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MONITORING ACHIEVEMENT OF SOCIAL GOALS IN THE 1990'S

Monitoring Progress in Implementing Strategies for Health for All

Report prepared by the World Health Organization

1. Most countries have as a major social goal the health of their people. Governments need to know if they are making progress in the inmplementation of their health strategies, and whether these strategies are having the desired effect in improving the health status of the people. To this end countries need to introduce, if they have not already done so, a process of monitoring and evaluation that is appropriate to their needs as part of their managerial process for national health development. Whatever the precise nature of the process, it should include monitoring progress in carrying out the measures decided upon, the efficiency with which these measures are being carried out, and the assessment of their effectiveness and impact on the health and socioeconomic development of the people.

2. When Member States unanimously adopted the Global Strategy for Health for All by the Year 2000 (resolution WHA34.36, May 1981), and the Plan of Action for implementing it (resolution WHA35.23, May 1982), they agreed to monitor progress in the implementation of their national strategies and to evaluate their effect in improving the health status of the people, using appropriate indicators to this end. Member States further agreed to establish at the earliest stage a process of monitoring and evaluation that was appropriate to their needs as part of their managerial process for national health development.

3. The World Health Assembly decided to monitor the progress and evaluate the effectiveness of the implementation of the Strategy at regular intervals, proposing that reports on progress be reviewed biennially by the regional committees, the Executive Board and the Health Assembly and that, every six years, an assessment be made of the effectiveness and impact of the Strategy at national, regional and global levels. Member States initiated the process with a first report on the monitoring of progress in the implementation of their national strategies in 1983 and with a first report on the evaluation of the effectiveness of the implementation in 1985.

4. Recognizing the need for Member States to strengthen their national capability in monitoring and evaluation, including the related information support, as part of their overall managerial process, the Thirty-ninth World Health Assembly in resolution WHA39.7 (May 1986) decided to institute reporting on monitoring of progress in the implementation of the Strategy every three instead of every two years, maintaining the evaluation of the effectiveness of the implementation of the Strategy on a six-year cycle, starting from 1985. Thus there was a second monitoring performed in 1988, and there will be a second evaluation in 1991, and a third monitoring and evaluation in 1994 and 1997, respectively.

5. Monitoring, being an integral part of any managerial process, is a continuous activity. Reporting on progress and outcome to be reviewed at national decision-making levels is periodic, and in most cases annual. As described above, countries have also decided to report to WHO on progress in the implementation of their national strategies every three years. This distinction between monitoring at national level as a process and reporting to

WHO as a periodic activity is important. For the latter, selected information on the progress concerning the main components of the health-for-all strategy and the global indicators (as well as any regional or national indicators if they exist) has to be collected, analysed and synthesized. It was realized that reporting in a systematic manner and the synthesis of information at regional and global levels would be facilitated by the adoption of a common (standard) framework. Thus in 1982 a Common Framework and Format (CFF) was developed to assist Member States in collecting and analysing relevant information for monitoring progress in the implementation of their national strategies for health for all, and to report on progress to the regional committees, the Executive Board and the World Health Assembly. Subsequently, an expanded CFF was prepared for reporting on the evaluation of the effectiveness of the implementation of the Strategy.

6. If countries have already a process for monitoring progress and evaluating the effectiveness of the implementation of their strategies, it is expected that the reports to be presented to the WHO regional committees will be derived from the information which is being systematically collected and analysed to support their national health development efforts. On the other hand, if such a process has not yet been introduced or is not functioning effectively, countries can use the common frameworks as tools and as opportunities to initiate the building up of a national mechanism for the monitoring of progress and the evaluation of the effectiveness of the implementation of their strategies. The results of the monitoring and evaluation process could serve for wider consultation both within the health sector as well as with other sectors, and help decision makers in identifying what key measures need to be taken to accelerate the implementation of their national strategies.

7. By using a Common Framework, Member States are thus able to:

- compare their health situation from one reporting period to the other;
- measure progress in relation to their targets;
- identify difficulties and obstacles encountered; and
- use the resulting analysis to improve their health plans, carrying out reprogramming as necessary.

8. It is emphasized that the CFF is not "just another WHO questionnaire", but on the contrary an important tool for supporting the monitoring and evaluation process which is essential to the basic functioning of countries' managerial processes for national health development. Final responsibility for the monitoring of the progress and evaluation of the implementation of the national strategies for health for all remains with each Member State.

9. Countries have already agreed on a short list of indicators for assessing health and socioeconomic status at global level (see Annex). Some WHO regions have also established additional regional indicators, while many countries may also be using additional indicators in keeping with their needs and capacities. A periodic comparison of the indicators at national, regional and global levels will be useful for assessing trends. In addition, the 1989 World Health Assembly has called for a review of the global indicators with a view to reassessing their relevance and adequacy. This review is currently in progress. Future selection of indicators for monitoring and evaluation will be guided by consideration of the enhanced use to which they will be put, based on the global strategy for health for all.

10. WHO is also collaborating with the UN Statistical Office in developing the UN Women's Indicators and Statistical Data Base (WISTAT), and with UNICEF in developing statistics and indicators for the WHO/UNICEF Common Goals for Health Development of Women and Children by the Year 2000. In all these ways WHO is contributing to the monitoring of the achievement of social goals in the 1990's.

WHO's 12 Global Indicators

The number of countries in which:

(1) Health for all has received endorsement as policy at the highest official level, e.g., in the form of a declaration of commitment by the head of state; allocation of adequate resources equitably distributed; a high degree of community involvement; and the establishment of a suitable organizational framework and managerial process for national health development.

(2) Mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning, i.e., active and effective mechanisms exist for people to express demands and needs; representatives of political parties and organized groups such as trade unions, women's organizations, farmers' or other occupational groups are participating actively; and decision-making on health matters is adequately decentralized to the various administrative levels.

(3) At least 5% of the gross national product is spent on health.

(4) A reasonable percentage of the national health expenditure is devoted to local health care, i.e. first-level contact, including community health care, health centre care, dispensary care and the like, excluding hospitals. The percentage considered "reasonable" will be arrived at through country studies.

(5) Resources are equitably distributed, in that the per capita expenditure as well as the staff and facilities devoted to primary health care are similar for various population groups or geographical areas, such as urban and rural areas.

(6) The number of developing countries with well-defined strategies for health for all, accompanied by explicit resource allocations, whose needs for external resources are receiving sustained support from more affluent countries.

(7) Primary health care is available to the whole population, with at least the following:

- safe water in the home or within 15 minutes' walking distance, and adequate sanitary facilities in the home or immediate vicinity;
- immunization against diphtheria, tetanus, whooping-cough, measles, poliomyelitis, and tuberculosis;
- local health care, including availability of at least 20 essential drugs, within one hour's walk or travel;
- trained personnel for attending pregnancy and childbirth, and caring for children up to at least 1 year of age.

(8) The nutritional status of children is adequate, in that:

- at least 90% of newborn infants have a birth weight of at least 2500 g;
- at least 90% of children have a weight for age that corresponds to the reference values given in Annex 1 to Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000 ("Health for All" Series No. 4, WHO Geneva, 1981).

(9) The infant mortality rate for all identifiable subgroups is below 50 per 1000 live-births.

(10) Life expectancy at birth is over 60 years.

(11) The adult litaracy rate for both men and women exceeds 70%.

(12) The gross national product per head exceeds US $ 500.