Author's response to reviews

Title: Health and Demographic Surveillance Systems: A Step towards Full Vital Registration in Sub Sahara Africa?

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Author's response to reviews: see over
Subject: Resubmission of manuscript: 5895714636813313

Dear Editor,

The authors have revised the manuscript to address the reviewer’s comments. It should be noted that we invited two additional co-authors to bring more perspectives from the HDSS sites and the INDEPTH Network. Their contributions greatly contributed to improve the manuscript. We provided point-by-point response to the reviewer’s comments and made reference to specific paragraphs in the manuscript when necessary (see page 2 of the cover letter). Changes in manuscript are highlighted for easy reference.

The authors hope this revised version will meet the standards of “BMC Public Health” and can now be accepted for publication.

Please note that the online system did not allow me to add the two additional co-authors. I hope you will be able to update the list for us.

Thank you for your consideration

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Point by point responses to reviewers’ comments

Response in bold

Reviewer 1: Peter Byass

Point 1: Some of your data on INDEPTH are not up to date. As it happens, there will be an article on INDEPTH sites coming out in the June edition of the International Journal of Epidemiology, and it may be helpful to refer to that.

Response: We have updated this, especially with the contribution of Osman Sankoh the Executive Director of INDEPTH as a co-author. We also made reference to paper suggested by the reviewer. (see section “HDSS - Brief History and Current Situation”, paragraph 3)

Point 2: I don't think it is true that most HDSS sites are funded by private institutions and foundations. Quite a number are operated by in-country public institutions such as universities and others from international public funds. There is, nevertheless, in some cases a lack of connection with national interests and priorities.

Response: We have reviewed this statement and have referred to the paper. See section “Some Key Challenges of HDSSs” first paragraph

Point 3: what evidence do you have to say that “the population covered is in most cases not representative”? I agree that it is extremely difficult to prove that an HDSS population IS representative (because you wouldn't have the HDSS if you already knew enough about the surrounding population to be able to answer that question). However, it is scientifically incorrect to jump to the conclusion that HDSS populations are unrepresentative, just because you can't demonstrate representativity. You may find it helpful to look at a recent paper on the subject PLoS ONE 2011, 6(8): e22897

Response: We have reviewed this statement and have referred to the paper. See section “Some Key Challenges of HDSSs” Second paragraph two

Point 4: explaining the differences between individual HDSS and SRS approaches is very important. It is unhelpful though to describe an SVR as only registering events - critically they have to also count the population among which the events occur. The main difference is (a) that there are nodes distributed over a wider area and (b) they are less likely to be concerned with details of morbidity, etc.

Response: We have reviewed this section accordingly- see page:…

Point 5- cause of death and verbal autopsy is an important area. It would also be appropriate to mention that VA is generally shifting away from using physicians to arrive at cause of death,
towards more automated procedures, which are cheaper and faster. You might want to refer to Epidemiologic Reviews 2010; 32:38-55 for more details.

Response: We have provided more information on Vas, see page:....

Reviewer 2: Ties Boerma

Point 1: The argument that HDSS can be an important source of information for countries is underpinned by a series of examples of the use of HDSS in country health policy making. At the same time, it would be necessary if the paper also discussed the weaknesses of the HDSS in greater detail. Some aspects such as the local nature of the data are mentioned but there are others such as (1) the general track record of HDSS to provide timely data on e.g. causes of death is generally weak. This affects for instance the use of HDSS data in annual health sector reviews. (2) the fact that HDSS often needs research money to run the site which implies interventions, making the HDSS less typical for the country.

Response: Point 1: on the weaknesses of HDSSs: We have expanded this section.

Point 2: There is a need for a very careful assessment of the SRS approach. The India system has its strengths and weaknesses, but it seems that the country is stuck in this approach rather than moving towards a full CRVS. In China, a combination of CRVS and demographic surveillance is used, but also progress towards a full CRVS has been lacking for a long time. The development of a SRS totally reliant on external funding is bound to fail when the donor pulls out, as for instance happened with the AMMP in Tanzania. And too much reliance on the Ministry of Health also seems to be a weak point as continues data collection and analysis investments is generally not a priority in the Ministry of Health, unless it is directly related to service provision. The bottom line is that there is no evidence that a stepwise approach from HDSS to SRS to CRVS is working. In fact, the Statistical Community argues the opposite argument: that investing in SRS will compete for scarce resources with the efforts to establish a full CRVS. The arguments therefore need to be presented very cautiously, weighing all the positive and negative factors. The paper should address this issues better.

Response: Point 2: on the need for a detailed review of the merits and demerits of a combined HDSS/SVR approach – We agree with the reviewer and have stressed this point. This could be another paper.