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The Ministry of External Affairs, Government of India, presents its compliments to the Secretariat of South Asian Association for Regional Cooperation, Kathmandu and with reference to the **Third Meeting of the Heads of SAARC Statistical Organisations (SAARCSTAT)** held at **Bhutan** on **18-19 November 2010** has the honour to send herewith the draft Framework on the Manual on Health Statistics.

2. Member States are requested to send their comments/observations on the draft framework at the earliest.

3. The Ministry of External Affairs, Government of India, avails itself of this opportunity to renew to the Secretariat of South Asian Association for Regional Cooperation the assurances of its highest consideration.

Secretariat of South Asian Association for Regional Cooperation
Kathmandu

SAARC Secretariat
Kathmandu
FAX/E-MAIL IN
Msg ID: 1017/4/66
ate: 22/4/11 Time: 0930

FRAMEWORK DOCUMENT

MANUAL ON HEALTH STATISTICS FOR SAARC COUNTRIES

Background: Health Statistics/Information is crucial for decision-making at all levels of health care. It facilitates better decisions in policy design, health planning, management, monitoring and evaluation of programme and services including patient care etc. and facilitates improvements in overall health services performance and outcome. Health management information incorporates all the data needed by policy makers, clinicians and health service users to improve and protect population health. Few countries in the world today have effective and comprehensive systems in place to gather this data.

There has never been a greater need for robust health information. As the world community has turned its attention to meeting Millennium Development Goal targets, and ever increasing resources are going towards preventing and treating high burden diseases such as HIV and AIDS, tuberculosis and malaria, decision-makers need to be able to measure whether policies and programs are working, and whether progress is being made towards the goals that have been set. Donors are also placing more emphasis on performance, linking the release of funds to performance based measures.

The World Health Organization (WHO) duly emphasized that investment in health management information systems (HMIS) now could reap multiple benefits, including:

- Helping decision makers to detect and control emerging and endemic health problems, monitor progress towards health goals, and promote equity;
- Empowering individuals and communities with timely and understandable health-related information, and drive improvements in quality of services;
- Strengthening the evidence base for effective health policies, permitting evaluation of scale-up efforts, and enabling innovation through research;
- Improving governance, mobilizing new resources, and ensuring accountability in the way they are used.

There are four critical components for the success of any HMIS. The first component relates to availability of the HMIS on the basis of a standard framework of statistical terms, concepts and measures with well defined metadata for all data elements/indicators, methods and processes. Without this quality, coverage, etc cannot be improved. The second is the sensitization and capacity building right up to the grass roots level, the level at which the data gets generated and transmitted. The third is ensuring the coverage, quality, relevance and reliability of the data so that the information available through HMIS is effectively used for health management. The fourth is the analysis, timely dissemination and feedback on the

information available through the system. Efforts on all these fronts are to be made to improve the quality of data to sustain the HMIS and its effective utilization by health policy planners and implementers and can be a source for official health statistics in the near future.

In the context of developing countries, the Goal is to improve the availability of and access to quality health care for all, especially for those residing in rural areas, the poor, women, children, the excluded and the marginalised. While there are a number of strategic instruments including various intervention programmes, policies and plans to accomplish this broad goal, improvements to these measures cannot be achieved without continuous assessment of the outcomes, which can be statistically measured with the help of credible data.

The HMIS thus play a key role in achieving these objectives. The main implications of these considerations for the design of the HMIS include:

- Creation of integrated data warehouse – which can serve as one point of data entry and report generation.
- Provide various tools for data quality checking and data validation/triangulation. System capable of entering all data in required formats and the generation of all reports.
- Contain a dashboard that is capable of monitoring targets and tracking progress and outputs.
- Provide analytical tools for evaluation.
- Contain infrastructure data so as to be able to compare existing facilities with IPHS norms and identify gaps.
- Be integrated with GIS so that all the above information can be tracked spatially.

Keeping above in view SAARSTAT intends to bring out a Manual on Health Statistics for SAARC countries to operationalize a uniform framework for the health statistics to be elicited for wider dissemination and overall utility towards meeting the objectives stated so far.

The manual will serve the purpose of a Comprehensive and step-by-step reference book for both beginners and practitioners and other stakeholders working within and outside the Health System. Though the manual will be primarily used by the practicing statisticians including the field functionaries working at the National/Regional/local levels, the manual will also meet the requirements of researchers, academicians, university students, Industry and Trade Associations, policy makers, planners in understanding the concepts, definitions, metadata, methodology, policies and programme, sources, etc. relating to compilation of Health Statistics and its usage in Monitoring and Evaluation through various Indicators and for formulation of various policies and programmes. This manual is also expected to facilitate data aggregation and data comparison both at inter-regional and intra-regional levels, besides international comparisons.

Given the high priority being assigned to the health programmes by SAARC Countries, such a manual would certainly enhance the abilities of government policy and programme formulation to introduce, implement and monitor health programmes.

HEALTH STATISTICS: Health Statistics is a branch of official statistics

- mainly meant to cater to the needs of statisticians, professional and institutional users of official statistics
- Apart from administrative data on Health related parameters, it also covers measures, estimates and counts derived from survey and census results
- Does not cover statistical practices or information in fields of medical/bio-medical/pharmaceutical/bio-technological/clinical fields, which fall under the purview of technical statistics

Keeping in view the above definition, the Manual on Health Statistics is envisaged:

- To be broadly determined by health systems for data monitoring and indicators on quality of care, as well as better policies to prevent disease, and improve health-system efficiency via care coordination and the implementation of information technologies.
- Encompass Systems to help countries to design pharmaceutical policies, and address future health workforce and long-term care needs
- Covering specific domains of nutrition and diabetis, public hygiene and hygienic conditions, drug use/abuse and de-addiction, disability, etc.

The broad suggestive framework for the manual on Health Statistics is as under:

1. **Chapter – 1: INTRODUCTION**

   a. Background
   b. Importance of health statistics
   c. Health Statistics and Millennium Development Goals
   d. Purpose, objective and scope of the manual
   e. Intended learning
   f. Organization of the manual

2. **Chapter -2: OVERVIEW OF POPULATION & HEALTH POLICIES AND PROGRAMMES IN SAARC COUNTRIES**
   a. Health Policy
      - National Policy instruments
      - Data requirements following policy guidelines and strategies
   b. Constitutional and Legal provisions
      - Constitutional provisions
      - Acts/Statutes and Laws under constitutional provisions
      - Statistical implication of the legal requirements – data needs, reference population, age-groups, background characteristics, etc.
      - Institutions of legal actions
   c. International Conventions and Treaties ratified by Government
      - Major objectives and framework of actions
      - Statistical implications
      - Compliance status
   d. Public Institutions and development programmes in the health Sector
      - Target groups
      - Plan fund distribution
      - Mode of execution/operation of the programme
      - Statistical products

3. **Chapter – 3: HEALTH STATISTICS**

   a. Concepts and definition covering Rates, Ratios, Prevalence and incidence rates, Life Tables, Kaplan-Meier etc.
   b. Basic measures of health and demography
   c. Methods of estimation of health and demographic measures. All common prevalent methods being used at National/International levels are to be used.

4. **Chapter – 4: SOURCES AND QUALITY OF HEALTH DATA**

   a. National Systems of Health Statistics
      i. Administrative Statistics
      ii. Distribution of statistical responsibilities in different parts of the country
      iii. Sources of data
      iv. Nodal Agency and its role
      v. Coordination mechanism

vi. Data recording and compilation processes – organisation of data – types of data in organized forms
vii. Health through Information System (HMIS)
viii. Limitations

b. Vital Registration System
   ix. Importance of vital registration system
   x. Current status
   xi. Sample registration system in India

c. Surveys and Census Statistics
   xii. Main periodic surveys/census exercises- periodicity- scope and coverage- agencies involved- nodal responsibility and coordination
   xiii. Methodology of operations- comparability over time and quality
   xiv. Types of measures and estimates generated

NOTE: As the basic approach, periodicity, coverage etc are quite different for these two types of sources, the section will have two sub-section, one on surveys and another on Census.

d. Harmonization of International classifications
   xv. International Classification of Diseases-10th Revision (ICD)
      - on diagnosis and health condition, but not on functional status
   xvi. International Classification of Functioning, Disability and Health (ICF)
      - ICF complements ICD-10, looking beyond mortality and disease
   xvii. WHO Family of International Classifications (WHO-FIC)
      - Combines ICD and ICF

e. Methods of assessing quality of health statistics

5. **<u>Chapter – 5</u>: INDICATORS FOR MEASURING HEALTH STATUS**

a. What is an indicator
b. Types and hierarchy of indicators (input, process, output, outcome, impact)
c. Indicators of
   a. Health status:
      - Disease burden and epidemiological indicators
      - Reproductive and child health indicators
   b. Health Care Resources and Burden

6. **<u>Chapter - 6</u>: HEALTH EXPENDITURE AND FINANCING**

a) Indicators
b) Types of Expenditure i) Domestic ii) Foreign
c) Sources of funding
d) Linkage with GDP
e) PPP

Note: *For each Indicator, the details pertaining to their Name (standard vis-à-vis variants), Definition, Formula, Rationale for use, Goal(s) to which relates, if any, Method of Estimation/Computation, Sources of Data, Methods of data collection and its limitations, Decomposition of data, and other Conceptual limitations; Associated Terms and Health Service Institutions in the country context need to be included to the extent possible.*

A list of minimum suggestive items for deciding Indicators to be included is enclosed.

7. **Chapter – 7: PROJECTIONS AND FORCASTING OF HEALTH INDICATORS**

   a. Need for projections
   b. Methods of projection of population and health indicators
   c. Limitations and sources of errors in projection

NOTE: This chapter to cover only basic and simple methods as the advanced methods for detailed projection are quite time consuming.

8. **Chapter– 8: HEALTH STATISTICS FOR MONITORING AND EVALUATION OF HEALTH PROGRAMMES**

   a. Basic concepts and definitions
   b. Logical frame-work approach
   c. Results based management
   d. Monitoring indicators of development programmes

9. **Chapter – 9: PROJECTS FUNDED BY DONOR AGENCIES**

   a) Types of Projects
   b) Objectives
   c) Funding Pattern
   d) Their advance to the area of statistics generation

Appendices

1. **Glossary of Terms**
2. **Acronym of Organizations**
3. **Important survey design elements**

List of Suggestive Theme/Items/Indicators:

1. **Health Status**
   1.1 Life expectancy
   1.2 Infant mortality
   1.3 Under-5 mortality
   1.4 Mortality from all causes
   1.5 Mortality from cardiovascular disease
   1.6 Mortality from cancer
   1.7 Mortality from injuries
   1.8 Maternal mortality
   1.9 HIV/AIDS
   1.10 Tuberculosis
   1.11 Malaria
   1.12 Diabetes
2. **Determinants of Health**
   2.1 Reproductive health
   2.2 Low birth weight
   2.3 Breastfeeding
   2.4 Nutrition
   2.5 Underweight and overweight
   2.6 Water and sanitation
   2.7 Tobacco
   2.8 Alcohol
3. **Health Care Resources and Utilisation**
   3.1 Doctors and nurses
   3.2 Drugs
   3.3 Diagnostic Centers
   3.4 Hospital beds
   3.5 Blood Banks
   3.6 IPD: Inpatients Load
   3.7 OPD: Outpatients Load
   3.8 MCH:
      3.8.1 Antenatal care,
      3.8.2 Delivery Care,
      3.8.3 Postnatal Care
      3.8.4 Children's Immunization
4. **Health Expenditure and Financing**
   4.1 Health expenditure per capita
   4.2 Health expenditure in relation to GDP
   4.3 Financing of health care

4.4 Health expenditure by function
4.5 Health expenditure by provider