General Data Dissemination System (GDDS) Project - Phase 2
Socio-Demographic Statistics Project for Anglophone Africa

**Report of the Launch Workshop
of the Module on Health Statistics**

Gaborone, Botswana
October 8-12, 2007

Organizer:
World Bank Group

Consultant:
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Table of Contents

Acknowledgements

Abbreviations

DQAF   Data Quality Assessment Framework
GDDS2   General Data Dissemination System Phase 2
HMN   Health Metrics Network
ICT   Information Communication Technology
IMF   International Monetary Fund
IT   Information Technology
NBS   National Bureau of Statistics
StatsSA   Statistics South Africa
TA   Technical assistance
WB   World Bank
WHO   World Health Organization

1   Background

A launch workshop on the health statistics module was held from 8th to 12th October 2007 in Gaborone, Botswana, and was attended by participants from five countries that had selected the health statistics module from the GDDS Phase 2 project for Anglophone Africa. The participating countries were: Botswana, Lesotho, Mauritius, Sudan and Tanzania. Additionally, one person from South Africa took part in the workshop as an observer.

The objective of the health statistics module is to improve the coverage and the quality of statistics on health outcomes, and on the delivery and use of health services. A main purpose of the launch workshop is to choose three priorities for each country and a work program including a timetable for the country visits by the technical expert.

The workshop participants from countries were:
Botswana   5 participants
Lesotho   1 participant
Mauritius   3 participants
Sudan   3 participants
Tanzania   3 participants

In addition, the following attended the workshop throughout the week: the World Bank GDDS Manager, Ronald Luttikhuizen; the International Monetary Fund Resident Coordinator, GDDS Project, Kenya, Oliver Chinganya; a World Bank Senior Demographer, Sulekha Patel, a World Bank Consultant, Stanislaw Orzeszyna. A list of participants is included in Annex A.

2   Workshop proceedings

The workshop agenda is included in Annex B.

Opening session

The workshop started on Monday, 8th October with an opening session that included the following items:

A welcome address by **Mrs O. Mokopakgosi**, Director of Policy, Planning, Monitoring and Evaluation of the Ministry of Health, who officially opened the workshop. The opening was followed by short introductions by the participants.

The GDDS Manager, **Mr Ronald Luttikhuizen**, of the World Bank, presented a workshop overview.

An overview of the General Data Dissemination System (GDDS) modular approach was done by **Mr Oliver Chinganya**, International Monetary Fund. He described the principles of modules for strengthening statistics. The General Data Dissemination System (GDDS) builds on the main elements of the UN's Fundamental Principles of Official Statistics around four aspects: data (relevance, coverage, timeliness and periodicity); quality (methodology, sources); integrity of the data production processes; and, access to the data by the public. This presentation is included in Annex D.1.

A welcome message was delivered by **Dr Sally K. Stansfield**, Executive Secretary, Health Metrics Network.

An **introduction** to workshop objectives, expected products and methods of work was done by Dr Stanislaw Orzeszyna, WB consultant. The presentation is included in Annex D.2. A compact disk (CD) that was distributed to the participants consists in its substantial part of a set of selected readings aimed at facilitating the preparation and conduct of the launch workshop and helping to implement the module on strengthening health statistics. The CD contains also all the presentations that were available at the time when it was produced. The reader is described in a Reader Content, a document attached to this report in Annex C.

The **Reader** is divided into following parts: general principles, assessing health information systems, strengthening health information systems and country data. Each reference quoted in the reader content is hyperlinked to the corresponding document placed on the CD. Additionally, each reference is also hyperlinked to the original uniform resource locator (URL) if the document was downloaded from the Web.

Country presentations

The afternoon session on Monday started with country presentations on their current status of health information system development and plans for improvement. These presentations were delivered by all five participating countries, and, additionally, by an invited representative from Statistics South Africa. All country presentations are included in Annexes[1]:. The country presentations brought very useful information on countries' current status of development of their health information systems. Thanks to this high level of understanding and professionalism, it was possible to change the agenda of the meeting. It was decided to replace some general presentations on the principles of health information system to allow the countries to share their practical experience, their issues and problems that they want to solve with international collaboration.

Ms Ntebaleng Chobokoane, Executive Manager: Health and Vital Statistics, Statistics South Africa, described the current situation and plans in the production of health information, in particular, death registration, birth registration, and health statistics. The presentation is included in Annex D.14.

Presentations of cooperating agencies

Dr Sally K. Stansfield, Executive Director of the Health Metrics Network made a presentation on the HMN goals and objectives. She described the governance and management of the Network and its achievements up to now. In particular, she described the HMN country work, including leadership, coordination and assessment, planning and priority setting and implementation of HIS strengthening. Lessons from country work include: aligning HIS reform with management reform, structure systems and processes to assure prompt, local use, engage a high-level "champion", involve a broad range of stakeholders, obtain expertise in communication and advocacy, and link HIS subsystems through a comprehensive HIS architecture. The presentation is included in Annex D.5.

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[1] Country presentations: Botswana - Annex D.3.1, Lesotho - Annex D.3.2 –, Mauritius - Annex D.3.3 –,– Sudan - , Annex D.3.4, Tanzania Annex D.3.5

Mrs **Sulekha Patel** of the World Bank described the data quality assessment framework that provides a structure for assessing existing practices against best practices, including internationally accepted methodologies. The data quality assessment framework serves two purposes: it guides country efforts to prepare self-assessments of the environment in which statistics are prepared, and the quality of those statistics; it guides data users in evaluating data for policy and planning purposes. The framework addresses five dimensions of data quality: assurances of integrity, methodological soundness, accuracy and reliability, serviceability and accessibility. The presentation is included in Annex D.8.

Mr Johan Saebo of the University of Oslo described a pilot district health information system established in four districts in Botswana. The pilot system uses a free and open source software that was initially developed in South Africa and is now operational in several countries. The strengths of the software cover the flexibility to customize data elements and indicators, organizational structure, language and graphical user interface, reports and graphs. The presentation is included in Annex D.10.

Selecting priorities

The **Consultant** presented a checklist of topics that were discussed by the participants of the workshop. The checklist consists of 66 items grouped in the following sections: participative review of the present HIS system; supporting health information system reform; capacity development program targeted at all users; strengthening data processing and analysis; improving the use of health information; strengthening population-based data sources; strengthening facility-based data sources; strengthening of information and communication technology. The presentation is included in Annex D.7 and file with a needs assessment checklist is included in Annex E. This checklist was used to develop and describe their priorities.

In **Botswana**, data is received from 26 health districts and all hospitals are staffed with medical record officers. Health care delivery and thus health information is a shared responsibility of different ministries. Primary health care is under the Ministry of Local Government, hospitals are under the Ministry of Health and civil registration is under the Ministry of Home Affairs. Further, a Health Statistics Unit of the Central Statistics Office is under the Ministry of Finance and Development Planning. The Unit is seconded to the Ministry of Health under the Department of Policy, Planning, Monitoring and Evaluation. Data collection tools were revised in 2004 and new software implemented. It is planned to increase capacity of health statistics staff in epidemiology and demography. Dissemination of annual reports on timely basis will make available statistics for planning and evaluation purposes and will increase its use at different levels. Another aspect of capacity building will be ICD-10 training to alleviate existing coding problems. Integration of the health information system at the national level, revision of the current set of core health indicators and support to benchmarking have been specified as priority activities. The file containing this summary is in Annex F.1.

In **Lesotho,** routine data are used for evaluation of health systems. Fifteen national core health indicators and 105 district indicators were developed and are used to track progress and measure performance of health services. It is felt that there is poor demand for data and low quality and timeliness of statistical reports. Other weaknesses include a lack of satisfactory

information dissemination system, poor harmonization of vertical programmes and an absence of metadata dictionary. Building consensus of different stakeholders around health information issues is an important part of country priorities. Another priority is directed at the district level, decentralization of data processing, increasing capacity for data analysis and use, creation of a district based data warehouse. On the other hand, it is foreseen to develop a strong central support system to provide professional back-up, quality control and stewardship. It is also planned to enhance data use. The file containing this summary is in Annex F.2.

The **Mauritius** delegation presented a summary of the current status of the health information system in their country. The civil registration system of births, deaths and marriages is complete and comprehensive hospital service and disease surveillance data are available. The international classification of diseases ICD-10 is implemented and health information data are easily accessible and timely disseminated. It is felt, however, that the health information system should be more aligned to Health Metrics Network principles. Data producers should have their analytical and reporting skills strengthened. There are some data gaps, mainly related to the private sector in health. The research component of the health information system should be enhanced and integrated. It is planned to strengthen collaboration between data producers and users in view of making the health information system "action driven" rather than "data driven" and enhance the culture of data use. The file containing this summary is in Annex F.3

In **Sudan**, low coverage and quality of health information is due to shortages of human and material resources and to inadequate skills of staff. Also, insufficient communication facilities, networking and other equipment can be observed. Lack of supervision and monitoring and evaluation activities is due to inavailability of transportation means and appropriate guidelines. There is insufficient coordination between producers and users of health information resulting in low utilization of available information for planning and decision making. Insufficient coordination of vertical programs results in duplication of work and overloading of HIS staff, particularly at the peripheral levels. To remedy this situation, the following activities are considered appropriate: designing a meta data dictionary; revision and finalization of the strategic plan framework and policy; revision of the intermediate health statistics diploma curricula; improve the utilization and dissemination of information; revising the network and databases, improving supervision and monintoring and evaluation.

The **Tanzania** delegation presented a summary of their status and priorities for action. The health information activities are implemented by several sectors under coordination of a monitoring and evaluation technical committee for health. In the Ministry of Health and Social Welfare the unit responsible for health statistics is a Health Information and Research section of the Department of Policy and Planning. The National Bureau of Statistics produces health and demographic statistics in line with Millennium Development Goals. At present there is no intersectoral data warehouse. Among the challenges it is felt that there is much health data but poor information is disseminated to the public; data generated is not adequately used for decision making; a lack of competent staff at lower levels in statistical analysis and computer applications. The plans to strengthen the health information system include developing monitoring and evaluation policy guidelines for health statistics; capacity building of health managers to use evidence based data for decision making; improving capacity for analysis and use of information at lower levels of health services; improving monitoring and supervision at all levels; and, conducting a major review of data collection, reporting tools, computer software and developing a data warehouse. The file containing this summary is in Annex F.5.

3   Notes on discussions in the workshop

October 8, 2007

Opening session:

Mrs. Mokopakgosi opened the workshop, welcoming the GDDS 2 health module, which she hoped would:
- Help fill data gaps
- Improve health statistics; and
- Strengthen the health system

A common problem with many African countries is weak health systems, which are then unable to guide health priorities. To date, stakeholder involvement was weak, but it is imperative that they be involved in helping formulate a clear plan for improving health statistics, and, by definition, a coherent health system. In the following discussion the question was raised about the need to better understand the user-needs, in order to make the system a user driven system. The expert explained that a method has been developed and used to describe the user needs at different levels. From the side of the chair it was mentioned that the analysis of users needs should be used to support and extend the system. There is a danger when much emphasis is paid to user needs when data is not their or of a poor quality.

The World Bank presented an outlined of the plan for the workshop, and the outcomes expected. These are summarized below:
- This initiative was for a period of 18 months;
- By the end of the week, each country would have prepared a draft work plan, identifying 3 realistic priorities to improve their health information systems;
- These would be discussed in bilateral sessions, leading to concrete work plans; and
- Consultants would be identified to work with countries. There would be three consultancies for each country, according to a schedule worked out by the countries.
- The topics that have the first priority will be treated as the most important the other priorities will be addressed when time permits, or in agreement with the partners, realizing that this may effect the work on the first priority.

The IMF presented the background of the GDDS, built on the UN's Fundamental Principles of Official Statistics, and its evolution, which was based on the program's successes.
- The GDDS was developed as a framework for statistical improvement, and has three components:
  - Quality of data, including methodology, sources, coverage, timeliness and periodicity;
  - Development plans for improving statistical systems:
    - Diagnosis of current situation
    - Elaboration of detailed plans, short and medium term
    - Tracking progress
  - Dissemination of data

- The GDDS project was revised in 2006, reflecting the move in the development community towards results-based management. This covers:

- o Fewer initiatives which are well-planned;
- o Agreement on achievable improvements and defining expected results
- o Creation of capacity-building blocks which foster:
  - ▪ Sustained capacity
  - ▪ Coherent and coordinated activities
- o Alignment of statistical activities to national priorities; and
- o Enhanced collaboration between different national entities and development agencies.

Health Metrics Network's Dr. Sally Stansfield described the HMN as a network of technical and international agencies, based on the principle that good statistics provide a solid foundation of good governance. Dr. Stansfield emphasized the role of the HMN in strengthening health information systems. To date, many health information systems remain weak because of failure to create a comprehensive data base, especially the population-based information.

Presentation 1: Introduction

The consultant, Dr. Stanislaw Orzeszyna, presented the outline of the program and contents of the reader, which is a library of documents relevant for the discussions that would follow. He distinguished between the Health Information Systems (HIS) and the Health Management Information Systems (HMIS): the former is a combination of all data categories that provide information on the functioning of the health system; the latter is restricted to administrative/institution-based data only.

Following the presentation there was a brief discussion of monitoring health status, and the need for a core set of indicators. HMN agreed that a core set needs to be identified (Note: example of a core set that already exists, it is called the Millennium Development Goals). Lesotho noted that they have identified a set of 15 core indicators and 105 additional indicators, in collaboration with stakeholders (within the country?). Botswana sought for ways to reconcile the internationally required MDGs with country-owned indicators. Tanzania noted their larger mandate for poverty reduction and economic growth, and the need to harmonize competing demands from health and other sectors within this larger framework.

Botswana raised the issue of ways to measure use of information. Mauritius noted that in addition to improving use, countries also need to address two additional issues closely related to use of information: countries often collect data that are not used because of lack of demand; and the need to identify additional information/data that can be used. HMN noted that Mauritius's intervention pointed to missed opportunities for the use of data for policy and programs. HMN also noted that one criterion of measuring use of information is how often the press quote health statistics.

After the first presentation it became clear that the countries were very well prepared were well informed on the main issues. Therefore further presentations were replaced by having the countries giving their own country presentations on HMNs. Sudan noted that its data management was still paper-based, and information on infrastructure, human resources, and finances was not included in its detailed assessment forms. Lesotho noted a lack of interest and involvement from a higher level (political support) in health statistics. It also noted that the scoring system in the HMN framework does not convey the actual practice on the ground, and that the scoring system needs to be re-evaluated.

HMN noted that a major flaw with the HMN framework is that it does not show changes over time. In addition, scoring during an assessment is often dominated by the most powerful voice, although this can be considered transforming because of the involvement of stakeholders in the assessment. Another major setback is that assessment reports prepared by countries have not been transferred into plans for improvement. HMN is working to trim down the assessment tool and to incorporate a more objective set of verifiable questions to show changes over time.

Sudan noted that its HMN assessment revealed two threats to the efficient functioning of the HMN: turnover of qualified staff; and competing demands from different users.

October 9, 2007

The first presentation was from HMN. Dr. Stansfield mentioned the need to define an externally validated process to accredit country HIS. Benefits could accrue from such an accreditation, such as fewer reporting requirements. She also noted the need for:
- Moving from assessment to planning;
- Integrating country HIS with the 2010 round of censuses;
- Monitoring vital events and cause of death;
- Developing survey tools that can be used at local levels.

Some of the lessons learned to date from the HMN and its application in countries:
- Align HIS reform with broader health management reform;
- Structure systems and processes to ensure local use;
- Obtain expertise in ICT and advocacy.

Following the presentation, and picking up on the issue of advocacy, Sudan agreed with the need for advocacy to help explain to policy-makers the high payoff from a large investment in health information. Mauritius offered to be a pilot country for any new HMN initiatives. Lesotho inquired if there was any "gold standard" for assessing health status, and whether any kinds of awards could be given for using data.

HMN responded that that there is really no gold standard for conducting assessments, because there is an assumption that in each country this would be done by a group. Regarding awards, HMN noted that small cash awards could be given at HMN partner forums.

Two additional points were made: Mauritius noted that data were often used incorrectly by journalists; and Tanzania raised the issue of tracking data quality.

The HMN presentation was followed by Sudan giving lessons learned from its just completed assessment of the HMN (a publication was distributed at the workshop):
- Low coverage and quality stemming primarily from shortage of human and material resources and low skill levels of staff;
- Poor working environment and lack of a network for communication;
- Lack of supervision and poor monitoring and evaluation resulting from lack of communication and transport and lack of commitment and proper guidelines;
- Poor utilization of available information;
- Duplication of effort resulting from parallel systems of data collection and vertical systems of data collection with no connection to the HIS;

- Invalid and unused laws

The consultant presented a checklist of topics that were discussed by the participants. The complete checklist is in the consultant's report. In addition the chair made some additional explanatory remarks. He explained how the check list can be used as a diagnostic tool and can be combined in relation with the use of a classification of the main statistical activities. During that explanation some questions were raised. .One person said that the reference to use of registers is incorrect, the term should be coverage. In reaction was that coverage is only an aspect of a register. Surveys can be based on a full coverage or a partly coverage of the population to be observed. Another remark was about the use of the concept of surveys. The question was whether this concept only refers to the selective approach of households ort that it can be applied also to other forms of data collection; in particular to the data collection on a routinely basis on all patients in hospitals. The answer was that survey is a generic concept that can apply to all forms of data collection from all kinds of populations.

This was followed by the presentation of the World Bank on the main aspects of the DQAF, to be used for health statistics. Country presentations followed, starting with Mauritius, which reported on its current situation and plans for improvement. A pilot district health information system developed for Botswana was presented.

October 10, 2007

Tanzania and Lesotho presented their current situations and priorities for improving their HIS (presentations in consultant's report). Mention was made by Tanzania of legislation regarding statistics that has never been implemented. It also mentioned that the Statistical Master Plan had the mandate to monitor all socio-economic activities. Hence the HIS is not yet linked with other ministries that produce health/disease data, and there is no data warehouse.

Following the two country presentations, Ms. Chobokoane, from Statistics South Africa, described the production of health information, focusing on death and birth registration. A discussion followed presentation of the ten leading causes of death, with the top three causes being TB, influenza, and intestinal parasites. HIV/AIDS did not feature in the top ten in spite of having the largest prevalence of HIV/AIDS worldwide. The reason for this is that only the primary cause of death is recorded. Since most HIIV/SIDS patients die from TB or influenza/pneumonia, these become the causes of death. This recording, it was pointed out by Mauritius, is contrary to the guidelines issued by the WHO, which specifies that a patient suffering from HIV/AIDS who dies should have AIDS as the cause of death regardless of immediate cause of death. South Africa noted that this is a highly politicized issue in the country.

The discussion on the checklist continued. The classification on the main statistical activities was applied and it was shown by the chair that each topic of the checklist can be situated in a specific part of the statistical production process for that topic. The consequence of that approach is that in this way the questions the countries have can easily be linked to specific units in the organization, and be discussed with people with specific skill to deal with that question. The approach was presented in reality and it was concluded that there are only a few topics that are potentially being by several units in the organization. However, if these topics are defined in a more specific way the responsible unit can be better identified.

October 11, 2007

Botswana presented its constraints and priorities for improving its health statistics. This was followed by the Bank describing the activities for the following two days: individual country meetings resulting in country priorities and action plans. These are reported in the consultant's report. These discussions were in most cases chaired by the chair Mr. Ronald Luttikhuizen and in the case of Lesotho chaired by Mrs. Sulekha Patel.

October 12, 2007.

The bilateral discussions continued. At the end of all meetings a closing meeting was held in which the countries presented their own work plans with the priorities. The countries expressed their content with the workshop and said that this way of working was highly appreciated. The countries submitted their evaluation forms which are presented in Annex J.

4   Country priority and action plans

Mr Ronald Luttikhuizen, the GDDS Manager described the work plan structure and planning of activities.

Following country presentations and discussions, it was possible to group the activities proposed by participating countries. The grouping of activities was done with respect of GDDS classification of activities into seven major categories. The following table allows distinguishing clusters of country activities. It thus appears that most demand was expressed for activities in the group of organization and management, present in all countries. The issues of use of data, dissemination and ICT were also represented. Relatively little interest was shown in question of integration, registers and sample frames and surveys. One country expressed interest in five groups of activities and the remaining four countries indicated one or more activities in four groups.

Areas of proposed HIS strengthening by GDDS activities					
	Sudan	**Mauritius**	**Lesotho**	**Tanzania**	**Botswana**
1 Use of data	x	xx	x	x	
2 Dissemination (existing data and quality, data gaps)	x		x	xxx	Xx
3 Integration					X
4 Surveys	x	x			
5 Registers / sample frames	x				
6 Information and communication technology		x	xxx	x	X
7 Institutional framework, management, organization	xxx	x	xx	xxx	Xx

Bilateral discussions were held on Thursday afternoon with Mauritius and Lesotho to prepare a country work plan following a predetermined pattern. Bilateral discussions with Botswana, Sudan and Tanzania were conducted on Friday.

Each country plan specified three priorities selected by the country. For each priority, the following characteristics had to be indicated:
1. Problem being addressed
2. Strategic objectives
3. Activities required
4. Input required (international)
5. Own preparation required
6. Output planned
7. Changes anticipated
8. Linking with further activities
9. Other donors supporting this topic
10. Timing

A Country Work and Action Plan Template is included in Annex G.

A summary of priorities selected by the countries is presented in the following table.

	Summary of selected country priorities		
	Priority 1	**Priority 2**	**Priority 3**
Botswana	Integration of HIS at National level.	Revision of the current Health Indicators and data collection tools.	Timely production of Annual reports and Improve data dissemination.
Lesotho (revised)	Finalize the strategic framework	Development of District data Warehouse	
Mauritius	Review HIS in order to make it compliant to HMN Framework by 2010	Address issues of data gaps	Strengthening the data producer's skills
Sudan	Designing a metadata dictionary	Revision and finalization of the policy and the strategic plan	Technical assistance in revising the network and databases
Tanzania	Major review of routine data collection and reporting tools	Development of the monitoring & evaluation Policy guidelines	Improve use of information for decision making

The complete country priority and action plans are included in Annexes H.1 (Botswana), H.2 (Lesotho), H.3 (Mauritius), H.4 (Sudan) and H.5 (Tanzania).

During the bilateral discussions with countries a draft country action plan was completed for each country. These drafts will be submitted to the participating countries for comments and changes and presented back to the GDDS Manager. Lesotho has already send in a revised action plan for their now two priorities.

5   Workshop evaluation and closure

A workshop evaluation questionnaire form was administered at the end of the workshop. The form is included in Annex I. The results of the evaluation by participants are available in Annex J. The result is that this workshop had with an overall approval of the workshop of 4.9 and a 4.5 for the approval module approach very good evaluation results.
The GDDS Manager summarized the country work and action plans that were produced by countries, thanked and congratulated the country teams on their achievements.

The Mrs Amelantje, the Director General of Central Bureau of Statistics in the presence of Mokopakgosi, the Director of Policy, Planning, Monitoring and Evaluation, Ministry of Health, Botswana, officially closed the workshop.