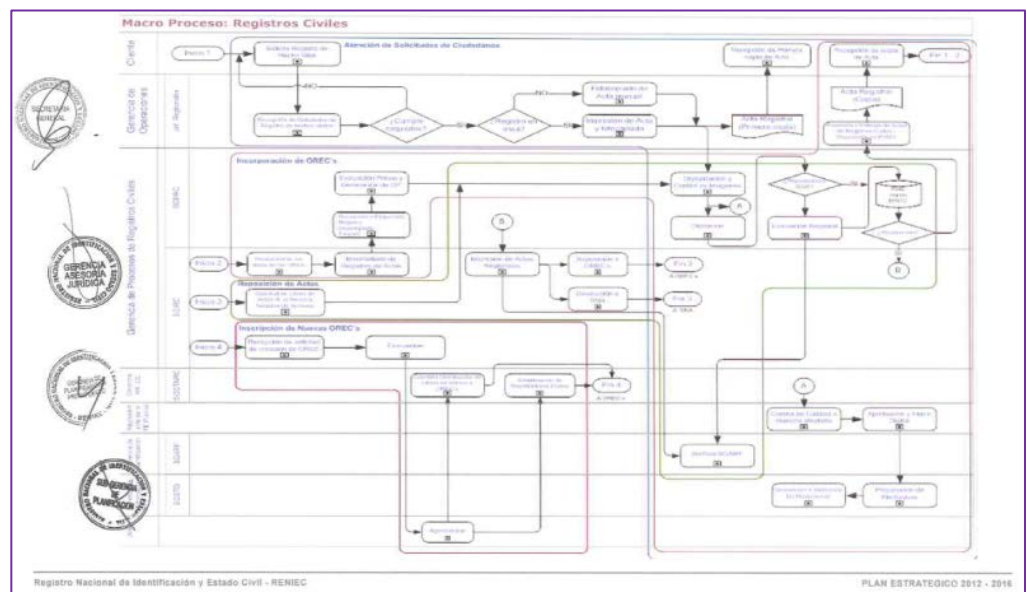


Innovation Profile 1: CRVS Systems Architecture & Analysis

What's the innovation?

We will take a unique perspective to CRVS strengthening by applying systems science and systems analysis (Enterprise Architecture Business Process Mapping) to better describe, understand, analyze and compare national CRVS organization, processes, workflows and system functionality at baseline and end line in each of the participating D4H countries/cities. This will result in a systematic review applying systems thinking as a necessary prerequisite for better understanding how other CRVS interventions or innovations developed by the D4H Initiative can be most effectively applied.

Enterprise Architecture (EA) is often used to improve the manageability, effectiveness, efficiency and agility of the “business” processes in a complex enterprise. We will use it initially to do three types of descriptive process mapping that, when put together, will help all stakeholders better identify and understand problems with: 1) CRVS organizational design including social network analysis; 2) CRVS processes, standards, and integration; and 3) CRVS performance. CRVS systems need to generate continuous flows of essential information. EA is the organizing logic that can be applied for understanding how CRVS processes and CRVS information technologies work together to deliver system performance and products. If successful, we can employ EA in a later phase for CRVS systems development and optimizing design.



Why is it significant?

Many CRVS systems in low and middle-income countries are failing to achieve adequate levels of coverage and quality despite attempting to apply standard methods proven to work well in high income countries. This suggests system failure rather than technical failure. Most attempts to improve CRVS systems have been aimed at the technical faults and capacities, but have been slow to achieve results. On the other hand, system strengthening has the potential to achieve high-leverage tipping points that could rapidly improve overall performance of CRVS.

Countries will be provided for the first time with an end-to-end visualization and analysis of how their CRVS system works for births, deaths, and causes of death, both in facilities and in communities, be able to see how it is currently designed to function, and be able to discuss its future from a common understanding and viewpoint.

The CRVS architectures and process diagrams may emerge as one of the most informative parts of the baseline and end line assessments, will contribute to a better understanding of system requirements and will contribute to the development of Standard Operating Procedures (SOPs).

What is the potential impact?

Actors in one part of the CRVS system may not know how other parts of the system work and may also struggle to describe precisely what should happen in their own part of the system. This CRVS systems architecture and analysis approach will be an important contribution to collective thinking and could have important ramifications for CRVS reform through its use and influence on CRVS design, strategic investment plans and roadmaps for long term CRVS vision. If this approach proves successful in D4H countries, a simplified adapted EA mapping tool and training materials will be developed for wider use.

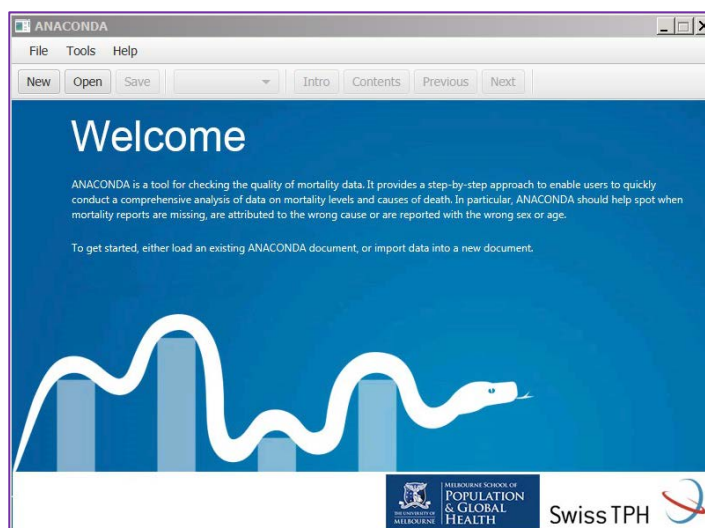
When will it be in the field?

This activity constitutes or draws on a major part of the D4H baseline assessments and will commence in the 4th quarter of 2015, being implemented in parallel with the baseline assessment exercises. If successful, we can employ EA in a later phase for CRVS systems development and optimizing design.

Innovation Profile 2: CRVS Data Quality Assessment Tool

What's the innovation?

There are immense challenges for low and middle income countries striving to achieve adequate quality for cause of death data from their CRVS Systems. There is only one tool currently available for such countries to examine and manage their data quality, the WHO ANACoD (Analysing mortality levels and causes-of-death) tool. The proposed Data for Health innovation improves upon ANACoD in that it is built upon a platform suitable for easy deployment to countries, has greater functionality and more checks, and can be extended to adopt more functions and checks in future. Thus, there will be better local evidence about the prime drivers of poor quality CRVS data in low and middle income countries to guide and monitor improvement efforts.



We therefore propose to develop a new tool to facilitate a number of essential, sequential quality checks of registered mortality and cause of death data with enhanced visualizations, reporting functions, and trend and comparator data displays. The tool will allow more flexible data input formats through an easier import and entry of data from a variety of data formats and configurations used at country level and will have an improved user interface to encourage its regular use. The tool will be built such that it can be deployed as a single executable with all necessary libraries included, including on-board help, and will operate on all contemporary computer operating systems. All steps that graphically display comparator data will be handled by toggles to quickly overlay comparator data for easy visualization. We will also include the computation of the new Vital Statistics Performance Index (VSPi) for use by the actual producers of CRVS data and will provide more detailed focus on garbage codes that are key to D4H interventions to improve CoD certification practices. All this will be in a more robust and extensible format with better visualizations.

Why is it significant?

For progress, it is crucial that national vital statistics offices and analysts are able to interrogate the quality of vital registration information on mortality rates and causes of death in real time as it becomes available in order to take timely corrective action. Furthermore, assuring and knowing the quality of mortality data should increase the confidence of CRVS personnel to interpret and use such data available for further analysis, dissemination and use. This is not currently the case in most low and middle income countries where CRVs data are widely underutilized because of ill-informed, but justified concerns about their quality.

This tool, once developed and validated, will provide a rapid and deep insight into the quality of any annual mortality data set from CRVS, including medically certified deaths from health facilities; HDSS; SAVVY; and CRVS verbal autopsy (VA) data. This will make it of critical importance to D4H interventions in selected countries undertaking VA in health facilities and beyond as part of their CRVS strengthening.

What is the potential impact?

We expect that this tool will be a major driver towards measurable and significant short term (during the life-span of D4H) and longer term improvements in CRVS data quality by providing real time intelligence about data quality. This tool will be used in all D4H countries and will be a major deliverable for use beyond D4H countries

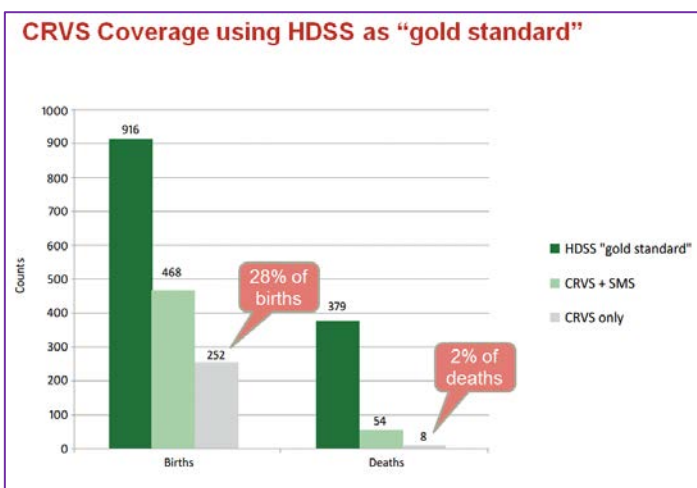
When will it be in the field?

The prototype will be piloted in the field by the development team in Q4 2015 and applied in all D4H countries from Q1 2016. Eventually we envisage the use of this tool routinely at country level by country level analysts for quality control and analysis providing assistance in recognizing, identifying and rectifying a number of data quality issues that are not easily visible to the CRVS system.

Innovation Profile 3: Integrating Mortality Surveillance into CRVS systems

What's the innovation?

This innovation will design and test approaches to engineer effective, continuous collaboration, technical exchange and data sharing between longitudinal Health and Demographic Surveillance Systems (HDSS) or sentinel registration systems (SAVVY) sites and routine CRVS systems. The innovation has two goals: a) establish procedures and practices so that HDSS/SAVVY populations can become “gold standard” observatories through which the routine CRVS system can be validated and calibrated with regard to timeliness of reporting, completeness of reporting, and comparative cause-specific mortality fractions; and b) identify and validate standards by which HDSS/SAVVY sites can be effectively integrated into national CRVS systems. This will require methods for deterministic or probabilistic record linkage through formal confidential partnership between the two systems. Results and discrepancies from annual linkages will be used to identify specific weaknesses in the CRVS system (or HDSS system).



Why is it significant?

At least half of the currently selected D4H countries have HDSS or SAVVY sites which monitor pregnancies, births, deaths, and causes of death via verbal autopsy (VA). These sites provide islands of relative excellence with both high coverage and high data quality for events occurring in sentinel or sample populations of the country. HDSS sites have never been harnessed as routine technical partners in CRVS in any of these countries. This is a huge missed opportunity for both the CRVS systems and the HDSS sites that can be relatively quickly addressed. It is ironic that two data intensive enterprises, CRVS and HDSS, that measure the same births, deaths and causes of death in the same countries, never collaborate. HDSS expertise and data remains in its own national silo and is not seen as an integral part of the fabric of national health information systems or CRVS systems. The leadership of the INDEPTH Network has recently signaled intentions to redress this situation and is looking for initiatives and methodologies to re-engineer relationships

Other benefits: As D4H CRVS interventions are developed, they can be piloted cost-effectively, as necessary, in the HDSS sites, and their effects can be best monitored within such sites. Collaboration with continuous household survey operations as done in the HDSSs means that some other work such as the qualitative client satisfaction and the focus groups for incentives studies planned on Incentives for Death Registration could be cost-effectively conducted on the ground by HDSS teams. Alternatively, or in addition, in the case of each death registered or not,

questions could be asked at a later date why families did not comply with CRVS reporting needs and this could be assessed routinely over time as interventions are rolled out.

What is the potential impact?

The major immediate benefit of this innovation is that it will increase reported births and deaths, with a cause of death, in the CRVS system by capturing all events in the HDSS/SAVVY sites. It is likely that there will be dramatic initial differences in coverage of vital events as seen by the two systems, especially in rural areas. Understanding why will provide CRVS stakeholders with the intelligence and political motivation to consider more radical rather than incremental improvements. Connecting demographic and analytic expertise between the HDSS/SAVVY and CRVS communities will be mutually supportive and should lead to greater confidence in CRVS data and its eventual use. This requires careful operating protocols to ensure confidentiality of findings to ensure good long-term working relationships between the sites, the CRVS authorities and other stakeholders, and be supportive in improving coverage and quality without embarrassing the CRVS systems as they move forward.

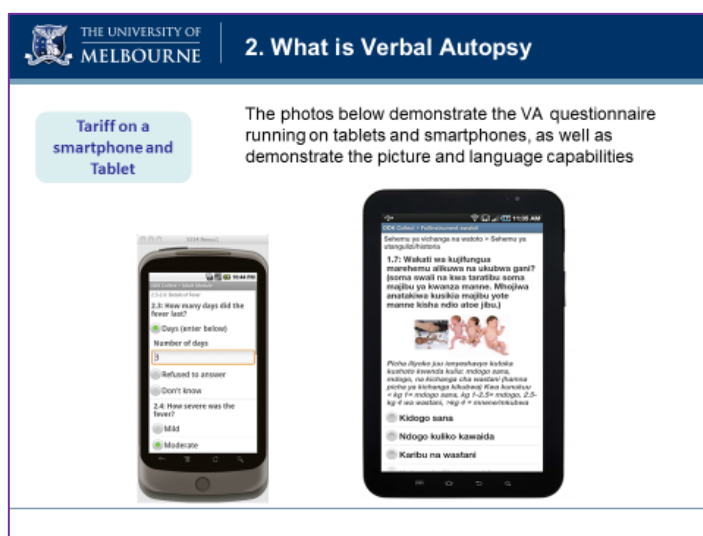
When will it be in the field?

Five D4H Countries will be trained and facilitated to work in 2016 to link their 2015 CRVS and HDSS data sets.

Innovation Profile 4: Applying Tablet-Based VA in CRVS systems

What's the innovation?

Many deaths in low and lower-middle income countries occur in settings without health professionals present or easily accessible to determine the cause of death. Verbal autopsy (VA) is the only viable option to determine causes of death in the absence of health professionals. VA is usually used to determine causes of death at population level in research settings, rather than individual level as required in CRVS. The idea of using VA in CRVS is an innovation, but until now the proposition has been impractical because of the need for high level skills and the laborious nature of managing paper-based instruments and physician coding methods, and because of concerns about the length of time required for the interview. The advent of tablet-based VA to determine the cause of death based on diagnostic algorithms now makes testing VA for use in routine CRVS a potentially transformative innovation for improving cause of death information in CRVS systems.



The full extension of VA has yet to be incorporated in CRVS anywhere, except Brazil. Due to rapid developments in VA automated cause of death diagnostic algorithms such as SmartVA, InterVA, InSilico VA and recent developments in short-form VA questionnaires that can feed these algorithms to adequately assign causes of death to acceptable cause lists for public policy, VA deployment on mobile tablet-based devices is now in reach. There is a real opportunity for the D4H Initiative to lead this movement of extending mobile VA into routine CRVS systems. Equally, with increasing mobile phone coverage, there is real potential to increase the reporting of births and deaths via mobile phone based- platforms such as SMS.

Why is it significant?

The future of health information systems, of which CRVS systems are a key element, will increasingly exploit mobile and internet enabled devices to extend the quality and speed the flow of essential information. This is particularly needed by CRVS systems which chronically suffer from unacceptably low coverage and quality in resource constrained settings. This innovation will operationalise the development of novel technologies for reporting births and deaths, especially in remote populations, and for improving information about causes of death in populations where there is none, thus filling an important data void. It includes the technical development of tablet and app based mobile technologies for capturing, controlling and communicating such data and integrating it within modern CRVS and Health Information Systems.

What is the potential impact?

A key outcome indicator for the D4H Initiative is to effect large increases in the numbers of CRVS events correctly monitored. This cannot be achieved without pushing CRVS registration closer to where people are born, live and die. Extending static institutional CRVS registration points will be very costly in physical infrastructure, human resources and time. Exploiting modern mobile communication technologies holds much promise for much more rapid and low cost expansion of CRVS coverage, and for generating reliable data on community level causes of death. There are many unanswered questions around how to do this, and these will not be answered spontaneously. This innovation project will bring the best technical advice on innovations together and agree on the most promising way to test prototype technologies, refine these, and provide evidence for countries and CRVS stakeholders.

When will it be in the field?

Consensus workshop on criteria for VA in CRVS systems in November 2015. Expect to be in the field in four test sites in countries with HDSS/SAVVY experience in VA from the INDEPTH Network in 2016.

Innovation Profile 5: CRVS Incentives for Death Registration

What's the innovation?

This innovation is linked with the Systems Analysis and the Baseline Assessments. It will make a deep dive into the potential to analyze in local contexts, the incentives and disincentives for death registration. In selected settings we conduct some qualitative focus group work on client experiences and ideas for improving CRVS. We will convene a specific innovation workshop to brainstorm on potential interventions particular for mortality reporting. This will include experts in incentivising behaviour on both the **provider side** (e.g. removing disincentives, adding pay-for-performance, cash on delivery funding for CRVS, and other results based funding approaches, legislative approaches to burial permits, free burial grounds, revising procedures to provide more client friendly access) and **demand side** (e.g. conditional cash transfers, non-cash benefits, etc.). Potential additional ideas for exploration include: Advantages to community & local government to know mortality structure; Local Authority requires certificate for permit to bury; enforcement; Community surveillance; Municipality incentives via agreement; Social marketing; mobile credits; decentralizing; Funeral mutual savings schemes; burial societies; Defray funeral costs; Certificate as voucher; Shift responsibility; e.g. from family to key informants or responsible government agent; Churches/parish registers/etc with linkages. Disincentives include: Loss of pension benefits; Punitive costs; Capitation funding.

This exploratory work will lead to potential interventions to test in selected settings, and to a guidance document on how to assess incentives and disincentives for the CRVS Systems Analysis.

Why is it significant?

Unlike birth registration, there are fewer evident benefits and less enforceable regulatory authority for registering a death and for securing a death certificate. This is a major determinant of low coverage of death registration in CRVS. Some systems may require repeat return visits of the family to distant registrars, unnecessary bureaucracy or complex and client unfriendly procedures, procedures not well known in the community, fees and other costs, etc.

What is the potential impact?

Understanding disincentives and incentives, and being able to demonstrate experience with their application, will provide essential intelligence for custodians of CRVS systems about relatively low cost measures to take to reform procedures to improve completeness of death registration.

When will it be in the field?

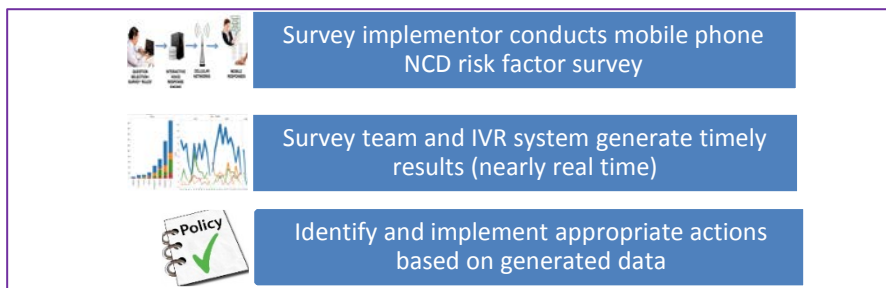
Design workshop for assessing incentives/disincentives will be conducted after the first five countries with Systems Analyses and Baseline Assessments are completed, and will likely take place in early 2016.

Innovation Profile 6: Rapid Feedback for Data Use

What's the innovation?

The NCD mobile phone survey team is building a methodology designed to generate results of NCD risk factors at a much faster rate and frequency than the traditional nationally representative surveys. It is

anticipated that the results will become available within a very short time of their collection, and surveys could be conducted more frequently. This platform will allow for real time monitoring of the data, facilitating relatively low cost adjustments to sample size and resulting in better representativeness of the population.



Why is it significant?

The use of data for decision-making is recognized as key in improving health. It serves to provide decision-makers objectively verifiable evidence on health care needs, perceived priorities, coverage and reach of interventions as well as their effectiveness and efficiency. Traditionally, the Public Health community has relied on household surveys to collect population based data for decision-making and programming. However, nationally representative household data is not only expensive and time-consuming to collect, the final cleaned and validated results often become available after a long delay. There is thus the risk that interventions come too late, sometimes after the situation has deteriorated or been resolved, with little opportunity to learn what aggravated the situation or was effective in resolving the problem. Moreover, the cost and delays means that such surveys are conducted every 4-5 years or greater. The new system will provide for more rapid and more frequent feedback on what is happening at population/household level with regards to NCD behavioral risk factors. Rapid feedback of results will provide timely data for decision makers to monitor trends and improve and implement programs and policies on NCD risk factors.

What is the potential impact?

The system will have a module that produces key results and indicators on NCD behavioral risk factors presented in easy-to-read tables and graphics, thus allowing rapid feedback of key results from the study team to national decision-makers. Examples of results that could lead to more timely interventions include but are not limited to; geographic locations or demographic groups that show a particularly high rate of behavioral risk factors for NCDs e.g., tobacco use and smoking, excessive alcohol intake (binge drinking), low fruit and vegetable intake, etc. The system will have the ability to anonymously aggregate the results e.g., by region, sex, age-group, etc, thus facilitating the development of more targeted messages.

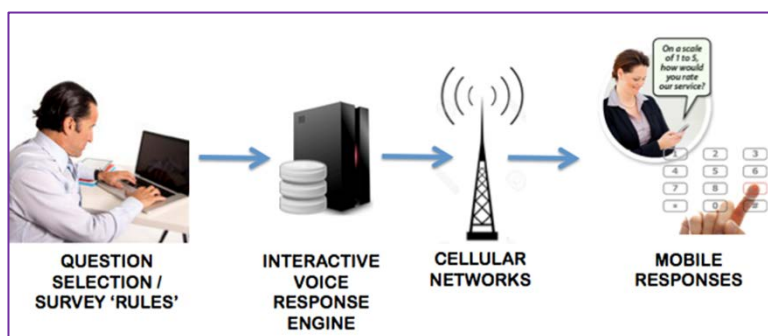
When will it be in the field?

The system will be deployed in Bangladesh and Morocco starting Q1/Q2 in 2016.

Innovation Profile 7: Standard Global Protocol for Mobile Phone Methodology

What's the innovation?

A suite of tools and protocols is being developed for mobile phone surveys for interim health surveillance in low- and middle-income countries (LMICs) using interactive voice response (IVR) technologies and random digit dialing (RDD). A "comparison factor" will be used to test the validity for data collected by the mobile phone technology versus traditional



household surveys for non-communicable disease (NCD) risk factors (i.e., STEPS, which will be conducted concurrently in 6 of the 10 selected LMICs, including both pilot countries).

Why is it significant?

Although mobile phone surveys have previously been conducted in the United States and other high income countries, a standard methodology does not exist for obtaining nationally representative estimates in LMICs. If this approach is successful, mobile phone surveys have a number of important advantages over face-to-face surveys:

- (1) They are likely more cost and time effective;
- (2) The sampling frame can include areas that may be hard for interviewers to access in person; and
- (3) Respondents have higher anonymity since surveys are automated and conducted over the mobile phone, which can increase the validity of information being reported.

What is the potential impact?

This methodology will provide timely, accurate and regular data to decision makers for improving and implementing health programs and policies. Cross-country and over-time comparisons can be made, as the protocol is globally standardized for scalability, so that countries will be able to evaluate the impact of their programs and policies, as well as compare their results and progress with other nations across the globe.

When will it be in the field?

The pilot results for Bangladesh and Morocco will be available by June 2016.

Innovation Profile 8: Using Spot Urine Testing in STEPS Survey Sodium Monitoring

What's the innovation?

The World Health Organization (WHO) will utilize spot urine testing to measure urinary sodium excretion as a biomarker for estimating mean population intake of sodium/salt in population-based surveys. Prior to the utilization of spot urine test, few countries had measured data on mean population salt intake, despite a globally agreed target in this area.



Why is it significant?

Hypertension is a leading risk factor for noncommunicable diseases (NCDs). As part of the WHO's Global Monitoring Framework for NCDs, member states have committed to a global target of 30% relative reduction of sodium intake of salt/sodium in mean population by 2020. Currently, few countries have data on sodium intake as methods to estimate population sodium intake relying on self report, food-frequency surveys are seen as unreliable, and 24 hour urine collection (the "gold-standard" for measuring sodium/salt excretion is unfeasible in population-level surveys.. The use of spot urine test aims to provide mean population sodium intake estimates in countries as required by the Global Monitoring Framework for NCDs agreed-upon by the global health community.

What is the potential impact?

More precise estimates for mean population sodium intake can help member states track their progress in achieving the global targets on sodium reduction. Spot urine testing in a country's STEP survey will provide strong evidence that policies aimed at reducing sodium intake are working. By using innovations like spot urine testing to gather more precise health data, member states can track a real impact on the prevalence on cardiovascular diseases.

When will it be in the field?

Potentially spot urine testing will occur in the Bloomberg-Supported STEPS surveys, including Bangladesh and Morocco.

Innovation Profile 9: Wearable Technology for Monitoring Physical Activity in WHO STEPS Survey

What's the innovation?

The World Health Organization (WHO) will pilot utilizing wearable technology to physical inactivity objectively in population-based surveys. Prior to the utilization of wearable technology, WHO STEPS survey had relied on self-reported data to estimate physical inactivity to member states. STEPS survey respondents will now be asked to wear portable devices to track physical activity patterns to help calibrate self-reported data on physical activity patterns, and help member states improve estimates of physical inactivity in their populations.



Why is it significant?

Physical Inactivity is a crucial risk factor for non-communicable diseases (NCDs). As part of the WHO's Global Monitoring Framework for NCDs, member states have committed to a global target of 10% relative reduction of insufficient physical activity by 2020. Currently, data on insufficient physical activity is generated from self-reported questions which estimate physical activity patterns in work, transport and leisure domains. However self-reported data from surveys may significantly under and over-estimate real patterns of physical activity. The use of wearable technology aims to improve the precision with which physical inactivity estimates in countries are developed, as required by the Global Monitoring Framework for NCDs agreed-upon by the global community.

What is the potential impact?

More precise estimates can help countries track their progress in achieving the global target of a 10% reduction in insufficient physical inactivity. Wearable accelerometers in a country's STEP survey will provide strong evidence that policies aimed at increasing physical activity are working. By using innovations like wearable technology to gather more precise health data, countries can track a real impact on the prevalence of NCDs.

When will it be in the field?

Potentially wearable technology to improve physical activity surveillance will occur in the Bloomberg-Supported STEPS surveys, including Bangladesh and Morocco.

Innovation Profile 10: Data-to-Policy Training Course

What's the innovation?

Union North America and CDC are collaborating to develop an innovative training course that combines successful elements of existing Union and CDC training models, adapted for developing skills for policy-relevant data analysis and presentation among ministry staff.

The Union's existing course – Structured Operational Research and Training Initiative (SORT-IT) – focuses on building operational research skills. CDC's existing training for its Field Epidemiology Training Programs focuses on outbreak investigation and other field epidemiologic studies, primarily on infectious disease topics. We will incorporate the following successful elements of the two approaches: “product”-driven training, oriented toward a clearly defined output at the end of the process (SORT-IT); case-study-based learning (CDC/FETP); and a strong mentoring component (both). The adaptation will be that the skill development will be oriented toward analytic approaches most relevant to policy development (health impact modeling, cost-effectiveness analysis, attributable fraction/burden-of-disease estimation, etc.) and presentation techniques most useful for communication and advocacy (mapping and other data visualization approaches). Trainees will produce “policy briefs” as the end-product of the training, and provide them to Ministry leadership to advance agency priorities.

Why is it significant?

Significance is in the unique focus of the training on policy-relevant skills, combining rigorous methodologic principles with practical, advocacy-oriented approaches, as well as in the focused output of a specific policy brief on an issue pre-defined by the ministry as a priority.

What is the potential impact?

Impact will be to develop a cadre of staff within ministries with a specific set of skills that can be applied to a wide range of issues.

When will it be in the field?

Will be in the field by the spring of 2016.

Innovation Profile 11: Driving demand for data

What's the innovation?

Demand from leadership is well-described as an important determinant of a strong data-use organizational culture. Cultivating such demand is an important requirement and challenge in implementing an effort to enhance data use across a ministry of health. We propose to develop an innovative program of engaging ministry leadership around the value of enhanced data use and strategies to build such demand and overcome organizational barriers.

The program will entail group discussions and individual follow-up with senior leadership from ministries of health, potentially as part of an existing Harvard School of Public Health/Kennedy School of Government program or via other forums linked to international or regional events. The innovation will lie in the specific focus on data-driven planning, prioritization, resource allocation, and communication, and ways in which the strategic leveraging of data can help advance organizational priorities. The program will be delivered by recognized international experts, and will incorporate dialogue and exchange between countries. We will build a follow-up activity focusing on sharing of experience and collective action.

We also plan to adapt proven approaches to engagement and training of external stakeholders -- journalists, civil-society organizations, and parliamentarians – in order to build interest and appreciation of the value of public health data systems and how data should be used to guide policy.

When will it be in the field?

Will be in the field by the spring of 2016.

Innovation Profile 12: Data-driven internal planning and decision-making support

What's the innovation?

A core feature of the Data Use program will be to assist ministries in developing policies, processes, and tools for compiling, analyzing, and visualizing data for planning and decision-making. This activity will entail 2 components: a) combining ministry-identified priority indicators with a set of metrics based on a list of D4H-consensus data use best practices (e.g., leading causes of death and premature death calculated from leading behavioral risk factors); b) developing both visualization and internal decision-making/program accountability processes based on the information. The innovation will lie in the articulation and use of the core set of best-practice analyses as well as the integration of technology (customization of existing business intelligence software for dashboards, etc.) and protocols for data-driven planning and impact assessment/performance monitoring.

When will it be in the field?

Will be in the field by the spring of 2016.

Innovation Profile 13: Data Use Committee

What's the innovation?

An established data use committee aims to help build a culture of data use and generate data demand among decision makers and inform policy decisions. Ministry of Health leaders, active institutional partners, research institutes/labs will all be essential members and participants of the established data use committees. Interest generated through FETP quarterly seminars can lay the groundwork for these data use committees within the Ministry of Health.

Why is it significant?

The data use committee will be a unique mechanism for public health scientists to share their data with policy makers to promote policy development and change. The data use committees will ensure that FETP residents, who regularly collect health data, will be involved in an active dialogue with steering committee members.

What is the potential impact?

The data use committee will build opportunities to share data, stimulate discussion among decision makers and technical experts, and ensure solid evidence-based data will be used in policy change recommendations.

When will it be in the field?

One or two Data Use Committees could be established by June 2016.

Innovation Profile 14: Online Network for Health Policy Trainees

What's the innovation?

Establish an e-neighborhood for sharing best practices in health policy development among those attending the Data for Health Policy Training using CDC or UNA websites or a third-party public site, such as phConnect. Upon registration for the course, login account information will be developed and access granted to the e-neighborhood. The forum would allow shared studies or articles of interest addressing mutual problems.

Why is it significant?

Ministry of Health and Field Epidemiology Training Program (FETP) policy work will likely be similar across countries and regions. An online network for Health Policy Trainees will allow more rapid dissemination of best practices, including: costing, stakeholder analysis, and mapping included in their policy briefs. Furthermore, participants can share challenges and successes in moving from policy briefs to implementation. The site could facilitate monitoring and long-term evaluation, i.e. continued policy brief outputs and organizational changes with the trainee's institutions. And perhaps such a network could eventually evolve into an e-observatory of health policy in low and middle income countries. Further iterations could allow forums to share ideas for regional public health bulletins, facilitate best practices in scientific writing, or UNA technical assistance.

When will it be in the field?

March 2016 (at launch of health policy training)



Innovation Profile 15: Public Health Bulletins

What's the innovation?

A public health bulletin authorized by the Ministry of Health and held to the highest scientific standards. The public health bulletin will serve to rapidly disseminate new findings with important implications for the practice of medicine or public health and promulgate evidence-based recommendations. The main aim of the bulletin will be to publish surveillance data on both communicable and noncommunicable diseases which will be useful to epidemiologists and public health planners. Furthermore, the bulletin will foster a culture of rigorous scientific analysis of health data as the basis for public health policy and in turn build national public health capacity through the international exchange of ideas and recognition of exceptional scientific work by clinicians and public health professionals.

Why is it significant?

There is a recognized need for a public health bulletin in all or nearly all countries. However few national public health bulletins exist. The public health bulletin will make the practice of public health more efficient by promoting the exploitation of data for making decisions.

When will it be in the field?

One or two bulletins could be in the field by June 2016

