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Meeting Report: Centre on Global Health Security

Health Information in Conflict Situations: Collection and Dissemination Challenges

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INTRODUCTION

This paper is a summary of a meeting that took place at Chatham House on December 13 2010 on Health Information in Conflict Situations: Collection and Dissemination Challenges. The Centre on Global Health Security and the International Security Programme at Chatham House, Medact and the Peace & Security Liaison Group jointly organized the meeting.

The meeting was held in roundtable format; following two expert speakers, working groups provided a platform for debate among the wide range of participants with academic and technical expertise and/or practical experience of these issues.

The meeting was held under the Chatham House rule and the views expressed are those of the participants. This meeting summary aims to contribute to the momentum of the debates held that day and spur further research and interest.

The Chatham House Rule

'When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.'

Key Findings

- Technical challenges in relation to data collection in conflict situations still exist, particularly in relation to protracted crises, morbidity, and aggregation of data. Overall, the quality of surveys although improving, still needs attention. New technologies, such as the use of satellites and mobile phones to assess denominators, have potential.
- There should be more focus on prospective surveillance linked to preparation and outbreak response; there has been too much attention on retrospective surveys. It was stressed that any system monitoring the quality of data collection should not constrain the necessary response to more informal sources of information.
- In the balance it was agreed that issues of access, interpretation, monitoring and accountability present greater challenges than technical

issues do. More work is needed to agree minimum standards in these areas, and how they could be monitored.

- It would be difficult to find one actor to take overall responsibility for monitoring and accountability in relation to data and health information in all situations; flexibility is needed depending on the specific context.
- There is a need for those involved in data collection to be aware of the policy and political context they are working in, while at the same time resisting political and other influences.
- More training needs to take place at the field level and be integrated into existing structures and programs, including health systems strengthening.

BACKGROUND

Conflict can cause ill health and premature death, both directly through injury and indirectly through the breakdown of infrastructure and systems of government leading to failures in public health management and disease control, and difficulties of access to services due to insecurity. An accurate picture of what is needed is key for an effective response to the devastating consequences of conflict. However, quality data and information is often difficult to obtain, and as public health deteriorates the pressure increases for immediate and decisive action. Severe disruption of the usual data collection mechanisms often compounds the problem.

There is a large and informative body of work on different methodologies for collecting information in insecure situations. In acute conflict, rapid assessment techniques, surveys and surveillance are commonly used; while the national health information system may still provide a geographical breadth of data even when it is disrupted. When conflict is less intense tools range from community assessments to random cluster sample surveys.

However, significant challenges still exist, particularly around standardization and coordination, affecting the quality of data and the possibility of aggregation. Without data of known quality, the consequences of a particular conflict can be ignored and responses are likely to be less efficient and harder to evaluate.

Health information can play a part in assessing how a conflict has been conducted, and has the potential to feed into future conflict resolution and development assistance. It can also provide evidence for trials in the case of major infringements of international humanitarian law or human rights.

Health information that emerges from different conflict situations receives significantly varying degrees of quality assurance, analysis, dissemination, examination and follow-up. Media drivers and strategic political, corporate and individual interests are major influences on what does and does not receive attention, and can also influence how data are interpreted and represented. These pressures may also influence the accuracy of health needs assessments and the appropriateness and effectiveness of responses.

SUMMARY OF TALKS AND DISCUSSION

Present situation

Assessing the severity of a situation and of future risks is particularly important for responding according to need and hence maintaining impartiality. Prevalence data on acute malnutrition is the most widely used indicator to gauge the severity of a situation. The highest rates have generally been associated with complex settings, forced displacement and insecurity. There has been an overall reduction in extreme rates (over 50%); this could be partly because responses have become more effective, but could also be as a result of a relative lack of data.

Prevalence can vary on a seasonal basis. However, in many protracted crises the prevalence of acute malnutrition appears to remain at unacceptably high levels for years. There are also many emergency contexts in which malnutrition does not reach an emergency level. There is an increasing emphasis on context-specific trends showing relative change rather than absolute prevalence.

Malnutrition and mortality, in a wide range of contexts, do not always move in tandem, possibly because of the size and design of surveys; this is counter-intuitive and difficult for decision makers. Morbidity is as important, if not more important, than mortality; possibly too little attention is given to morbidity that may have the greatest impact on population health.

Much work has been done to develop standardized methods for causal analysis; this is important in deciding the appropriate actor to respond.

There are still methodological issues that need to be addressed, such as the validity of questionnaires and the strength of some sampling designs. In order to get studies that are comparable both over time and between studies some taxonomy issues need attention.

Work continues on epidemic surveillance and optimizing early warning alert and response networks for unusual events such as outbreaks. In some respects these may be more in the interests of the developed world rather than enhancing the health of lower- and middle-income states where epidemics may arise. This involves the collection of data from large networks of health facilities on a number of conditions thought to be of epidemic potential, with some disaggregation by age and sex. There are also instances

when such systems have been unnecessarily heavy and not always focused on the actual goals, which can give limited results despite a lot of effort.

A recent review of outbreaks and fragile states confirmed that in practice, trends are often detected by a formal alert from a surveillance system, or an informal alert such as a rumor. There should be more focus on detecting signals and implementing outbreak preparedness, investigation and response. With the spread of the Internet and mobile phones, opportunities exist for developing new approaches, for example monitoring the volume of Internet searches on specific diseases or symptoms.

Overall the quality of surveys, and their standardization, has improved. However there is still a need for more standardized data, a longer historical perspective, and for larger surveys that differentiate more in terms of cause and age.

Existing resources

There are guidelines, handbooks and initiatives aimed at supporting humanitarian information systems and improving practice and accountability; some are actual information systems. At a global and regional level, there are more than fifty electronic databases, initiatives and systems for data collection, forecasting and early warning assessments. Key to mention is The Health and Nutrition Tracking Service (HNTS), which is in its pilot phase and linked to the UN cluster system. A number of UN clusters have implications for malnutrition and mortality. Nutrition is officially lodged with UNICEF, although the World Food Programme (WFP) is a key organization for nutrition and has the biggest impact on it.

Technical challenges – severity & duration

Different benchmarks exist for determining the severity of a crisis, directly influencing the response and the agency responsible for it. WHO's widely used threshold for emergencies is 15% acute malnutrition; however, rates may often be much higher than this. As a consequence, it is difficult to distinguish between situations of over 15% malnutrition, and responses cannot be adapted to the needs of situations where adult malnutrition levels reach 30-40%.

The duration of an elevated prevalence of wasting or mortality is often neglected; it could indicate that an emergency is chronic and needs a different

response. Levels may also be seasonal. However, the situation may be reported as stable, even if the prevalence is over 15%, because there has been no change. There is a lack of tools and approaches to address these protracted crises.

In 2004 WFP, UNICEF and the Sudanese Ministry of Health planned region-wide surveys to provide aggregate statistics for the entire Darfur region, and undertook three in the period 2005 – 2007. These showed that North Darfur consistently had a higher prevalence of acute malnutrition, and overall that the situation was getting worse, a situation that would not have been revealed by surveys more limited in area and time.

Technical challenges – population size

Data on the estimated size of affected populations tends to be poor and is a neglected area. Poor information on a population's size will hinder an effective response. A couple of months after the 2010 earthquake in Haiti, although displacement camps were accessible and established, there was still no accurate estimation of the size of the affected population. One of the ways this could be improved is through the use of high-resolution satellite imagery, and this is already used to count shelters. At a lower resolution and larger regional scale this could also be used to scan for fresh displacement and population movement in places such as DRC where access is difficult.

Political challenges – access

Results from surveys in Darfur in early 2010 showed overall prevalence rates of acute malnutrition of between 15% and 30%, and the results of some surveys were blocked after the expulsion of the NGOs in early 2009. The explusion is an issue that was only raised publicly by UNICEF recently. The results of most of the available surveys are above the emergency threshold. The ability of governments (and indeed any organization) to hide health-related data that is embarrassing needs addressing.

In Sri Lanka in 2010, approximately 300,000 civilians were interned in camps, yet no data on mortality, nutrition, or epidemic diseases was available from such a devastating emergency. There is a need to learn how to better engage with governments and combatants to ensure that the operational space to collect data exists. This may require some compromise on the publication of

the data beyond UN or similar authorities who have a role in responding to emergencies.

Institutional challenges – coordination

Overlapping roles and sectoral responsibilities in the collection, collation and dissemination of health information represent a considerable institutional challenge. There are also complex institutional frameworks, and a multiplicity of modalities for international response: humanitarian, early recovery, development, peacekeeping, peace building, high-level peace processes and international judicial processes. All present challenges for coordination and joined up data collection and advocacy policies. In Darfur, the language of the International Criminal Court, for example, is often humanitarian in tone, which can be problematic for other actors.

Political challenges – security

Political challenges have implications for security. For example, since the expulsion of the agencies from Darfur in 2009, there has been a shift from requisition of humanitarian goods to targeting humanitarian staff, with international staff being pulled back as a result. Donor fatigue and change of focus, linked to nationalisation, protracted crises and a switch of attention to the south, are also issues with implications for security.

Security issues limiting access and the ability to collect data affect all actors. In Sri Lanka the government suppressed information so as not to reveal what was happening in the final months of the conflict; in Darfur, agencies were not allowed to disseminate information or they would be expelled. The role of the media and the degree of freedom of the press are also factors.

Political challenges – instrumentalisation and nationalisation of aid

The instrumentalisation and nationalisation (or re-assertion of sovereignty) of aid has implications for data, and is a significant issue in Sudan and elsewhere. While there have been some positive consequences there are issues of capacity and continuity of donor funding.

It was noted that even clearly expressed data will only be taken into account if it is in the interests of the decision maker, although this also highlights the importance of holding decision makers to account according to their roles and responsibilities. Particular communication problems can arise when actors consider it the norm to work on the basis that aid should further foreign policy objectives, and do not recognize the impartiality embedded in humanitarian principles.

Some solutions - prospective surveillance

There has perhaps been an over-reliance on retrospective surveys as a method, particularly for mortality. The more practical approach - prospective surveillance, which measures things as they occur – has received less attention. It is often considered difficult, particularly in remote rural settings. However, a positive example was given of results from a prospective surveillance system of mortality and malnutrition implemented in a very remote area in the Central African Republic. With the necessary technical skills and inputs this generated crude mortality rates and prevalence of acute malnutrition, showing present trends. The sensitivity of the mortality surveillance system was estimated and was very good.

The practical importance of the prospective approach was emphasized, in that it estimated present need and what resources were required, although all resources needed would not necessarily be based on surveillance data. It may also be the precursor of the disease rather than the disease itself that should trigger action. WHO, for example, is good at putting out disease risk assessment at the outset of a crisis. Agencies may not be so good at preparing to respond, and assessments may need to be refined.

The issue of reacting to more informal information from the field was discussed, and whether formal data collection and trend analysis inhibits this. The lack of preparation and readiness to respond to an outbreak was stressed.

Some solutions – community informants

Key community informants as a source of mortality information is another method being studied, and includes trying to validate a method for measuring mortality over short recall periods of one or two months, using WHO verbal autopsies to attribute the cause of death and providing operationally relevant

data. The proportion of deaths that the method was able to detect - the sensitivity - is presently too low for it to be used. However with more work to refine this method, it might provide another option.

Monitoring technical quality

The Health and Nutrition Tracking Service is working on a systematic and objective way to score the quality of humanitarian surveys of mortality and nutrition, using an algorithm to identify a variety of errors, and give a score from 0-100%. Some results from all the available mortality surveys from Darfur during the period 2004-08, were:

98% of mortality surveys did not report on attrition (the proportion of households that did not respond to the questionnaire because they were absent or refused)

58% of surveys didn't report a confidence interval.

In general the quality is fairly poor, and there are clear differences between agencies, and work on nutrition appears better than on mortality, although this may be due to the construction of the algorithm. There could be a wider adoption of other recently suggested quality checks, for example there is software for analysis of nutrition surveys that conducts a variety of data quality checks and tries to assess bias.

There is an unfortunate degree of caution in carrying out large surveys because of the controversy they have caused in the past few years. One way to ensure quality and shield surveys from future controversy would be a system of independent study monitoring during their implementation, as for clinical trials. The identification of individuals or organizations assessed as 'independent' by various parties will however be a practical challenge to such an approach.

Training and expertise

There is a great need for on-site training and support. Epidemiological capacity, for example for nutritional assessment, is currently too intra-agency and insufficiently shared. Skills tend to be focused at the level of headquarters and academia, and concentrated in rich countries - an issue of equity and long-term development. There are many short courses, and some modules take place in more accessible places such as Nairobi and Kinshasa. Training

needs to take place to a greater degree in the field and at the outset of a crisis.

The need for an overlap with the health system strengthening agenda, involving national staff at all levels and more institutionalized training, which could include disaster preparedness, was discussed. There is a need for capacity building not only in conflict situations but also in relation to information systems more generally. Strengthening health systems in all situations will build resilience should conflict occur, with a better chance of good data.

A more systematic deployment of international epidemiology teams to major crises to provide more field support should be considered, spanning population estimation, mortality, nutrition, food security, surveillance, and vaccination strategies. It is important to rely as much as possible on national scientists and counterparts; in Zimbabwe during the cholera outbreak it was very negative to see how little considerable local capacity was relied on.

In addition, there is a need for a coordinated global programme for humanitarian and epidemiological training, consolidating existing initiatives such as SMART (Standardised Monitoring and Assessment of Relief and Transitions). Some online and open-access material could be a solution. It is a priority to train more national staff, ministry of health staff, with whom it is often possible to work very constructively even in situations where general relationships with government may be more difficult.

However, many felt that a more balanced approach to training was needed; that it received relatively too many funds, and was often of unknown quality and unrelated to specific activities. A concomitant investment in education is also needed; this would strengthen potential partnerships.

Difficulties may often arise with the commissioning and analysis of data, and there is a need to train both policy makers and those who commission surveys and data collection, and those in related fields such as security, as necessary.

Coordination, cooperation and integration

Good collaboration, rather than individuals knowing everything, is essential. Health as a discipline has the advantage of well-developed expertise, particularly around nutrition, which should feed into the policy. Policy people do not need to know how to do everything, but they are key in that they know

the resources to draw on and who they can consult. Language and the target audience need to be considered, particularly when presenting data.

Coordination needs leadership, and criticism needs to be constructive. There will always be problems with coordination but criticisms of current practice need to be made and lessons need to be learned, including context-specific ideas about improved coordination.

Integrating technical and policy areas

Discussion underlined the need to integrate technical and policy areas; there is a need to better understand the policy outcomes that data is meant to support before developing systems of collection or undertaking particular research.

Those who come from a purely technical perspective clearly have views on policy but may not take these into account when interpreting data. The pressure on clinicians to publish can limit the potential for interaction with policy areas, as it can result in publications in journals not read by policy makers, in a language targeted at other health professionals, and increasingly in an incomplete form in journals where the main data is held on the web.

Recent work has also shown that measuring the density of mobile phone access to transmitting/receiving masts gives a very accurate picture of population movements and can prospectively be used to identify future foci of communicable infectious diseases, but raises issues of data protection.

Quality and benchmarks

Different systems have varying benchmarks and levels for determining severity. As mentioned above, the WHO critical threshold for emergencies is 15% acute malnutrition; it is important to have a system that can distinguish degrees of severity above 15%.

There are some intrinsic dangers with benchmarks. If access is difficult, obtaining data of a certain standard might not be possible, and it will be a challenge to obtain information that can be used – for example about rape – for advocacy purposes. Although many women are saying the same thing, is it right that this information cannot be used if it does not meet the standard?

An important safeguard in clinical medicine is the prospective registration of research. This means it is much harder to hide outcomes and can prevent

unnecessary work and duplication. Also, there is a need to consider the cross-sectoral areas where much data is collected that has a direct impact on health, or that is a direct result of health, and to identify who will draw together all these other sources; this has also been discussed as a cross-cluster approach.

Monitoring, accountability and governance

The cluster system has made progress on technical challenges related to standardization and methodology. Decision-making, interpretation and use of data are the more problematic areas, and there is a lack of accountability in these areas.

Potential solutions suggested include a system of financial penalties or conditional funding. This would have to be tailored so as to affect the main limiting factor in data collection. In Haiti, it would need to taken up with the cluster system; in Sri Lanka the limiting factor was the Ministry of Health.

There was discussion of whether the necessary governance could be achieved through a global overarching system or a more decentralized approach. Also discussed was the nature of the relationship between an independent monitoring body and national governance. An independent monitoring body would need to be separate from national counterparts. For example, a mortality survey in Iraq in a year's time would have to be carried out by external experts, who would declare their conflicts of interest and would be appropriately funded to ensure their independence.

Responsibilities of such a body would include support to host nation systems –a role that WHO could play– support to state health systems strengthening, programme support to international organizations and some sort of advocacy function. It was felt that regional organizations in particular might be influenced by politics, and that an organization dealing with technical programming issues, the host nation, or an independent advocacy organization would probably be more suitable. One of the larger donors or one of the EU bodies might provide programme support.

An independent body could also set standards, define the research agenda, mediate in the event of disputes, develop core capacity and provide some field support. The Health and Nutrition Tracking Service is a respected interagency initiative, but still needs to get off the ground, and there is a need to learn from the problems it has already encountered. There has been some institutional

mismanagement and a lack of focus on objectives and deliverables, which has alienated some donors. To some extent it has also been taken hostage by the agendas of some individual agencies.

OCHA, and specifically the UNOCHA Humanitarian Information Centre (HIC), was also considered as a possible independent body for this task. There was no consensus on what type of organization could best ensure the quality of health information across all sectors and in all kinds of conflict situations. Many considered that it was impossible for one body (existing or created) to take on the role of holding governments to account in relation to health information.

Underlying principles for monitoring, accountability and governance

There is a multiplicity of actors involved in gathering, collecting and analysing data in conflict. The regulation of minimum standards for the standardization of methodology and research, similar to that in other areas in the Sphere project, is one way to ensure quality. Funding could be made dependent on these standards. This would need international buy-in and the acceptance of a number of academic organizations. There was discussion as to whether this should be a top-down or a bottom-up approach.

Governmental buy-in to the process is important; if not possible, the buy-in of other national institutions decided on through a stakeholder analysis process. For example, national medical associations could be potential domestic partners. Consent will be needed at all levels of the data collection process, and the history of the situation and existing expertise and organizations in the country need to be taken into account. There needs to be a balance between training and the setting of international technical standards.

Organizations collecting data will have to be sensitive to attitudes and specific governance issues in relation to data in different contexts. States such as Iraq and Afghanistan are sensitive to mortality and morbidity indicators; as are international intervening forces for which data may influence the legitimacy of their interventions.

There are also more technical issues such as survey methodologies. Funding is increasingly disbursed on the basis of results that in turn depend on data with a degree of robustness. The kind of incentive system that could be set up to encourage data that represents results was discussed.

There are already numerous agreements on the responsibility of states towards their populations, from the Alma Ata agreement and international humanitarian law to the Responsibility to Protect, and analysis of agreed statements, but it was doubtful all included the collection, interpretation and dissemination of data and perhaps they should. Learning from other disciplines has important potential.