Ministry of Health

Malawi National Health Information System Policy

LILONGWE SEPTEMBER 2015

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ACRONYMS

CMED	Central Monitoring and Evaluation Division
DHIS2	District Health Information Software, version 2
EMRS	Electronic Medical Records System
EHRS	Electronic Health Records System
HIS	Health Information Systems
HMIS	Health Management Information Systems
HMN	Health Metrics Network
HSSP	Health Sector Strategic Plan
IHRMIS	Integrated Human Resource Management Information Systems
ICD	International Classification of Diseases
IDSR	Integrated Disease Surveillance and Response
IFMIS	Integrated Financial Management Information Systems
IHB 2003	Indicator Handbook of 2003
IT	Information Technology
UHC	Universal Health Coverage
LIMS	Laboratory Information Management Systems
LMIS	Logistics Management Information Systems
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MHMIS	Malawi Hospital Management Information System
MOH	Ministry of Health
NHA	National Health Account
PAMIS	Physical Assets Management Information Systems
TWG	Technical Working Group
UHC	Universal Health Coverage
WHO	World Health Organization

FOREWORD

A culture of evidence-based management decisions would help us achieve highest level of efficiency in the provision of basic essential health care to all Malawians. To establish such a culture the health sector needs a robust Health Information System that provides reliable information as solid evidence for making rational decisions. The transition from Millennium Development Goals to the post-2015 Sustainable Development Goals within the context of Universal Health Coverage have emphasis on measurement and accountability which can only be achieved through a vibrant National Health Information System aligned to the Five-Point Call to Action in Measurement and Accountability for Results in Health endorsed at the Washington Summit of June 2015.

However, our existing Health Information Systems are unnecessarily fragmented and are not capable of generating quality information at the time they are needed. Efforts have been underway, in collaboration with our partners, for harmonizing and synthesizing various data-management systems in the entire health sector. Despite those concerted efforts of key stakeholders, we continue to face challenges in the areas of data collection, data analysis, information dissemination, and information use. The problems with regard to data accuracy, timelines of reporting, analysis, and completeness continue to exist.

The MOH and its partners have realized that our existing policies related to the management of health information systems are inadequate to address these issues and problems. As a way forward, the existing policies have been revised into a complete new policy that will guide the implementation of Health Information Systems in the country.

I hereby endorse this “National Health Information System Policy 2015”.

Hon. Dr Peter Kampalume, MP
Minister of Health

September, 2015

ACKNOWLEDGEMENTS

This Health Information Systems Policy, 2015 is a result of tireless effort of a team that spent hours on a long and complex process of intensive consultations, drafting and review. Ministry of health officials, the private sector, co-operating partners and other stakeholders were all involved in the process.

The Ministry of Health is grateful to everyone who contributed to the successful development of this policy. The efforts of going to and fro, putting together vital pieces of information, comments, criticisms and suggestions have not gone unnoticed.

First and foremost, we acknowledge the Director of the Department of Planning and Policy Development and the Head of the Central Monitoring and Evaluation Division (CMED) for their leadership, stewardship, constant engagement and strategic guidance during the policy formulation process.

We also particularly acknowledge the financial and technical support to CMED from the Training and Education Center for Health (I-TECH), the German International Cooperation (GIZ) and EPOS Health Management under the Malawi German Health Programme (MGHP) in the active drafting and formulation of this policy, in consultation with all other stakeholders including USAID, CDC, WHO, Baobab Health Trust, Luke International Norway, SSDI-Systems, SSDI-Services, Village Reach, D-Tree International, Norwegian Embassy and partners in the M&E Technical Working Group.

Finally, the Ministry of Health expresses its profound gratitude to all other stakeholders and institutions who continue to contribute towards improving the health of the people of Malawi.

MacPhail Magwira, PhD
Secretary for Health

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1. RATIONALE

Health information is a critical and strategic resource for the management and monitoring of health sector performance. Clear and concise up-to-date policy guidance is needed for effective and efficient management of this important resource. This document seeks to provide policy updates to mitigate policy gaps with regard to implementing and utilizing the health information systems in Malawi for evidence-based decision support.

The first *Health Information System Policy and Strategy* was developed in 2003, along with the *Indicator Handbook of 2003* comprising 110 indicators for monitoring the health sector. Changes in the health sector since 2003, which have also impacted on health information management have necessitated the need to review the *Health Information System Policy and Strategy* of 2003. These changes are influenced by the endorsement of new policies, procedures and strategies to steer the health sector in response to shifting priorities, the emergence of various sub-systems for operational management of the health sector and the increased use of Information and Communication Technology (ICT) as an enabler in the health sector coupled with the need to streamline the same.

Today, vertical programmes and fragmented systems with sometimes parallel data collection and consolidation procedures compromise data integrity and increase the burden of data collection, consolidation and dissemination for decision support, putting to question the reliability of information thus generated. HMIS core indicators defined in 2003 can no longer sufficiently measure health sector performance and changes in Malawi's health profile and are not necessarily aligned to the HSSP indicators. Furthermore, the resources necessary for information management in the health sector (skilled human resource, finance, technical and physical infrastructure, laws and policies etc.) have not evolved in parallel to cope with increased demand for data management and information dissemination and use in the health sector; and the criticality of the role of the private sector in health service delivery cannot be overemphasized.

At global level this policy responds to international frameworks, notably, the Millennium Development Goals (MDG) in retrospect and the post-2015 Universal Health Coverage (UHC) which among others seeks to ensure that all people receive quality health services that meet their needs without being exposed to financial hardship in paying for them, alongside Sustainable Development Goals (SDGs). This policy subscribes to the Five-Point Call to Action for Measurement and Accountability for Results in Health in post-2015 era endorsed at the Washington Summit of June 2015. Furthermore, formulations in this policy have taken due consideration of the *Health Metrics Network Framework (HMN) and Standards for Country Health Information Systems*.

Locally, this policy recognizes the *National Framework for an Integrated Monitoring and Evaluation System, Health Information System Strategic Plan - HSSP (2011-2016), Malawi Health Sector Strategic Plan (2011 – 2016), e-Health Strategy (2011 – 2016)* and *IDSR guidelines*. This Policy is valid for HSSP 2011-2016 and subsequent strategic plans. Upon the release of subsequent HSSPs, where necessary this policy and all other relevant pertinent documents affected by this policy shall be revised.

2. OVERALL GUIDING PRINCIPLES

This policy was elaborated for the health sector of Malawi, i.e. public and private. The stipulations therein therefore apply to all public and private health facilities alike.

Through this policy, the responsibility to coordinate data collection, consolidation, analysis and dissemination is vested with the Central Monitoring and Evaluation Division which is responsible for HMIS.

All programs and partners with interest to collect health data on basic health services shall utilize HMIS.

The development of this policy was guided by the main principle of "**information for action, action for improving efficiency, quality, and equitable coverage**".

In line with the main guiding principle above, this policy is guided by the following specific principles:

2.1 The need to generate relevant and quality information in a timely manner for all intended users at community, health facility, district, zone, and national levels.

2.2 The need to support the establishment and sustainable development of simple, coherent, scientifically sound, easily understandable and dynamic information systems.

2.3 Recognition of the need to establish clear HIS structures and adhere to, implement, and utilize such structures in support of the information systems and accountability of its results.

2.4 The need to build a dynamic system using appropriate technology to ensure effective dissemination of information (communication and feedback) to all stakeholders.

2.5 The need to inculcate the use of reliable information for evidence-based decision support, which calls for a shift from data collection to transforming data into information that shall be utilized at all levels for better management.

2.6 The need for a holistic approach to health information management that builds a unified HIS composed of a central data warehouse with sub-systems for collecting information relevant for decision support.

2.7 The need to recognize the value of data that are disaggregated by sex, age groups, geographical areas and social income groups to the extent that they have practical use in achieving greater equity, efficiency, and quality.

2.8 The need for concerted efforts of all stakeholders in the country to carry out local analysis and use of information for improvement of quality and coverage of health services.

2.9 The need for robust systems, including HMIS, LMIS, IFMIS, PAMIS, IHRMIS, Vital Registration, census, and surveys with separate databases as specialized components of the national HIS; with the responsibility to design, develop and operationalize such sub-systems vested in the respective departments in collaboration with CMED and relevant Technical Working Group (TWG).

2.10 The need to establish a national health data repository (warehouse) containing cohort data on all indicators; with data in the repository routinely updated by extracting, transforming, and uploading data from relevant sub-systems in accordance with the *Malawi HIS Integrated Information Architecture*.

2.11 The need to prohibit any vertical reporting on **basic health services** and instead promote an integrated and consolidated approach using a central data repository**.**

2.12 The recognition of the HMIS sub-system as the only routine health information system that captures complete information on health services in accordance with the *Malawi HIS Integrated Information Architecture*.

2.13 The need to build institutional capacity to manage health data across all levels of care, i.e. collect, consolidate, analyze, disseminate, interpret and use for decision support.

2.14 The need to increase the level and efficiency of investment in Health Information Systems

2.15 The need to promote country and global governance with citizen's and community's participation in health information systems monitoring.

3. PURPOSE, VISION, MISSION, AND OBJECTIVE OF HIS

3.1 **Purpose of the HIS**
Ensure an adequate provision of information support to all stakeholders in the health sector for evidence-based decision making in the planning and management of health services.

3.2 **Vision of the HIS**
A health sector with quality health management information ensuring each management decision is evidence-based.

3.3 **Mission of HIS**
To continuously strengthen the capacity of information producers and information users to exploit their full potentials in enhancing quality and making the best use of health information.

3.4 **HIS Objective**
To generate quality information (accurate, complete, timely, relevant, and reliable) and make them accessible to all intended users through standardized and harmonized tools across all programs that avoid duplication and reduce the workload on data capture by already stretched human resource at health facility level.

4. HIS RESOURCES AND INFRASTRUCTURES

4.1 A Health Information Systems Technical Working Group (HIS TWG) involving a representative from each relevant ministry and stakeholders shall oversee the design, development and operation of HIS that include HMIS, LIMS, LMIS, IHRMIS, PAMIS, rapid assessments, annual health facility census, and periodic surveys.

4.2 MOH shall maintain a fully equipped CMED in the MOH headquarters to coordinate the implementation of this policy. CMED shall serve as a secretariat for the HIS TWG.

4.3 MOH shall establish separate national repositories for patient level data and aggregate **data repository (currently DHIS2)**. The repositories shall hold disaggregated time series data on all national health indicators. Data in the repositories shall be updated routinely on stipulated dates by extracting, transforming, and uploading data from all relevant sub-systems.

4.4 MOH shall maintain **a web portal** to make ready-to-use data available to all stakeholders. The functional relation of HIS and HMIS sub-systems, repository and web portal can be seen in the *Malawi MOH HIS Integrated Information Architecture*.

4.5 MOH shall allocate a reasonable amount in a separate budget for the implementation of the HIS systems across all levels of healthcare. Additionally, each cost center, including district cost centers, and health programs shall ensure **rational allocation of budget** for HIS functions. District health offices shall therefore have a dedicated HIS budget line in the respective charts of accounts.

4.6 Costs necessary for the implementation of HIS activities as allocated in the budget shall be shared by MOH, the private sector, Health Development Partners (HDPs) and any other pertinent stakeholders.

4.7 Skilled personnel trained in HIS shall be fully dedicated to HIS functions at the national and referral hospitals, and district levels. A fully trained focal point shall be designated for each basic health care facility. The positions of HIS officers at district and central hospitals shall be upgraded to at least level P8.

4.8 Job descriptions of all health and support personnel shall be reviewed in light of production and utilization of quality data. An appropriate training program with respective training manuals shall be developed and incorporated into the respective curricula to impart **necessary knowledge and skills** to carry out the information management functions.

4.9 HIS data shall be computerized at secondary hospitals, tertiary hospitals and at national levels. CMED in collaboration with the National Data Standards Sub-TWG and the IT unit of MOH shall develop relevant **hardware and software** standards and specifications in this respect, against which systems to be deployed shall be assessed and certified.

4.10 An appropriate **standardized communication system** shall be gradually deployed to all health facilities for the notification of diseases and other urgent communications.

4.11 **Tools and Guidelines** required for data management and use shall be developed by CMED, endorsed by the HIS TWG and officially approved by MOH. The availability of such tools in health facilities, administrative offices and other relevant institutions shall be coordinated by CMED.

4.12 MOH reserves the right to full access, including administrative access, to all systems (applications, databases, servers, network equipment etc.) developed for or in the interest of MOH by stakeholders and any other third parties in line with existing national laws relating to health data access.

5. INFORMATION NEEDS AND DATA SOURCES

5.1. The health sector's monitoring data needs shall be identified and published in the **comprehensive indicators matrix of the health sector** as an integral part of this policy and in line with the HSSP of MOH in force and other pertinent documents.

5.2 For reporting purposes, relevant sub-systems shall be configured to generate required indicators. However, this clause shall not prohibit the collection of specific information for conducting research of national interest.

5.3 HIS **data sources** include routine information sub-systems such as HMIS, LMIS, LIMS, HRMIS, IFMIS, and PAMIS complemented by rapid assessments, annual health facility census, periodic surveys, vital registration and national census. Any further pertinent data that are not routinely captured by any of the routine sub-systems shall be captured through **the annual health facility census**.

The HIS sub-systems shall operate within the following scopes:

Data Sources	Scopes
HMIS	Complete information on preventive, promotive, curative, and rehabilitative health services.
LIMS	Complete information on medical laboratory and diagnostic services.
LMIS	Complete information on medicine and medical supplies.
IHRMIS	Complete information on human resource planning, production, recruitment, and administration.
IFMIS	Complete information on budget, expenditure, revenue by major program component and cost centers.
PAMIS	Complete information on building, medical equipment, vehicles and all other durable supplies and their management.
Rapid Assessment	Information on providers and consumers satisfaction. Data quality assessment and adjustment.
Annual Health Facility Census	All detailed data that are not captured by any of the routine data systems shall be captured in the annual health facility census. Age and gender disaggregated data shall also be captured in the census.
Surveys	Surveys (such as MDHS MICS, SPA) shall cover information on all impact indicators.
Vital Registration	Complete information on births and deaths.
Census	Complete population data with a breakdown of target group for various health programs.

5.4 CMED shall be responsible for obtaining up to date estimated/projected authentic catchment population data for each health facility from the designated government source.

5.5 MOH shall conduct an assessment every five years in line with the HSSP to identify the applicable use of information and **determine the potential information needs** leading to an update of the comprehensive indicator matrix of the health sector followed by an update of the HIS policy and any other pertinent documents where applicable.

6. DATA COLLECTION

6.1 All health data shall be recorded in relevant paper or electronic registers at the time of event.

6.2 In order to ensure interoperability and data integrity, all systems used for data collection and/or management (electronic- and paper-based) including Electronic Medical Records Systems (EMRS) shall be designed and managed in compliance with approved national standards and guidelines on health data management.

6.3 CMED is the sole authority responsible for introducing new routine data collection tools including registers and approving changes to all tools used for capturing data on basic health services. All requests or suggestions for new tools and for changes to existing tools should be made in accordance with the *change request procedure* put in place by CMED. Any changes made noncompliant to the *change request procedure* in place shall be considered null and void. This policy therefore prohibits any institution or stakeholder from collecting data directly from health facilities without the express written approval of CMED.

6.4 Programme-specific reports shall have minimum datasets to ensure generation of HMIS core indicators.

6.5 Programme coordinators shall in collaboration with respective HMIS staff (at health facility and district level) capture electronically into the central data repository all programme-specific reports in a complete, timely and accurate manner.

6.6 Service providers shall collect client's data in the approved format at the time of interaction, assessment, service delivery or follow-up actions. The respective data collector shall be responsible for ensuring the data captured in the relevant instruments (registers, checklist, forms, and clinical cards) are correct and complete.

6.7 Patient diagnoses shall be recorded in line with the International Classification of Diseases (ICD) 10 or above.

6.8 Electronic Medical Records system shall be gradually introduced in all health facilities nationwide. When a fully functional EMR is introduced at a health facility, this shall be the primary data source.

6.9 Human resource, finance, physical assets, and logistics data management systems shall follow the government wide system. Nevertheless, each of them shall have to accommodate the information or data as per comprehensive indicator matrix of the health sector.

6.10 All health facilities shall submit data regularly to CMED through HMIS office at the District Health Office in accordance with approved data collection procedures in place. HMIS office at central hospitals shall regularly receive data from all departments and input into the central data repository.

7. CONFIDENTIALITY

7.1 In all HIS operations, efforts shall be exercised to protect the clients' rights in line with prevailing data privacy and confidentiality policy, without compromising safety and knowledge sharing.

7.2 Health workers and other staff that have privileged access to patient's records and other information shall be accountable for maintaining the highest level of confidentiality and ensure that shared confidentiality is practiced in the interest of the patient and in accordance with the law. Violation of confidentiality shall be punishable by law.

7.3 Each facility is obliged to maintain adequate physical security of patient records and secure access to storage areas.

7.4 In the event that the privacy of client data has been compromised at any level of health service delivery, concerned heads of institutions shall within their powers immediately institute remedial controls and shall immediately notify CMED for further remedial processes.

8. DATA COMPILATION / AGGREGATION

8.1 Each individual responsible for recording data shall also be responsible for daily aggregation of the data in the approved format.

8.2 Routine data collected and aggregated (weekly, bi-weekly, monthly, quarterly, semi-annually and annually) shall be plotted on approved charts and used for monitoring trends.

8.3 Designated focal points shall be responsible for compiling data from multiple sources (providers, sub-systems) and generating detailed and summary report for the facility/institution.

8.4 Where health facilities cannot access the central data repository (DHIS2) for data analysis, interpretation and use, the District Health Office shall be responsible for preparing facility specific reports and sharing with such health facilities in her jurisdiction.

9. DATA ANALYSIS

9.1 Each Health Institution (Facility, District, Zones and Programmes) shall to the extent to which it is possible, conduct appropriate analysis that responds to the key health system performance questions which include Utilization, Coverage, Efficiency, Quality, Safety and Equity of services delivered.

9.2 CMED shall provide the necessary tools, templates and technologies, and build the capacity of the institutions and individuals on how to use such tools to perform the relevant analyses.

9.3 Institutions (Facility, DHMTs, Extended DHMT, Zone, National level) shall hold regular review meetings to discuss institutional performance based on the indicator data highlighted through the relevant analysis.

10. DATA QUALITY ASSESSMENT AND ADJUSTMENT

10.1 The head of the facility and all administrative offices shall be fully accountable for the quality of data that he/she reports or disseminates. Both paper-based and electronic data shall be verified and approved prior to release or reporting to the next level.

10.2 Community structures (including NGOs, CBOs, Chiefs, and Village Health Committees etc.) shall be strengthened to take a supervisory role in monitoring data collection and submission and to actively participate in health performance monitoring in their respective jurisdiction.

10.3 Comprehensive internal data review, adjustment, interpretation and planning for response sessions shall be conducted monthly at health facility, quarterly at district, zonal support office, and project or program levels.

10.4 CMED shall develop, publish, and update guidelines on data management in collaboration with relevant divisions, programs and all other pertinent stakeholders.

10.5 National data quality assessments, coordinated by CMED in collaboration with all other pertinent stakeholders, shall be carried out semi-annually and based on the findings, necessary adjustments shall be made in the semi-annual and annual health statistics. Independent of the national assessments, districts and health facilities are encouraged to perform their own independent data quality assessments on a regular basis as part of the continuous improvement effort.

10.6 Continuous supportive supervision and feedback shall be carried out from each supervisory level in line with the supportive supervision procedures in place.

10.7 A cluster of disease specific sentinel sites, covering all geographic regions, shall be selected and implemented for generating more accurate statistics which shall be used for deriving true disease statistics of the nation. CMED, in collaboration with the National Health Institute, shall determine such sentinel sites.

11. REPORTING AND DATA TRANSMISSION

11.1 All health facilities shall submit on a regular basis health statistics in line with routine reporting policies and procedures, and stipulated submission deadlines. Health facilities failing to meet the set deadline shall be held accountable.

11.2 Each HIS sub-system shall exercise fully integrated reporting and shall channel the report through a single route within its domain (such as Department of Finance, Human Resource, etc.).

11.3 Immediate case-based and weekly zero-reporting on nationally endorsed notifiable diseases shall be sent directly to IDSR focal point. Such cases shall be included in HMIS monthly report and channeled through the single reporting channel of HMIS sub-system.

11.4 If data is captured electronically, it shall be reported as such to avoid duplicating efforts.

12. DATA STORAGE

12.1 Each health facility / institution shall be responsible for safe storage and easy retrieval of all records under their care. For backup purposes, all records in electronic formats shall be stored in external storage media and safeguarded by passwords and other protective measures.

12.2 All patients' records and registers, reports, and other data paper-based or electronic shall be retained by the data custodian in-charge in line with prevailing data retention policies and procedures.

12.3 Any health-related research data collected shall be deposited with the Research Unit once a year and/or at the end of the study along with meta-data file, structured according to the meta-data dictionary defined by the Ministry of Health.

12.4 Any health related data whether physical or electronic shall be stored only within the borders of Malawi except for the purpose of continuation of care.

13. DATA ACCESS

13.1 The Central Monitoring and Evaluation Division in the Ministry shall ensure that analytic national health statistics are posted regularly on the MOH web portal for unrestricted access to all interested users.

13.2 The time series raw data on all indicators shall be available on the HIS repository. Access to this shall be limited to relevant direct stakeholders through a controlled pass code system. Researchers and non-regular stakeholders shall be provided access to only the data of their interest after proper authorization.

13.3 The IT Unit of MOH shall ensure that the Intranet and MOH Web portal are fully functional and provide uninterrupted access as per aforementioned HIS data access policy.

13.4 Any researcher required to access personal data with identification details shall have to obtain written ethical clearance from National Health Service Research Committee. This shall be in conformity with the aforementioned confidentiality clause. Researchers requesting access to aggregate raw data shall obtain written permission from the Head of the respective Office.

13.5 The Ministry shall from time to time set rates for processing fees required to meet any demand or request for data not available through existing reports.

13.6 Use of data shall be limited only to the purpose it was intended for at the time of request.

13.7 CMED shall develop, implement, and update a data release protocol/procedure for health sector.

13.8 The patient or person shall have full access rights to any health related data collected about them.

14. DATA OWNERSHIP

14.1 The ownership of any health related data shall rest with the Ministry of Health.

14.2 Each patient or any person shall have a personal health passport which will contain their key personal health details which shall freely be taken home by the patient for ease of reference and personal monitoring of their health matters, in addition to the individual patient records kept in the facility.

14.3 All health facilities and health practitioners whether in public or private facilities shall ensure that patients/persons seeking care in their facilities have, in their possession personal health passports in addition to patient files kept in the facility.

14.4 All health facilities and health practitioners whether in public or private facilities shall ensure that patients/persons seeking medical care present health passports to their care providers.

14.5 All Health Practitioners be it in public or private facilities shall update their patients' health passports with relevant key details extracted from patient files kept at the facility each time they are presented to a health practitioner at the time of seeking care.

14.6 Updates of the health passport in the custody of the patient shall include proposed diagnosis, plan of care, treatment given and follow-up date.

14.7 All sharing of patient personal identifiable information with third parties by public health facilities, private health facilities, insurance companies or individual health practitioners shall be done only with written consent from the patient or their care givers where the patient is a minor.

15. INFORMATION DISSEMINATION AND USE

15.1 Each health facility shall display weekly, monthly, quarterly and annually, performance data based on HMIS core indicators. CMED shall provide necessary templates, tools and guidelines in this respect.

15.2 Each district shall display monthly, quarterly and annually, performance data based on HMIS core indicators. CMED shall provide necessary templates, tools and guidelines in this respect.

15.3 CMED shall create demand for and promote the use of HIS through the timely supply of accurate and easily understandable information.

15.4 CMED shall regularly publish a national comprehensive health statistics report on the MOH web site to enhance access by individual researchers, research institutions and the public at large. Limited hard copies shall be made available to strategic partners who have no means to download and print.

15.5 CMED shall in collaboration with other stakeholders and on an on-going basis identify creative and innovative approaches to gear up demand for data and to promote a culture embracing the use of reliable information for evidence-based decision support across all levels of care.

16. REVOCATION

Health Information System: National Policy and Strategy 2003 has been revoked.

Furthermore, this policy revokes any previous statements or guidelines related to health information management that contradict stipulations made herein.