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Decisions before dashboards

Five shifts to make routine health data work for districts in developing countries

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ABOUT THIS PUBLICATION

Publication details



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ABOUT THIS BRIEF

Praxis Policy Briefs distil evidence on a current institutional challenge into practical recommendations for leaders, boards and policymakers. Each brief is short enough to read before a meeting, cites every source so that readers can check it, and ends with actions an institution can take within one budget cycle.

This brief asks what it would take for district health management teams to use routine health data to make better decisions, routinely and with confidence. It draws on World Health Organization technical guidance, peer-reviewed studies from sub-Saharan Africa, and official and sector reports on the 2025 aid cuts. Sources were checked against original or authoritative sources, are dated on or before 16 October 2026 and are listed in full at the end. Health financing after the aid shock is treated only as context; it is the subject of a separate Praxis report.

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SUMMARY

Abstract

More than 80 low- and middle-income countries now use DHIS2 to run their routine health information systems. Yet at district level, where most health services are planned and managed, collected data often do not become decisions. Studies across sub-Saharan Africa show high reporting rates alongside weak data use, persistent quality problems and a heavy recording burden on health workers.

The 2025 cuts to external aid, including the end of United States funding for the Demographic and Health Surveys (DHS) Program, have made countries more dependent on their own routine data. This brief reviews the evidence on data quality, data use and accountability at district level, sets out the strongest case against relying on routine data, and responds to it.

It makes five recommendations for ministries of health, district health management teams and partners, and provides a district data-use checklist, questions for leaders and a 90-day plan.

AT A GLANCE

Key messages

1. **Reporting is not using.** In one Ghanaian region, 93% of facilities studied submitted data to the national platform, but only 26% of community-level facilities used those data in annual action plans (2020 study).
2. **The burden falls on front-line staff.** A five-country study found an average of 34 registers and 35 monthly reporting forms per country, with recording taking about one-third of consultation time (fieldwork 2016–2017).
3. **Quality problems are real but fixable.** A ministry-led data quality intervention in Mozambique raised median agreement between source records and reported data from 56.3% to 87.5% (2009–2013).
4. **Use depends on management, not software.** Regular review meetings, supervision, feedback and direction from senior managers predict data use more than technology alone.
5. **The aid shock raises the stakes.** In a WHO survey of 108 country offices in March–April 2025, over 40% of countries reported disruption to key information systems. Routine data are now the main continuous source of local evidence that many countries have left.
6. **District decisions should be the test of every data system.** Ministries and partners should measure whether data change plans, budgets and supervision, not only whether reports arrive on time.

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WHO THIS BRIEF IS FOR

- **Ministers and senior officials in ministries of health** who set national standards for health information.
- **District health management teams** who plan services, supervise facilities and manage budgets.
- **Health information and monitoring and evaluation officers** who run DHIS2 and other routine systems.
- **Donors, global health partners and NGOs** whose reporting requirements shape what facilities collect.
- **Researchers and training institutions** who build data-use skills.

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Praxis Global Institute's mission is to deliver practical training, applied research, ethical AI and technology solutions, and strategic advisory that improve performance, strengthen systems and empower professionals.

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HOW TO USE THIS BRIEF

Read the abstract and key messages for the argument in two minutes. Sections 02 and 03 give the context and the evidence, including the strongest case against relying on routine data; Section 04 sets out five shifts; Section 05 gives a district checklist, questions for leaders and a 90-day plan; and Section 06 concludes.

01

Introduction

What would it take for district health management teams to use routine health data to make better decisions, routinely and with confidence?

This brief asks one question: what would it take for district health management teams to use routine health data to make better decisions, routinely and with confidence? It is written for ministries of health, district health management teams, donors and global health partners.

The district is where most health services are planned, supervised and paid for. It is also where the gap between the data that are collected and the decisions that are made is widest. Closing that gap is now more urgent: since the 2025 aid cuts, routine data are, for many countries, the main continuous evidence they have.

Scope and approach

The brief draws on World Health Organization (WHO) technical guidance, peer-reviewed studies from sub-Saharan Africa, and official and sector reports on the 2025 aid cuts. All sources are dated on or before 16 October 2026. Health financing after the aid shock is treated only as context; it is the subject of a separate Praxis report.

KEY TERMS

Routine health information system (RHIS)
The system through which health facilities record services, then summarise and report them, usually monthly, to district and national levels.

Health management information system (HMIS)
The national RHIS operated by a ministry of health. The terms are often used interchangeably [14].

DHIS2
Open-source software for collecting, analysing and sharing health data, developed by the HISP Centre at the University of Oslo with a global network of partners [5].

Data quality dimensions
WHO's data quality guidance assesses four dimensions: completeness and timeliness; internal consistency of reported data; external comparison with other data sources; and consistency of population data (denominators) [7].

Data use
The analysis, review and interpretation of data to inform decisions on plans, resources, supervision and services [10][15].

02

Context: routine data after the 2025 aid shock

The constraint is no longer software. It is whether the data are trusted and used.

The 2025 reductions in external assistance hit health information systems directly. Between 7 March and 2 April 2025, WHO surveyed 108 of its country offices, mainly in low- and lower-middle-income countries. WHO reported that "Over 40% of countries experienced disruptions to key information systems", including health management information systems and household surveys [1]. According to the Organisation for Economic Co-operation and Development (OECD), official development assistance fell in 2025 by 23.1% in real terms compared with 2024 [2].

The DHS Program shows what is at stake. The United States ended funding for the programme in February 2025. A Gates Foundation grant of US$39 million, plus US$4 million from Bloomberg Philanthropies, has kept a narrower programme running, with 15 surveys under way as of July 2026, but the Gates grant ends in 2028 and the programme's long-term future remains unresolved [3]. As John Wilmoth, Director of the United Nations Population Division, put it: "We would really have almost no data for certain countries without the DHS" [3].

A 2026 commentary in *BMJ Global Health* argued that the DHS pause exposed "the fragility of the international data infrastructures on which many national health

systems rely", and that future surveys "should work to complement the national production of routine health data" [4].

Countries already have the infrastructure for that national production. DHIS2 is used by more than 80 low- and middle-income countries and, including programmes run by non-governmental organisations, is in use in more than 100 countries [5]. The constraint is no longer software. It is whether the data are trusted and used.

03

Evidence and cases

Countries have invested more in collecting data than in using them, and front-line staff carry the cost.

34
registers per country, on average, in primary care facilities (five-country study) [14]

35
monthly reporting forms per country, on average [14]

⅓
of consultation time spent recording [14]

9 hrs
per health worker per month to complete monthly reports [14]

The gap between data collected and data used

WHO's SCORE (Survey, Count, Optimize, Review, Enable) global report, which assessed 133 country health information systems covering 87% of the world's population, found that only 59% of countries had well-developed or sustainable capacity for using data to drive policy and planning, and only 42% had good capacity for data access and sharing (report launched February 2021) [6]. WHO concluded that "no country has a fully mature system capable of meeting their evolving needs for health information" [6].

At district level the gap is sharper. A study of 12 districts in Ghana's then Brong-Ahafo Region found that 93% of facilities submitted data to the national DHIS2-based platform (DHIMS2). Yet only 26% of community-level facilities used those data to inform annual action plans, and 58% of district-level units, a small base, issued directives based on the data (Figure 1). The authors found that data activities skewed "towards data quality checking with less focus on examining findings, making comparisons, and taking action-based decisions" [12].

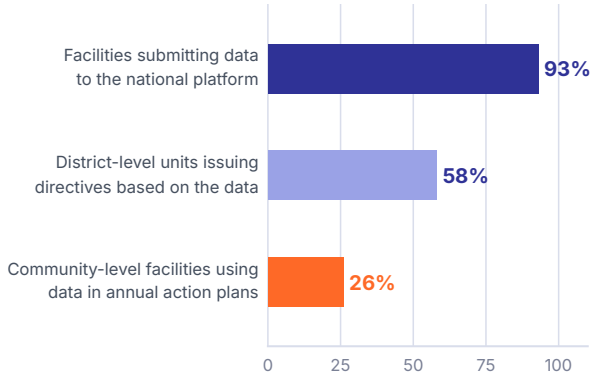


Figure 1. Reporting is not using: routine data submission and use in selected districts of Ghana's then Brong-Ahafo Region. Source: Odei-Lartey et al. (2020) [12].

In Ethiopia's Amhara Region, a 2019 survey of 386 department heads in 83 facilities across ten districts estimated that only 46% used routine health information for decision-making [13]. As Nutley and Reynolds observed, "too often data sit in reports, on shelves or in databases and are not sufficiently utilised" [10].

Data quality: complete is not the same as correct

Reporting rates are often high. Quality is the harder problem. Working with ministry analysts from 14 countries in Eastern and Southern Africa on data from 2013 to 2017, Maïga and colleagues found that "although completeness of reporting was generally high, there were persistent data quality issues", especially at subnational

level. These included extreme outliers, inconsistency over time and between related indicators, and unreliable population projections used as denominators [11].

Uganda illustrates the denominator problem. Across all 135 districts (2015–2019), facility reporting was near 100% complete, but reported vaccinations were "improbably high" compared with projected births [19].

The reporting burden

Health workers carry the cost of collection. A WHO-supported study in Cambodia, Ghana, Mozambique, Nigeria and Tanzania (fieldwork 2016–2017) found an average of 34 registers per country (range 16–48) and 35 monthly reporting forms (range 19–52). Recording took about one-third of consultation time, and completing monthly reports took an estimated 9 hours per health worker per month (range 4–15) [14].

The authors concluded that "the immediate uses of the data appear limited" and noted that "programmes that are heavily supported by donors tend to collect large volumes of data through health facilities" [14]. Every indicator without a local user adds work and invites error.

> **Reporting is not using. The test of a data system is whether it changes a decision.**

Incentives that point upward

Most routine systems are designed to send numbers up the hierarchy. The Performance of Routine Information System Management (PRISM) framework, published in 2009, argued that information system performance depends on technical, organisational and behavioural determinants, not only on tools and forms [8][9]. The Ghana findings fit this pattern: districts invest effort in checking and submitting data, the part of the job that is monitored, rather than in acting on it [12].

The Ethiopian study points to what changes behaviour. Data use was strongly associated with keeping minutes of performance monitoring teams, receiving directives from senior management, supervision, and using routine data for target setting [13]. These are management practices, and they cost little.

Where district data use improved decisions

Kano State, Nigeria: a dashboard backed by routine meetings

In November 2014, Nigeria's National Primary Health Care Development Agency and partners piloted a routine immunisation module and dashboard in DHIS2 in Kano State. A 2016 assessment found that local government area (district) staff used the dashboard to identify under-performing facilities and prioritise them for support, and to decide on training, cold chain and stock issues. Kano State adopted a policy in 2015 requiring monthly review of the data. Partners described the dashboard as a "game changer". But use at facility level remained limited: only 47% of facility respondents had seen the dashboard [15].

Sofala Province, Mozambique: audit and feedback improve quality

A three-year, ministry-led data quality intervention in 26 health facilities raised median concordance between audited source records and routine reports from 56.3% (2009–2010) to 87.5% (2012–2013) (Figure 2). The authors recommended "increased investments" in "data audit and feedback activities" [16].

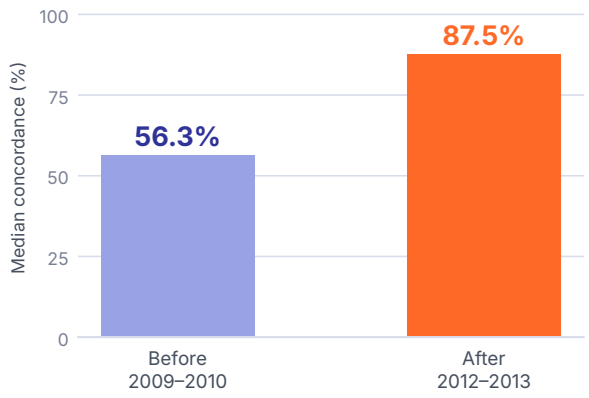


Figure 2. Median concordance between audited source records and routine reports in 26 health facilities, Sofala Province, Mozambique. Source: Wagenaar et al. (2015) [16].

Central Mozambique: data use needs resources to act

The Integrated District Evidence to Action (IDEAs) strategy brought facility, district and provincial managers together twice a year to review routine data and agree action plans in 12 districts and 154 facilities (2016–2020). Results were mixed: two of ten service indicators improved, six showed no change and two declined. The evaluators recommended allocating resources "at the level where the problems are identified" [17]. The lesson is important: reviewing data identifies problems, but districts also need the means to fix them.

A scoping review of intervention studies in low- and middle-income countries (20 articles on data quality and 16 on data use) reached a similar conclusion. Combinations of behavioural and technical interventions improved data quality and use, while interventions addressing organisational factors were "non-existent" [18].

The strongest counter-argument, and a response

The case against. Routine data are too poor to trust. Denominators are wrong, numbers are inflated when targets are attached, private facilities are under-represented, and household surveys remain the gold standard for population coverage. The Uganda and Eastern and Southern Africa studies document these problems [11][19], and the *BMJ Global Health* commentary notes persistent concern about routine data quality [4].

The response. These weaknesses are real, but they argue for fixing and using routine data, not abandoning them. First, surveys cannot do the district's job: they are infrequent, rarely representative at district level and, as 2025 showed, dependent on external funding [3][4]. Second, quality improves when data are used and checked. In Uganda, deriving denominators from facility data produced estimates that were more plausible and more consistent with surveys, and the authors concluded that district statistics are "possible with transparent adjustments and methods" [19]. In Mozambique, audit and feedback raised concordance by over 30 percentage points [16]. Third, the right model is triangulation. Surveys should calibrate routine data, and routine data should fill the years between surveys [4]. The priority is to make districts the first and most demanding users of their own data.

04

Five shifts for ministries, districts and partners

Five shifts from reporting to deciding. None needs new software; each changes what districts are asked to do and what they are given to do it.

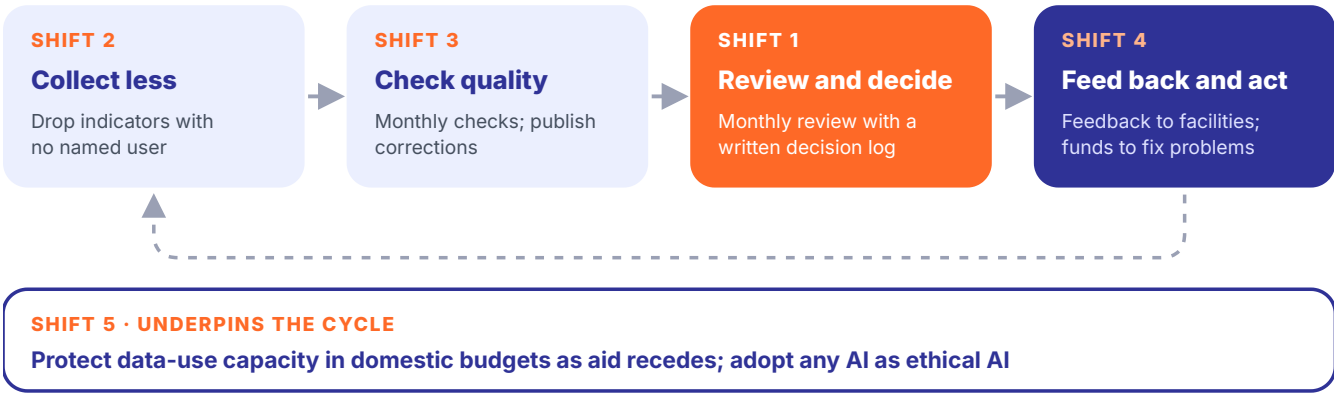


Figure 3. The five shifts as a monthly district cycle. Source: Praxis Global Institute.

1 Make district decisions the test of the information system

Ministries of health should judge routine information systems by whether they change district decisions, not only by reporting rates. Each district health management team should hold a monthly data review with a standing agenda and a written decision log. National reporting should ask districts to report the actions they took, alongside the numbers they submitted.

2 Cut the reporting burden by design

Ministries and partners should audit every register, form and indicator collected at primary care level. Any indicator without a named user at facility, district or national level should be dropped or moved to periodic surveys. Donors should align their reporting with the national DHIS2 instance and retire parallel tools [14].

3 Build routine data quality checks into district work

Districts should review data quality at least monthly, using WHO's four dimensions and the DHIS2 data quality application where available [7][20]. Corrections and denominator adjustments should be documented and published, so users can see what changed and why [11][19]. Annual reviews should compare routine estimates with surveys where they exist.

4 Close the feedback loop and fund the response

Districts should return analysed data to facilities every month, through review meetings and supervision visits [15][16]. Ministries should give districts and facilities small, flexible budgets to act on problems found in data reviews, as the IDEAs evaluation recommends [17]. Data review without the means to respond risks becoming another reporting ritual.

5 Protect data-use capacity as aid recedes

Governments should fund district information officers and data-use training in domestic budgets, so that capacity does not disappear with external projects [1]. Training should cover interpretation and decision-making, not only data entry. Where artificial intelligence (AI) or automated analytics are introduced, they should be adopted as ethical AI: with human oversight of decisions, clear accountability, protection of patient privacy and checks for fairness across districts and population groups.

05

Practical tools

Use the checklist at each monthly district review. Each "no" is the first item on next month's agenda.

Table 1. District data-use checklist

#	Check	Shift	Yes / No
1	The district health management team held a data review meeting in the last month.	1 · Decide	
2	A written decision log records what was decided, by whom and by when.	1 · Decide	
3	Completeness and timeliness of facility reports were reviewed.	3 · Quality	
4	Outliers and inconsistencies between related indicators were checked and followed up.	3 · Quality	
5	Denominators used for coverage were reviewed and any adjustments documented.	3 · Quality	
6	Each facility received written feedback on its own data in the last month.	4 · Feedback	
7	At least one supervision visit was targeted using routine data.	4 · Feedback	
8	At least one budget, staffing or supply decision cited routine data.	1 · Decide	
9	Actions from the previous review were followed up and closed or escalated.	4 · Act	
10	Indicators with no local use have been listed for review by the ministry.	2 · Burden	

Eight questions for ministry leaders and boards

1. Which decisions in the last quarter, at national and district level, changed because of routine data?
2. How many registers, forms and indicators do our primary care facilities complete, and who uses each one?
3. What share of districts held a documented monthly data review in the last three months?
4. How do we measure data quality, and do we publish corrections and denominator adjustments?
5. Which donor-funded programmes still require parallel reporting outside the national system?
6. Which district data roles were funded by external partners, and what is our plan to sustain them?
7. Do districts and facilities have any flexible funds to act on problems found in data reviews?
8. If we adopt AI or automated analytics, who is accountable for decisions, and how are privacy and fairness protected?

Getting started: the first 90 days

Table 2. A 90-day plan for a district health management team

Phase	Actions	Output by end of phase
Days 1–30 Diagnose	Agree three to five priority indicators linked to district plans. Run a desk review of completeness, timeliness, outliers and denominators for the last 12 months. List all registers and forms in use.	Baseline data quality summary; list of priority indicators; inventory of reporting tools
Days 31–60 Review and act	Hold the first structured monthly data review with facility in-charges. Open a decision log. Target supervision visits at the two lowest-performing facilities. Send written feedback to every facility.	First decision log; feedback sent to all facilities; targeted supervision completed
Days 61–90 Embed	Hold the second and third reviews and follow up actions. Document data corrections. Report to the ministry on actions taken, and propose indicators to drop. Identify a small budget line for follow-up action.	Three consecutive reviews; corrections log; short report to the ministry with actions and burden-reduction proposals

06

Conclusion: did the data change a decision?

The fix is managerial as much as technical.

Routine health data are no longer a supplement to donor-funded surveys. For many districts, they are now the main continuous evidence available. The evidence is consistent: countries collect a great deal, use too little, and ask front-line staff to carry the cost.

The fix is managerial as much as technical. Fewer indicators, regular reviews, honest quality checks, feedback to facilities and the means to act will do more than another dashboard. Ministries and partners should judge their data systems by one test: did the data change a decision in the district?

How Praxis can help

Praxis Global Institute supports this agenda through its Research & Data work on data validation and reproducible analysis, its Education & Training in research and data skills, and its Advisory & Partnerships capability programmes for teams and leaders. For enquiries about this brief, email Dr Aseno at simon@praxisglobal.ac, or contact Praxis.

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