

RHIS Working Group context and rationale

Health facilities generate data on an ongoing basis during the course of service delivery. Routine health information systems (RHIS) capture, compile and report service-generated data “...at regular intervals of a year or less through mechanisms designed to meet predictable information needs...”¹.

RHIS working definition for purposes of this working group

- RHIS data are self-reported² by health facility personnel.
- The frequency of reporting varies according to the data type, information needs and system capacity, e.g. daily, weekly, monthly, quarterly, six-monthly, annually.
- RHIS include data from all service components, programmes and facility-level resource management systems.
- RHIS reporting includes data on service utilization, health status at clinical encounters, vital events, interventions delivered, outcomes of interventions, human resources, logistics-based commodities and selected resource data.
- A RHIS ideally consists of a single, comprehensive, integrated system or set of interoperable data systems. In practice, however, it often consists of multiple, parallel data systems, e.g. a general “HMIS”³, various programme-specific data systems, various resource reporting systems (e.g. medicine and supply stock reports), and other information systems.

RHIS is one of the main health information sources for important services such as reproductive, maternal and child health services and disease surveillance, and, at district level and below, is often the only source of information for decision making.

While most healthcare data is collected at health facility and community levels, RHIS carries that information throughout the health system to make possible the measurement of coverage and quality of the health services provided, of resources used, and of resulting health outcomes. A strong national RHIS not only generates information for use by care providers and health managers, it also can make this information available to politicians, the media, and the civil population.

Many LMIC countries face challenges in achieving reliable RHIS data for decision-making. Challenges include multiple data demands, non-standardized data (i.e. metadata, data structures, data management and exchange standards, etc.), poor quality data, incomplete and delayed reporting, inadequate “top-down” feedback mechanisms, limited data analysis and use, inadequate data management systems, multiple parallel systems, lack of system integration and interoperability, inadequate infrastructure and

¹ Routine Health Information Network (RHINO). 2001. The Potomac Statement on Investment in Routine Health Information in Developing Countries.

² Results of supervision or ongoing monitoring assessments of service functionality (e.g. service availability, readiness, quality, management functions) may be included in the RHIS platform. These processes are distinct from intermittent, external, objective health facility surveys/assessments usually conducted at national level using standardized tools and methods.

³ “HMIS” or “Health management information system” has been used variously: sometimes it is used interchangeably with RHIS; sometimes it describes the system for data not reported through programme-specific systems; it has also been used to describe the overall HIS. Given these variations, the term RHIS is used in this document.

human resources, data access and transparency, poor data governance and uncoordinated partner investments.

In the past two decades substantial investments have been made to strengthen RHIS to address these challenges, but most of these efforts were focused on digitization, improving data quality and data analysis, and identifying problems. But the ultimate goal of RHIS is to use the data generated **to solve problems and to improve access to and delivery of quality health services**. This last step of translating data into action is the most challenging, and many barriers have been identified leading to poor use of data for action. While most of these barriers are technical issues that can be addressed by technical solutions, many barriers to data use are linked to organizational and behavioral factors as explained in the PRISM framework⁴. The decision-making and problem-solving behavior of data users can heavily influence the ultimate use of data for service delivery improvements. RHIS strengthening therefore involves building an information culture where information is valued at all levels of the health system.

This working group aims to address these issues through adaptation of existing globally-agreed RHIS standards and best practices and alignment of support to countries for RHIS strengthening.

RHIS Working Group Objectives

1. **Global Goods:** Review, define and harmonize standards for improved facility-based RHIS to improve health services and health system strengthening through :
 - a. Collation of resources and tools for RHIS indicators, data quality, analyses, and use;
 - b. Identification of ways in which investments in RHIS can be better aligned to ensure stronger, scaled and sustainable systems that reduce reporting burden, improve data quality and increase efficiency;
 - c. Contextualization of protocols and standards for integrating disease surveillance, public health and humanitarian emergency data into RHIS and documentation of best practices for learning;
 - d. Dissemination and promotion of standards for introducing information culture in country health systems, leading to improved use of data for improved service delivery at all levels of the health system, but particularly at district level and below.

2. **Country Support:**
 - a. In collaboration with HDC partners and country governments, align support for achievement of a country's RHIS goals. RHIS technical assistance and project funding will be aligned and coordinated to support national plans for RHIS strengthening.
 - b. Ensure collaborative processes with country engagement and engagement with all relevant stakeholders including civil society and the private sector.

Scope of work

1. Review, define and harmonize current standards, best practices and tools, including data elements and data indicators, for improved facility-based RHIS (incorporating information culture, data governance, collection, management, quality, analysis, and use).

⁴ Aqil A, Lippeveld T, Hozumi D.(2009) PRISM framework: a paradigm shift for designing, strengthening and evaluating routine health information systems. Health Policy and Planning 24:217–228.

2. Identify and review protocols and standards for linking/integrating disease surveillance, public health, humanitarian emergencies and health resources reporting into RHIS, including the harmonization of programme-specific data and digital configuration packages to support multi-sectoral implementation.
3. Align and harmonize partner efforts (activities, investments) designed to:
 - a. Develop RHIS elements of national health strategies and investment plans
 - b. Support the adaptation of global RHIS standards, best practices and tools into local settings
 - c. Build country capacity at all levels in RHIS data management, analysis and use, including through training materials/systems and strengthening of national institutes and statistics offices
4. Build a network of support (e.g. community of practice, learning missions (in-person or virtual), best practice repository) across regions and partners for dissemination and implementation of standards, tools and capacity building for RHIS.

Deliverables 2020-2023

Global

- Harmonisation of RHIS standards, best practice guidance and tools, as defined in RHIS WG annual workplans.
- Harmonisation of standards and protocols for integrating public health surveillance, public health and humanitarian emergencies reporting into RHIS, including *post facto* evaluation of emergency surveillance and essential health services continuity monitoring in RHIS, which could inform design/configuration proposals for future public health and humanitarian emergencies.
- Facilitate priorities for investment in global goods for RHIS development, implementation and maintenance.
- Documented country best practices on RHIS and modes of good governance.

Country

Based on target countries, country-specific needs and joint partner action, as defined in WG annual workplans:

- Support RHIS elements of country health sector strategy, digital health strategy and investment plans
- Global RHIS standards and best practices adapted, implemented and integrated into country RHIS

Approach and organizational arrangements

- ❖ Define key technical areas for which RHIS standards and best practices are required.
- ❖ Conduct a joint stock-take of existing global goods and partner efforts related to RHIS standards and best practices.
- ❖ Identify and prioritize key gaps and aspects for review/update.
- ❖ Define annual deliverables, leads per technical area and workplans.
- ❖ Conduct annual workplan reviews and adjust as needed.
- ❖ Working group is governed by two co-chairs with secretariat support



- ❖ Leverage and strengthen existing efforts of partners in these technical areas, including to promote monitoring of PHC, UHC and SDGs (e.g. work on surveillance standards, multiagency work on 100 core health indicators, EWEC, Countdown, ENAP/EPMM, Nutrition, HIV/TB/Malaria, Immunization, HSS, NCD, etc.)
- ❖ Ensure coordination and links with other HDC working groups (e.g. Digital Health and Interoperability, Community Data, Civil Registration and Vital Statistics, Epidemic intelligence)
- ❖ Monthly working group calls, attendance and providing of updates at monthly HDC SRG calls and attendance at HDC annual meeting
- ❖ Strengthen global to country alignment through regular communications at global, regional and national level and use of HDC website

Annex

Note for clarification in RHIS WG

The original HDC 2016-2018 working group called 'Facility and Community Data Working Group' included 5 sub-groups:

1. Routine Health Information Systems (RHIS) and Disease Surveillance Sub-group
2. Facility Surveys Sub-group
3. Community data Sub-group
4. Measurement of Quality of Care Sub-group
5. Logistics Management Information Sub-group (LMIS)

The current HDC working groups now include RHIS, Community data and LMIS as separate groups.

Clarification on HHFA, SPA / SARA and links to SCORE

Service Provision Assessments (SPA): was developed by ICF International, through the USAID funded-MEASURE evaluation DHS project. Unfortunately has only infrequently been used by USAID missions and is therefore currently being revised to increase its attractiveness and potential value for money. Revisions focus on a core set of Quality of Care indicators related to USAID specific program areas.

Service Availability and Readiness Assessment (SARA): This is WHO's tool on service readiness and builds on Service Availability Mapping (SAM) and SPA.

Harmonizing SARA with SPA: when a SPA is completed the SARA is included. SPA goes beyond assessing readiness and includes more information about processes of care and experiences of care.

WHO Harmonized Health Facility Assessment (HHFA): attempts to combine SPA, SARA and the World Bank's Service Delivery Indicators (SDI) HFA into one tool. The HHFA tool helps clarify and harmonize core indicators with SPA. All indicators in the new SPA will be in the WHO HHFA tool, however not all HHFA indicators will be in the SPA (as some will be USAID specific). Country specific adaptation processes (similar to DHS / MICS adaptation) could be considered using HDC partner resources.

WHO Maternal Child and Adolescent health (MCA) is in the process of defining Quality of Care (QoC) indicators in paediatric, small and sick newborns and has already defined these for maternal and newborn around the time of birth. If these newer indicators conflict with HHFA indicators, USAID SPA can adapt the new WHO MCA indicators (under the umbrella of the Quality, Equity, Dignity Network). The ongoing SPA revision process has potential to inform the next iteration of the HHFA indicators.

Use for UHC and considering SCORE package as an overarching approach in countries: Many health program Theories of Change (ToC) include a pathway showing increasing coverage, equity and quality of evidence-based interventions leading to improved health outcomes (reduced mortality and morbidity). This is an important aspect of UHC where those that need a service/intervention receive it and at a sufficient level of quality.



Routine Health Information Systems (RHIS)
Working-Group:
Terms of Reference

The SPA/SARA/HHFA can be used to prioritize efforts to address quality gaps and monitor trends. Data on quality of care of services and interventions is unavailable in most countries to address gaps and / or monitor trends. These data are essential for annual reviews and development of health sector plans.

This fits in [the SCORE standard](#) around the O (regular system to monitor service availability, quality and effectiveness) with a well established system to independently monitor health services.