1. Capturing Health Inequities in HMIS
2. Integrating Community Monitoring and
   Community Inputs into HMIS

Health inequities

- Indicate status of social justice and human rights in a population.
- Inequities in health arise due to administrative inefficiency, poor representation of minority groups in decision making, economic reforms pushed by WB & IMF, socioeconomic factors, political processes, etc.
- Equity can make primary health care effective and efficient.
- WHO and 2000 Millennium Declaration have emphasized upon restructuring healthcare systems to ensure health equity
- NRHM has addressing health inequities as one of its central concerns.

Health inequities

- 3 shifts in public policy have triggered health equity efforts:
  - In developed countries there seems to be ambivalence and reversal of earlier altruistic concerns for equity.
  - In the past decade developing countries were forced by 'economic adjustment' policies to cut public financing in health by 1/3rd.
  - China and Eastern Europe are engaged in 'political adjustments' resulting in abrupt collapse of health systems that were designed to promote equity.

Information/data needs

- Distribution of health and its proximate determinants
- Access to health services, and health outputs
    1. Geographic area
    2. By urban – rural divide
    3. By gender- male/female
    4. By community- religion
    5. By community – caste and ethnicity
    6. By economic quintile
- Understand Mechanisms that Sustain Disparities
- Effectiveness of strategies to reduce/eliminate disparities

Sources of Information/data

- Surveys – NFHS, DLHS, AHS,

- Surveillance- sentinel/over all

- Rapid assessments-

- Program data

- Routine health data (HMIS): Well established HMIS facilitate…

Problems of bringing inequity into HMIS

- In immunisation and few others– about data elements were to be reported as male/female = 80 basic indicators becomes 100-

- If all data elements were to be reported as SC/ST/others. Multiplied all data elements* 3= 300 subcenter elements

- Sharply decrease accuracy and increase errors in data.

- While aggregating many sources- medical colleges, district hospitals, corporations etc which do not collect such disaggregations would add in – and confuse the picture. Loss of reliability.

- High increase of burden of work – with no improved use. – if seen as a reporting- reminding function, it makes sense. But actual use for action- not worth it.

How then to collect data with equity linked dis-aggregations??

Evaluating four options…..

Option 1: Use of sentinel sites:

- Choose a number of sub-centers and PHCs and CHCs- which together represent 10% of case loads of that level. Draw it using rigorous sampling design.

- Here provide additional human resource. (Two part-time incentivised persons for a cluster of approximately two CHCs, two PHCs and about 10 sub-centers or two persons full time per district)

- Ask for maintaining all dis-aggregations manually and capture these electronically. Use these samples to comment on all dis-aggregations. Option of electronic primary records could be considered.

- Make it mandatory part of hospital management information systems- but would need some control over disease linkages to community profile.

- Problems of this approach are……

Option 2- sampling registers

- Registers in a district are standardised and have in the demographic or base line – all data with regard to dis-aggregations.

- A sample of registers is drawn annually/quarterly/ monthly and disaggregations are analysed.

- Problems of this approach are…..

Option -3- trace indicator

- Collect as per routine- but just for one key area where we suspect marginalization affects most and which is representative of the problem of access and marginalization- we collect disaggregated data

- For example we collect for
  - 1.skilled birth assistance/institutional delivery and
  - 2. use of Xrays.
  - 3. Under 5 Mortality

- needs high level of innovation and counter-intuitive thinking and field testing- agree on methodology to arrive at such indicator

- Should deaths be so recorded??

- Other problems of this approach are……

Option 4- Stick to the surveys

- Annual Health Surveys would give us all the information that we can use.

- Would be unable to manage undesirable pressures when we take any of the other options to scales.

What is the programme theory?

- Use of disaggregated data would help identify segments getting left out and plan to introduce demand side incentives/BCC/ more human resources to these areas.

- What is the use that has been made with current SC/ST data as available from surveys. Is it only to make a point?

What can be done with current data?

- We do have high quality data for geographic dispersion.
- Can this be co-related with community and economic dispersions?
- Perhaps there are " natural" sentinel sites out there?
- Can we start promoting use of available information on inequity for making more decisions?

Thank You