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 comments from the reviewer. 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.

Thank you for your consideration

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Point by point responses to the reviewer’ comments

Response in bold

Point 1: The paper has improved. It however still suggests in several places, including the title, that HDSS or SVR are alternatives to CRVS. For instance, in the abstract it says: “in the absence of an adequate national CRVS, HDSS serve as a viable and reliable alternative that provides a sample vital registration system…” This is not the point that the paper should be making. The point is that CRVS development will take time and that HDSS sites should be used better to generate relevant public health data in the meantime.

Response: We agree and that was an oversight since we already emphasized reviewer point in the abstract, Summary section: “The paper does not suggest that HDSSs should be seen as a replacement for civil registration systems. Rather, they should serve as a short- to medium-term measure to provide data for health and population planning at regional levels with possible extrapolation to national levels. HDSSs can also provide useful lessons for countries that intend to set up nationally representative sample vital registration systems in the long term.”

We have adjusted the statement to read: “This paper argues that, in the absence of an adequate national CRVS, HDSSs should be more effectively utilized to generate relevant public health data, and also to create local capacity for longitudinal data collection and management systems in SSA.”

Point 2: The title of the paper is not right. It would be better to say something like: Using HDSS to bridge the gap in mortality statistics in SSA.

Response: We do not agree that the title is not right. The reviewer’ suggestion and the current title are one and the same. We do not downplay the overall importance of CRVS; rather, like WHO/HMN themselves say in their figure below and the reviewer is part of the team, HDSSs are indeed part of CRVS efforts and can be used as stepping stones to higher coverage of the population in a country. The title in a way supports what WHO/HMN describe in their illustration of the current situation in SSA.
Point 3: Section on CRVS – this section is ok, could perhaps connect better with the current efforts of UNECA and ASSD, including the upcoming Minister’s conference. It should also do justice to South Africa where fairly reliable vital statistics are generated from the CRVS in spite of not having complete coverage.

Response: We thank the reviewer for his reference to the efforts of UNECA and ASSD but do not think it is necessary to state here. We hope that UNECA and ASSD will read this paper. Yes, we agree with his point regarding South Africa and have provided the following statement in the text: “It should be noted however that South Africa is making strides to generate fairly reliable vital statistics from its CRVS and Statistics South Africa (StatsSA) plays a leadership role in promoting the development of CRVS in SSA.”

Point 4: Section on intermediate (not alternative sources of data) – HDSS – section is ok, points out most important challenges for the purpose of filling the data gap, without having the pretention that this is a source of reliable national mortality statistics. It would be good to include more examples of situations where HDSS mortality trends (by cause or not) are good markers of national progress. A good example is Tanzania where the HDSS child mortality trends captured the decline before the household surveys did.

Response: We understand the reviewer’s key point that HDSSs are part of the CRVS and not alternative sources. We did refer to the TEHIP project in the paper.

Point 5: Other health indicators generated by HDSS – although this is a relevant function of HDSSs it is not a point that is relevant to the paper. There are several examples where HDSS generate very critical epidemiological information on for instance HIV trends, but that is not information that would be captured by a CRVS, so it is not really relevant to the paper. The focus of the paper should be exclusively on improving mortality statistics.
Response: We do not agree that some mention of other indicators that HDSSs generate shouldn’t be mentioned at all. The brief mention doesn’t divert from the focus of the paper.

Point 6: Birth registration or fertility estimates, the other major vital statistic generated by CRVS, are not discussed. CRVS coverage is much higher than for deaths in many countries, but not sufficient to estimate fertility. The paper should say a bit more about this.

Response: We did mention births in the HDSS section, refer to Figure 1. In fact, the dynamic HDSS cohort depends on birth registration. We have mentioned fertility estimates in the HDSS section.

Point 7: The section on SVR: The paper focuses on the role of HDSS (and indeed the conclusions of the paper spell out extensively how the HDSS can be used better) and deal with its main challenges of intervention effects, speed of generation reliable mortality statistics, link with national decision making processes etc. The argument should also be made more prominently that a larger number of HDSSs is better than having just one. The SVR section is now very short – which is fine but it should address the key issues. It should discuss the common concern that it could either stimulate or compete with the development of a CRVS. Does SVR indeed involve the same resources as CRVS strengthening? In countries with limited capacity and resources, how can it be run without affecting the CRVS development, how can it stimulate such development? Also, what should be the role of external funding?

Response: We agree with the point regarding the number of HDSSs in a country. In fact, there is an emerging trend: Ghana has 3, South Africa has 3, Uganda has 2, Kenya has 4, Bangladesh has 4, India has 2 (working on another), Vietnam has 3, Burkina Faso has 5, Gambia has 2, Senegal has 4.

We have mentioned the concern in the discussion section and have indicated that a fuller discussion of the issues should be subject of another paper.

Point 7: It seems to me that the VA section should be part of the HDSS section, not part of the SVR section.

Response: Yes, thanks to the reviewer for identifying this. We have taken the VA section to be part of the HDSS section where it is certainly more appropriate.