



Health Data
Collaborative

Monthly Stakeholders Representatives Group Meeting

17th August 2023

Meeting objectives

1

- To present initial findings of HDC Evaluation

2

- To update on RHIS investment case

3

- To discuss plans for October/November meeting

Agenda



Subject	Action	Time
Welcome	For Information	16:00-16:05 CET
HDC Governance HDC Evaluation - initial findings (CEPA)	For Feedback	16:05-16:30 CET
SDG3 GAP Update - SDG3 GAP Progress Report - Update on Data and Digital Accelerator	For Information	16:30-16:45 CET
Working Group updates RHIS investment case – final findings (Swiss Tropical and Public Health Institute)	For Feedback	16:45-17:00 CET
Communications and events Planning for October/November SRG	For Discussion	17:00-17:15 CET
Next steps and AOB	For Information	17:15-17:20 CET

HDC external evaluation: Presentation on draft findings, conclusions and recommendations

SRG meeting
17 August 2023



Evaluation objectives and framework

- **Evaluation objectives:** Review of HDC from inception in 2015 to Dec 2022, to support better positioning for impact on data to support progress on health-related SDGs at country level

Pillar 1: Relevance & Coherence

1. What is the value add of the HDC in relation to the work of global partners and in response to country needs? How relevant has the “re-orientation” of 2018-19 been and is there a need to further change any of the HDC objectives and design to better support achievement of the SDGs?

Pillar 2: Efficiency

2. How efficient has the HDC governance and operational structure (e.g. constituencies, Secretariat, Working Groups, etc.) been in practice? Has it built the right networks and partnerships and supported inter-agency communication as well as been productive and added value?
3. How has the merger with SDG GAP data and digital accelerator supported the functioning of the HDC?

Pillar 3: Effectiveness, sustainability & impact

4. To what extent has the HDC achieved its objectives of: (i) strengthening country capacity; (ii) improving efficiency and alignment of technical and financial investments in health data systems; and (iii) increasing the impact of global public goods on country health data systems? What is the evidence on HDC work contributing to reduced reporting burden and fragmentation alongside increased innovation and capacity at country-level? What aspects have worked well and less well in the achievement of objectives?
5. To what extent is the HDC platform and its activities financially and programmatically sustainable? What are key issues hindering or facilitating sustainability?
6. To what extent has the HDC contributed to (i) the improved availability and quality of health data, aligned with national priorities and (ii) improved use of data for evidence-based decisions, budget making, monitoring and implementation of health related SDGs?

Evaluation conclusions, lessons learnt and recommendations

7. What are the overall evaluation conclusions and lessons learnt? What are the key recommendations for the HDC to reorient itself to focus and address necessary data needs to speed up progress to the 2030 health related SDGs?

Conclusions and lessons learnt

- HDC launched amidst heightened political commitment
- 2019-20 re-orientation identified similar challenges to those identified in this 2023 evaluation
- Stakeholders nearly unanimous that there is a need for the HDC, but it should be reorientated and reformed (not disbanded), with diverse multi-partner structure viewed as critical
- However persistent challenges remain:
 - Broad objectives, lacking specificity, too ambitious in relation to resources
 - Lack of clarity amongst stakeholders on what HDC is set up to do, what it does in practice and how to engage with HDC – country stakeholders not viewed strong benefit
 - Heavy-handed governance structure – does not support strategic decision-making, transparency, accountability, poorly understood
 - Limited partner engagement – Secretariat as principal resulting in further dissonance
 - Inability to deliver against country-focused mandate
 - Limited information and awareness of progress and results facilitated by HDC
- Re-boot 2.0 in order to urgently address longstanding challenges

Feedback from SRG

- Do you agree with the set of recommendations?
- What do you view as the priority recommendations?

1. Reduce the scope of the HDC to focus on where it can add value and has a comparative advantage

Comments on HDC
scope/ role?

2. Develop an updated Theory of Change, work plan and M&E framework that is aligned with the adjusted scope, closely linked to partner work plans and activities and focuses on shared responsibility and accountability

How best to engage
partners?

3. Simplify the HDC governance structure and create a small Board to provide strategic direction to the HDC

Views on Board
membership?

4. Build an investment case around the new HDC objectives and work plan and advocate for funding (whether financial or in-kind partner support).

Views on how best to
fund raise?

5. Improve the engagement with countries including clear “bottom-up” mechanisms and drop the specific focus on a few select HDC countries

Views on how to engage
countries?

6. Improve the workings of the working groups and ensure that their outputs are relevant for country stakeholders

Specific suggestions for
the WGs?

7. Strengthen communications with countries and the wider HDC membership base

Concrete suggestions?



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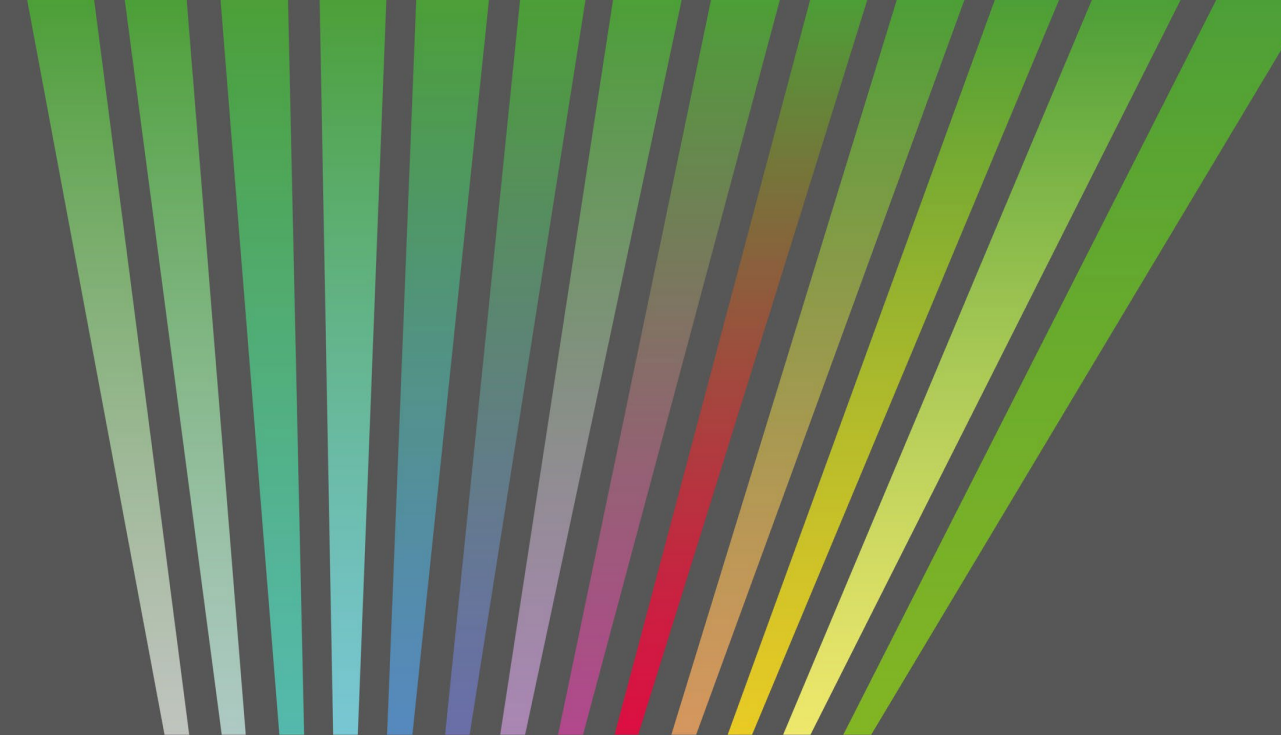
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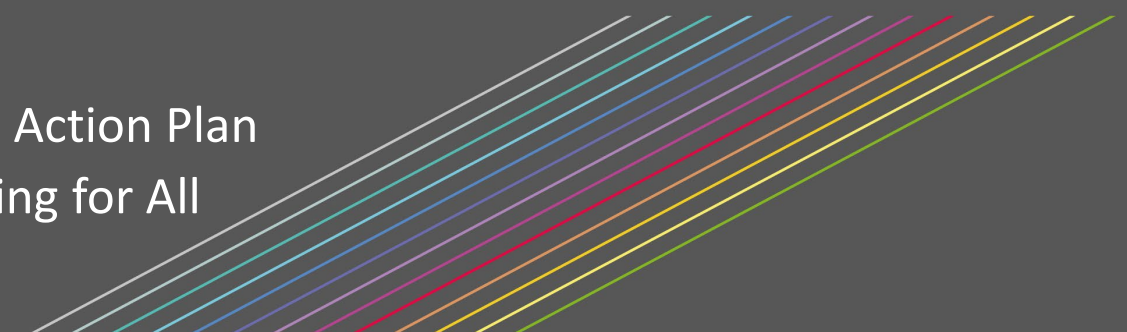




WHAT WORKED? WHAT DIDN'T? WHAT'S NEXT?

2023

progress report on the Global Action Plan
for Healthy Lives and Well-being for All



About SDG3 GAP – *Stronger Collaboration, Better Health*

Stronger multilateral collaboration to accelerate SDG progress

GOAL: Accelerate progress towards the health-related SDGs.

HOW: Improve SDG-focused collaboration and joint action among multilateral agencies in support of national priorities.

WHY:



Global health architecture is complex, sometimes leading to duplication, inefficiencies and a high burden on countries.



Many countries are off-track to achieve the health-related SDG targets by 2030.



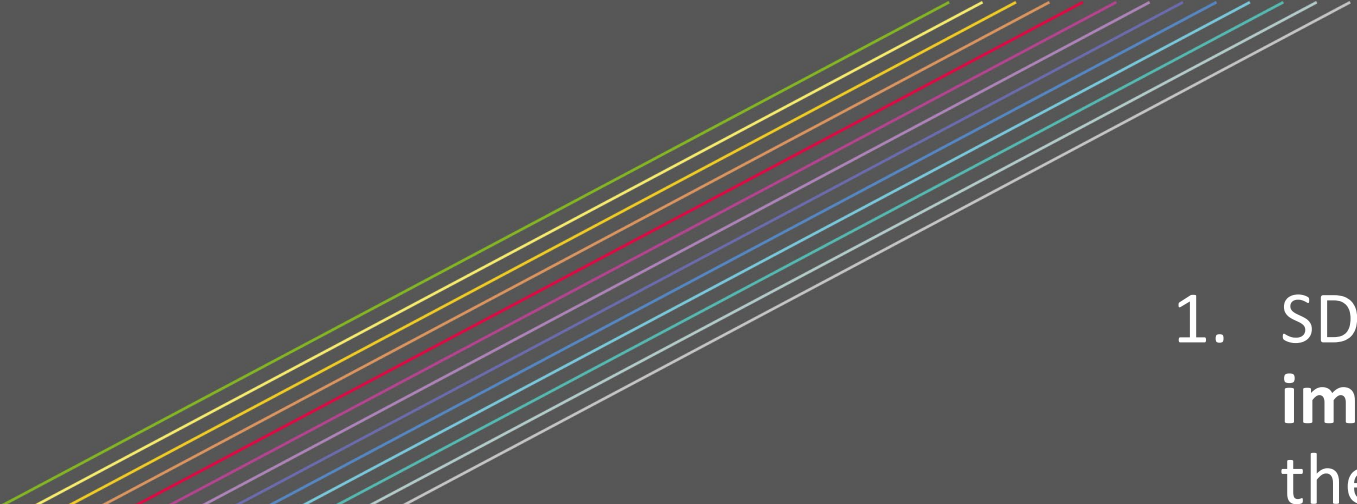
Stronger collaboration across the multilateral agencies is one way to accelerate progress towards the health-related SDGs.

WHO: 13 multilateral agencies:

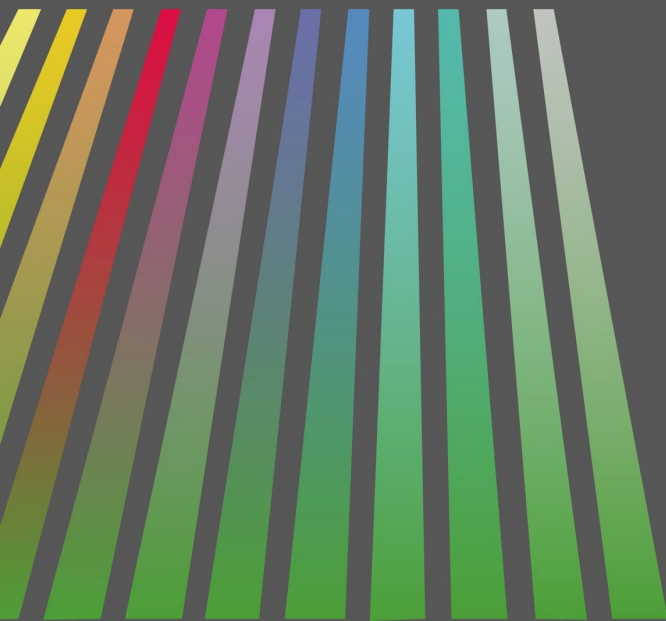


2023 Progress report - Context

- **SDG3 GAP was launched in 2019** as a self-commitment of 13 multilateral agencies to collaborate better in support of countries' efforts to achieve the health-related SDGs
- **2023 is the mid-point to the SDGs** and the world is going only at a fraction of the pace needed to achieve the SDGs by 2030
- **Enhanced collaboration** within the multilateral system is therefore **more important than ever to help accelerate progress** towards the SDGs
- Through the 2023 progress report, SDG3 GAP agencies discuss what has worked and what has not worked since 2019 and make **6 recommendations for the future.**

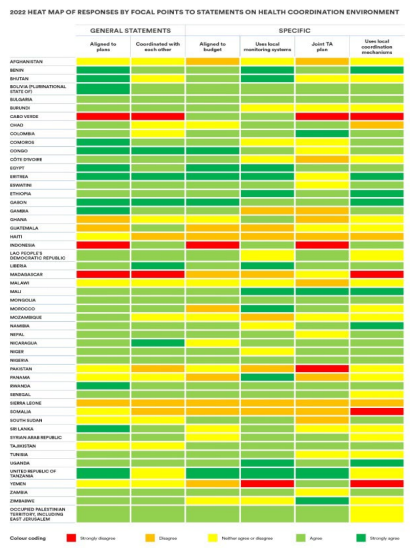
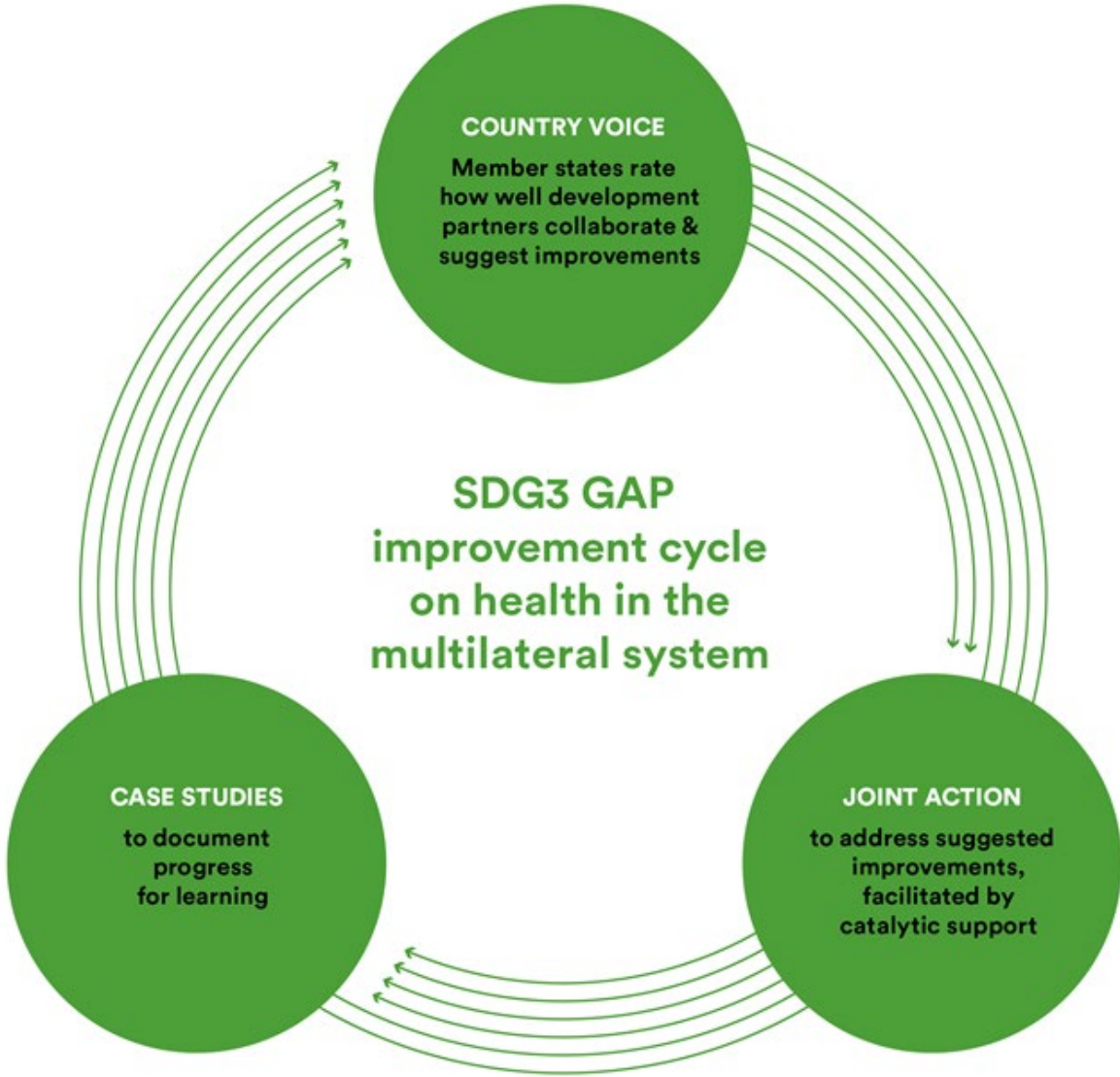


What has worked under the SDG3 GAP?



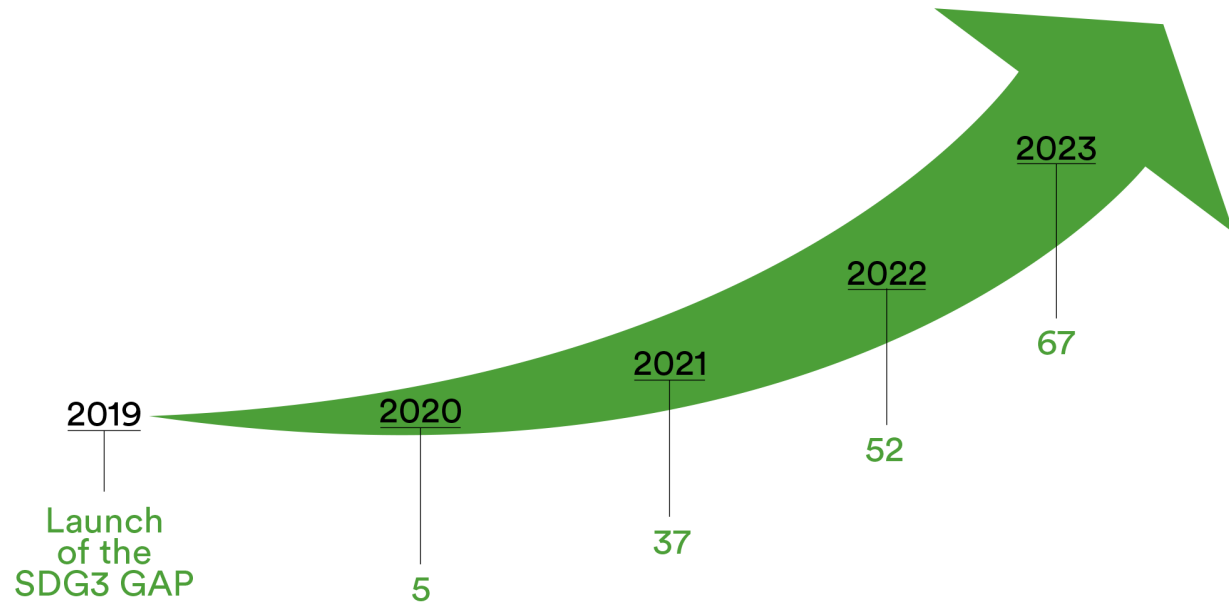
1. SDG3 GAP provides an **improvement cycle on health** in the multilateral system
2. SDG3 GAP provides **structures for collaboration**
3. **Country-level** specific and thematic approaches show promise

FIGURE 1: SDG3 GAP improvement cycle on health in the multilateral system



What has worked under the SDG3 GAP?

FIGURE 2: Number of countries engaged under SDG3 GAP, by year



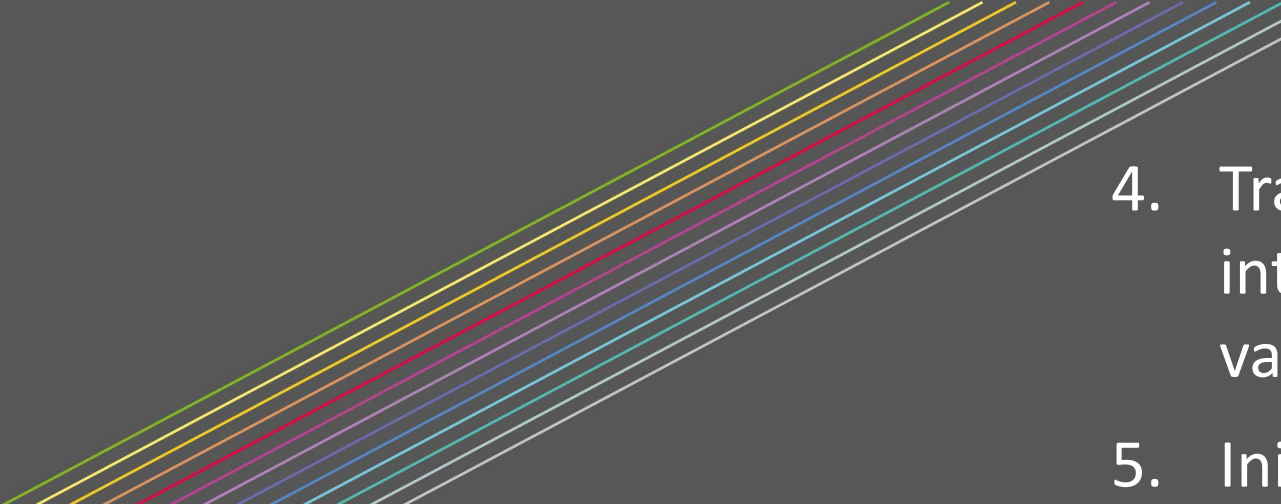
2022 HEAT MAP OF RESPONSES BY FOCAL POINTS TO STATEMENTS ON HEALTH COORDINATION ENVIRONMENT

	GENERAL STATEMENTS		SPECIFIC			
	Aligned to plans	Coordinated with each other	Aligned to budget	Uses local monitoring systems	Joint TA plan	Uses local coordination mechanisms
AFGHANISTAN						
BENIN						
BHUTAN						
BOLIVIA (PLURINATIONAL STATE OF)						
BULGARIA						
BURUNDI						
CABO VERDE						
CHAD						
COLOMBIA						
COMOROS						
CONGO						
CÔTE D'IVOIRE						
EGYPT						
ERITREA						
ESWATINI						
ETHIOPIA						
GABON						
GAMBIA						
GHANA						
GUATEMALA						
HAITI						
INDONESIA						
LAO PEOPLE'S DEMOCRATIC REPUBLIC						
LIBERIA						
MADAGASCAR						
MALAWI						
MALI						
MONGOLIA						
MOROCCO						
MOZAMBIQUE						
NAMIBIA						
NEPAL						
NICARAGUA						
NIGER						
NIGERIA						
PAKISTAN						
PANAMA						
RWANDA						
SENEGAL						
SIERRA LEONE						
SOMALIA						
SOUTH SUDAN						
SRI LANKA						
SYRIAN ARAB REPUBLIC						
TAJIKISTAN						
TUNISIA						
UGANDA						
YEMEN						
ZAMBIA						
ZIMBABWE						
OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM						

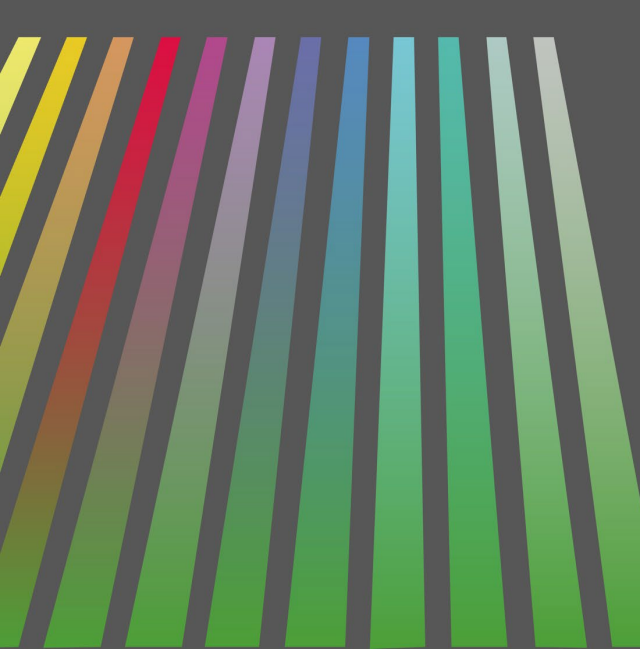
Colour coding Strongly disagree Disagree Neither agree or disagree Agree Strongly

Recommendations to sustain and bring to scale the elements of SDG3 GAP that are working

1. Strengthen the SDG3 GAP **improvement cycle for health** in the multilateral system: amplify country voices and helps shift power dynamics in favour of countries
 - Roll out the second round of country questionnaires by the end of 2023
 - Make incentives and resources available to catalyse stronger collaboration
 - Publish annual progress reports & case studies to document improvements
2. Maintain SDG3 GAP as an effective **structure for collaboration** on health in the multilateral system
 - Retain current structure of agency focal points & accelerator working groups
 - SDG3 GAP Principals should meet annually to review and discuss progress
3. Better focus work under SDG3 GAP at the **country level** and foster greater cross-accelerator collaboration in countries
 - Further emphasize successful country approaches
 - Implement coordinated country action with clear targets



What has not worked under the SDG3 GAP?

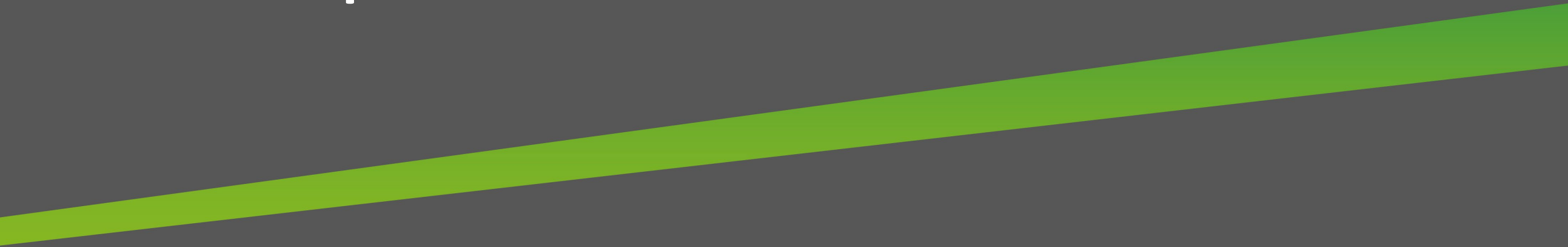


4. Translation of SDG3 GAP commitments into **action at the country level** has varied considerably
5. Initial **engagement of civil society** at the SDG3 GAP's inception has not been sustained
6. **Incentives for collaboration:** SDG3 GAP illustrates that “self-commitments” by agency principals at the global level may improve collaboration but can only achieve so much in the absence of external incentives that reinforce collaboration, esp. at country level

Recommendations to address the elements of SDG3 GAP that are not working

4. Enhance joint **action at the country level** through new approaches, such as delivery for impact
5. Strengthen **engagement of civil society** and communities through consultations to explore their interest in contributing to work under SDG3 GAP
6. Strengthen **incentives for collaboration** in the areas of
 - *Political leadership*: work with MS to develop and implement an approach to strengthen ownership and accountability to countries
 - *Governance direction*: each relevant agency governing body could review the annual progress reports and country-level coordination and alignment
 - *Funding for collaboration*: agencies should demonstrate what efforts are being mobilized to drive and deepen collaboration

Next steps



Through this progress report, and in the run-up to the 2023 SDG Summit and the other high-level meetings of the United Nations General Assembly in September 2023, SDG3 GAP agencies will:

- Consult with Member states, civil society and interested stakeholders to understand how best to jointly implement the 6 recommendations for the future
- Collaborate with other initiatives such as the GFF Alignment Working Group and the Future of Global Health Initiatives to improve collaboration

SDG3 GAP

Data and Digital Accelerator Meeting

12 September 2023

Meeting Objectives

1. To review achievements 2022-23
2. To discuss the evolution of SDG3 GAP
3. To discuss strategic priorities for 2024-25, including links with PHC and HDC





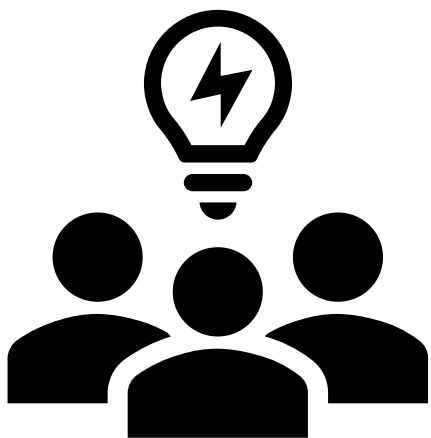
“

We have made important progress, but we still have a long path to travel to improve the way that multilateral organizations work together to support countries. We must listen to what countries tell us and act upon their guidance. I thank the partners for their collaboration and for the honest self-assessments contained in this report.

Dr Tedros Adhanom Ghebreyesus,

WHO Director-General and Chair of the SDG3 GAP Principals Group





Working Groups Updates

Updates from HDC Working Groups Co-chairs on progress related to groups' activities, potential areas of synergy with other working groups, support needed and issues to be discussed at the level of SRG



Swiss TPH



Making the case for investing in Routine Health Information Systems (RHIS) to achieve the health-related SDGs

RFP-2022-DDI-DNA-CNG-0001 | HQ/DDI/DNA/CNG and HQ/DDI/DNA/HIS

Synthesis of findings

Xavier Bosch-Capblanch, on behalf of the team
Geneva, 19th May 2023

Objectives of this assignment

In the RFP	In our response to it
1. To identify effective and ineffective models of investing in country RHIS (country case studies)	1. To explore RHIS definitions and frameworks
2. To identify and recommend possible frameworks, methods and costing tools to support integrated RHIS investments.	2. To describe how return of investments are portrayed in the literature
3. To estimate the return on investment in RHIS, where possible.	3. To estimates costs and returns of RHIS in selected countries
4. Production of technical materials and a peer review publication	4. (same)



Swiss TPH



2 Methodological considerations

Clarifications: the scope of our work

✓ We did...	× We did not...
✓ Draw on existing evidence and expert opinion	× Carry out primary research
✓ Focus on RHIS	× Address the whole spectrum of HIS
✓ Describe the status and costs of RHIS components	× Assess what works against standards
✓ Valued to potential contribution of RHIS to health outcomes	× Estimate a monetary return of investment



Swiss TPH



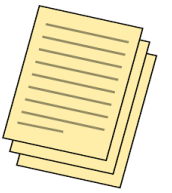
3 Synthesis of findings

RHIS are “special”

No other information system...

- encompasses the whole health system, from Tertiary University Hospitals up to community health workers – **65 million health workers**
- is permanently active, in each and every encounter with service users – **the whole population**
- has a universal distribution in all countries and territories, even in humanitarian crises – **almost 200 countries**
- data collection point = data use point – **is a process of care**
- carries personal information – **data security**

Economic analysis (1/3)



- Economic studies in the literature tend to be framed in the context of clinical care;
- No standard methodology
 - Comparability
 - “Health systems significance”
- Interpretation
 - health systems specific settings
 - items included in the calculations
 - analytical approach
 - time trends of the estimates
- Challenges: scope, assumptions, hypothesis | data requirements | approaches | interpretation

Economic analysis (2/3)

Value of Lost Welfare (VLW) due to Amenable Mortality in 2015 (millions, 2015 IND) using baseline Value of statistical Life (VSL) assumptions; VLW expressed as equivalent proportion of 2015 GDP and Value of lost welfare in 2022 USD

Country	Value of Lost Welfare 2015 (USD in millions)	% of GDP	Value of lost Welfare 2022 USD (millions)	Cost of RHIS (2022)	% RHIS vs foregone welfare
Colombia	35,419 (28,578 to 45,426)	5.4% (4.4% to 6.9%)	28,024,414	24,276,886	0.0001%
Côte d'Ivoire	17,249 (9,730 to 29,942)	22.2% (12.5% to 38.6%)	8,235	11,726,870	0.1424%
Nepal	8,755 (4,919 to 14,463)	12.3% (6.9% to 20.3%)	3,001	6,678,443	0.2226%
Nigeria	182,022 (111,440 to 318,036)	17.0% (10.4% to 29.8%)	1,589,108	53,914,580	0.0003%
South Africa	125,031 (103,540 to 148,511)	17.6% (14.6% to 20.9%)	62,714	8,100,216	0.0129%

Economic analysis (3/3)

Expenditure per capita on HIS and HAQ index score

Country	Expenditure per capita (2022)	2019 HAQ index score Overall
Colombia	0.47	61.1
Cote Divoire	0.42	34.3
Nepal	0.22	38.8
South Africa	0.14	44.6
Nigeria	0.02	31.6

- There did not appear to be any relationship between higher per capita investments in RHIS and improved HAQ scores.
- Some relationships between expenditure per capita in HIS and HAQ.



Swiss TPH



5 THE FUTURE

1 Paradigm change

× Old	✓ New
× Data – dashboards - planning	✓ SDG / UHC / Quality of care
× ‘Technocratic’ frameworks developed before the digital ‘explosion’,	✓ Innovation consistent with new knowledge
× Use of data without detail	✓ Specific decision-spaces
× Making health workers responsible	✓ Improving the system
× Observational research	✓ Experimental and mix-methods research
× De-implementation	✓ Evidence informed initiatives / no harm

What next?

- Multilaterals
 - Promote RHIS as a “health technology” (HTA)
 - Safeguard the link between RHIS and provision of care / UHC
 - Support high quality research
 - Convene partners to adhere to ethical principles of RHIS
- Governments
 - Demand a regulatory framework for RHIS (e.g. HTA)
 - Budget RHIS specifically, factoring contributions
 - Establish funding scenarios
- Technical partners
 - Stop unduly influencing RHIS
 - Use experts with up to date knowledge and expertise on key methods (e.g. HCD)
 - Adhere to ethical principles of data governance and also health care
- Funders
 - Stop unduly influencing RHIS
 - Acknowledge the radical importance of RHIS to achieve SDG / UHC
 - Factor the RHIS within competing funding needs
 - Fund high quality research



Communications & Events

Communications from HDC Secretariat and updates on upcoming events hosted by or promoted by the HDC

Communications and Events

Plans for Q4 SRG Meeting

- **Proposed meeting objectives**

- To present findings and consider recommendations of the HDC Evaluation
- To identify country HIS priorities and ways of aligning resources for country impact
- To provide feedback and agree on:
 - HDC work plan 2023-2025
 - Working Group products and outputs
 - Support mechanisms to scale up country impact
- To recommit and renew membership of HDC.

- **When?**

- **Where?** (can it be hosted in another region/country?) in person vs virtual?

Annex

HDC Stakeholder Representatives Group



7 Constituencies	13 Representatives	Alternates
Countries (3)	Zambia (Mwango Mutale) Botswana (Onalenna Seitio-Kgokgwe)	Uganda (Paul Mbaka)
Multilaterals (3)	WHO (Stephen MacFeely) UNFPA (Priscilla Idele) World Bank (Sam Mills)	WHO EMRO (Arash Rashidian) UNSD (Francesca Grum) UNICEF (Joao Pedro Azevedo)
Bilateral donors & Foundations (2)	USAID (Rachel Lucas) GIZ (Barakissa Tien-Wahser)	
GHIs (1)	CHISU (Steve Ollis)	GAVI (Heidi Reynolds)
Research, Academia & Technical Networks (2)	World Privacy Forum (Pam Dixon)	CDC (Chris Murril) Council for Scientific and Industrial Research (Laticha Walters) AeHIN (Alvin Marcelo)
Civil Society (1)	PharmAccess (Maxwell Antwi)	Save The Children (Margot Nauleau)
Private Sector (1)	MED Ex CARE (Patricia Monthe)	Medtronic USA (Rushika Singhal)

HDC SRG Co-chairs:

- Country: Onalenna Seitio-Kgokgwe (MoHW Botswana)
- UNICEF: Joao Pedro Azevedo (UNICEF)
- WHO: Stephen MacFeely (WHO)

HDC Secretariat

- Craig Burgess
- Mwenya Kasonde
- Tashi Chozom
- Isabella Maina
- Pandula Siribaddana

HDC Working Groups



Working Group	Co-chairs
Civil Registration & Vital Statistics (CRVS)	WHO (Doris Ma Fat), LSHTM (Debra Jackson), UNICEF (Bhaskar Mishra)
Community Data (Com. Data)	UNICEF (Remy Mwamba) & USAID (Ana Scholl)
Data and Digital Governance (DDG)	USAID (Marie Donaldson), Palladium (Vikas Dwivedi), USAID (Vidhya Mahadevan)
Digital Health & Interoperability (DH&I)	JSI (Carolyn Kamasaka), PATH (Putra Chilunga), WHO (Derrick Muneene) & Open Communities (Paul Biondich), University of North Carolina (Manish Kumar)
Geolocalisation Information Systems (GIS)	<i>TBC</i>
Logistics Management Information Systems (LMIS)	USAID (Lindabeth Doby) & WHO (Lisa Hedman)
Routine Health Information Systems (RHIS)	UiO (Jørn Braa), RHINO (Jean-Pierre de Lamalle), Kenya (Ayub Manyà)

HDC external evaluation: Presentation on draft findings, conclusions and recommendations

SRG meeting
17 August 2023



Contents

1. Introduction
2. Key findings and conclusions
3. Recommendations

1. Introduction

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Evaluation conclusions, lessons learnt and recommendations

7. What are the overall evaluation conclusions and lessons learnt? What are the key recommendations for the HDC to reorient itself to focus and address necessary data needs to speed up progress to the 2030 health related SDGs?

Evaluation methods

- **Mixed-methods approach**
 - Document review
 - 64 stakeholder consultations with HDC constituency groups, HDC SRG members including HDC Co-Chairs, HDC Working Group Co-Chairs, HDC Secretariat, UHC2030 and SDG GAP Secretariat, and WHO
 - Six country case studies (including a mix of countries where the HDC has been active (Botswana, Cameroon, Malawi and Nepal), recently disengaged (Tanzania) and not yet active (Pakistan))
 - An e-survey which reached 27 respondents
 - Data analysis of the HDC member base
 - Limited analysis of other WHO partnerships for best practice and learnings
- Challenges in implementing a **theory-based evaluation**
- Use of **robustness assessment framework** for findings

2. Key findings and conclusions

Relevance and Coherence

- **HDC objectives** are relevant to country priorities and needs, but too broad, unclear and ambitious
- **HDC activities** lack focus and do not present an integrated plan towards objectives
- **HDC model** requires reform to deliver on its mandate
 - Diverse multi-stakeholder base and convening power lie at the heart of HDC's added value but HDC needs to meaningfully engage **partners** in support of its mandate and delivery of workplans, beyond selected WGs
 - Need for focused approach and functioning mechanisms to support **country engagement**
 - **Governance structure** of HDC is complicated for its size and budget, and needs to better support strategic direction and accountability among stakeholders
- HDC needs to clearly and concisely articulate its **value-add** proposition so to partners and country stakeholders

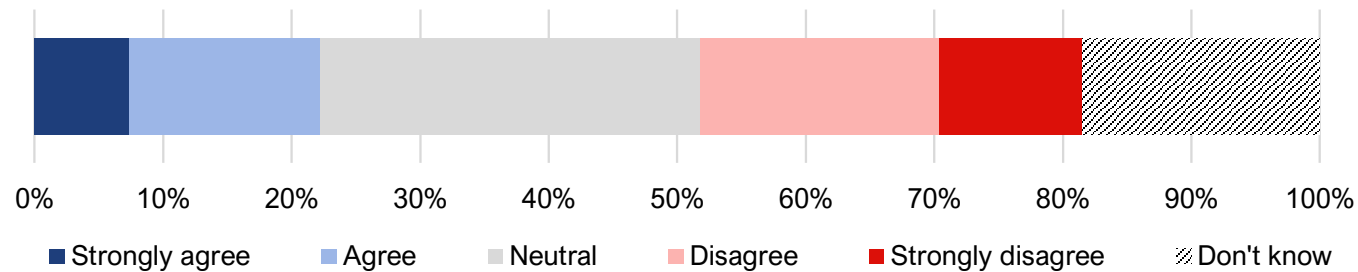
Efficiency

- **HDC governance structure** is complex and heavy-handed, especially given limited human and financial resources
 - **Constituency structure** is critiqued as burdensome and of limited value
 - **SRG** lacks clarity in process and leadership due to weak member engagement, clarity needed for purpose & procedures of SRG meetings, & poor communication between SRG representatives and constituency groups
 - There is significant variation in the structure and purpose of the **WGs** which causes confusion amongst stakeholders on their roles and impacts delivery and accountability. Coordination of the WGs has been challenging.
 - **Secretariat** received positive feedback from stakeholders but highly constrained by resources
- Diversity of **HDC membership base** is widely regarded as a strength, but only a small percentage of members are actively engaged
- **Communication flow** between HDC governance structures not functioning optimally, affecting **decision-making, transparency and coordination**
- **SDG GAP D+D Accelerator merger** led to some efficiencies, but implementation not done in strategic/ transparent way; low visibility of merger

Effectiveness, Impact & Sustainability

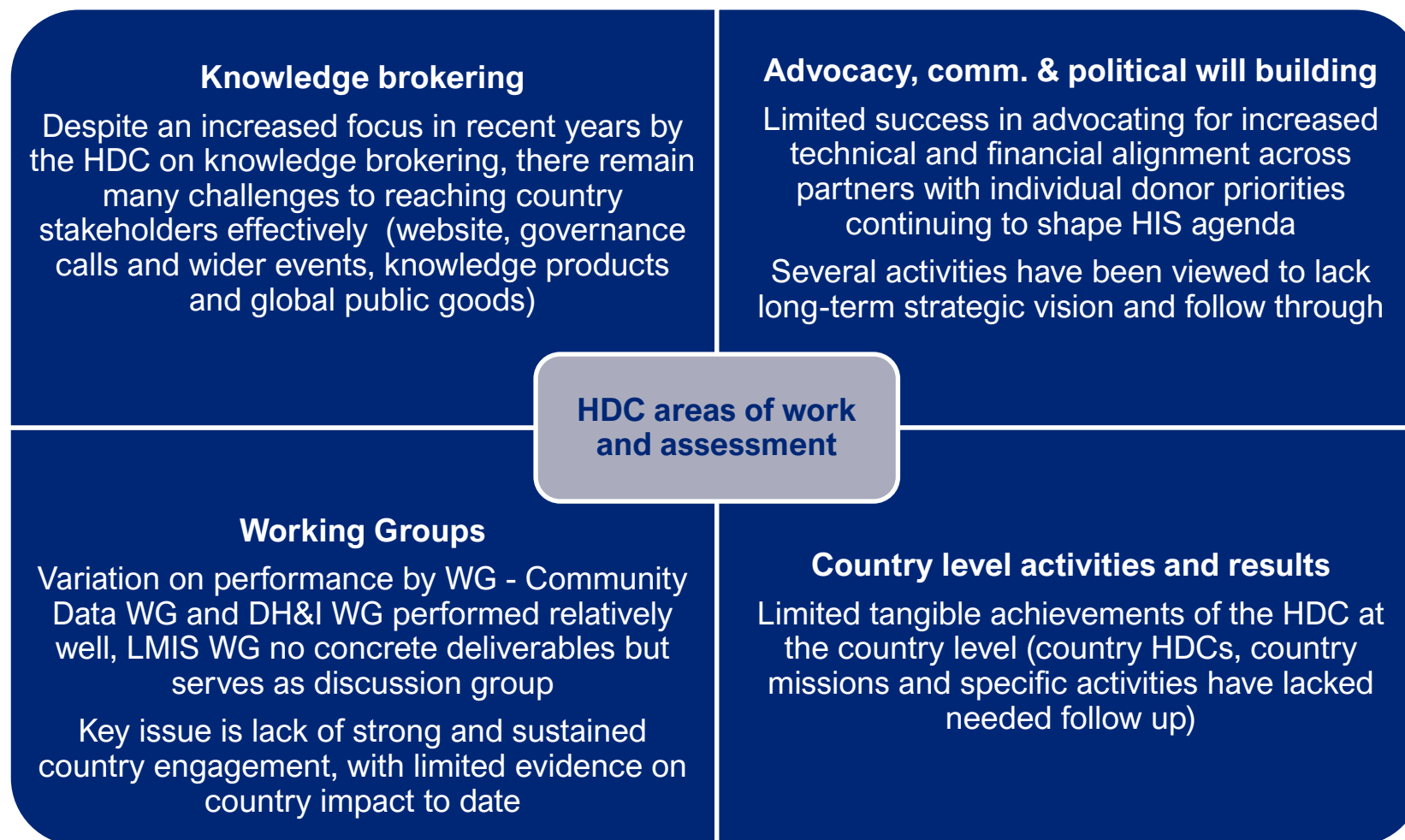
- **TOC** not well-defined and used, and poorly understood by stakeholders
- Lack of relevant and appropriate **M&E framework** (including for WGs) and ad hoc progress **reporting**
- **Limited progress to date by the HDC against its three objectives** – partly due to the range of challenges the HDC faces with its structure and design and the long periods of hiatus and low Secretariat functioning

Figure 2.5: Percentage of survey respondents who feel the HDC has made substantial progress on its objective since inception



- **COVID-19** as a disrupter and facilitator for data coordination efforts

Effectiveness, Impact & Sustainability



Conclusions and lessons learnt

- HDC launched amidst heightened political commitment
- 2019-20 re-orientation identified similar challenges to those identified in this 2023 evaluation
- Stakeholders nearly unanimous that there is a need for the HDC, but it should be reorientated and reformed (not disbanded), with diverse multi-partner structure viewed as critical
- However persistent challenges remain:
 - Broad objectives, lacking specificity, too ambitious in relation to resources
 - Lack of clarity amongst stakeholders on what HDC is set up to do, what it does in practice and how to engage with HDC – country stakeholders not viewed strong benefit
 - Heavy-handed governance structure – does not support strategic decision-making, transparency, accountability, poorly understood
 - Limited partner engagement – Secretariat as principal resulting in further dissonance
 - Inability to deliver against country-focused mandate
 - Limited information and awareness of progress and results facilitated by HDC
- Re-boot 2.0 in order to urgently address longstanding challenges

3. Recommendations

Recommendation 1: Reduce the scope of the HDC to focus on where it can add value and has a comparative advantage

Implementation responsibility - HDC Board (see recommendation 3) and HDC Secretariat

Timeline: Immediate/ Short Term; Capacity requirements: Low-Medium

- Would ensure resources not stretched too thin and allow for more effective planning, implementation and follow-up
- Also help sharpen HDC profile and communicate value-add
- CEPA assessment – HDC role aimed at country impact but through global coordination:
 - (i) knowledge brokering and (ii) coordination / review of global public goods and their dissemination – bringing together developers and users, with country tailoring as needed and supporting wide dissemination through website and global/regional events
 - (iii) advocacy and communications for more efficient and effective HIS – focusing on highlighting benefits of donor coordination and costs of fragmentation

Review of options for HDC scope of work and focusing (*positive assessment for the HDC in green and negative in red*)

Objective	Potential HDC role	Resource intensive?	Feasibility given positioning?	Requiring country presence?
Donor/ financial alignment and coordination	Support financial alignment of donors investments in HIS	Yes	No	Yes
In-country financial alignment and coordination	Support for the operationalisation of country coordination in HIS	Yes	No	Yes
Country capacity building, technical alignment of HIS funding	Development, review, coordination and dissemination of global public goods (guidances and tools)	No	Yes	No
Advocacy	Advocacy and communications on HIS	No	Yes	No
Country capacity building	Coordination of TA for country HIS	Yes	No	Yes
Increased investment in country HIS	Catalytic funding of country HIS to support improved systems, capacity, etc.	Yes	Yes	Yes

Recommendation 2: Develop an updated TOC, work plan and M&E framework that is aligned with the adjusted scope, closely linked to partner work plans and activities and focuses on shared responsibility and accountability

Implementation responsibility - HDC Sec with input from partners, and approval by Board

Timeline: Short Term, Capacity requirements: Medium

- **Develop an updated TOC** which is closely aligned with the updated scope
- **Develop a clear workplan** closely linked to key partner activities and workplans and focusing on providing accountability, with linkages to WGs
 - Starting point should be a review of partner work plans and priorities, and assessment of where HDC can add value through multi-partner base
 - Workplan should assign responsibilities to partners, and outline role of Secretariat
 - WGs should take a similar approach to develop workplans
 - Development of workplans should be mindful of existing resources
 - Work plans should focus on country impact
- **Develop an updated M&E framework** which builds on the workplan, and regularly report against it – “light touch”, focus on output, outcomes and impact rather than activities, regular reporting

Recommendation 3: Simplify the HDC governance structure and create a small Board to provide strategic direction to the HDC

Implementation responsibility - HDC Secretariat

Timeline: Short term, Capacity requirements: Low-Medium

- Simplified structure comprising a small Board for strategic direction and guidance and a Secretariat for day-to-day delivery only (i.e. remove other governance structures)
- The Board could be a repurposed SRG but fundamentally should include a small but diverse number of highly engaged stakeholders
- The Board should have a clear mandate for providing strategic direction to HDC i.e. define the HDC's objectives and scope of work, review of annual work plans, assess progress and course corrections over time
- The Board should oversee implementation of evaluation recommendations
- Not a political level Board, although may include senior members from representative organisations

Recommendation 4: Build an investment case around the new HDC objectives and work plan and advocate for funding (whether financial or in-kind partner support)

Implementation responsibility - HDC Secretariat, with support from HDC partners

Timeline: short-to-medium term, Capacity requirements: moderate

- **Develop an investment case around the new HDC objectives and workplan** to serve as both a communication and fundraising tool, aligned and build on work being conducted on the investment case for good data governance and HIS and the upcoming broader data dividend work being presented at the UN SDG summit in September
- **Raise additional resources on the back of this investment case**
 - Focus on re-engaging key HDC partners with the objective of getting additional resources (financial or in the form of dedicated staff time)
 - Resources raised should be aimed at ensuring HDC Secretariat comprises multi-partner staff/ consultants (i.e., beyond WHO)

Recommendation 5: Improve the engagement with countries including clear “bottom-up” mechanisms and drop the specific focus on a few select HDC countries

Implementation responsibility - HDC Secretariat, with support from partners and guidance from the Board

Timeline: medium term, Capacity requirements: Medium for the HDC Secretariat

- **Strengthen country engagement and ensure a bottom-up / demand driven approach to HDC’s work on HIS, e.g. through:**
 - Access to country voice through proposed Board and as WG Co-Chairs
 - Annual survey of country needs
 - Rely on WHO regional and country offices to “feed-up” country priorities
 - Engage with key donors who have country presence and/or existing structures to solicit country views to understand what HDC can contribute
 - Work through regional representatives engaged by HDC
- **Re-orient events and meetings to ensure maximum utility for countries-** including through South-South sharing of experiences and lessons
- **Move away from pre-selected list of HDC countries**

Recommendation 6: Improve the workings of the Working Groups and ensure that their outputs are relevant for country stakeholders

Implementation responsibility - HDC Secretariat and WG leads

Timeline: short term, Capacity requirements: moderate

- **Develop annual workplans for the WGs and support their use and follow-up**
- **HDC Secretariat should continue to support the coordination, agenda, and follow-up of WG meetings**
- **Improve the connection and collaboration between WGs** through annual workplans, joint knowledge products/ public goods, touch points of WG co-chairs, etc.
- **Support country engagement of the WGs** through (i) increased country stakeholder participation in WGs, (ii) making sure WGs are aware of bottom-up country priorities, (iii) explore ways for WGs to tailor global public goods for specific country contexts

Recommendation 7: Strengthen communications with countries and the wider HDC membership base

Implementation responsibility - HDC Secretariat

Timeline: short-to-medium term, Capacity requirements: low- medium

- **Communicate the value-add of the HDC platform to partners** and link this to suggested improvements to the M&E framework
- **Target communication to HDC members** to ensure clear value-add to the HDC and members
- **Improve the website to increase utility to country stakeholders**

Feedback from SRG

- Do you agree with the set of recommendations?
- What do you view as the priority recommendations?

1. Reduce the scope of the HDC to focus on where it can add value and has a comparative advantage

Comments on HDC scope/ role?

2. Develop an updated Theory of Change, work plan and M&E framework that is aligned with the adjusted scope, closely linked to partner work plans and activities and focuses on shared responsibility and accountability

How best to engage partners?

3. Simplify the HDC governance structure and create a small Board to provide strategic direction to the HDC

Views on Board membership?

4. Build an investment case around the new HDC objectives and work plan and advocate for funding (whether financial or in-kind partner support).

Views on how best to fund raise?

5. Improve the engagement with countries including clear “bottom-up” mechanisms and drop the specific focus on a few select HDC countries

Views on how to engage countries?

6. Improve the workings of the working groups and ensure that their outputs are relevant for country stakeholders

Specific suggestions for the WGs?

7. Strengthen communications with countries and the wider HDC membership base

Concrete suggestions?



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Making the case for investing in Routine Health Information Systems (RHIS) to achieve the health-related SDGs

RFP-2022-DDI-DNA-CNG-0001 | HQ/DDI/DNA/CNG and HQ/DDI/DNA/HIS

Synthesis of findings

Xavier Bosch-Capblanch, on behalf of the team
Geneva, 19th May 2023



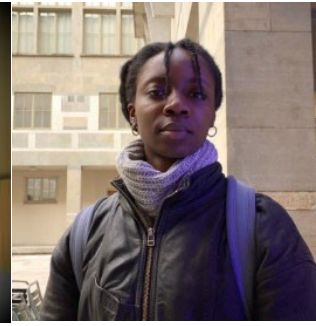
Xavier
Bosch-Capblanch



Christian
Auer



Fabrizio
Tediosi



Marguerite
Batta



Natalie
Leon



Edward
Nicol



Donnela
Besada

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1 Perspectives and objectives

2 Methodological considerations

3 Synthesis of findings

4 Conclusions

5 THE FUTURE

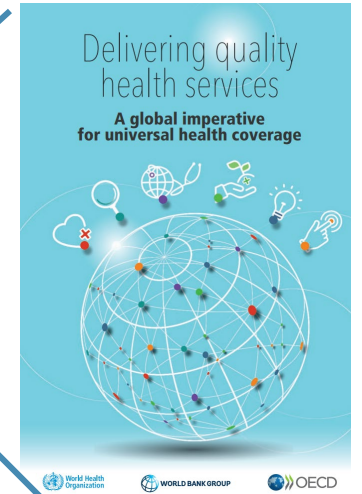
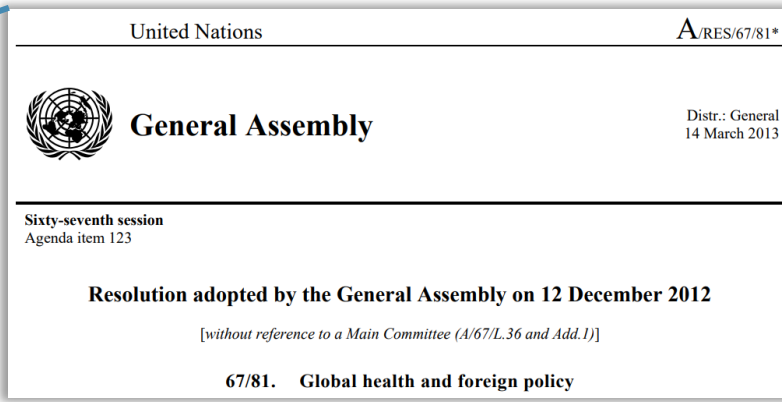


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1 Perspectives and objectives

Global perspective



3.8 “Achieve **universal health coverage**, including financial risk protection, access to **quality essential health-care services** and access to safe, effective, quality and affordable essential medicines and vaccines for all”

“Universal health coverage means that **all people have access to the full range of quality health services** they need, when and where they need them, without financial hardship.”

From Alma-Ata towards universal health coverage and the Sustainable Development Goals

Astana, Kazakhstan, 25 and 26 October 2018

“All this needs to be done with a clear eye on **strong linkages between measurement and improvement** – measuring alone will not improve quality.”



Data Governance perspective



GLOBAL STRATEGY FOR OPTIMIZING ROUTINE HEALTH INFORMATION SYSTEMS IN COUNTRIES 2022–2030

Enabling delivery of Primary Health Care and
Universal Health Coverage

1. Policy and strategic plans
2. Intelligence: information and analysis for decision-making
3. Tools for implementation – structures, powers, regulation, standards, incentives; enforcement and sanctions
4. Collaboration across sectors
5. Accountability: independent oversight, monitoring, transparent availability and publication regulations, openness to scrutiny by political representatives and civil society

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Over 2 half days in June and September 2021, the summit identified potential solutions to the challenges of implementing standards, solutions and infrastructure to increase the value of health data as a strategic asset. Best practices and challenges included data from **public health, routine health structures, research, trials** and **GIS**, with specific focus on data storage, sharing, legal and ethical aspects.

Strategic objectives :

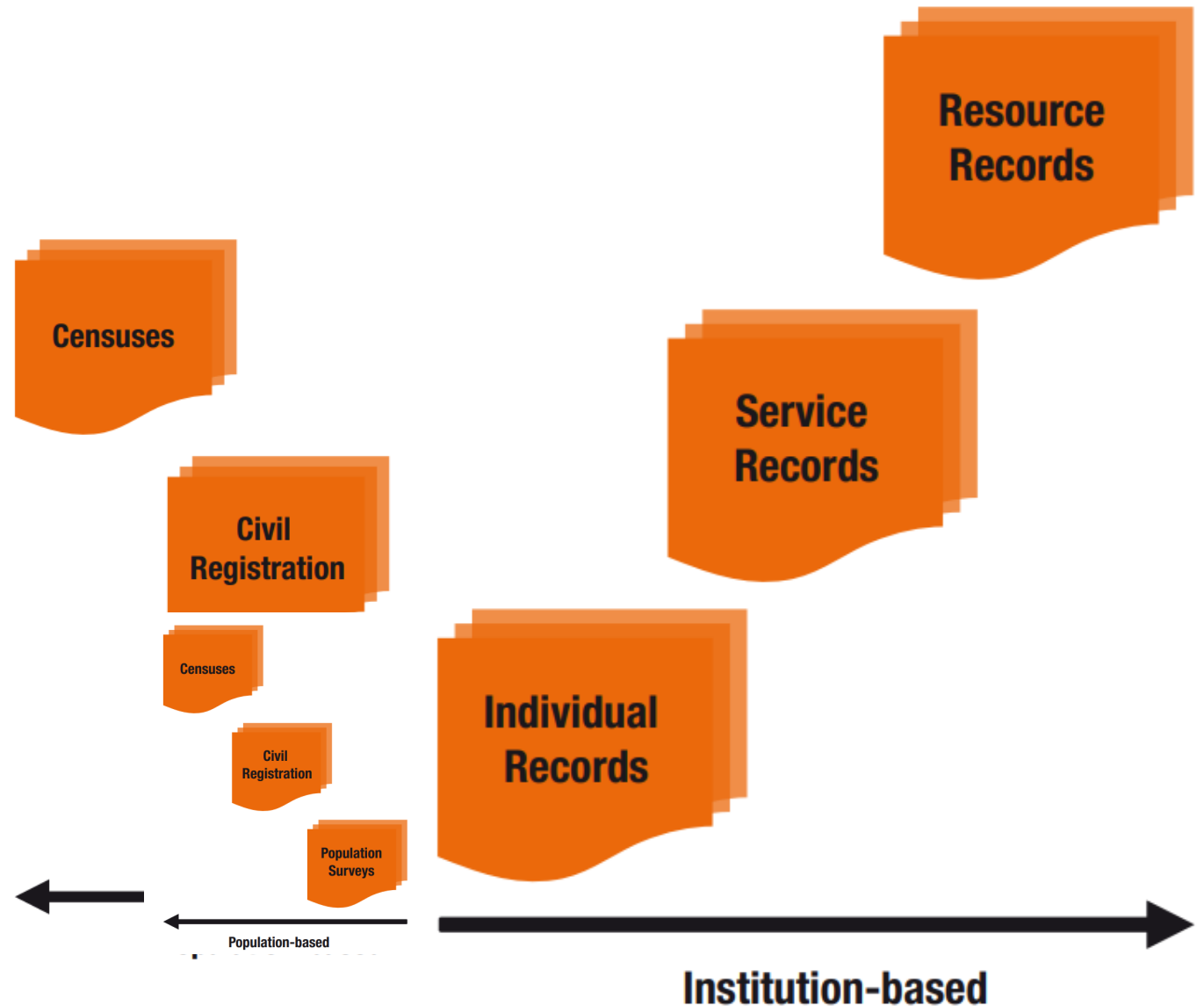
1. Governance and partnership structures for RHIS
2. RHIS data collection, health information management and data quality
3. Integration and interoperability of RHIS
4. Building capacities for RHIS data analyses, data use and dissemination
5. Human and financial resources required for a sustainable RHIS.

RHIS perspective

RHIS collect health service data **directly from the health facilities**, where they are produced by the **health-care workers and community health workers**.

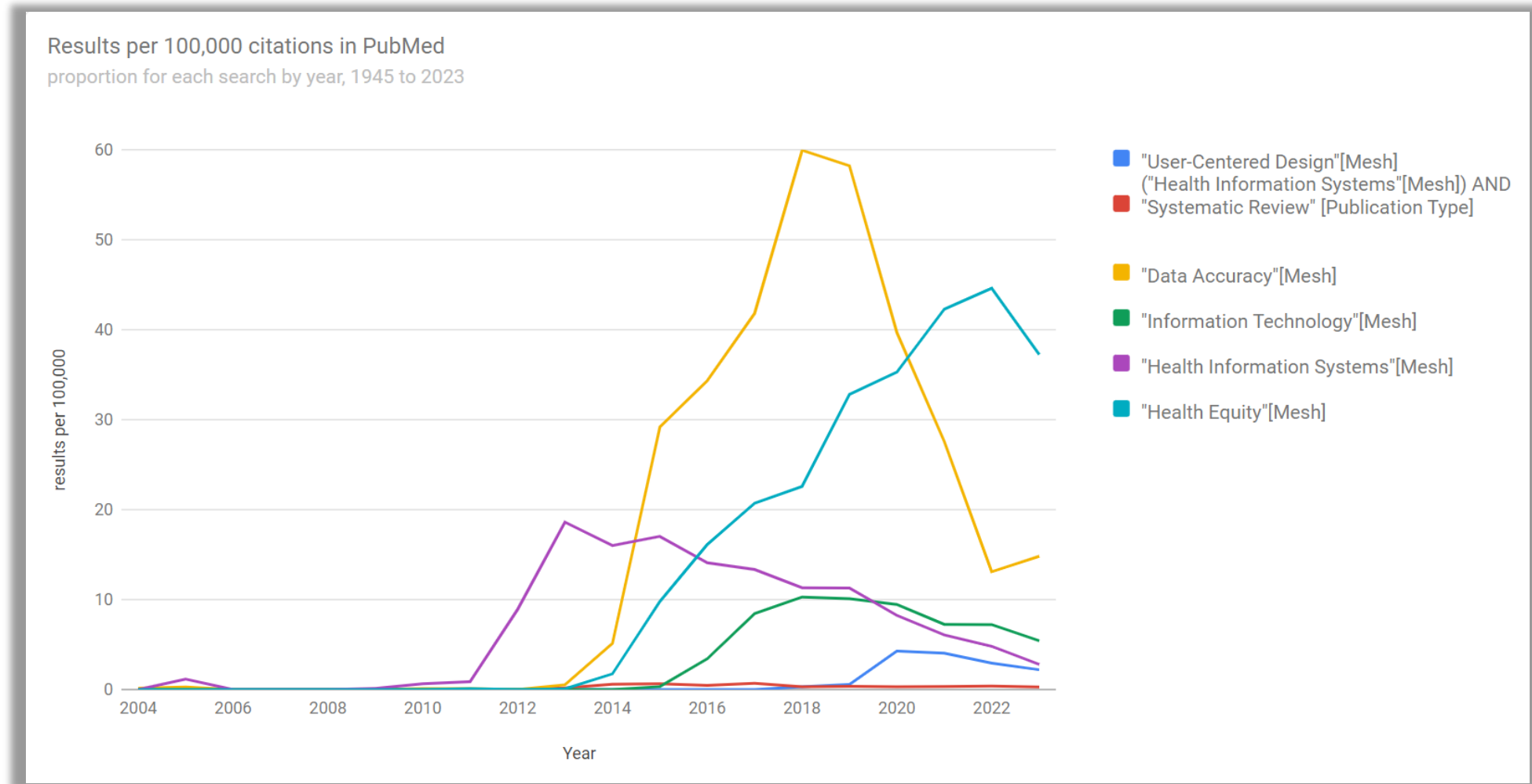
[...] RHIS have the potential to produce frequent – almost real-time – information on service **performance** and **quality** at all levels of the health system.

Global Strategy for Optimizing Routine Health Information Systems in Countries. Adapted from the Final Draft Terms of Reference 23 October 2020 of the Routine Health Information Systems (RHIS) Working Group of the Health Data Collaborative (HDC).

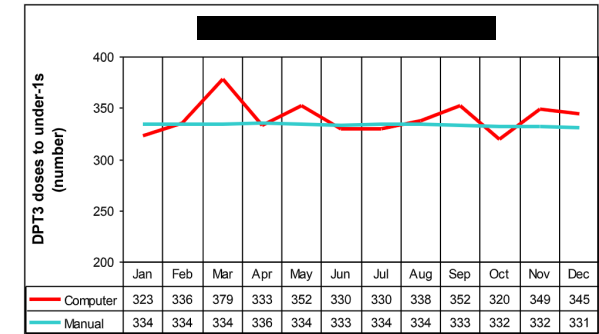
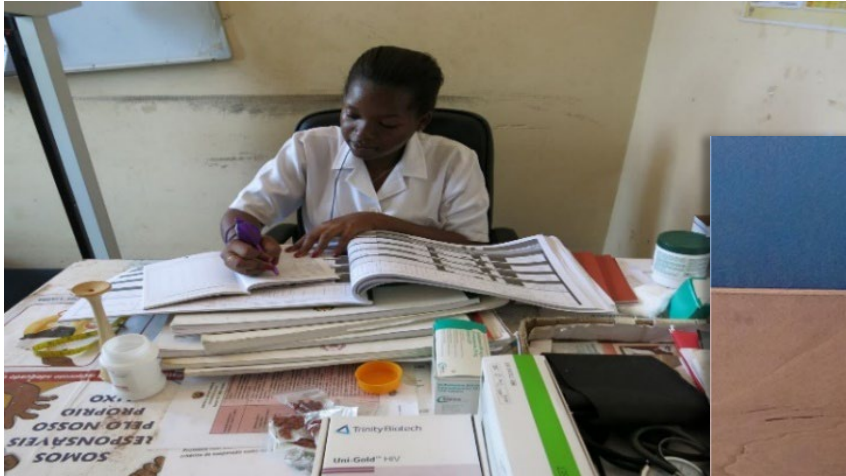


Health Metrics Network & World Health Organization. (2008). Framework and standards for country health information systems, 2nd ed. World Health Organization. <https://apps.who.int/iris/handle/10665/43872>

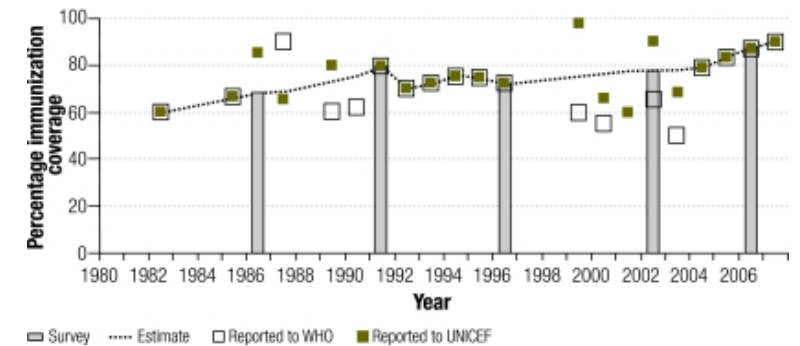
Historical perspective



Reality perspective



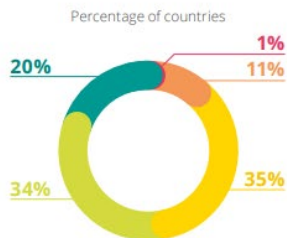
Xavier Bosch-Capblanch – personal communication



Burton A, Monasch R, Lautenbach B, Gacic-Dobo M, Neill M, Karimov R, Wolfson L, Jones G, Birmingham M. WHO and UNICEF estimates of national infant immunization coverage: methods and processes. Bull World Health Organ. 2009 Jul;87(7):535-41. doi: 10.2471/blt.08.053819. PMID: 19649368; PMCID: PMC2704038.



SURVEY
populations and health risks

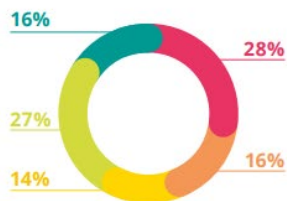


	Number of countries	Percentage of world population
Sustainable	26	51%
Well-developed	45	24%
Moderate	47	11%
Limited	14	1%
Nascent	1	0%

68%
of countries have good capacity for public health threat surveillance

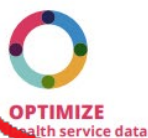


COUNT
births, deaths and causes of death

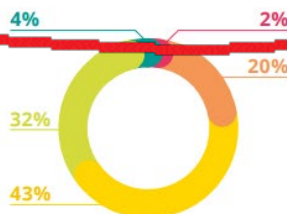


	Number of countries	Percentage of world population
Sustainable	21	7%
Well-developed	36	32%
Moderate	18	22%
Limited	21	12%
Nascent	37	14%

40%
of the world's deaths remain unregistered



OPTIMIZE
health service data

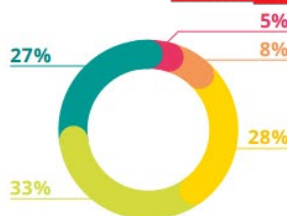


	Number of countries	Percentage of world population
Sustainable	5	3%
Well-developed	42	62%
Moderate	57	17%
Limited	26	4%
Nascent	3	1%

50%
of countries have limited or less capacity for systematic monitoring quality of care



REVIEW
progress and performance

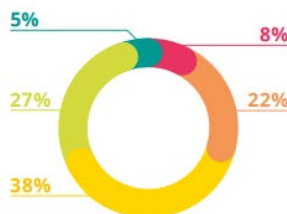


	Number of countries	percentage of world population
Sustainable	36	55%
Well-developed	44	21%
Moderate	37	10%
Limited	10	1%
Nascent	6	0%

60%
of countries have good capacity to review progress and performance of the health sector



ENABLE
data use for policy and action



	Number of countries	Percentage of world population
Sustainable	7	6%
Well-developed	36	55%
Moderate	51	21%
Limited	29	4%
Nascent	10	1%

59%
of countries have good capacity to use data to drive policy and planning



Objectives of this assignment

In the RFP	In our response to it
1.To identify effective and ineffective models of investing in country RHIS (country case studies)	1.To explore RHIS definitions and frameworks
2.To identify and recommend possible frameworks, methods and costing tools to support integrated RHIS investments.	2.To describe how return of investments are portrayed in the literature
3.To estimate the return on	3.To estimates costs and returns





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2 Methodological considerations



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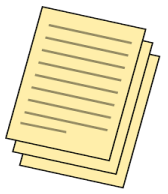
1 Definitions and frameworks

For objective 1

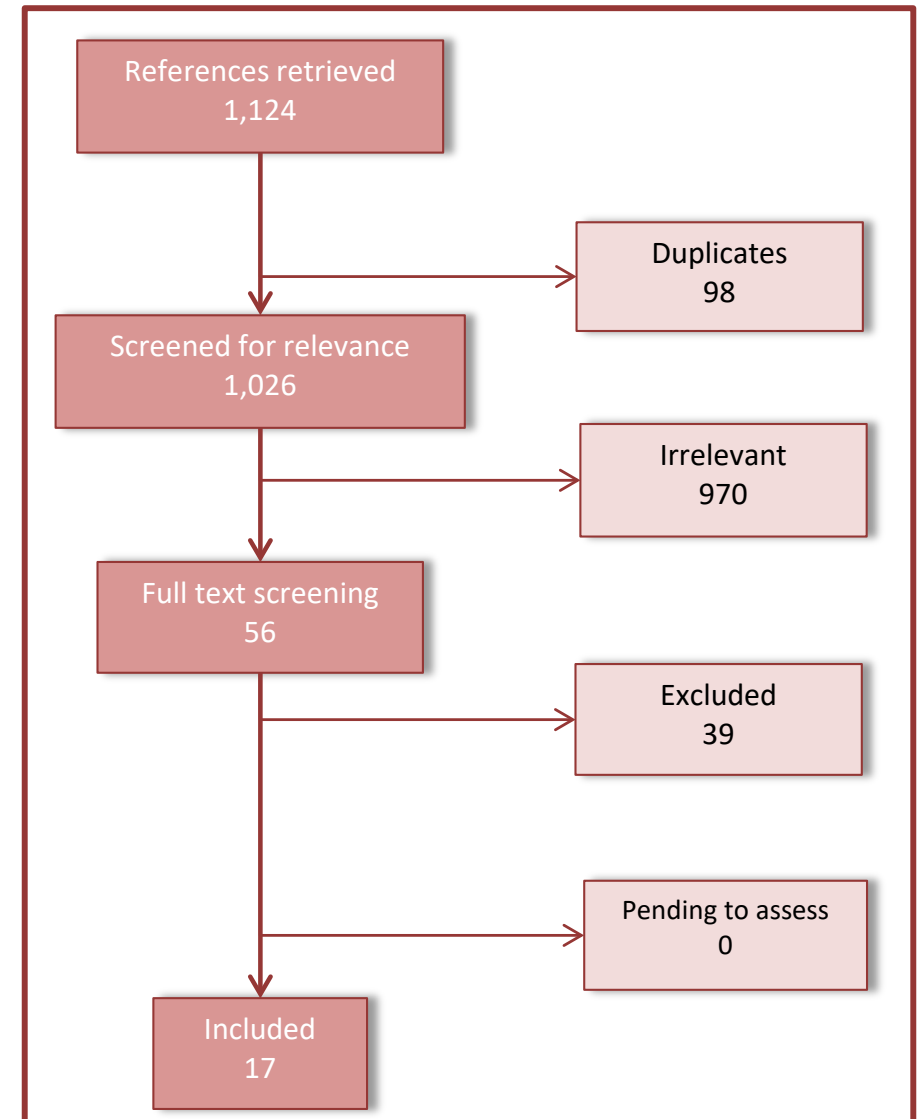
Objective 1 – Definitions and frameworks

- Focus
 - on processes
 - data issues
 - Much less on outcomes
- Links to health services and health systems anecdotal
- No obvious “conceptual changes” over the years, despite technological progress.

Objective 1 - Scoping review on examples of returns of investments



- Selection criteria
 - studies showing investments and returns
 - with health systems components / interventions
 - excluding merely clinical interventions or tools
 - from 2007
- Single selection and data extraction
- No assessment of risk of bias
- 17 included | 39 excluded





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2 Country case studies

For objective 2

Objective 2 (1/3) - Country case studies

- Protocol based
- Selection of countries criteria
- WHO contacts with country offices
- Swiss TPH teams
- Data collection tools in XLSForm
- Levels of uncertainty data / documents / expert opinion
- Clearance



6 National

2 Sub-national:

Cross River state (Nigeria)

Western Cape (South Africa)

Objective 2 (2/3) - Country case studies

- Systems design
- 'Magnitude' of the RHIS across health systems tiers and health facilities
- Costing and level of effort
- Funding and external support map
- Hypothesis generation through data exploration (e.g. correlation)
- Measures of health outcomes and quality of care – attribution scenarios

Objective 2 (3/3) – Economic analyses

- Amenable deaths: prevented through public health interventions policies + appropriate services
- Healthcare Access and Quality Index (Global Burden of Disease)
 - comparative assessment of health system performance across countries
 - indicator for potential health care improvements that can be achieved globally (UHC, quality of care)
- Value of lost output: indication of GDP losses over time; value of lost welfare, reflecting losses.
 - calculated using the WHO Projecting the Economic Cost of Ill-health (EPIC)
- Per capita investments in HIS across 6 countries
- Relationship between investments in HAQ

Clarifications: the scope of our work

✓ We did...	× We did not...
✓ Draw on existing evidence and expert opinion	× Carry out primary research
✓ Focus on RHIS	× Address the whole spectrum of HIS
✓ Describe the status and costs of RHIS components	× Assess what works against standards
✓ Valued to potential contribution of RHIS to health outcomes	× Estimate a monetary return of investment



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3 Synthesis of findings

RHIS are “special”

No other information system...

- encompasses the whole health system, from Tertiary University Hospitals up to community health workers – **65 million health workers**
- is permanently active, in each and every encounter with service users – **the whole population**
- has a universal distribution in all countries and territories, even in humanitarian crises – **almost 200 countries**
- data collection point = data use point – **is a process of care**
- carries personal information – **data security**

RHIS in countries – selected features

- High level regulations attain data security and technology (i.e. data protection laws) | specificities of HIS and RHIS are in lower level documents
- Adherence to international standards (Colombia)
- The most relevant historical hallmarks in RHIS include:
 - “Observatories” (National Health Observatories, Colombia 2011)
 - Digitalisation (Nepal, 2013)
- Organised across the health systems tiers with reporting schedules (all countries)
- Specialised data-managers only in higher managerial levels or in secondary and tertiary care
- Data related events tend to happen at higher tiers of the system
- Systems are supported by external partners (Côte d’Ivoire, Nigeria, Nepal)
- Data dictionaries and standards available (Côte d’Ivoire, Colombia, South Africa)
- Initiatives running, interoperability, digitalisation... (Côte d’Ivoire, Nepal, South Africa)

RHIS in countries – generic issues

- Lack of integration with hospitals information (Côte d'Ivoire)
- Lack of integration of multiple systems / duplicity (Colombia)
- Lack of integration of HIV programme data (Nigeria)
- Lack of integration with the private sector (Colombia, Nigeria)
- Undifferentiation between health care and data activities (all countries)
- Unequal compliance with data requirements, particularly by community health workers (Nepal)
- Multiplicity of sub-systems

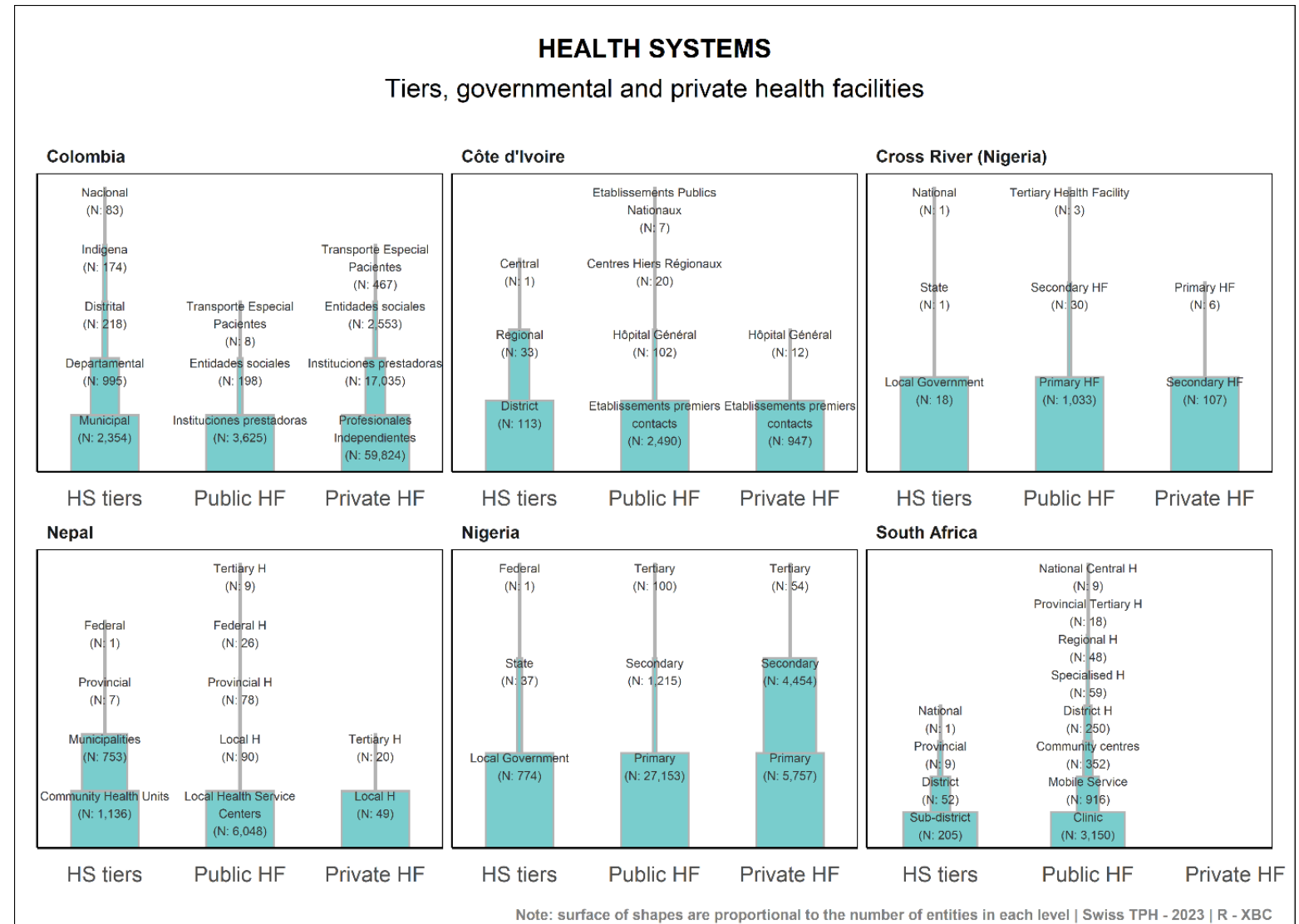
DHS2, ESIGL, OPEN Elis, SIGDEP, MSupply, MAGPI, DATIM (DHS2), COMCARE, SiHO, REPS, SIPE, ReTHUS, MIPRES, MiVAcuna, Massive Survival Consultation, RUAFND, ICD 11, ICF, ICHI, eLMIS, eTB register, SORMAS

RHIS in countries – Covid-19 related issues

- New databases, new procedures and new management (Côte d'Ivoire)
- New digital tools specific to Covid-19; however other health care events ceased to be reported timely
- Establishment of the Information Management Unit, outsourced to local companies, specific for Covid-19 (Nepal)
- Covid-19 stopped the uptake of the NHMIS 2019 changes; weak reporting through regular mechanisms (Nigeria)
- Multiple adaptations reported, including organisation of health care (South Africa)

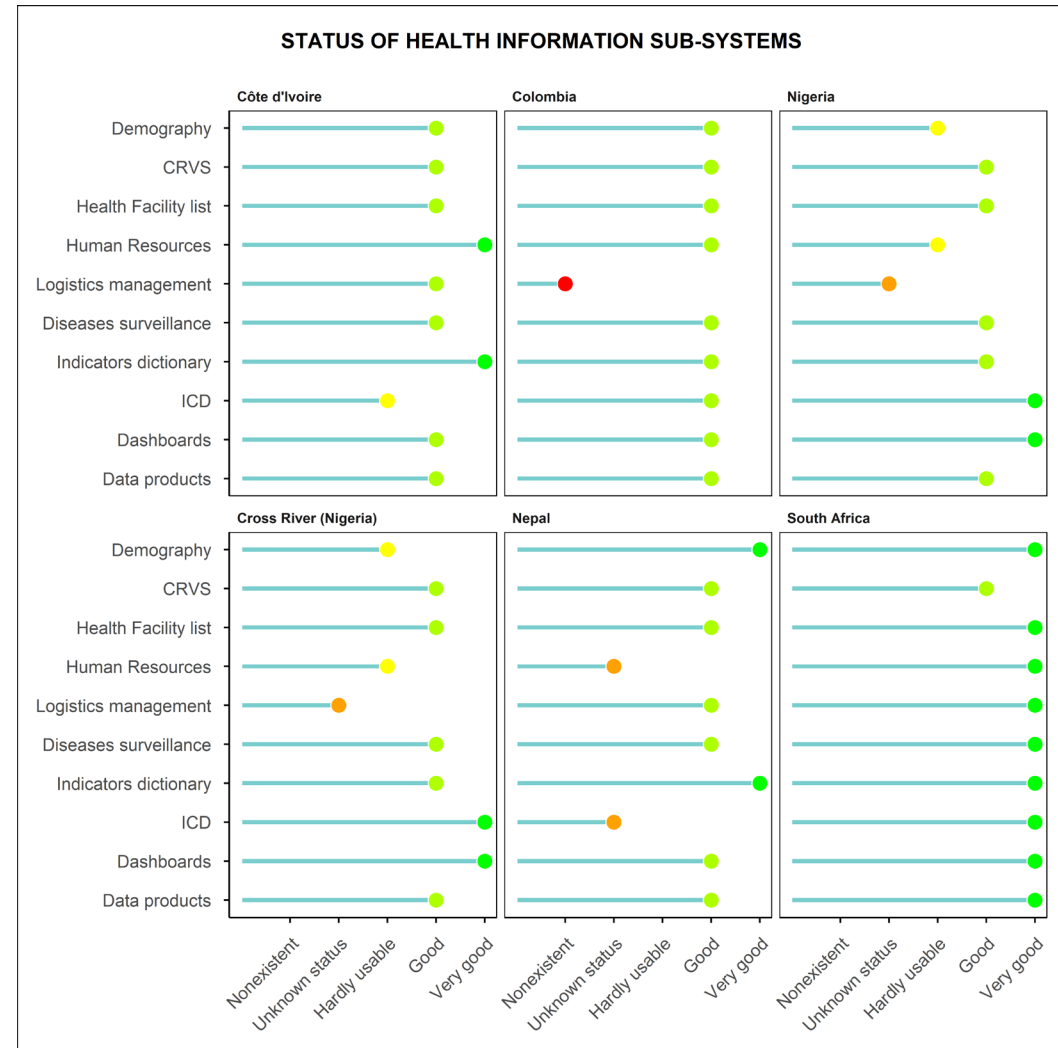
Data for measuring AND for acting

- RHIS are organised following the health system tiers
- There is a large number of management units and health
- These makes RHIS complex, large and linked to health care

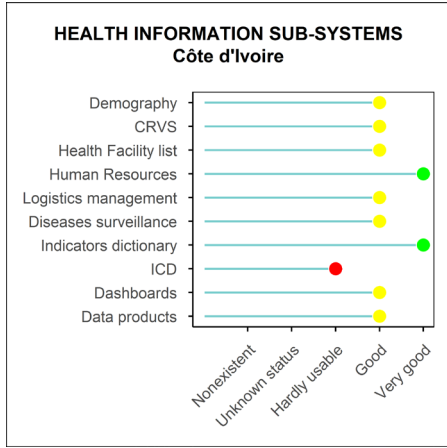
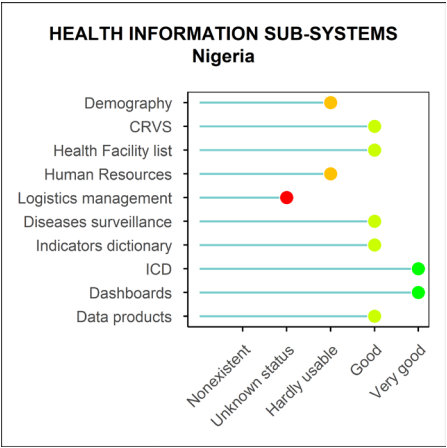
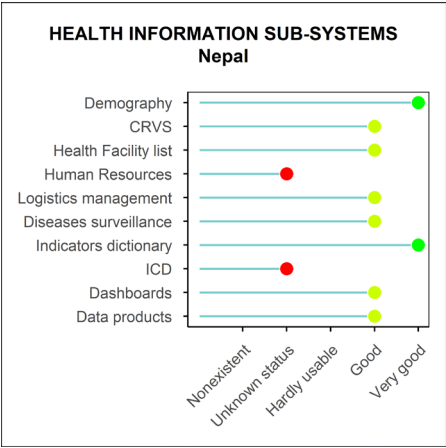
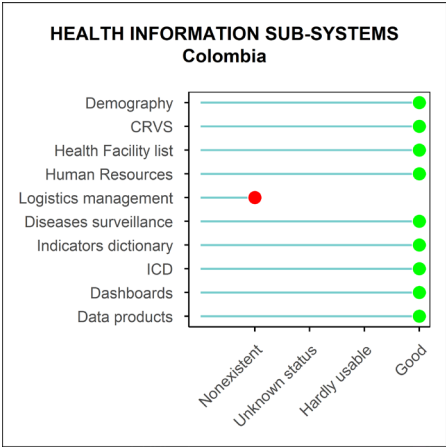
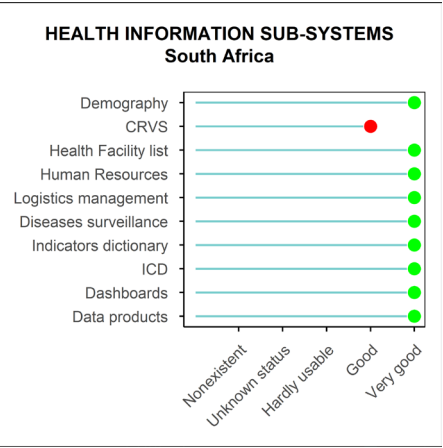
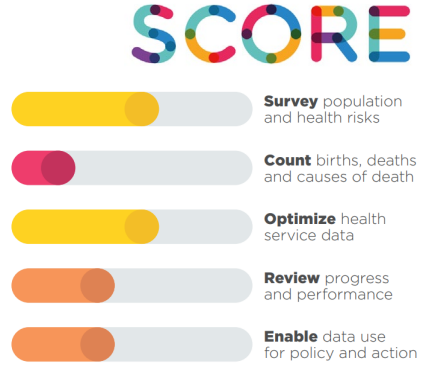
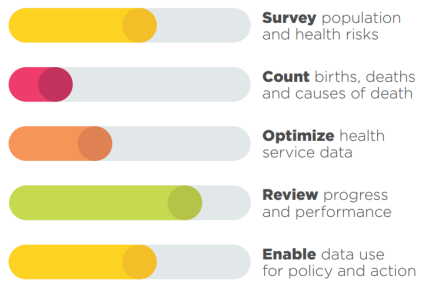
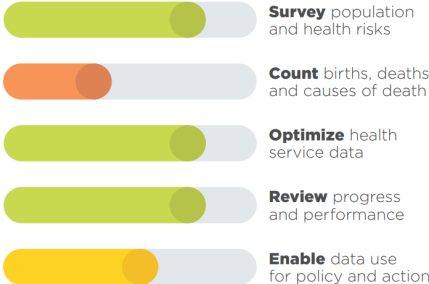
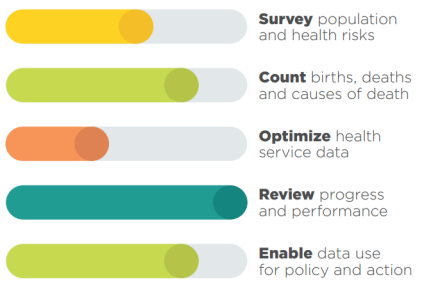
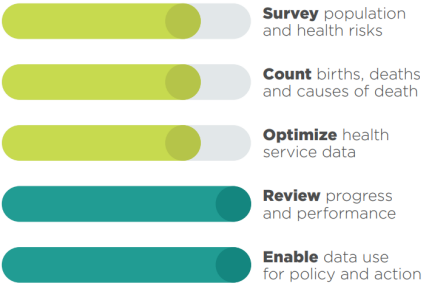


Availability and status of RHIS components

- All items at least existed in all countries, except the LMIS in Colombia.
- The LMIS was the least developed, being inexistant in Colombia and of unknown status in Nigeria and in Cross River state.



HIS status across the six countries



Funding of RHIS

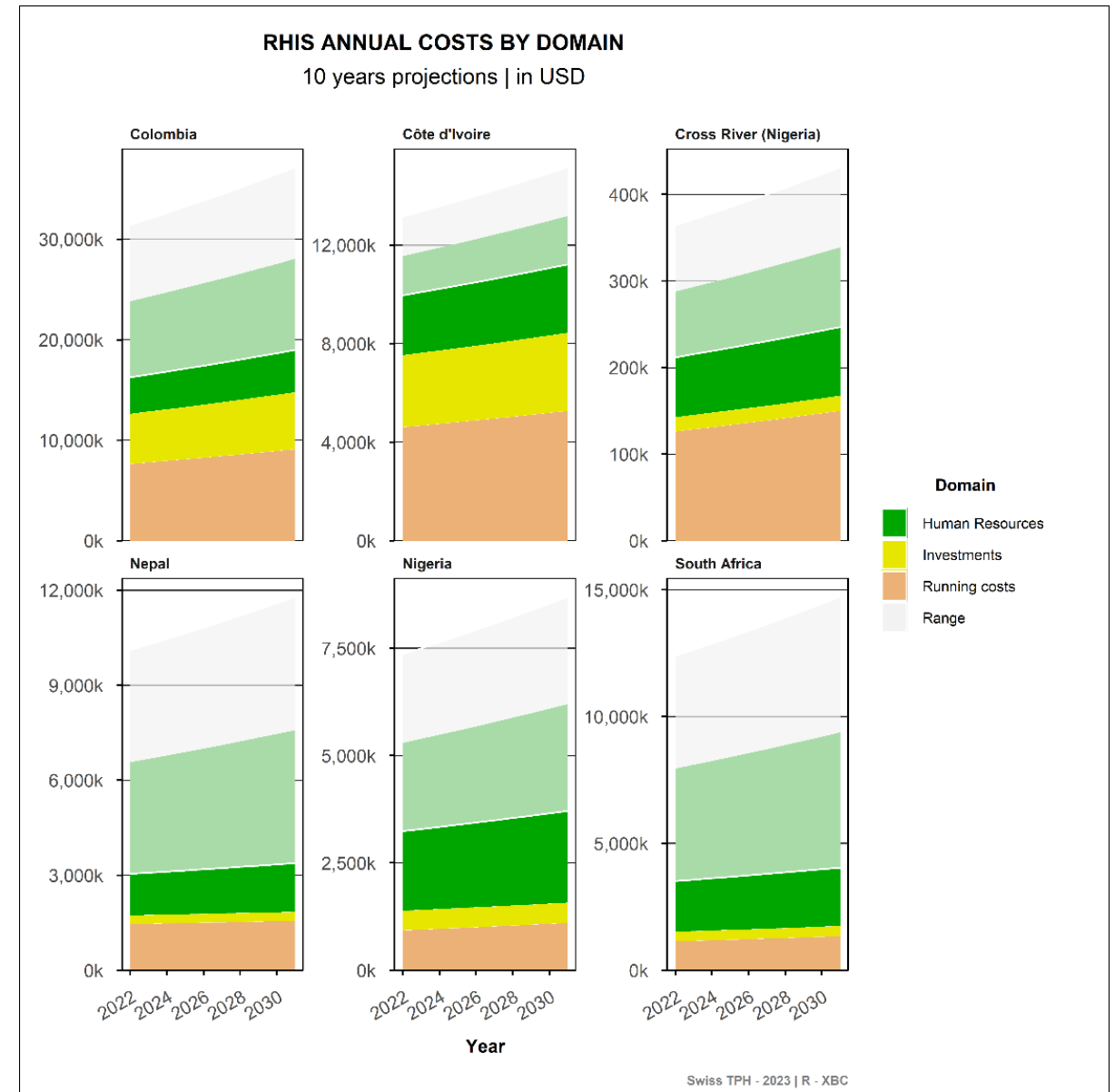
- Governmental budget for RHIS (USD, % of health expenditure)
 - Colombia: 35 million (0.2%)
 - Nigeria: 2.2 million (0.1%)
 - South Africa: 0.8 million (0.004%)
- External support as proportion of RHIS
 - Nigeria: 30%
 - Nepal: 20%
 - Items: infrastructure, software, direct financial support, equipment, training

Annual costs of RHIS (x 1,000 USD)

	Minimum	Mid-point	Maximum
Côte d'Ivoire	9,960	11,560	13,160
Colombia	16,270	23,840	31,420
Cross River (Nigeria)	210	290	360
Nepal	3,040	6,570	10,110
Nigeria	3,240	5,300	7,360
South Africa	3,520	7,950	12,390

Annual costs of RHIS by domain (x 1,000 USD)

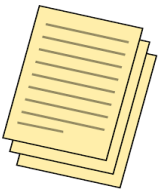
- Costs are dependant on the estimated proportion of workload dedicated to data
- Human resources (green) get the greatest share of costs (Nepal, Nigeria and South Africa)
- Most of human resources costs are incurred at peripheral level
- Median cost per capita: 0.5 USD



Time spent in data issues by health workers

- Annual person-time (hours) spent on data in the whole country:
 - Colombia: 26 million
 - Côte d'Ivoire: 8 million
 - Nepal: 11 million
 - Nigeria: 43 million
 - South Africa: 5 million (?)

Economic analysis (1/3)



- Economic studies in the literature tend to be framed in the context of clinical care;
- No standard methodology
 - Comparability
 - “Health systems significance”
- Interpretation
 - health systems specific settings
 - items included in the calculations
 - analytical approach
 - time trends of the estimates
- Challenges: scope, assumptions, hypothesis | data requirements | approaches | interpretation

Economic analysis (2/3)

Value of Lost Welfare (VLW) due to Amenable Mortality in 2015 (millions, 2015 IND) using baseline Value of statistical Life (VSL) assumptions; VLW expressed as equivalent proportion of 2015 GDP and Value of lost welfare in 2022 USD

Country	Value of Lost Welfare 2015 (USD in millions)	% of GDP	Value of lost Welfare 2022 USD (millions)	Cost of RHIS (2022)	% RHIS vs foregone welfare
Colombia	35,419 (28,578 to 45,426)	5.4% (4.4% to 6.9%)	28,024,414	24,276,886	0.0001%
Côte d'Ivoire	17,249 (9,730 to 29,942)	22.2% (12.5% to 38.6%)	8,235	11,726,870	0.1424%
Nepal	8,755 (4,919 to 14,463)	12.3% (6.9% to 20.3%)	3,001	6,678,443	0.2226%
Nigeria	182,022 (111,440 to 318,036)	17.0% (10.4% to 29.8%)	1,589,108	53,914,580	0.0003%
South Africa	125,031 (103,540 to 148,511)	17.6% (14.6% to 20.9%)	62,714	8,100,216	0.0129%

Economic analysis (3/3)

Expenditure per capita on HIS and HAQ index score

Country	Expenditure per capita (2022)	2019 HAQ index score Overall
Colombia	0.47	61.1
Cote Divoire	0.42	34.3
Nepal	0.22	38.8
South Africa	0.14	44.6
Nigeria	0.02	31.6

- There did not appear to be any relationship between higher per capita investments in RHIS and improved HAQ scores.
- Some relationships between expenditure per capita in HIS and HAQ.



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4 Conclusions

RHIS...

- RHIS are core to the achievement of SDG, UHC and quality of care outcomes
- RHIS are likely the largest and more complex HIS:
 - Encompasses the whole system
 - It is inextricable from the process of care
 - It is largely driven by the periphery of the system
 - Relies on health care providers
- ...however
 - Provide data to only 5% of health-related SDG indicators
 - Are marginally funded
 - Rely on the time shared by health workers

RHIS...

- The problems of RHIS have been widely described in the published and grey literature for decades
- Problems encompass every aspects of RHIS, including governance, organisation, infrastructures, communication, equipment, human resources and finances
- Attempts to improve RHIS:
 - Have not been impressively effective
 - Seem to be based in old paradigms, where different decision-spaces are not contemplated
 - Are rooted on the idea that good system as conceived by experts is a good system in real life situations
 - Is based on unreasonable demands to health workers
 - Are based on scanty, weak and inconclusive evidence

Economic analyses issues

- Comparisons to consider
 - Different cadres of staff
 - Costs
 - Performance
 - Time use of care
 - Digital versus paper-based; and types of digital
 - Disease areas
 - Number of indicators
 - Other
- Outcomes
 - Health status
 - Coverage
 - Processes of care / quality of care
 - Health systems components performance
 - Data use
 - Quality of data
 - Health seeking behaviour



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5 THE FUTURE

1 Paradigm change

× Old	✓ New
× Data – dashboards - planning	✓ SDG / UHC / Quality of care
× ‘Technocratic’ frameworks developed before the digital ‘explosion’,	✓ Innovation consistent with new knowledge
× Use of data without detail	✓ Specific decision-spaces
× Making health workers responsible	✓ Improving the system
× Observational research	✓ Experimental and mix-methods research
× De-implementation	✓ Evidence informed initiatives / no harm

What next?

- Multilaterals
 - Promote RHIS as a “health technology” (HTA)
 - Safeguard the link between RHIS and provision of care / UHC
 - Support high quality research
 - Convene partners to adhere to ethical principles of RHIS
- Governments
 - Demand a regulatory framework for RHIS (e.g. HTA)
 - Budget RHIS specifically, factoring contributions
 - Establish funding scenarios
- Technical partners
 - Stop unduly influencing RHIS
 - Use experts with up to date knowledge and expertise on key methods (e.g. HCD)
 - Adhere to ethical principles of data governance and also health care
- Funders
 - Stop unduly influencing RHIS
 - Acknowledge the radical importance of RHIS to achieve SDG / UHC
 - Factor the RHIS within competing funding needs
 - Fund high quality research

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