

SESSION 10: INTERPRETING AND USING INFORMATION

Aim of the session:

The aim of Session is to create awareness of approaches to interpreting information and how this information can be used to improve HIV and AIDS related services.

LEARNING OUTCOMES:

By the end of this session, participants should:

- ✧ Have gained awareness of potential uses for the information they collect

SESSION CONTENTS:

- ✧ Approaches to interpreting information

READING:

- ✧ Kasper T, Coetzee D, et al. (2003) Demystifying antiretroviral therapy in resource-poor settings. Essential Drugs Monitor. Issue no. 32: 2003

10.1 Approaches to interpreting information

So far we have discussed:

- ✧ how to obtain data
- ✧ how to make sure the data is of good quality
- ✧ how to turn data into usable information in the form of indicators
- ✧ how to present information in ways that are easy to see and understand

Now we come to the next stage in the information cycle: using the information to make decisions and take action. Before information can be used, it must be interpreted. The **purpose of interpretation is to monitor progress**. Monitoring of progress should take place at **various levels**, e.g. self assessment at facility level and broader programme assessment at district or provincial level.

Different decisions are made at different levels of the health system and therefore different information may be needed at each level, but there is always interaction between the different levels. Many decisions, for instance budget allocations, are also in practice a result of protracted discussions and negotiations between many stakeholders at different levels, including stakeholders outside of the health sector (NGOs, media, faith-based groups, etc)

Interpretation involves looking at information and asking ourselves what it means. This involves looking at the information within its context, i.e. in relation to other pieces of data/information and/or information from other sources. Sometimes the term **"interrogating the data"** is used to describe this process.

It is not easy to teach "interpretation". Interpretation of information requires knowledge of the technical and management aspects of the service as well as the particular context. All these aspects cannot be covered in this workshop. However, we can provide some guidance on the kinds of questions to ask in order to interpret data.

Interpretation involves examining the following:

- ✧ How are our services performing in terms of our goals, objectives and targets?
- ✧ How are our services performing compared with benchmarks?
- ✧ What is happening in our services over time? (trends)
- ✧ How are our services performing compared with other facilities?
- ✧ How is our district and province performing compared to others?

The next step could involve the following questions:

- ✧ "...Why are we doing well (or badly)?"
- ✧ What are others doing that we can learn from?
- ✧ How can we do better?
- ✧ Can we improve quality of care with existing resources?
- ✧ How can we be more effective or efficient?...¹⁵

An easy approach to interpretation of information may be to ask the following questions in relation to an indicator:

Who, what, when, where, why and how?

These questions are usually asked when studying epidemiology (the study of the causes and distribution of illness in populations). However, they can also be applied to service issues.

For example, when assessing trends in numbers of clients accessing accredited service points, we could ask the following questions:

- ✧ Who is accessing our ART services? Who is not?
- ✧ By what referral route are they coming? What routes are they not using?
- ✧ When do they present?
- ✧ Where do they come from?
- ✧ Why do they use (or not use) our services?
- ✧ How can we increase access to our services? (e.g. Should we increase access deliberately by actively pursuing potential clients and/or "advertise" ourselves? Or should we instead focus on improving our service to existing clients?)

In asking and answering these questions, we can find out whether the implementation of the current plan is satisfactory and can make decisions about how to improve services. This is the reason we collect data - it is the basis of monitoring and evaluation - and the most important part is monitoring of ourselves and our own practices.

Understanding dynamic relationships between indicators

It is crucial, in particular when interpreting trends and what they mean for our service delivery, that we maintain a dynamic perspective. **A dynamic perspective means that we understand the relationships between different indicators** – if one goes up, we expect others to also go up or to go down, depending on their relationship. A dynamic perspective is not only necessary in order to avoid pitfalls and misinterpretations, but also to recognise progress and/or success early.

Using VCT as an example: Two years ago, when VCT was in its infancy in South Africa, you would expect (a) a high testing acceptance rate, and (b) a high HIV positive rate among those tested. *Why? Because when VCT clients were few, the majority of them were medically referred (symptomatic and/or co-infected with STIs or TB).* With the massive expansion of VCT the last two years, we would expect more and more self-referred clients that feel healthy and thus less pressured to accept testing – so the acceptance rate might decline somewhat. If you expect a certain decline, you would also avoid the pitfall of e.g. blaming the decline on lazy or poor counsellors. Similarly, as you test more and more people, you would expect a gradual decline in the HIV positive rate – until the day (theoretically speaking) you test everybody in the community and get an HIV positive rate identical to the true HIV prevalence.

Furthermore, it is important not only to understand and interpret these dynamic relationships as best as you can, but also to use that understanding when discussing objectives and targets. Again, taking VCT as an example: For 2004, most provinces provided VCT to around 5% of the population 15 years and older, and 30-50% of those

¹⁵ Heywood A and Rhode J. (undated) Using information for action. A manual for health workers at facility level.

finally tested were HIV positive. The HIV positive rate among VCT clients tested are higher than the provincial prevalence rate as measured by the annual antenatal survey. This indicates that VCT should increase further – the question is, how much is enough? *In other words, what do current trends tell us about our target (if we have any!!) for VCT? Should we set a target of 10%? 15%? 20%?*

One “trick” you can use in trying to make sense of various indicators, is to look at indicators and their targets and then calculate backwards from targets to “raw” data. For instance, if we set a target of 20% for VCT and if we assume that nobody shows up twice, it would take 5 years to provide VCT to every adult 15 years and older (20% each year). There are about 33 million adults in SA, so total VCT visits per year would be 20% of that or 6.5 mill. Every adult will not come for VCT, of course, and some will come several times – but such relatively simple calculations done for your own facility helps you in discussing what it would take. How many lay counsellors? Consultation rooms? Is there capacity to follow-up, to do CD4 counts and/or clinical eligibility assessments for all those found to be HIV positive, to assist them in living healthily?

In some cases, research and international/national targets or benchmarks might help us both to think about these issues and to finally decide. For instance, in the case of TB there are clear WHO guidelines / benchmarks for sputum testing in passive case detection: WHO recommends a testing frequency of 1:10, i.e. that one in ten sputum samples are positive. If an area/facility has more than one in ten samples positive, it means they are not testing enough suspect cases. Some pulmonary TB patients will not be identified/treated and continue to infect others. On the other hand, if an area/facility has less than one in ten positive sputum samples, it means they are testing too many cases (i.e. wasting time and money).

By reflecting on and discussing the dynamic relationship between indicators – each representing different aspects of HIV/AIDS/ART services – as well as established or potential targets, you will gradually be able to assess your own performance in various areas of the programme.

In order to gain a comprehensive understanding of the HIV and AIDS epidemic, it is important to look at various kinds of information related to the epidemic and how this information links together to provide an overall picture.

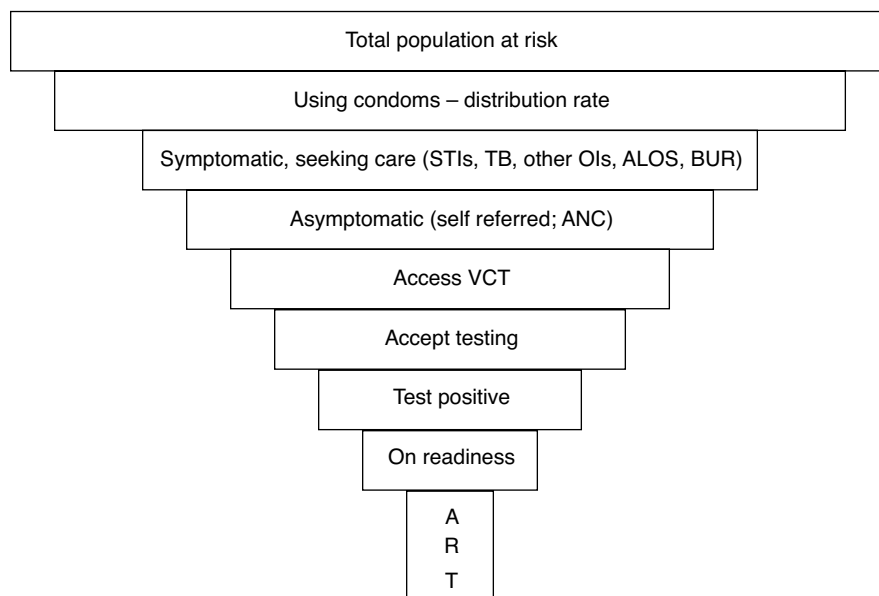
Examples:

Information	Relevance
HIV prevalence	Reflects extent of the epidemic.
STIs	STIs reflect risky sexual behaviour and therefore risk of acquiring HIV; presence of an STI increases risk of transmission; STIs are opportunistic infections; also reflects access and quality of health services.
Male condom distribution rate	Provides an indication of awareness of the need for safer sex; indication of quality of services (male condom availability).
TB	TB is a very common opportunistic infection in people with HIV: HIV and TB have been termed “parallel” epidemics: i.e. high TB prevalence parallels HIV/AIDS epidemic; TB is a common cause of death of people living with HIV and AIDS.
VCT	Reflects awareness of HIV in the population (self referral); availability and quality of VCT services and referral mechanisms within health services.
PMTCT	Availability and quality of VCT services and antenatal care.
Bed Utilization Rate (BUR); Average Length of Stay (ALOS)	May reflect HIV/AIDS burden on health system (patients admitted frequently and for extended periods).
ART	Reflects awareness HIV/AIDS in population; availability and quality of services.

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We can think of some of the HIV/AIDS related information available to us as reflecting different levels of a “funnel”. Looking at the funnel gives a sense of potential numbers of clients at various levels, and may give an idea of the numbers of patients we need to plan for to provide effective ART coverage. This funnel also reflects the importance of having information from various sources brought together and of staff working in different “vertical” programmes to meet and share information.

Figure 10.1: HIV and AIDS Client and Information “funnel”



Note: The diagram merely represents a concept and is not a true reflection of proportions.

Conclusion

The reason for this workshop was to help in using information to improve HIV and AIDS service delivery. If we want to improve services, we need good quality information about those services so that we can make informed decisions. Information empowers people for action.

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