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IDEAS Private Sector Study of MNCH Data Sharing

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Lucknow, September 3, 2014

Improving health worldwide

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IDEAS Overview

• IDEAS: Informed DECisions for Actions in maternal & newborn health
• 5 year measurement, learning & evaluation grant
• Funded by Bill & Melinda Gates Foundation
• Delivered by London School of Hygiene & Tropical Medicine, with local partners
• Evaluation of Bill & Melinda Gates Foundation maternal and newborn health strategy across three countries.
• Working in Ethiopia, NE Nigeria and Uttar Pradesh, India
Study overview

In support of TSU’s Objective 3a

• Sub-obj: Create robust systems for data collection, analysis, and planning to improve programme management (e.g. HMIS)

Utility of the findings

• To jointly develop and test a strategy for data sharing on key MNCH services with the private health sector in UP.

Aim of the present study

• To explore current data management and reporting systems for MNCH data in the private sector, and barriers and facilitators to obtaining private sector data and setting up such systems
### Private sector in healthcare (UP-AHS, 2012-13)

**Table 1: Institutional deliveries**

<table>
<thead>
<tr>
<th>% of institutional deliveries (UP)</th>
<th>% of deliveries in govt. institutions</th>
<th>% of deliveries in private institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>56.7</td>
<td>39.0</td>
<td>17.6</td>
</tr>
</tbody>
</table>

**Table 2: Care seeking for acute and chronic illnesses**

<table>
<thead>
<tr>
<th>% seeking care for acute illnesses, any source</th>
<th>% seeking care from govt. sources</th>
<th>% with chronic illnesses, getting regular treatment</th>
<th>% seeking regular treatment from govt. sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>97.4</td>
<td>5.4</td>
<td>58.7</td>
<td>15.6</td>
</tr>
</tbody>
</table>
Method

Approach

• **Qualitative:** 54 in-depth interviews with stakeholders

Sampling

• **Districts:**
  Largest number of Level 3 (tertiary) facilities – Allahabad
  Largest number of Level 1 (basic primary) facilities - Hardoi

• **Constituencies:** government; professional associations; private commercial health facilities; significant NGO programmes

• **Respondent selection:** leadership and knowledge; involvement in data processes; engaged in MNCH services (esp. deliveries and newborn care)
Process of facility/stakeholder selection (district level)

1. **DPMU**
   Overview of district processes & facilities, who’s who, HMIS

2. **CMO’s office (to select blocks)**
   Overview of registered private facilities,
   Reporting hubs for PCPNDT, MTP, deliveries, births and deaths
   Monthly Progress Report (MPR) consolidation

3. **Selected block PHCs & CHCs (to select block facilities)**
   Discussions with key informants to identify private facilities

4. **Local pharmacies/pathology centres/other local clinics**
   Cross verify information on facilities

5. **Visits to selected local health facilities**
   Interviews/scheduled appointments
Example – Allahabad

Rural (20 blocks)

• 16 have zero reporting out of which Koraon, dhanupur, pratappur, manda have no nursing homes at all.
• Chaka – 45 deliveries/June; 10-12 kms from the city
• Holagarh – 32 deliveries; 32 kms
• Sohraon – 25 deliveries; 22 kms
• Kaurihar – 11 deliveries; 20 kms
• Jasra is zero reporting and is within 20 kms.
• Mauaima is zero reporting and 35 kms.
• Phoolpur is zero, and within 40 kms but its on the main road and has a lot of nursing homes (and the names of nursing homes are given on PHC reports).
## Facilities interviewed

<table>
<thead>
<tr>
<th>Volume</th>
<th>Hardoi (14 facilities)</th>
<th>Allahabad (11 facilities)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reporting</td>
<td>Non Reporting</td>
</tr>
<tr>
<td>High</td>
<td>Facilities: 2</td>
<td>Facilities: 2</td>
</tr>
<tr>
<td></td>
<td>Beds: 18, 100</td>
<td>Beds 20, 100</td>
</tr>
<tr>
<td></td>
<td>Deliveries: 100, 144</td>
<td>Deliveries 95, 100</td>
</tr>
<tr>
<td>Medium</td>
<td>Facilities: 4</td>
<td>Facilities: 3</td>
</tr>
<tr>
<td></td>
<td>Beds: 20, 20, 20, 20</td>
<td>Beds: 5, 10, 60</td>
</tr>
<tr>
<td></td>
<td>Deliveries: 15, 10, 10, 20</td>
<td>Deliveries: 15, 8, 25</td>
</tr>
<tr>
<td>Low</td>
<td>None</td>
<td>Facilities: 3</td>
</tr>
<tr>
<td></td>
<td>Beds: 10, 20, 30</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Deliveries 1, 2, 2-8</td>
<td>None</td>
</tr>
</tbody>
</table>
Part 1: Availability of MNCH data in private facilities
Private facilities report and maintain data on ultrasounds, MTPs and deliveries

<table>
<thead>
<tr>
<th></th>
<th>No. of private facilities registered</th>
<th>Reporting on ultrasounds (PCPNDT Act)/total regstd.</th>
<th>Reporting on MTPs / total regstd.</th>
<th>Reporting on deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hardoi</td>
<td>34</td>
<td>19/19</td>
<td>8/8</td>
<td>7</td>
</tr>
<tr>
<td>Allahabad</td>
<td>283</td>
<td>217</td>
<td>9</td>
<td>??(na)</td>
</tr>
</tbody>
</table>
Standardised formats for ultrasound reporting
Standardised formats for MTP reporting

FORM -II
[Refer regulation 4(5)]

1. Name of the State
2. Name of the Hospital/approved place
3. Duration of pregnancy (give total No. only)
   (a) Upto 12 weeks.
   (b) Between 12-20 weeks
4. Religion of woman
   (a) Hindu
   (b) Muslim
   (c) Christian
   (d) Others
   (e) Total
5. Termination with acceptance of contraception.
   (a) Sterilisation.
   (b) L.U.D.
6. Reasons for termination:
   (a) Danger to life of the pregnant woman.
   (b) Grave injury to the physical health of the pregnant woman.
   (c) Grave injury to the mental health of the pregnant woman.
   (d) Pregnancy caused by rape.
   (e) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.
   (f) Failure of any contraceptive device or method,

Signature of the Officer-in-charge with date
Records maintained by pvt. facilities

Types of registers
- OP/IP register; OT register; labour/delivery register; paediatric/immunization
- max may be 20 registers (incl. medicines & accounts)
- manual but some places computerised

Register clientele
- ANC cases, deliveries, newborns, children

Types of data (varies across facilities)
- name, age, address, date of admission & discharge
- normal/casearean delivery, order of birth
- newborn: sex, birth weight, live/dead, full term/preterm, time of birth
Quality issue: Formats used for reporting deliveries are not standardised
Types of records at pvt. facilities
Facility records are updated frequently

- Data updating on deliveries is very frequent, every delivery is recorded almost as soon as it happens – on the same day or within a couple of days.

- However, deaths may not be recorded even in the facility’s own registers; either maternal or newborn
Unregistered facilities & reporting

• Not registered, but well known even to the formal establishment
• But no exact estimates
• Providers informally trained / AYUSH
• Cheap and popular; high delivery loads
• Tie ups for quick and affordable referrals; and for birth certificates (with a doctor)
• NO RECORDS AT ALL
Private sector barriers and enablers to maintaining MNCH records

BARRIERS

No formal, standardised formats
• Existing ones not developed in consultation with private sector

Varying needs and interest
• Each keeps records that are enough for their needs.
• Govt is more interested in preventive aspects and the private sector in curative aspects

Systems and effort
• Computer system not available everywhere.
• Time consuming to maintain detailed records.

Large numbers of unregistered facilities
• Out of any reporting requirements
Private sector barriers and enablers to maintaining MNCH records

ENABLERS

The need to keep records
- Bigger hospitals keep records as a safety net against medico legal cases,
- All need some birth proof to give their patients

Basic system is in place
- Some staff time available everywhere for keeping records—multi tasking staff that also look after records.

General willingness to maintain and share records
- Even those with rudimentary records are not averse
- Unregistered also willing if asked
- Associations willing to cooperate
Public sector barriers and enablers to maintaining MNCH records

BARRIERS

Lack of information and sustained follow up of the private sector

- Many private facilities say that they’ve never been asked to maintain and submit records on deliveries, especially the newer hospitals.
- No sustained or systematic efforts made by the public sector to get private facilities to maintain and submit data on deliveries.
Public sector barriers and enablers to maintaining MNCH records

ENABLERS

Importance attached to official communication by the public sector

• The hospitals that do submit delivery records (older and more established ones) say that they received a communication and a format from the CMO’s office.

• So a communication from the health department does carry weight.

Basic data is similar to the ‘Births and Deaths Registration’ data, so formats can be easily standardised
FEEDBACK AND DISCUSSION
Part 2: Data collection, sharing & utilisation
Pathway of ultrasound and MTP reporting: strictly enforced

1. Ultrasound and MTP
2. Private Nursing Homes, Hospitals and Ultrasound Units
3. Nodal Officer PCPNDT Act
4. Dy CMO (Admin)
5. Director General Medical Health

State Monitoring Format used to Report on Abortions

Comprehensive Abortion Care
State Monitoring Format (Quarterly)
Please do not modify, change or delete columns in this format.

Name of State/U.T.: 
Month and Year of reporting: 
Number of districts in the State: 
Reporting period (Specify the quarter): 

Name of State Nodal Officer for MTP activities:
Designation and Contact Number:
Email-ID:

<table>
<thead>
<tr>
<th>S.No</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Districts in which Comprehensive Abortion Care (CAC) Training and Service</td>
</tr>
<tr>
<td>2.</td>
<td>District Level Committees (DLCs)*</td>
</tr>
<tr>
<td>3.</td>
<td>Approved NGO &amp; Private clinics and hospitals</td>
</tr>
<tr>
<td>5.</td>
<td>Number of applications pending with the DLCs for one year (at end of reporting period)</td>
</tr>
<tr>
<td>6.</td>
<td>Number of new applications received in the reporting period</td>
</tr>
<tr>
<td>7.</td>
<td>Number of applications out of the new applications pending with the DLCs at the end of the reporting period**</td>
</tr>
</tbody>
</table>

* Is MVA equipment being procured and supplied? (Y/N)............................
* Are the drugs for MMA included in the essential drug list? (Y/N)...........
* As per MTP Act, Rules and Regulations 2002-2003
**Applications on which no action has been taken (as per MTP Rules).
Pathway of reporting deliveries also exists

Institutional Deliveries

- Private Nursing Homes and Hospitals (City)
  - District Health Visitor
    - ARO (CMO Office)
    - DPMU
    - HMIS (NRHM)

- Private Nursing Homes and Hospitals (Block)
  - Block PHC/CHC
    - Consolidated with PHC/CHC Report
  - Dy CMO (RCH)
    - Director General Family Welfare

ARO (CMO Office)
District Health Visitor
DPMU
HMIS (NRHM)
Block PHC/CHC
Consolidated with PHC/CHC Report
Dy CMO (RCH)
Director General Family Welfare
Private hospital deliveries reported in the MPR but not in the HMIS

<table>
<thead>
<tr>
<th></th>
<th>June 2014 MPR</th>
<th>June 2014 HMIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allahabad</td>
<td>113 (R) 571 (U)</td>
<td>0 (blank cells)</td>
</tr>
<tr>
<td>Hardoi</td>
<td>84(R) 308 (U)</td>
<td>0 (blank cells)</td>
</tr>
</tbody>
</table>
Institutional deliveries - MPR 2014

<table>
<thead>
<tr>
<th>संस्थागत ग्रस्त की उपलब्धि</th>
<th>जनवरी - जून 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>नाम</td>
<td>संख्या</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>1</td>
<td>वस्त्रस्वास्थ्य सरकार</td>
</tr>
<tr>
<td>2</td>
<td>वस्त्रस्वास्थ्य विभाग</td>
</tr>
<tr>
<td>3</td>
<td>वस्त्रस्वास्थ्य अधिकारी</td>
</tr>
<tr>
<td>4</td>
<td>सामुदायिक स्वास्थ्य, हिमायली</td>
</tr>
<tr>
<td>5</td>
<td>सामुदायिक स्वास्थ्य, बिसन्गम</td>
</tr>
<tr>
<td>6</td>
<td>सामुदायिक स्वास्थ्य, नगराल</td>
</tr>
<tr>
<td>7</td>
<td>सामुदायिक स्वास्थ्य, संतोया</td>
</tr>
<tr>
<td>8</td>
<td>प्रसारक स्वास्थ्य, संतोया</td>
</tr>
<tr>
<td>9</td>
<td>प्रसारक स्वास्थ्य, वेल्दा</td>
</tr>
<tr>
<td>10</td>
<td>प्रसारक स्वास्थ्य, कोटकोटा</td>
</tr>
<tr>
<td>11</td>
<td>प्रसारक स्वास्थ्य, मोन्द्राँ</td>
</tr>
<tr>
<td>12</td>
<td>सामुदायिक स्वास्थ्य, मोन्द्राँ</td>
</tr>
<tr>
<td>13</td>
<td>प्रसारक स्वास्थ्य, लाञ्चुर</td>
</tr>
<tr>
<td>14</td>
<td>प्रसारक स्वास्थ्य, लाञ्चुरपुर</td>
</tr>
<tr>
<td>15</td>
<td>प्रसारक स्वास्थ्य, फर्रुखाबाद</td>
</tr>
<tr>
<td>16</td>
<td>सामुदायिक स्वास्थ्य, फिनी</td>
</tr>
<tr>
<td>17</td>
<td>सामुदायिक स्वास्थ्य, शाहजादपुर</td>
</tr>
<tr>
<td>18</td>
<td>सामुदायिक स्वास्थ्य, खरसागर</td>
</tr>
<tr>
<td>19</td>
<td>सामुदायिक स्वास्थ्य, बापुठेर</td>
</tr>
<tr>
<td>20</td>
<td>पैदा सेंट्रल, हर्वेदीर</td>
</tr>
<tr>
<td>21</td>
<td>पैदा सेंट्रल, बिजनापुर</td>
</tr>
<tr>
<td>22</td>
<td>पैदा सेंट्रल, शाहजादपुर</td>
</tr>
<tr>
<td>23</td>
<td>पैदा सेंट्रल, सांगिता</td>
</tr>
<tr>
<td>24</td>
<td>अन्य टेलिया सेंट्रल अस्पताल</td>
</tr>
<tr>
<td>25</td>
<td>विश्वविद्यालय हर्वेदीर</td>
</tr>
<tr>
<td>26</td>
<td>केरिया विश्वविद्यालय हर्वेदीर</td>
</tr>
<tr>
<td>27</td>
<td>संघीय विश्वविद्यालय हर्वेदीर</td>
</tr>
<tr>
<td>28</td>
<td>संघीय विश्वविद्यालय हर्वेदीर</td>
</tr>
<tr>
<td>29</td>
<td>अन्य विश्वविद्यालय हर्वेदीर</td>
</tr>
<tr>
<td>30</td>
<td>शिक्षण विश्वविद्यालय हर्वेदीर</td>
</tr>
<tr>
<td>कुल योग</td>
<td>51249</td>
</tr>
</tbody>
</table>
## HMIS June 2014

### Reproductive and Child Health

<table>
<thead>
<tr>
<th>Part A</th>
<th>Description</th>
<th>I</th>
<th>J</th>
<th>K</th>
</tr>
</thead>
<tbody>
<tr>
<td>M2</td>
<td>Deliveries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Deliveries conducted at Home:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1.1</td>
<td>Number of Home Deliveries attended by:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1.1.a</td>
<td>SBA Trained (Doctor/Nurse/ANM)</td>
<td></td>
<td>1123</td>
<td>1123</td>
</tr>
<tr>
<td>2.1.1.b</td>
<td>Non SBA (Trained TBA/Relatives/etc.)</td>
<td></td>
<td>883</td>
<td>883</td>
</tr>
<tr>
<td>2.1.1.c</td>
<td>Total (a) to (b)</td>
<td></td>
<td>2006</td>
<td>2006</td>
</tr>
<tr>
<td>2.1.2</td>
<td>Number of newborns visited within 24 hours of Home</td>
<td></td>
<td>605</td>
<td>605</td>
</tr>
<tr>
<td>2.1.3</td>
<td>Number of mothers paid JSY incentive for home deliveries</td>
<td></td>
<td>71</td>
<td>71</td>
</tr>
<tr>
<td>2.2</td>
<td>Deliveries conducted at Public Institutions (Including C-)</td>
<td></td>
<td>3590</td>
<td>3590</td>
</tr>
<tr>
<td>2.2.1</td>
<td>Out of 2.2, Number discharged under 48 hours of delivery</td>
<td></td>
<td>2221</td>
<td>2221</td>
</tr>
<tr>
<td>2.2.2</td>
<td>Number of cases where JSY incentive paid to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2.2.a</td>
<td>Mothers</td>
<td></td>
<td>3032</td>
<td>3032</td>
</tr>
<tr>
<td>2.2.2.b</td>
<td>ASHAs</td>
<td></td>
<td>2597</td>
<td>2597</td>
</tr>
<tr>
<td>2.2.2.c</td>
<td>ANM or AVN (only for HPS States)</td>
<td></td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>2.3</td>
<td>Deliveries conducted at Private Institutions (Including C-)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3.1</td>
<td>Number of institutional delivery cases where JSY incentive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3.1.a</td>
<td>Mothers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3.1.b</td>
<td>ASHAs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3.1.c</td>
<td>ANM or AVN (only for HPS States)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M3</td>
<td>Number of Caesarean C-Section deliveries performed at</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>No. of C-section deliveries performed at Public facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1.1</td>
<td>C-Section deliveries performed at facility at PHC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1.2</td>
<td>C-Section deliveries performed at facility at CHC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1.3</td>
<td>Sub-divisional hospital/District Hospital</td>
<td></td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3.1.4</td>
<td>At Other State Owned Public institutions</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3.1.5</td>
<td>Total (3.1.1) to (3.1.4)</td>
<td></td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3.2</td>
<td>No. of C-section deliveries performed at Private facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| M4     | Pregnancy outcome & weight of newborn
HMIS: Source data does not include private sector deliveries
**MPR: Format available but inconsistent/incomplete data**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Value 1</th>
<th>Value 2</th>
<th>Value 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name 1</td>
<td>2014-12-31</td>
<td>100</td>
<td>200</td>
<td>300</td>
</tr>
<tr>
<td>Name 2</td>
<td>2014-11-30</td>
<td>150</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Name 3</td>
<td>2014-10-31</td>
<td>-</td>
<td>250</td>
<td>-</td>
</tr>
</tbody>
</table>

*Note: The table contains incomplete data and inconsistencies.*
**MPR: main problems**

- No precise estimate of facilities providing delivery services
- Delivery data is not reported by all nursing homes; only a few that have been reporting continue to report
- PHCs/CHCs follow up only with those that report regularly
- Only data on number of deliveries, and in few case on C-Sections is consolidated into the MPR
- Unclear how other data on birth weight, order of birth, gestational maturity, live/stillbirth, gender of child is used.
- Different methods of data collection by AROs/ANMs: receive reports, view facility registers, verbal reports etc.
- HMIS – only JSY deliveries included; and only rural ones so far
Reporting of Birth and Death Data – RBD Act 1969

Reporting of births and deaths is mandatory by law.

The designated authority (‘informant’) of a facility has to report births, stillbirths and deaths, together with some of their characteristics in the prescribed reporting form to the concerned Registrar to facilitate registration of the event.

-Section 8 & 9 of the Act
Form 1 – Birth report formats and characteristics
Process of reporting RBD data

1. Birth and Death
2. Private Nursing Homes and Hospitals
3. Respective Municipal Corporations
4. Nodal Officer B&D
5. Dy CMO (RCH)
6. Director General Medical Health
Issues in birth and death reporting under the RBD Act

• Only urban facilities required to report to Nagar Palika; rural to panchayats; rural/urban demarcation may just be a road
• Not all facilities report births and deaths to anyone; typically just give a proof of birth to the family of the newborn
• Link between Panchayats and Nagar Palika or CMO’s office?
• Good data on all reported births compared with the data on institutional deliveries can provide a good overview of all births, and home births vs institutional deliveries.
Enablers: Why do some hospitals report deliveries?

Perceived as mandatory

‘This is a law – that those who do deliveries, have to send the numbers every month. We had a circular from the govt about 7-8 years ago for submitting their report and we have been submitting since then. Format was given by the govt, but copy of that format is not available now. But we use the same columns as were given in the format.’

- If accredited for JSY (e.g. Kamla Nehru Memorial Hospital)

A system has been in place

- ANM follows up on a fixed date every month
- ‘Have been submitting data since the last 8 years. First we used to send birth and death data to nagar palika (municipal authority) – about births and deaths. Then they did not do it well, so responsibility was given to the CHC.’
- It’s never been stopped!

Personal motivation / hospital credibility

- I live here 24 hours and work on the computer. No other entertainment, so keep doing this. My family lives in Lucknow, I go only on Wednesdays.
- ‘we are a big hospital, anyone can visit anytime.’
Other enablers – private sector

Used to recordkeeping and reporting

Used to submitting very rigorous records in a timely manner (e.g. PCPNDT & MTP)

Overall willingness

Willingness to share data if the health department asked for it.

Professional bodies like IMA and UPNHA are willing to influence their members if the associations are roped in and involved.

Birth data cannot be hidden

Although fear of income tax exists, but at the same private facilities have to give some birth proof to all their patients, so that necessarily requires reporting accurate data on deliveries.
Enablers – public sector

Available system and mandate

A system for reporting deliveries exists which can be strengthened

A legal cover provided by the RBD Act which can be invoked.

RBD system has initiated an online registration system which is not yet well known or well utilised, but it is there.
Reasons why most hospitals do not report

**Never been asked to**
Haven’t been asked to submit any reports so far...can submit if required

**Low volume of deliveries**
We don’t perform so many deliveries – just one or two

**Not perceived as a hospital duty**
Getting births registered is the responsibility of patients

**Effort required**
Need a person to go there and submit..tedious process

**Perception that reports are anyway treated as garbage**
They just throw away our reports anyway

**No motivation**
Not paid for submitting, so why submit? If paid, maybe all will submit
Other barriers – private sector

Lack of communication or follow up by the public sector
....with those facilities that do not report.

Limited interactions with public sector
....in forums like DHS etc.

Fears..
...that govt will use this information for calculating income tax. Package multiplied by number of cases will disclose the income.
....that it will lead to additional work.
.....of unfriendliness of government staff -rough attitudes, especially when hospital staff go to submit any reports.
.... of harassment especially for reporting any deaths. They will be asked all kinds of questions with no understanding as to the contextual circumstances
...of inviting visits and having their quality standards exposed.

Lack of incentives
No monetary incentives or other incentives to report.
Barriers to reporting – Public Sector

System in place and being used for the MPR but
-data collection processes and formats are not standardised
-not covering all the hospitals that provide MNCH services

MPR and HMIS issues

-Two parallel systems with different data entry persons
-Different provisions for private sector reporting at source
-Overburdened data entry at DPMU level (in Allahabad, the district data entry assistant is also managing accounts)
-Lack of ownership of the HMIS in the system
-Limited feedback on private sector reporting by the state offices
-Cross analysis of birth/death registration with delivery data?
Barriers to reporting – Public Sector

Lack of a central coordination cell
• No central coordinating body in either CMO office or DPMU for private sector

No exchange of commodities
for which public sector can ask for a return utilisation certificate. E.g. vaccinations.

Conflict of interest
• Govt doctors in private practice. Some also have their own nursing homes.

Limited capacity
• Limited ability to analyse the data – and also limited computers and skills.
• Limited feedback from the state (especially for the MPR system)– for incomplete or erroneous data
• Also a concern that if the data starts coming in, how will the govt handle this data? Are they equipped to handle it?

Disinclined to use
• Public sector may sometimes not want to draw attention to adverse situations reported by the private sector. So may not be comfortable to report any data that shows their district health system in a bad light.
Suggestions for improving reporting

Strengthen the system

• Use the provision of law by the RBD Act.
• Get orders passed, issue a letter
• A coordinating body for the private sector – could be linked with the Clinical Establishments Act authority
• Cross sharing with the Birth and Death registration data
• Govt should take responsibility; it should not be left to the choice of the pvt sector

Improve engagement and interactions

• Include pvt sector in training cum review workshops of district health officials
• More public private platforms and increased opportunities for interaction in existing platforms
Suggestions for improving reporting

Design a user friendly system

• Develop formats in consultation with pvt bodies
• Prioritize the most critical data
• Either password protected online data entry system; or streamlined data collection systems
• The system should be simple and should not create extra burden
• Rationalize reporting frequency
• System that enables self analysis for the pvt facilities also

Capacity building

• Technical assistance for setting up the system – training etc.
• Meetings and follow ups to explain and guide
Suggestions for improving reporting

Motivation

• Orientation to highlight the importance of data sharing
• Simple incentives – financial and non-financial (including for public sector officials too)
• Disincentives for non-submission
• Periodic facility inspections
• Engage health insurance to increase need for reporting

Address fears

• Reassurance against any potential harassment by government
• Confidentiality and risk cover
• Govt approach - less fault findings, more strengthening
Summary

- Private sector is already reporting, even on deliveries
- Not showing up in HMIS, but it is in MPR, due to gaps in source data
- But even in MPR, it is incomplete and processes and formats not standardised
- Good data on births and newborns, but how is it/will be used?
- Private facilities do have data and are willing to share; good system has to be set up
- Legal cover is available via the Birth and Death registration Act.
- Major barriers: system lacking; communication & engagement; effort; data utilisation; effort required; fears; HMIS vs MPR; unregistered facilities
- Major enablers: RBD Act; a patchy system exists; general willingness; used to recordkeeping
- Key suggestions: system strengthening; regular engagement and interactions; designing a user friendly system; capacity building; motivation; address fears
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Thank You