Public Health Information Services (PHIS)
Successes, Challenges, Ways Forward

Dr Boris Pavlin
Epidemiologist / PHIS Task Team Coordinator
World Health Organization
History of PHIS

- PHIS Standards developed by GHC Task Team mid 2016-2017 (mainly by partners)
- Proposed ‘soft launch’ & phased, prioritized country roll-out agreed with GHC TT, WHE-HIM & OFDA - March 2017
- Standards endorsed by GHC SAG in April 2017
- Transition of GHC TT leadership to WHE-HIM in October 2017
- PHIS roll-out supported by GHC OFDA funds & SCUK
- GHC OFDA funds for PHIS now ended.
Key Aspects of PHIS Approach

• Appropriate country-level staffing
• Integration of IM assets
• Standardized information services/products
• Consistency in IMO competencies (NOT REVIEWED HERE)
Intensified Support Modality

- Selection of countries with greatest need (and existence of base capacity)
- Prioritizing filling in-country IMO positions
- Provision of Strategic Advisors to guide technical work
  - Field scoping missions / recommendations
  - Remote followup
- Remote and onsite support from WHE
Countries with Intensified Support in 2017

- NE Nigeria
- South Sudan
- Somalia
- Ethiopia
- (Yemen)
Other Countries with PHIS Support

• Ukraine
• DRC
• Bangladesh
• Kenya
• Fiji
• Chad
• ...

Yemen

- IM Team Leader (IM TL) selected but long-delayed by visa issues
- HC without dedicated IMO
  - Multiple proposals (SBPs/iMMAP) rejected by WCO
  - Eventual candidate did not arrive due to int’l evac.
- Team management issues b/w HIM and HCC
- Despite this...
  - Extensive support to design/implementation of Cholera Response Monitoring (full monitoring by 60+ partners of DTCs/ORCs) which equates to a cholera specific HeRAMS
  - 1.5 week technical workshop to design/setup HeRAMS plus continued follow-up
NE NIGERIA - INCREASED SUPPORT SINCE JUNE 2017
Inputs

• Remote support from HIM staff (multiple)
• Two field visits from HIM staff (Boris – 5 days; Caroline – 7 days)
• Three-month deployment by WCO staff for HeRAMS (Ifeanyi)
• One field visit from external PHIS Advisor (Olivier, PHE – 10 days)
• Remote support from EMO intern (Emma)
  – Tech guidance and admin followup
## Status - Nigeria

<table>
<thead>
<tr>
<th>Domain</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>“IM TL” but only working on epi. HC IMO WCO IMO</td>
<td>IM TL HC IMO WCO IMO</td>
</tr>
<tr>
<td>IM Workplan</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Team Structure</td>
<td>Not integrated</td>
<td>Partially integrated (IM TL + epi, separate HC IMO but close collaboration)</td>
</tr>
<tr>
<td>Shared files</td>
<td>No</td>
<td>Best in Class VSHOC</td>
</tr>
<tr>
<td>WCO Situation Report</td>
<td>External sitrep at onset but then stopped</td>
<td>Best in Class</td>
</tr>
<tr>
<td>PHSA</td>
<td>Draft in old format</td>
<td>Yes</td>
</tr>
<tr>
<td>3Ws</td>
<td>Not regularly public</td>
<td>Public</td>
</tr>
<tr>
<td>HeRAMS</td>
<td>Yes</td>
<td>Yes (model (paper-based, survey) difficult to use for ongoing monitoring)</td>
</tr>
<tr>
<td>EWARS</td>
<td>Yes (Borno only)</td>
<td>Yes (Borno and Adamawa only; but highly functional in these areas)</td>
</tr>
<tr>
<td>HC Bulletin</td>
<td>Yes (bimonthly) (Borno only) (3 in 2016)</td>
<td>Best frequency&lt;br&gt;Yes (bimonthly) (21 in 2017)</td>
</tr>
</tbody>
</table>

N.B. – not all PHIS services/products are reflected.
New WCO Internal Sitrep Organized by Operational Plan Strategic Objectives

<table>
<thead>
<tr>
<th>STRATEGIC OBJECTIVES</th>
<th>KEY OUTPUTS</th>
<th>CHALLENGES</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Objective 1: To improve access to timely &amp; equitable package of basic health care services to crisis affected population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1. Hard to Reach mobile health intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicators</td>
<td>Adamawa</td>
<td>Borno</td>
<td>Yobe</td>
</tr>
<tr>
<td>Number of clients treated for common illnesses</td>
<td>3569</td>
<td>9035</td>
<td>10,163</td>
</tr>
<tr>
<td>Number of children vaccinated</td>
<td>3386</td>
<td>34851</td>
<td>13,730</td>
</tr>
<tr>
<td>No of children screened for malnutrition</td>
<td>2156</td>
<td>9017</td>
<td>8707</td>
</tr>
<tr>
<td>Supervisory visits:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• In Borno 68 supportive supervisions were conducted by WHO LGAFI to the H2R Meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provided support to the design of the joint health sector micro plan to support the health needs of Adamawa returnees from Cameroon.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Had a meeting with SMOH to assess the preparedness status for Cerebrospinal meningitis outbreak.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• WHO had a meeting with Directors of SMOH to select health facilities to be renovated by WHO. A preliminary agreement has been reached on the priority LGAs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Participated in January 2018 Nutrition sector coordination meeting in Damaturu, Yobe state.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Participated in state technical team meeting on MNCH and RI in Damaturu, Yobe state</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stock out of essential medicines/ drugs for CORPs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The available fund to continue the H2R mobile activity is only for the first quarter of 2018</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Multiple partners engaged in rehabilitation but the effort is fragmented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• WHO Abuja logistic team to facilitate delivery of procured supply.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Support to access to basic health services (H2R and CORPs) prioritized for resource mobilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Conduct a consensus building workshop among partners and establish a working group.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CORPs achievement in December, 2017</th>
<th>Adamawa</th>
<th>Borno</th>
<th>Yobe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicators</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of clients seen</td>
<td>867</td>
<td>6721</td>
<td>2465</td>
</tr>
<tr>
<td>Malaria</td>
<td>303</td>
<td>1816</td>
<td>870</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>399</td>
<td>2386</td>
<td>1143</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>165</td>
<td>970</td>
<td>472</td>
</tr>
</tbody>
</table>
Public 3Ws for all Three States
Public Health Situation Analysis – Conflict and humanitarian crisis in North-East Nigeria

Version 18 January 2018

Health status and threats

Somatic health problems

It summarizes the current analysis of the magnitude (in terms of access, mortality, and morbidity) of the main health problems impacting the crisis-affected population, grouped into major disease categories. The magnitude of expected health problems and their expected evolution over time is shown in the table below:

- Severe shortage of clean drinking water with water-borne outbreaks reported
- Limited access to health services
- High prevalence of communicable diseases

Health problem | 1 | 2 | 3-4 | 5-12
--- | --- | --- | --- | ---
Severe shortage of clean drinking water | | | | |
Limited access to health services | | | | |
High prevalence of communicable diseases | | | | |

The table above shows the expected evolution of health problems over time. The color intensity indicates the severity of the problem. Yellow indicates low severity, green indicates medium severity, and red indicates high severity.

The same progress in urban areas, availability of safe drinking water and basic sanitation is not present with the pace of economic development. Nigeria did not achieve the MDG targets on health indicators. According to estimates, only 9% of the population has had access to proper sanitation since 1990. Annually, 600,000 children (0-500) under five are attributed to lack of proper sanitation and hygiene (WASH). Nigeria ranks 116 from the bottom on a list of 195 countries providing data in 2012 (source: GHSO). Open defecation stands at 21% nationwide in 2015. The already poor WASH situation is expected to have deteriorated in areas affected by the conflict and is a major concern in PHSA situation.
General Challenges

• IMTL focused almost exclusively on epidemiology
  – Important to have clear TORs
  – Need strong push from leadership for integrated IM

• NE Nigeria hub very separated from WCO
  – Makes information-sharing and communication more difficult
General Successes / Enabling Factors

• Excellent support for PHIS from EMO EO
  – One message from EO and HIM team: Build PHIS
  – Regular followup on PHIS in TCs etc.

• Highly skilled and motivated national staff
SOUTH SUDAN – INCREASED SUPPORT SINCE APRIL 2017
Inputs

• Remote technical and managerial support from HIM + GHC staff (multiple)

• Two field visits from external PHIS Advisor (Francesco – LSHTM/APW – 10 days + 9 days)
  One field visit from HIM staff (Chris – 35 days EWARS upgrade)

• Standby partners filling IMO posts in country
## Status – South Sudan

<table>
<thead>
<tr>
<th>Domain</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>No IM TL</td>
<td>IM TL</td>
</tr>
<tr>
<td>IM Workplan</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Team Structure</td>
<td>Not integrated</td>
<td><strong>Best in Class</strong></td>
</tr>
<tr>
<td>Shared files</td>
<td>No</td>
<td>Shared Drive (VSHOC added in 2018)</td>
</tr>
<tr>
<td>WCO Situation Report</td>
<td>Twice (plus cholera bulletins)</td>
<td>No</td>
</tr>
<tr>
<td>PHSAs</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3Ws</td>
<td>Yes (1 in 2016)</td>
<td>Yes</td>
</tr>
<tr>
<td>HeRAMS</td>
<td>Yes (Survey)</td>
<td>Yes (Monitoring)</td>
</tr>
<tr>
<td>EWARS</td>
<td>Yes</td>
<td>Yes (Expanded to additional sites)</td>
</tr>
<tr>
<td>HC Bulletin</td>
<td>Yes (3 in 2016)</td>
<td><strong>Best in Class</strong> (7 in 2017)</td>
</tr>
</tbody>
</table>

N.B. – not all PHIS services/products are reflected.
Fully Integrated IM Unit

Health Information Team Lead (R Burbach)

Health Information Advisor (F Checchi)

Senior Data Manager (G Tut)

Epidemiologist (J Wamala)

IMO (M Gai)

IMO (TBD)

IMO - Flying (TBD)

HMIS (T Kongelel)

Data Manager - NTD (J Sube)

MOH/WHO w. Dr. Matthew

EPI Officer (P Iranya)

Data Manager - IDSR (R Lasu)

Data Manager - IDSR (R Dagarna)

PHO - IDSR (Abraham)

PHO - IDSR (Alice)

Data Manager - IDSR (R Lasu)

Data Manager - IDSR (R Dagarna)

PHO - IDSR (Abraham)

PHO - IDSR (Alice)
HC Bulletin

South Sudan
Emergency type: Complex Emergency
Reporting period: 1 – 31 October 2017

1.9 million displaced
1.9 million targeted
7.5 million affected
2.7 million affected

FINDINGS

- The mental health and psychosocial support (MHPSS) community in South Sudan successfully observed the World Mental Health Day in Juba, Bentiu, Malakal, and Yambio. Various events and activities highlighting MHPSS issues in the country were organized by the national coordination and local working groups. The celebration aimed to increase awareness on mental health issues such as depression and suicide prevention and fighting the stigma experienced by people accessing mental health services.

- To mitigate the risk of cross-border spread of the confirmed Marburg outbreak in Kwanza Democratic Republic of the Congo, WHO is working with MOH and partners to strengthen preparedness and readiness capacities for case definition, investigation and response in addition increasing public awareness.

- To fill the critical gap in medical supplies, Christina Mission Aid delivered medicines and health supplies and distributed to five PHCs in and around the town of Yambio in Western Province. The drugs will combat the high cases of infectious diseases that have been reported in the health facilities.

- LRA committed to coordinate access to HIV/AIDS counselling, testing, and treatment services in the Bentiu, Malakal and Yambio protection of civilian (PoC) sites, benefiting an estimated population of 171,000 people, as well as the host communities.

- The health sector is challenged by the ongoing cholera outbreak and resurgence of malaria during this rainy season which is characterized by flooding and mudslides. Cholera and malaria outbreaks are a concern in the country, with outbreaks reported in Juba, Bentiu, and Malakal. The cholera and malaria situation remains a challenge, with reports of multiple cases in these areas. The health sector continues to work closely with partners to address these challenges and ensure that affected populations have access to essential health services.

- The health sector is also faced with challenges related to nutrition, particularly among children and pregnant women. Malnutrition rates remain high, and efforts are being made to address this issue through the provision of nutrition supplements and other interventions. The sector continues to work closely with partners to improve nutrition outcomes for vulnerable populations.

- The health sector is also facing challenges related to access to clean water and sanitation. Poor water and sanitation infrastructure continues to pose a significant challenge, particularly in conflict-affected areas. Efforts are ongoing to strengthen water and sanitation services, including the provision of water treatment and sanitation facilities. The sector continues to work closely with partners to address these challenges and improve access to clean water and sanitation for all communities.

- The health sector is also facing challenges related to disease surveillance and response. The country continues to experience outbreaks of acute respiratory infections, typhoid, and other diseases. The sector is working closely with partners to improve disease surveillance and response efforts, including the provision of diagnostic tools and other resources. The sector continues to work closely with partners to address these challenges and improve disease surveillance and response efforts.
General Challenges

- Change management issues between IMTL and HCC
- Lack of clarity on respective roles of IMTL and HCC – prompted IIMU Concept Note
- SBP IMO support temporarily suspended by donor due to internal issues
- Acting WR or no WHE Lead for much of year
- Simultaneous contract breaks/absence of multiple IM assets
- Size of IM team decreased by three international staff since formation
- EWAR expanded but not complete
  - Two parallel systems: remnants of facility-based IDSR, plus county-level EWAR
- No independent funding sources yet supporting IMU
- Event-based surveillance emphasized by Advisor, but not started
General Successes / Enabling Factors

- Supportive WR (both appointed and Acting)
- Dynamic IM TL
- Strong donor interest / pressure
SOMALIA – INCREASED SUPPORT SINCE JULY 2017
Inputs

• Remote support from HIM staff (multiple)
• One field visit from PHIS Advisor (Nada – 7 days)
• SBP IMOs deployment for cluster – (Abdi, GHC/SCUK Health Cluster Support Project)
### Status - Somalia

<table>
<thead>
<tr>
<th>Domain</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffing</strong></td>
<td>No IM TL</td>
<td>IM TL</td>
</tr>
<tr>
<td></td>
<td>One IMO (Nairobi)</td>
<td>WCO IMO (Mogadishu)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HC IMO (Mogadishu)</td>
</tr>
<tr>
<td><strong>IM Workplan</strong></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Team Structure</strong></td>
<td>Not integrated</td>
<td>Partially Integrated (IM TL + HC IMO + WCO IMO; separate epis)</td>
</tr>
<tr>
<td><strong>Shared files</strong></td>
<td>No</td>
<td>VSHOC</td>
</tr>
<tr>
<td><strong>WCO Situation Report</strong></td>
<td>Focused only on outbreaks</td>
<td>Broader focus</td>
</tr>
<tr>
<td><strong>PHSA</strong></td>
<td>No</td>
<td>Partially complete</td>
</tr>
<tr>
<td><strong>3Ws</strong></td>
<td>Yes - Excel</td>
<td>Adapted for PRIME (no users!)</td>
</tr>
<tr>
<td><strong>HeRAMS</strong></td>
<td>No</td>
<td>Partially prepared</td>
</tr>
<tr>
<td><strong>EWARS</strong></td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

N.B. – not all PHIS services/products are reflected.
IM Team Structure – Partial Integration
WCO Sitreps

Prior sitreps were epi bulletins only

Later sitreps covered broader range of topics

1st Holistic sitrep

Later holistic sitreps
EWAR Bulletin

Before

- No EWAR Bulletin

After

Epidemiological week 47 (Week ending 26 November, 2017)

**Highlights**

- Reports were received from 220 out of 260 reporting facilities (85.0%) in week 47 an increase in the reporting completeness compared to 26 (21.5%) in week 46.
- Total number of consultations increased from 52,853 in week 46 to 69,529 in week 47.
- The highest number of consultations in week 47 were for other acute diarrhoea (2,316 cases), Influenza like illness (1,753 cases) followed by severe acute respiratory illness (801 cases).
- AWD cases decreased from 166 in week 46 to 75 in week 47.
- No AWD/Cholera deaths reported in all districts in the past 12 weeks.
- The number of measles cases increased from 487 in week 46 to 292 cases reported in week 47.

**Cumulative figures as of week 47**

- 78,717 cumulative cases of AWD/cholera in 2017.
- 46,274 (58.8%) are children less than 5 years while 46,274 (51.2%) are 5 years and above.
- 1,359 cumulative deaths of AWD/cholera in 2017
- 55 districts in 19 regions reported AWD/cholera cases.
- 21,100 cumulative cases of suspected measles cases.
- Of the 21,100 cases, 10,545 (49.8%) whilst 10,555 (50.2%) are 5 years and above.

**Table 1. Summary of alerts for epidemic prone diseases and syndromes**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Week 46 2017</th>
<th>Week 47 2017</th>
<th>Cumulative cases (Week 1 - 47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total consultations</td>
<td>62,463</td>
<td>69,529</td>
<td>149,913</td>
</tr>
<tr>
<td>Other Acute Diarrhoea</td>
<td>2,316</td>
<td>75</td>
<td>60578</td>
</tr>
<tr>
<td>Influenza like illness</td>
<td>1,753</td>
<td>71</td>
<td>54724</td>
</tr>
<tr>
<td>Severe Acute Respiratory Illness</td>
<td>801</td>
<td>107</td>
<td>18449</td>
</tr>
<tr>
<td>Confirmed Malaria</td>
<td>206</td>
<td>296</td>
<td>12062</td>
</tr>
<tr>
<td>Suspected measles [1]</td>
<td>487</td>
<td>290</td>
<td>20614</td>
</tr>
<tr>
<td>Bloody diarrhoea</td>
<td>29</td>
<td>107</td>
<td>2140</td>
</tr>
<tr>
<td>Acute Watery Diarrhoea [2]</td>
<td>46</td>
<td>75</td>
<td>78717</td>
</tr>
<tr>
<td>Whistling (Cough)</td>
<td>81</td>
<td>13</td>
<td>761</td>
</tr>
<tr>
<td>Viral Haemorrhagic Fever</td>
<td>0</td>
<td>6</td>
<td>136</td>
</tr>
<tr>
<td>Ophthalmia</td>
<td>3</td>
<td>4</td>
<td>128</td>
</tr>
<tr>
<td>Acute Tonsillitis</td>
<td>1</td>
<td>1</td>
<td>168</td>
</tr>
<tr>
<td>Neonatal Tetanus</td>
<td>3</td>
<td>0</td>
<td>174</td>
</tr>
</tbody>
</table>
Great 4Ws Form – But No Entries!
Specific Challenges

• Strategist visit delayed five months due to SSAFE training issues
• Change management issues between IM TL and WCO IMO
• Still multiple overlapping data products (EPI/POL Bulletin, EWAR Bulletin, HC Bulletin,...) 3Ws/HeRAMS
General Successes / Enabling Factors

• Strong HC IMO (Abdi)
  – SBP, now gone, being replaced by another SBP.
• Supportive WR
• IM TL very responsive to feedback
ETHIOPIA - INCREASED SUPPORT SINCE AUGUST 2017
Inputs

• Remote support from HIM staff (multiple)
• Heavy remote support from consultant PHIS advisor (Fatma)
  – Esp. for HeRAMS
• One scoping visit from PHIS Advisor (Fatma – 12 days)
• Heavy onsite support from partner (iMMMAP)
## Status - Ethiopia

<table>
<thead>
<tr>
<th>Domain</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>No IM TL (Yes Epidemiologist)</td>
<td>NO IM TL (candidate removed)</td>
</tr>
<tr>
<td></td>
<td>No HC IMO</td>
<td>HC IMO (iMMAP)</td>
</tr>
<tr>
<td></td>
<td>Multiple Data Managers</td>
<td>Multiple additional staff (iMMAP)</td>
</tr>
<tr>
<td>IM Workplan</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Team Structure</td>
<td>Not integrated</td>
<td>Partially Integrated</td>
</tr>
<tr>
<td>Shared files</td>
<td>Unknown (not VSHOC)</td>
<td>Unknown (not VSHOC)</td>
</tr>
<tr>
<td>WCO Situation Report</td>
<td>Internal</td>
<td>Internal</td>
</tr>
<tr>
<td>PHSA</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3Ws</td>
<td>Draft 3W map</td>
<td>Yes (ReportHub) but not widely used</td>
</tr>
<tr>
<td>HeRAMS</td>
<td>No</td>
<td>Prepared but waiting for GoE signoff</td>
</tr>
<tr>
<td>EWARS</td>
<td>No</td>
<td>Discussions underway to revitalize</td>
</tr>
<tr>
<td>HC Bulletin</td>
<td>No</td>
<td>No (soon to issue Dec 2017 bulletin)</td>
</tr>
</tbody>
</table>

N.B. – not all PHIS services/products are reflected.
IM Team Structure

- IMTL now vacated
- HC IMO from iMMAP works inside this team
Interactive 3Ws Dashboard (Pilot)
Specific Challenges

- Lack of access to data (both govt and WCO)
- National structure for emergency: several national counterparts exist with multiple layers of reporting
- Multiple vacancies in IM Team
  - IMTL appointed but then removed
  - No dedicated HC IMO prior to July
    - HC IMO now provided bilaterally by iMMAP
General Successes / Enabling Factors

• Very active Strategist
• Strong support for PHIS from partner (iMMAP)
GENERAL OBSERVATIONS
General PHIS challenges

- Low WCO familiarity with PHIS Standards
  - Much time in support missions spent on familiarization
- Turnover in WCO staff
- Transition of PHIS TT leadership
- Presence of PHIS product ≠ quality of product
- Insufficient funding for in-country activities (e.g., visiting sub-clusters)
- Difficulty finding (esp. francophone) strategic advisors
- Low engagement from other partners (except iMMAP and SCUK) in PHIS TT
- Difficulty finding IMO staff
  - Heavy reliance on Standby Partners
- Insufficient publicity of PHIS achievements
Heavy Reliance on SBP

N.B.: these are general SPB statistics, not specific to the countries highlighted
General PHIS successes (1)

• PHIS Standards document finalized, endorsed, available in English & French
• PHIS Toolkit created & available via GHC website
  – (Not all tools user friendly)
• IIMU Concept Note drafted
  – Needs final endorsement and dissemination
• Close collaboration between PHIS and Capacity Development Task Teams
General PHIS successes (2)

- Close collaboration between GHCU and MDC
- Joint IMO-HCC training through GHC / additional training (e.g., PRIME) for IMOs
- IMO mentoring programme being piloted to build competencies (but still very small-scale)
- IMO Competencies / Professional Development Plan template developed
- PHIS Consortium model proposed
- Much support able to be provided remotely
CONCLUSIONS
The Current Model Works, But...

OUTSTANDING NEEDS

• Strong in-country leadership for PHIS (incl. use of willing partners)
• Increase awareness of PHIS
• Larger pool of IMOs from which to draw
• More predictable/sustained/larger IMO staffing
• More sustained Strategic Advisor support
• Take advantage of remote support opportunities
• PHIS core products (HeRAMS, EWARS, HC Bulletin) to be part of IMO/IMTL/HCC PMDS Line-item budgets for PHIS/IM
• Increase sharing of best practices between PHIS countries
• Secure long term funding and strategic partnership
Next Steps for WHO

1. Strengthen in-country WHO Country Office InfoMgmt operations through Country Business Model and stronger Regional Office engagement in HC activities
2. New MDC Country Support Team to provide focused strategic PHIS support to countries
3. Prioritize ongoing training for existing IMOs
4. Closer engagement with operational partners in specific responses (e.g., iMMAP in DRC)
5. Establish Consortium to expand work of PHIS TT