# Uses of data in planning process at LGAs: Stories from Council Health Management Team (CHMTs).

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## Introduction

The National Health Policy (2007) stipulates clearly that Local Government Authorities (LGAs) have the task of providing health services at primary level. The LGA is responsible for managing District Hospitals, Health Centres and Dispensaries. Administratively, the health services at the LGA are subordinated to the health department that is headed by the District Medical Officer (DMO). The council is required by the Central Government's health policy to formulate an action plan for implementing the health services at LGA. It is the duty of health department to prepare the Comprehensive Council Health Plan (CCHP) that includes all level of services provision.

The planning processes among other things needs data from different sources to as the basis for planning (Anasel, 2017). Most of researchers argued that, good planning and management of health services depend much on the availability of reliable, accurate and timely reported data (Garner, Harpham and Annett 1992; Robey and Lee 1990). In the health sector, most of the data are collected through MTUHA and other sources and imported in District Health Information System Software (DHIS2). The DHIS2 is a web-based application and powerful software for analyzing reporting and disseminating data for health programmes. It is an intergraded warehouse to store all national data from many national data sets in one place and make them available in some internet browser such as IE and Chrome. When used properly it can provide feedback on performance of facility to the lower and higher levels (Lungo, 2008). DHIS2 provides baseline data for district planning process, the level of implementation and monitoring of major indicators of disease patterns, preventive services and physical resources (Karuri et al 2014).

The National Guidelines for Health Data Quality Assessment (2016), stipulates clearly that despite the improvement of health data in Tanzania in the last 15 years, including the introduction of DHIS2, the data quality audits conducted by a variety of programmes and funders 'highlighted concerns about the quality of the data collected through the routine systems'. Therefore, this study is aimed to go beyond that by examining the uses of data by the CHMTs members in the planning process. The study will answer two main questions: (1) how do the CHMTs members prepare the LGA's Health plans and (2) what are the sources of

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data used by LGAs in planning process?

## Methods

### *Study Approach*

The main focus of this study was to get the general perspective of the actual practice in planning process done by CHMT members and the use of data in planning process. To achieve this, a purely qualitative study was performed to get insights from group of CHMTs on how planning process proceeds in LGAs. So the source of the information was from CHMT members enumerating the general perspectives in LGA planning processes and data uses for this activity. To obtain the needed information, three Focus Group Discussions (FGDs) were conducted. The first FGD involved three (3) participants, the second FGD had six (6) participants; and the third FGD involved six (6) participants; making a total of 15 participants. FGD method was selected simply because it is commonly used method when carrying out studies to get communal perspectives on certain phenomena.

### *Sampling*

The FGD were done at Mzumbe University premises where one office was selected and arranged in half cycle shape. Purposeful sampling technique was used to select the CHMT members from two Master's classes at Mzumbe University in the Department of Health Systems Management that is MSc-Health Monitoring and Evaluation (MSc.HME); and Master of Health Systems Management (MHSM). The approach was done to get a representation of all the seven (7) Zones in Tanzania as categorized by Tanzania Demographic Health Survey (DHS). That is, the participants of the FGDs are the representatives of the seven (7) Zones in Tanzania as shown in Table 1. This strategy was cheap and convenient since it used the students who were readily available at the University. It could be very expensive to get the participants from the seven zones if we had to travel to all these zones. To avoid biasness in this research, the students were informed about the study and they were assured that the FGDs had nothing to do with their studies as well as their job. Also, two FGD were selected from the graduates that is the Msc.HME and MHSM students who had already completed their studies but waiting for graduation. There were no any noted difference in participation in the FGDs between the graduates and those who are proceeding with their studies.

**Table 1: Characteristics of Respondents**

| Attributes of Respondents | Frequency | Percentage |
|---|---|---|
| **Age of Participants** | | |
| 30 - 35 | 4 | 26.7 |
| 36 - 40 | 5 | 33.3 |
| 41 - 45 | 5 | 33.3 |
| 46 - 50 | 1 | 6.7 |
| **Sex** | | |
| Male | 10 | 66.7 |
| Female | 5 | 33.3 |
| **Education Level** | | |
| Bachelor | 3 | 20 |
| Master | 12 | 80 |
| **Working Experience** | | |
| 0 - 5 | 3 | 20 |
| 6 - 10 | 5 | 33.3 |
| 11 - 15 | 5 | 33.3 |
| Above 15 | 2 | 13.3 |
| **Marital Status** | | |
| Married | 14 | 93.3 |
| Single | 1 | 6.7 |
| **Region** | | |
| Tabora | 2 | 13.3 |
| Dodoma | 1 | 6.7 |
| Mara | 2 | 13.3 |
| Coast Region | 1 | 6.7 |
| Singida | 1 | 6.7 |
| Dodoma | 1 | 6.7 |
| Morogoro | 2 | 13.3 |
| Lindi | 1 | 6.7 |
| Songwe | 1 | 6.7 |
| Tanga | 1 | 6.7 |
| Ruvuma | 1 | 6.7 |
| Mwanza | 1 | 6.7 |

*Data Collection*

The FGDs were conducted with the master students to obtain the required data. The thrust of FGDs was on the planning process, sources of data used in planning and quality of the data used. FGD guide was developed and translated into Swahili language to guide the researchers. The FGDs were conducted by two researchers. The first researcher played the role of moderation and the second researcher was the recorder of all behaviours shown by participants in a note book, undertaking audio recording and drawing the discussion flow (cobweb) as shown in figure 1. The moderator used different probes to make sure that the FGD participants provided relevant information to address the research objectives. More probing were done when there were emerging issues/concept(s) that emanated from a question that was not predetermined in the FGD guide.

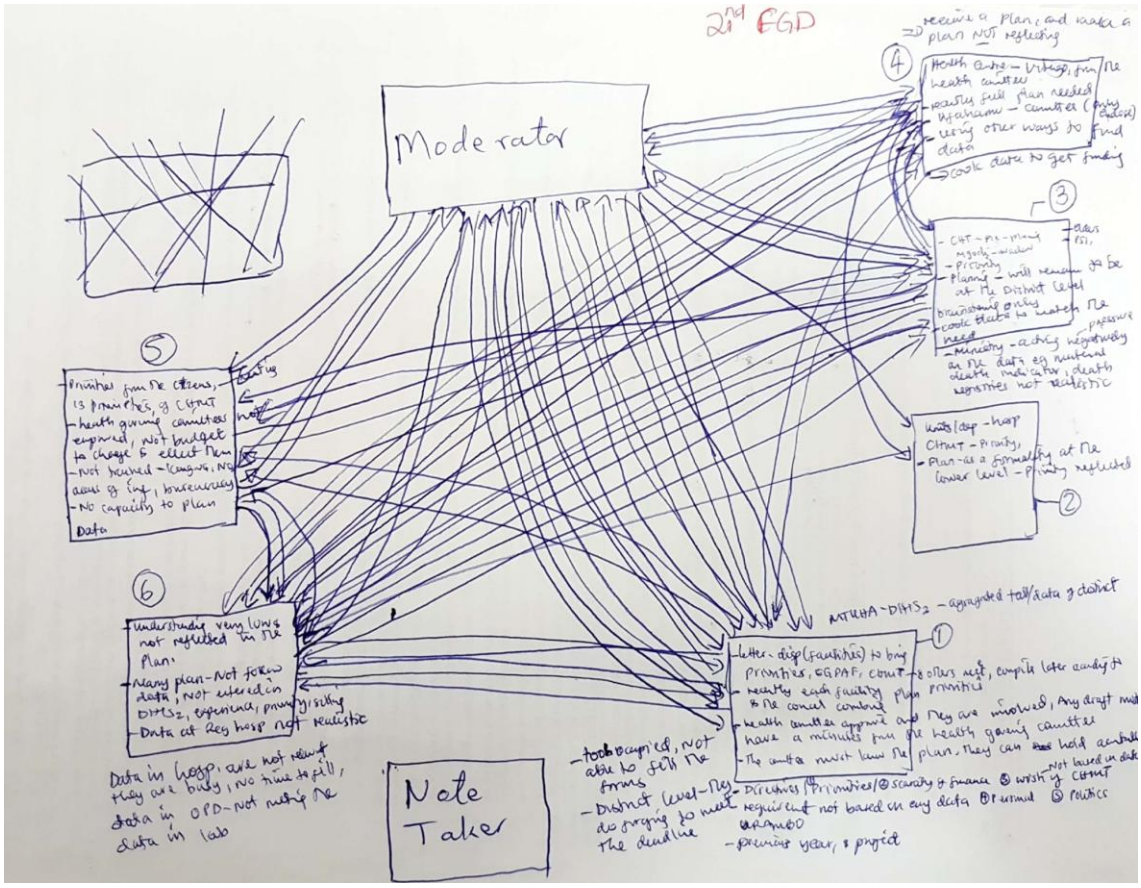


*Figure 1: The cobweb for FGD two and three*

*Data Analysis*

Thematic analysis was done to describe different themes arising from the participants. The identified themes were revolving around planning process and sources of data used in planning processes.

Transcription of the recorded information was done within 72 hours after the interview. The transcription was done in English while the FGD was done in Swahili. This was followed by repeatedly reading the transcripts to cross check the quality of the data and acquire sense of the overall data. Thereafter, the transcribed texts were imported to Atlas.ti. Within the programme, all data were coded inductively revolving around two main themes that are planning process and the uses of data in planning. The grouping was done for the similar themes to form families. The two main families formulated were the planning process and data uses in planning. After coding and creation of code family the memoing process was done to add the researchers' views on the coded concepts. This was included in the descriptive report produced by the Atlas.ti. The final report was written based on the downloaded output from the software.

**Results**

*Planning Process*

The FGD participants stated clearly that the CHMT members collect the plans prepared by the district hospital, health centres, dispensaries, and include them in Comprehensive Council Health Plan (CCHP). Thereafter, it is followed by another meeting of the Council Health Planning Team (CHPT) which deliberates the plans and approves them. This is followed by a series of scrutiny before submitting them to the President Office Regional Administration and Local Government (PO-RALG) for assessment, approval and funding. The process takes long time which continues even after approval of the Health Budget by the parliament.

It was found that the planning process in LGAs is done into two stages, namely, pre-planning and the real planning. Pre-planning is mainly done at least one or two months before the real planning and it involves inviting all individuals and organisations that support, cooperate or work with the respective LGA in the area of health. The main purpose of pre-planning meeting is to familiarise the members on how the real planning will be done and inform various stakeholders and the officials about the planning so as to get their views on priorities to consider. The pre-planning meeting is thus a forum for members to have the opportunity for providing preliminary inputs on the plans from the dispensaries. The pre-planning meeting is, according to the majority of FGD participants, attended by CHMT team, Council Planning Officer, representatives from the dispensary and other stakeholders supporting or working with the LGAs such as Engender Health, Deloitte, Marie stops, PSI depending on the NGO that is providing services in respective LGA. The inputs and priorities are combined together to have a zero draft for discussion in the planning meeting. It was also found that the facilities particularly the Dispensaries prepare their plans and forward to the council and they

are also discussed in pre-planning meeting. The engagement of the health governing committees and health boards in planning process seems to be an important element in the planning process as clarified by the participants of the FGD.

There are a number of challenges in the planning process as highlighted by the FGD participants such as the capacity and experience of the health governing committees at the dispensary and health boards in hospitals; the difficulties in deciding the priorities of the dispensaries; personal preferences and the influence of politics; high demand from the facilities and limited budget; aligning the budget as per the priorities of the government and the guideline; and the system that requires each facility to be given their money, formula, criteria and the basis for distribution are not yet clear.

*Sources of Data Used*

Regarding the source of data used in prepare the plans the findings have mixed results. Majority of the participants said that MTUHA focal person provides the data, while others said that they depend on the data provided by the coordinators. It was clarified that before the CHMT meeting all members such as MTUHA focal person and coordinators must have the relevant data that they will use in the planning activities. It was noted that in most cases the data claimed to be used during the planning processes are in notebooks and other data from the dispensaries. Some participants in the FGD said that in most cases they do not bother to prepare any data to be used in the planning process since they are busy with many tasks and that the health secretaries, coordinators and MTUHA focal person are responsible for that. They also gave the experience of the situation where the health secretaries were not present in the meeting that the whole activity of planning became very difficult since they could not trace the data which were in notebooks of the health secretaries.

The FGD participants highlighted that they sometimes use ‘cooked data’ to meet the required standards of preparing the health plans. This is when the available data are not realistic and relevant while the system needs a certain percent or amount to be filled for the plans to be accepted. Formally the manual system of planning was used, but of recent the online system of preparing CCHP was introduced. The system is very sensitive and so sometimes manoeuvring of data is done to make sure the data filled will be accepted in the system. With the new system, the expenditure must reflect the plans according to what is on the system. This has been a problem in the councils because what is implemented is not what is on the actual plan.

They further clarified that the data in the hospitals in most cases are worse compared with the data in the dispensaries. The data in the hospital are not filed well and sometime not filed at all. For instance the data in OPD data do not match with the laboratory data. The ‘good data’ (data that tells what the higher authority and donors want to hear) are reported, but in most cases they do not reflect the reality in the health facilities. Data related to abortion, maternal mortality and deaths caused by cholera were mentioned as examples of data that are likely to differ from the original and may sometimes not be documented. All these have to do with the quality of data. The same scenario was also mentioned by the majority of CHMTs members

as the reasons for their reluctance to use DHIS2 data in planning. They said that the data entered into the database do not actually reflect what is happening in the facility, and they sometimes differ significantly with the data available in health facilities in MTUHA monthly summary form.

Despite the fact that all CHMTs participated in FGD have the access to DHIS2 database, all of them declared that they never accessed the DHIS2 data for neither cross checking the quality of data entered into database nor downloading the data for use in planning activities and preparation of various reports. They did not give any reason for their reluctance although they declared that the system is easy to use and seem to be important if it is used well. They shifted the blame to MTUHA focal person that their duty is to make sure that the data that are entered into database are correct.

The participants informed that data are supposed to be submitted to the system before 15$^{th}$ of each month to avoid queries from central government (regions and the ministry). This shows that the culture of data use in planning and in producing various reports in health is still low for all CHMTs. Whereas they have a mentality that the data collected are for 'them' (the higher authorities and donors) and not for their personal use especially in the planning process in the LGAs.

**Conclusion**

The paper concludes that despite the fact that the CMHTs follow the required guidelines in preparation of Health plans which in this case is CCHP, the question still remains on the use of data for health planning and also the quality of the data used in preparation the CCHP. This is attributed mainly to the culture of not using the data and perhaps low analytical skills.

The paper recommends that the CHMT members should undergo intensive training on how to conduct simple analysis of DHIS2 data. This will impact on their data analysis skills and the likelihood to develop a culture of using data for planning in so doing, improvement in the quality of plans to reflect the real situation/problem at lower levels can be realised. In addition, training on simple analysis and data use to lower level staff is recommended so as to ensure quality of data collected and empowerment of data collectors in terms of capacity to make a sense of data from the collection stage.