activities? (Please verify)	☐	☐	☐
		Adequate	Fairly Adequate	Not adequate
3.	Is the furniture in your office adequate?	☐	☐	☐
		Yes	**No**	
4.	Do you have a vote of charge (VOC) for HMIS/PHC M&E activities?	☐	☐	**Comments if any**
	(If no please go to Q9)			
	_____			
5.	If yes, is the VOC funded? (Please verify amount and record under comments)	☐	☐	
	_____			
6.	If VOC is funded, what % of health/programme budget is this amount? (Please record under comment)	_____%		
7.	Is this amount totally released for your activities this current year? (if no, please go to Q 9)	☐	☐	
		Adequate	Fairly Adequate	Not adequate
8.	If yes, is this amount considered adequate for your activities?	☐	☐	☐
9.	Do you have an annual work plan for these activities? (If yes, please see the annual work plan for the current year,	☐	☐	☐

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if no, please go to Q 11)

10. What % of the activities on your plan has been carried out so far this year? (Verify and record under comments) _____

STAFF COMPLEMENT IN HMIS UNIT

11. Total number of staff in HMIS/PHC M&E office _____

12. Please fill the table below as accurately as possible. Use extra sheet if necessary.

Name Of Staff In HMIS/PHC M&E Office	Basic Qualification	Designation	Relevant Training Since Joining Institution	Basic Computer Skills		Training on NHMIS Form		Training on HMIS Software	
				Yes –List software	No	Yes	No	Yes	No

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Name Of Staff In HMIS/PHC M&E Office	Basic Qualification	Designation	Relevant Training Since Joining Institution	Basic Computer Skills		Training on NHMIS Form		Training on HMIS Software	
				Yes –List software	No	Yes	No	Yes	No

Adequate **Adequate** **Fairly Adequate** **Not**

13 Are the staff adequate in number for your activities? ☐ ☐ ☐

14. Are the staff adequate in skills? ☐ … ☐ ☐

15. If no, how many additional staff do you need? Fill table below for additional staff.

Basic qualification of Staff	Number needed	Proposed Designation after Joining Organization

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HMIS/M&E MINIMUM PACKAGE FOR LGAs

16.

S/N	Requirements	Available (Write Number)	Functionality (where applicable)		Not available (Tick)
			No. functional	No. not functional	
1.	HMIS policy document				
2.	HMIS instructional manual				
3.	Microcomputers PC for data processing				
4.	Printer				
5.	Photocopier				
6.	Telephone line				
7.	Fax machine				
8.	Internet services				
9.	Websites (give website address below)				
10.	HMIS software				
11.	Binding Machine				
12.	Motocycles				
13.	Generators				
14.	GIS softwares (LGA types below)				

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HMIS/PROGRAMME M&E DATA COLLECTION FORMAT

17. Are the following HMIS forms available? Please fill table for this.

S/N	Types of Forms	Available	Quantity Enough for 6 months Stock? (Tick)		Not available (Please Tick)
			Yes	No	
1.	Household format				
2.	Community tally sheets for - ANC				
	- LDR				
	- FPS				
	- Tracer diseases				
	- Mortality				
	- Home activities				
3.	Community monthly summary sheet				
4.	Health facility- community outreach services summary form				
5.	Health facility daily register - ANC				
	- LDR				
	- Immunization				
	- FPS				

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	- GMP				
	- OPD				
	- IPC				
6.	LGA quarterly summary form				
S/No	**Other types of forms at LGA level (For programme M&E)**	**From where received and Intervals of submission**	**Any Link with NHMIS Forms**		**Where submitted and Sponsors**
			Yes	No	

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HMIS PROCESSES (Exclusive for PHC/M&E Officer)

		YES	NO
18.	Do you have a functional HDCC	☐	☐
19.	If yes, how many times have you met in the last 6 months	_____	
20.	Total No of HF reporting HMIS data to LGA in the last month (Oct 08)_____ Public_____ Private_____		
21.	Do you receive HMIS forms timely from health facilities?	☐	☐
22.	Do you collate data?	☐	☐

		Computer	Manually	Other
23.	If yes, indicate method of collation?	☐	☐	☐
24.	Do you give feedback to health facilities on data received?	☐	☐	

		Timely	Untimely
25.	When did you forward the last quarterly summary data to State HMIS unit? **(Decide if such submission to State HMIS unit is timely or untimely. Circle as appropriate).**	☐	☐

		YES	NO
26.	Have you conducted monitoring supervision to a health facilities in last month? (Oct 08)	☐	☐

		Weekly	Monthly	Quarterly
27.	How often have you conducted such monitoring supervision at each facility in the last 3 months?	☐	☐	☐

		YES	NO
		☐	☐

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28. Do you analyze reports received from health facilities?

(If yes, see copies of analysis in form of tables, graphs for data received for the last quarter from health facilities based on at least 3 indicators)

29. If yes, have you taken any decision or action based on analyzed data? (Verify based on evidence and list below)
1. ……
2. ……
3. ……

CONSTRAINTS/CHALLENGES – All respondents

30. Which of the following do you consider to be major constraints to the performance of health information/M&E activities in this LGA?

MAJOR CONSTRAINTS	Yes Tick	No Tick
Inadequate personnel		
Quality of personnel		
Inadequate working materials		
Inadequate / lack of data collection		
Data culture		
Working environment		
Transport support (Vehicle or allowance)		
Training		
Funds		
Others (Specify)		

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31. Please give freely any other comments on the activities of the HMIS/PHC M&E unit which may improve its functions.

……..
……..
……..
……..
……..

Health Facility Tool

HMIS Needs Assessment in Health facilities

2008 FMOH/ PATHS II Collaboration

Questionnaire S/No; HF ☐☐

Interviewer's Name; _____

Respondents: (Only one of the following in a health facility)

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HEALTH RECORDS OFFICER ☐ **Name;**

_____

MEDICAL OFFICER ☐ **Name;**

_____

OFFICER IN CHARGE ☐ **Name;**

_____

HEALTH FACILITY LEVEL

HEALTH FACILITY IDENTIFICATION DATA

Name of Health facility_____ **State**_____

LGA_____ **Ward**_____

Type (Tick) Secondary ( ) Primary Health Care ( )

Ownership Public **(**) Private (for profit) ( ) Private (not for profit) ( )

Location Urban ( ) Rural ( )

HMIS MANAGEMENT **YES** **NO** **Comments if any**

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1. Do you have an office space exclusive for health records? ☐ ☐
…….
(If no please go to Q4)

	Adequate	Fairly Adequate	Not adequate
2. Is the office space adequate for your day to day activities?	☐	☐	☐

	Yes	No	
3. Is the furniture in your office adequate?	☐	☐	**Comments if any**
4. Do you have a budget for health record activities? (If no please go to Q 9)	☐	☐	
5. If yes, is the budget funded? (Please verify amount and record under comments)	☐	☐	

6. If budget is funded, what % of health facility budget is this amount? _____%_____
(Please record under comment)

	Yes	No
7. Is this amount totally released for your activities this current year? (If no, please go to Q 9)	☐	☐

	Adequate	Fairly Adequate	Not adequate
8. If yes, is this amount considered adequate for your activities?	☐	☐	☐

	Yes	No
9. Do you have an annual work plan for these activities? (If yes, please see the annual work plan for the current year, if No, please go to Q 11)	☐	☐

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10. What % of the activities on your plan has been carried out so far this year?
_____
(Verify and record under comments)

STAFF COMPLEMENT IN HEALTH RECORD UNIT

11. Total number of staff in health record office performing health records duties? _____

12. Please fill the table below as accurately as possible. Use extra sheet if necessary.

S/N	Name Of Staff In health record Office	Basic Qualification	Designation	Relevant Training Since Joining Institution	Training on NHMIS Form		Basic computer Skills	
					Yes	No	Yes – list software	No

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S/N	Name Of Staff In health record Office	Basic Qualification	Designation	Relevant Training Since Joining Institution	Training on NHMIS Form		Basic computer Skills	
					Yes	No	Yes – list software	No

	Adequate	Fairly adequate	Not Adequate
13. Are the staff adequate in number for your activities?	☐	☐	☐
14. Are the staff adequate in skills?	☐	☐	☐

15.. If no, how many additional staff do you need? Fill table below for additional staff.

Basic qualification of Staff	Number needed	Proposed Designation after Joining Organization

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HMIS MINIMUM PACKAGE FOR HEALTH FACILITIES

16..

S/N	Requirements	Available (Write Number)	Functionality (where applicable)		Not available (Tick)
			No. functional	No. not functional	
1.	Microcomputers PC for data processing				
2.	Printer				
3.	Solar Powered Calculators				
4.	Generator				
5	Internet availability				

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HMIS/PROGRAMME M&E DATA COLLECTION FORMAT

17. Are the following HMIS forms available? Please fill table for this.

S/N	Types of Forms	Available (Please tick)	Quantity Enough for 6 months Stock? (Tick)		Completeness of forms (tick)		Accuracy of data entry (tick)		Not available (Please Tick)
			Yes	No	Yes	No	Yes	No	
1.	Community tally sheets for - ANC								
	- LDR								
	- FPS								
	- Tracer diseases								
	- Mortality								
	- Home activities								
3.	Community monthly summary sheet								
4.	Health facility- community outreach services summary form								
5.	Health facility daily register - ANC								
	- LDR								
	- Immunization								
	- FPS								

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S/N	Types of Forms	Available (Please tick)	Quantity Enough for 6 months Stock? (Tick)		Completeness of forms (tick)		Accuracy of data entry (tick)		Not available (Please Tick)
			Yes	No	Yes	No	Yes	No	
	- GMP								
	- OPD								
	- IPC								
	Other Programme M&E Forms Used in Health Facilities to collect data	From where received and Intervals of submission			Any Link with HMIS?		Where submitted and Sponsors		
					Yes	No			

HMIS PROCESSES

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		Timely	Untimely
18.	When did you forward the last monthly summary data to LGA-PHC M&E/ HMIS unit? (Decide if such submission to LGA-PHC M&E/ HMIS unit is timely or untimely. Tick as appropriate).	☐	☐

		Yes	No
19.	Do you receive feedback from LGAs on data sent?	☐	☐

		YES	NO
20.	Have you been visited by a monitoring team from LGAs in the last 4 weeks?	☐	☐

		Weekly	Monthly	Quarterly
21.	How often have you received such monitoring visits in the last 3 months?	☐	☐	☐

		YES	NO
22.	Do you analyze reports generated by your health facility? (If yes, see copies of analysis in form of tables, graphs for data analyzed based on at least 3 indicators)	☐	☐

23. If yes, have you taken any decision or action based on analyzed data? (Verify based on evidence and list below)
    1. ……
    2. ……
    3. ……

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24. CONSTRAINTS/CHALLENGES

Which of the following do you consider to be major constraints to health record activities in your health facility?

MAJOR CONSTRAINTS	Yes Tick	No Tick
Inadequate personnel		
Quality of personnel		
Inadequate working materials		
Inadequate / lack of data collection tools		
Data culture		
Working environment		
Transport support (Vehicle or allowance)		
Training		
Funds		
Others (Specify)		

25. Please give freely any other comments on the activities of the record unit which may improve its functions.

……..

……..

……..

……..

……..

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Partners Discussion Tool

Partners' Questionnaire

1 **STATE** _____

2 Partner Name _____

3 Office Address

_____

_____

_____

4

Programme Areas of interest	Implementation sites in the state	Do you collect any routine data?		Data Flow/Interval (If yes)	Any Link with HMIS? Yes or No	Do you use NHMIS forms in collecting this data?	
		Yes	No			Yes	No

5 Do you support any HMIS activities in this State? (Yes or No)

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6 If yes please state scale of support below (tick)

Data collection tools	
Training	
Equipment	
Funding	
Others specify	

7 Are you aware of the Health Data Consultative Committee (HDCC)meetings as an integrated mechanism for health data management in the state? Yes or No?

8 What are the major challenges you encounter with HMIS in the state?

Thank You

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