Chapter 2. Conceptual Design Principles

This chapter provides a introduction to some of the key conceptual design principles behind the DHIS 2 software. Understanding and being aware of these principles will help the implementer to make better use of the software when customising a local database. While this chapter introduces the principles, the following chapters will detail out how these are reflected in the database design process.

The following conceptual design principles will be presented in this chapter:

- All meta data can be added and modified through the user interface
- A flexible data model supports different data sources to be integrated in one single data repository
- Data Input != Data Output
- Indicator-driven data analysis and reporting
- Maintain disaggregated facility-data in the database
- Support data analysis at any level in the health system

In the following section each principle is described in more detail.

2.1. All meta data can be added and modified through the user interface

The DHIS 2 application comes with a set of generic tools for data collection, validation, reporting and analysis, but the contents of the database, e.g. what data to collect, where the data comes from, and on what format, will depend on the context of use. This meta data need to be populated into the application before it can be used, and this can be done through the user interface and requires no programming. This allows for more direct involvement of the domain experts that understand the details of the HIS that the software will support.

The software separates the key meta data that describes the raw data being stored in the database, which is the critical meta data that should not change much over time (to avoid corrupting the data), and the higher level meta like indicator formulas, validation rules, and groups for aggregation as well as the various layouts for collection forms and reports, which are not that critical and can be changed over time without interfering with the raw data. As this higher level meta data can be added and modified over time without interfering with the raw data, a continuous customisation process is supported. Typically new features are added over time as the local implementation team learn to master more functionality, and the users are gradually pushing for more advanced data analysis and reporting outputs.

2.2. A flexible data model supports different data sources to be integrated in one single data repository

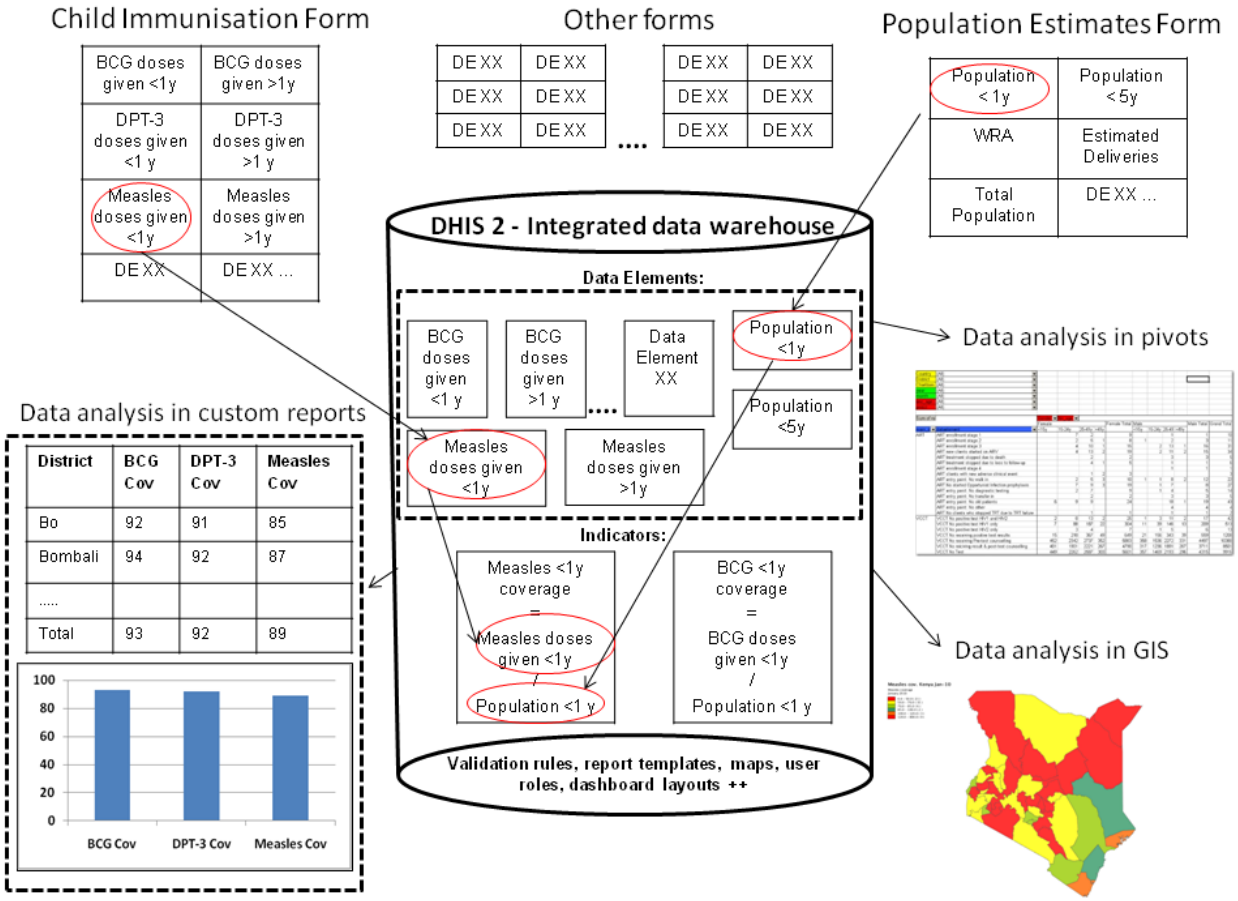
The DHIS 2 design follows an integrated approach to HIS, and supports integration of many different data sources into one single database, sometime referred to as an integrated data repository or a data warehouse.

The fact that DHIS 2 is a skeleton like tool without predefined forms or reports means that it can support a lot of different aggregate data sources. There is nothing really that limits the use to the health domain either, although use in other sectors are still very limited. As long as the data is collected by and orgunit, described as a data element (possibly with some disaggregation categories), and can be represented by a predefined period frequency, it can be collected and processed in DHIS 2. This flexibility makes DHIS 2 a powerful tool to set up integrated systems that bring together collection tools, indicators, and reports from multiple health programs, departments or initiatives. Once the data is defined and then collected or imported into a DHIS 2 database, it can be analysed in correlation to any other data in the same database, no matter how and by whom it was collected. In addition to supporting integrated data analysis and reporting, this integrated approach also helps to rationalise data collection and reduce duplication.

2.3. Data input != Data output

In DHIS 2 there are three dimensions that describe the aggregated data being collected and stored in the database; the where - organisation unit, the what - data element, and the when - period. The organisation unit, data element and period make up the three core dimensions that are needed to describe any data value in the DHIS 2, whether it is in a data collection form, a chart, on a map, or in an aggregated summary report. When data is collected in an electronic data entry form, sometimes through a mirror image of the paper forms used at facility level, each entry field in the form can be described using these three dimensions. The form itself is just a tool to organise the data collection and is not describing the individual data values being collected and stored in the database. Being able to describe each data value independently through a Data Element definition (e.g. 'Measles doses given <1 year') provides important flexibility when processing, validating, and analysing the data, and allows for comparison of data across collection forms and health programs.

This design or data model approach separates DHIS from many of the traditional HIS software applications which treat the data collection forms as the key unit of analysis. This is typical for systems tailored to vertical programs' needs and the traditional conceptualisation of the collection form as also being the report or the analysis output. The figure below illustrates how the more fine-grained DHIS design built around the concept of Data Elements is different and how the input (data collection) is separated from the output (data analysis), supporting more flexible and varied data analysis and dissemination. The data element 'Measles doses given <1 y' is collected as part of a Child Immunisation collection form, but can be used individually to build up an Indicator (a formula) called 'Measles coverage <1y' where it is combined with the data element called 'Population <1y', being collected through another collection form. This calculated Indicator value can then be used in data analysis in various reporting tools in DHIS 2, e.g. custom designed reports with charts, pivot tables, or on a map in the GIS module.



2.4. Indicator-driven data analysis and reporting

What is referred to as a Data Element above, the key dimension that describes what is being collected, is sometimes referred to as an indicator in other settings. In DHIS 2 we distinguish between Data Elements which describe the the

raw data, e.g. the counts being collected, and Indicators, which are formula-based and describe calculated values, e.g. coverage or incidence rates that are used for data analysis. Indicator values are not collected like the data (element) values, but instead calculated by the application based on formulas defined by the users. These formulas are made up of a factor (e.g. 1, 100, 100, 100 000), a numerator and a denominator, the two latter are both expressions based on one or more data elements. E.g. the indicator "Measles coverage <1 year" is defined a formula with a factor 100, a numerator ("Measles doses given to children under 1 year") and a denominator ("Target population under 1 year"). The indicator "DPT1 to DPT3 drop out rate" is a formula of 100 % x ("DPT1 doses given"- "DPT3doses given") / ("DPT1 doses given"). These formulas can be added and edited through the user interface by a user with limited training, as they are quite easy to set up and do not interfere with the data values stored in the database (so adding or modifying an indicator is not a critical operation).

Indicators represent perhaps the most powerful data analysis feature of the DHIS 2, and all reporting tools support the use of indicators, e.g. as displayed in the custom report in the figure above. Being able to use population data in the denominator enables comparisons of health performance across geographical areas with different target populations, which is more useful than only looking at the raw numbers. The table below uses both the raw data values (Doses) and indicator values (Cov) for the different vaccines. Comparing e.g. the two first orgunits in the list, Taita Taveta County and Kilifi County, on DPT-1 immunisation, we can see that while the raw numbers (659 vs 2088) indicate many more doses are given in Kilifi, the coverage rates (92.2 % vs 47.5 %) show that Taita Taveta are doing a better job immunising their target population under 1 year. Looking at the final column (Immuniz. Compl. %) which indicates the completeness of reporting of the immunisation form for the same period, we can see that the numbers are more or less the same in the two counties we compared, which tells us that the coverage rates can be reasonably compared across the two counties.

	DPT 1		DPT 2		DPT 3		Measles		Fully Imm		Immuniz Compl %
Organisation	Doses	Cov	Doses	Cov	Doses	Cov	Doses	Cov	Doses	Cov	
Taita Taveta County	659	92.2	630	89.1	580	81.0	574	80.2	551	77.4	81.4
Kilifi County	2088	47.5	1767	39.6	1954	43.0	3315	73.4	2540	55.5	82.1
Lamu County	238	82.6	200	70.0	268	91.4	283	97.7	195	60.6	81.0
Kwale County	1142	51.1	1077	48.3	1149	52.4	1909	86.3	1385	62.2	84.1
Mombasa County	2015	73.2	1711	62.4	1948	70.7	2737	98.0	2278	82.2	88.4
Tana River County	678	80.1	633	77.4	721	76.2	656	79.6	404	50.0	78.3
Coast	6820	60.6	6018	53.5	6620	57.7	9474	83.5	7353	64.6	83.2

2.5. Maintain disaggregated facility-data in the database

When data is collected and stored in DHIS 2 it will remain disaggregated in the database with the same level of detail as it was collected. This is a major advantage of having a database system for HIS as supposed to a paper-based or even spreadsheet based system. The system is designed to store large amounts of data and always allow drill-downs to the finest level of detail possible, which is only limited by how the data was collected or imported into the DHIS 2 database. In a perspective of a national HIS it is desired to keep the data disaggregated by health facility level, which is often the lowest level in the orgunit hierarchy. This can be done even without computerising this level, through a hybrid system of paper and computer. The data can be submitted from health facilities to e.g. district offices by paper (e.g. on monthly summary forms for one specific facility), and then at the district office they enter all the facility data into the DHIS 2 through the electronic data collection forms, one facility at a time. This will enable the districts health management teams to perform facility-wise data analysis and to e.g. provide print-outs of feedback reports generated by the DHIS 2, incl. facility comparisons, to the facility in-charges in their district.

2.6. Support data analysis at any level in the health system

While the name DHIS indicates a focus on the District, the application provides the same tools and functionality to all levels in the health system. In all the reporting tools the users can select which orgunit or orgunit level to analyse and the data displayed will be automatically aggregated up to the selected level. The DHIS 2 uses the orgunit hierarchy in

aggregating data upwards and provides data by any orgunit in this hierarchy. Most of the reports are run in such a way that the users will be prompted to select an orgunit and thereby enable reuse the same report layouts for all levels. Or of desired, the report layouts can be tailored to any specific level in the health system if the needs differ between the levels.

In the GIS module the users can analyse data on e.g. the sub-national level and then by clicking on the map (on e.g. a region or province) drill down to the next level, and continue like this all the way down to the source of the data at facility level. Similar drill-down functionality is provided in the Excel Pivot Tables that are linked to the DHIS 2 database.

To speed up performance and reduce the response-time when providing aggregated data outputs, which may include many calculations (e.g. adding together 8000 facilities), DHIS 2 pre-calculates all the possible aggregate values and stores these in what is called a data mart. This data mart can be scheduled to run (re-built) at a given time interval, e.g. every night.