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MONITORING PROGRESS IN THE IMPLEMENTATION OF HEALTH FOR ALL STRATEGIES - REPORT ON A STUDY TO IDENTIFY REGIONAL TARGETS

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MONITORING PROGRESS IN THE IMPLEMENTATION OF HEALTH FOR ALL STRATEGIES - REPORT ON A STUDY TO IDENTIFY REGIONAL TARGETS

1. INTRODUCTION

Member States of WHO decided at the World Health Assembly in 1977 that the main social target of governments and WHO should be "the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (resolution WHA30.43). This is popularly known as "Health for All by the Year 2000" or, in short, "HFA/2000". Subsequently, the Alma-Ata Declaration (1978) stressed that primary health care (PHC) is the means of attaining this target.

The WHO Global Strategy for HFA/2000 was adopted in 1981 (resolution WHA34.36). It invited Member States "to enter into this solemn agreement for health of their own volition, to formulate or strengthen, and implement, their strategies for health for all accordingly, and to monitor their progress and evaluate their effectiveness, using appropriate indicators to this end". The Plan of Action for Implementation of the Strategy was adopted a year later (resolution WHA35.23). The Plan requires that WHO's governing bodies monitor progress in the implementation and evaluate the effectiveness of these strategies at specified intervals. Evidently, such action by the governing bodies should be largely based upon reports received from Member States.

2. TOWARDS DEFINING REGIONAL TARGETS

As defined by WHO, "objectives are desired aims and targets are objectives that have been made more specific in quantified terms or in terms of time. Indicators are used as markers of progress towards reaching objectives and targets."

The Global Strategy has identified a short list of twelve indicators to be used for global monitoring and evaluation of the Strategy. "This implies the commitment of countries, individually as well as collectively in regional groupings, to use at least these indicators and provide the necessary information on them." Hence they are referred to as the "Global Indicators". Countries, however, may use additional indicators, in keeping with their needs and capacities. In an Intercountry Group Meeting held in 1983 in Damascus, Syrian Arab Republic, the participants discussed the countries' experience in the preparation of the first national progress reports. The group suggested a number of more specific and less aggregate indicators, to be used in the Region together with the Global Indicators; the Regional Committee in 1983 approved this list of suggested indicators (resolution EM/RC30A/R.5).

Each country will decide on its own norms but, as reiterated in the Global Strategy, "a minimum life expectancy of 60 years or more at birth, and a maximum infant mortality rate of 50 per 1000 live births, are suggested as indicating that the health status of the population is becoming a decreasing burden on individual, family and community development." Other figures were suggested as target values for the numerical Global Indicators. Because of difficulties in international comparisons, average global values of indicators would have little meaning. "For this reason, monitoring and

evaluation at the global level will be based on the number of countries in which certain indicators comply with predetermined norms."

The Plan of Action for Implementation of the Strategy stipulated that the regional committees will "consider the possibility of defining regional targets on the basis of national targets if they have not already done so." In fact, after reviewing the Second Report on Monitoring Progress in the Implementation of HFA Strategies, the Regional Committee (1988) requested the Regional Director "to conduct a study to identify Regional targets for HFA and report to the Thirty-sixth Session of the Regional Committee" (resolution EM/RC35/R.7). The present paper has been prepared in compliance with that resolution.

3. SELECTED INDICATORS FOR REGIONAL TARGETING

The Regional Programme Budget Policy, adopted by the Regional Committee in 1986 (resolution EM/RC33/R.5), defined priorities in the use of WHO's resources as follows: "WHO and Member States in the Region will place initial emphasis on the introduction and attainment of intermediary targets related to the four global indicators for the availability of primary health care to the whole population." These included: (a) safe water supply and adequate sanitary facilities; (b) immunization against the six target diseases of EPI; (c) availability of local health care; and (d) attending pregnancy and childbirth, and caring for infants, by trained personnel. Furthermore, "attention will be paid to other programme targets and activities as a function of their close relationship to the essentials of primary health care."

Accordingly, this paper will attempt to set Regional targets for a selected group of Global and Regional Indicators. These are as follows:

1. Proportion (%) of the population that have safe drinking water available in the home or within 15 minutes' walking distance, separately for urban and rural populations.

2. Proportion (%) of the population that have adequate facilities for hygienic excreta disposal in the home or immediate vicinity, separately for urban and rural populations.

3. Proportion (%) of infants reaching their first birthday who have been fully immunized against the six EPI target diseases, and of pregnant women who have been immunized against tetanus.

4. Proportion (%) of the population who have local health care, including a regular supply of at least 20 essential drugs, available within one hour's walk or travel, separately for urban and rural populations.

5. Proportion (%) of women cared for during pregnancy by trained personnel.

6. Proportion (%) of women cared for during childbirth by trained personnel.

7. Proportion (%) of infants cared for, up to at least one year of age, by trained personnel.

8. Infant mortality rate (per 1000 live births).

One would have liked to include here a few other related Global and Regional Indicators. Important among these are the percentage of newborns with a birthweight of at least 2500 g, the percentage of children below five years of age with weight-for-age corresponding to reference values, and the maternal mortality rate. However, this was not done for one reason or another, mainly because the data are usually based on small selected samples, resulting in limited comparability of such data.

4. METHODS

Data given by Member States in the Second Monitoring Reports (1988), compared to those in the First Evaluation Reports (1985) and the First Monitoring Reports (1983) were carefully analysed. Where available, earlier data, national targets, or views expressed in related intercountry meetings were given due consideration. The targets were set on the basis of such analyses.

5. DRINKING WATER SUPPLY AND SANITATION

On 10 November 1980 the United Nations General Assembly proclaimed the period 1981 to 1990 as the International Drinking Water Supply and Sanitation Decade (IDWSSD). Every developing country was urged to give priority to providing safe supplies of drinking water and adequate means of sanitation to as many of its people as possible. Safe water, accompanied by hygienic sanitation, was seen as the most fundamental step towards improving health and economic progress.

The "Decade" did not specify targets for the countries. What was required was that each country must work within its own constraints to develop plans and implement programmes consistent with the IDWSSD approach. Countries set their own targets.

Statistics were collected related to the situation in each country in December 1980, to represent baseline data for the "Decade". Updated questionnaires were collected to provide data at the end of 1983 and then the end of 1985, the mid-Decade point. More recent data were obtained from the Second Monitoring Reports of some countries (submitted in 1988). One may point out here that there are some differences between the IDWSSD definitions and those of the monitoring exercise.

5.1. Urban water supply

According to the "Decade" data, 18 countries set their targets by 1990 at 100% of the urban population, four at 80-99% and one at a modest figure of 38%. The latest (1985-87) data show that 12 countries have already achieved, or exceeded, their targets. The other 11 countries are still behind, evidently as a result of the sluggish economy that prevailed in the 1980s. Amongst this latter group the difference was small, within 10% of the target figure in six countries, and as large as within 20-50% of the target in three countries (which account for 9% of the Region's urban population).

The Regional average coverage increased from 78% (as of 1982) to the recent figure of 92%. One distressing aspect, however, is that for ten countries the latest coverage figures are lower than those given as the "Decade" baseline (i.e. as of end 1980). A partial reason for this is that expansion of water supply could not cope with rapid urbanization,

particularly for urban slums. Most probably, at least in some cases, the baseline data were artificial over-estimates and the result, as expected, was inability to demonstrate progress, or even maintain the stated level.

From the above discussion it is suggested to set the Regional targets for urban water supply as follows:

Target 1

(a) The 17 countries that have already crossed the 90% coverage mark should maintain or improve that level, so that by the year 2000 they should reach 98-100% coverage;

(b) Three other countries (which account for 28% of the Region's urban population) should reach 95% coverage by the year 2000;

(c) For the three countries with the lowest coverage (accounting for 3% of the Region's urban population and all in the group of "least developed countries" (LDCs)), the target should be 65% by 1995 and 75% by the year 2000;

(d) In short, safe drinking water should be available to at least 95% of the Regional urban population by the year 2000.

5.2. Rural water supply

In contrast to urban water supply targeting, eight countries only set their targets for rural water supply at 100%, six at 80-99% and five at 50% or less, all by 1990; the remaining four countries did not set targets. What is particularly striking is that the target for rural water supply was usually 35-70% of that for the urban population, a sign of gross inequity. In fact, the Regional target coverage was 66% for the rural population by 1990, against 95% for the urban population.

Ten countries have already fulfilled, or exceeded, their 1990 targets. The other 13 countries lag behind, to varying degrees. Two of them achieved 90-99% of their target (compared to six for urban water supply); at the other end of the scale, five countries could not achieve even 50% of their target. As a result, there was a meagre increase in the Regional average coverage from 36% (as of 1982) to a recent figure of 43%, indicating a long way to go in our Region where some 210 million population live in rural areas.

It is proposed to set the Regional targets with respect to rural water supply as follows:

Target 2

(a) The six countries that have reached full coverage (and which account for 1% of the Region's rural population) should, and could, maintain that level;

(b) The three countries with 80-90% coverage should, and could, increase coverage by at least 10% of their present levels, by the year 2000;

(c) The six countries with 50-75% coverage (and which account for 19% of the Region's rural population) should, and could, increase coverage by 30-50% of their present levels, by the year 2000;

(d) The remaining eight countries (which account for nearly two-thirds of the Region's rural population, and include the six LDCs in the Region), with a coverage as low as 17-35%, should increase the coverage by 40% of their present levels by 1995. (Regrettably, the local situation at present in some of these countries does not permit greater increase in the foreseeable near future). They should achieve another increase of 60% of their present levels by the year 2000.

(e) All in all, safe water supply should be available to at least 70% of the Region's rural population by the year 2000.

5.3. Urban sanitation

Thirteen countries had set their "Decade" targets at 100% by 1990 for coverage of their urban population with adequate sanitary facilities; only six of these have actually achieved that target. At the other end of the scale, eight countries have coverage rates at present lower than their Decade baseline (1980) data, a reflection of overshooting in those estimates.

The latest available data show that eight countries (with 27% of the Region's urban population) have achieved 100% coverage, five have achieved 90-99%, and five more (which account for 32% of the Region's urban population) 45-74%. In contrast, three countries (which account for 7% of the Region's urban population and are all among the LDCs) have coverage as low as 5-45%. The Regional average coverage is close to 80%, up from 63% as of 1982, an encouraging pace of expansion of these services.

It is reasonable to set Regional targets by the year 2000 with respect to urban sanitation as follows:

Target 3

(a) At least 85% of the total urban population should be covered;

(b) The 13 countries that have achieved at least 90% coverage should maintain, or improve, that rate to achieve at least 95%;

(c) The remaining ten countries should improve coverage by at least 15-30% of their present figures, or reach a coverage of 50-90%, whichever is higher.

5.4. Rural sanitation

The situation regarding rural sanitation in the Region is really pitiful. Five countries, which barely account for 1% of the Regional rural population, have achieved a coverage of 90% or more. At the other extreme, five other countries (which account for 57% of the rural population) have coverage rates of 5% or less. The result is that the Regional average coverage is about 22%, almost the same figure as for 1982. The Decade target for 1990 was set at 34%. Furthermore, the five countries with the smallest coverage, and which include four of the Region's LDCs, hardly showed any progress since 1980 and, because of prevailing conditions at the national and international level, are not likely to advance much further over the coming few years.

Target 4

A reasonable Regional coverage target for rural sanitation would be 50% by the year 2000. The upper-bracket five countries should achieve 100% coverage. The lower-bracket five countries should reach 30% coverage, recalling that they extend over 30% of the area of the whole Region. The remaining 13 countries should have as a target improving their coverage by at least 25-50% of their present levels, or reach a coverage of at least 40%, whichever is higher.

It should be stressed that the set targets, particularly for rural water supply and sanitation, may seem to be beyond the institutional capacities for a number of countries. However, they have been intentionally set at such high levels to force the countries to mobilize all resources, and give them support in contacting international donors, to improve the coverage of their populations.

6. IMMUNIZATION

Progress in the annual immunization of infants against the six target diseases of the Expanded Programme on Immunization (EPI) is monitored regularly. Achievements, constraints and targets are discussed in the regular intercountry meetings of national EPI programme managers. Member States had established in 1986 yearwise target levels to reach full immunization coverage by 1990.

It was essential for countries with low immunization coverage to organize accelerated EPI activities as a step towards meeting these set targets. In 1986, eight countries achieved 90% or more of the set targets for that year. During the last two years more and more countries are approaching their targets. On the other hand, four countries in 1987, and two countries only in 1988, could not achieve 50% of their targets. As a result, the average coverage for the individual antigens for ages under one year was 20-30% in 1982, increased to 40-50% in 1985, then to 65-75% in 1988. This is an encouraging pace of increase in immunization coverage.

It is noteworthy, however, that the lowest coverage by any antigen in 1987 was still less than 25% in six countries of the Region; it was in that range in one country only in 1988. It is known that immunization with BCG under one year of age is not part of the EPI schedule in some countries where it is considered that tuberculosis is no longer a problem, and in one country the schedule requires immunization against measles during the second year of life. In these countries such immunizations are excluded in deciding on "the lowest coverage by any one antigen" as a proxy indicator to the "proportion of infants who have been fully immunized against the six diseases".

Countries of the Region still adopt different policies on how to calculate the coverage with tetanus toxoid (TT) immunization for pregnant women. In some countries TT immunization is not a routine requirement since tetanus neonatorum almost disappeared as a problem. There are inherent difficulties in assessing cumulative coverage in women of childbearing age or their immune status at the start of pregnancy. Available data point out that TT immunization among pregnant women is still lagging far behind as compared to infant immunization. The Regional average coverage was less than the 5% mark in 1982, almost 20% in 1987 and 32% in 1988 when it exceeded the 50% mark in five countries.

Based on the above discussions, the Regional targets may be set as follows:

Target 5

(a) Regarding immunization of infants:

- By 1995, the lowest coverage rate by any antigen should be at least 90% (except in the six LDCs where it should be at least 60%);
- By the year 2000, the lowest coverage rate should be at least 95% (and at least 75% in the LDCs)

(b) Regarding TT immunization:

In view of differing national policies on TT immunization, it would be difficult to set a target level to be reached by all countries. However, since the objective is primarily the prevention of neonatal tetanus, it would be more practicable to monitor the annual immunization coverage amongst pregnant women with two doses of TT and/or a booster dose, using the annual number of newborns as the target of neonates that should have been protected from tetanus. The proposed target indicator will be to attain the same level of immunization coverage as in infants.

Incidence of EPI target diseases

Since what counts in the immunization programme is its effectiveness in prevention of the diseases, it has been agreed to use as a Regional Indicator the incidence rate of the EPI target diseases. Among the six diseases, poliomyelitis is the most amenable for setting a target. This is because of inherent problems in the notification of the other diseases, quantitatively as much as qualitatively.

The incidence of poliomyelitis has been showing steady decrease in recent years. During 1975, for example, there occurred more than 14 000 new cases in the Region. Data for 21 countries for 1988 show that four countries reported the absence of any new case of poliomyelitis, and the number of cases was less than ten in seven other countries. In fact, and despite defective notification and smaller population size in the past, the total number of new cases of poliomyelitis in these countries during 1988 was less than 2200, i.e. less than one-sixth of the number during 1975.

Target 6

With the rapid expansion of immunization coverage, it is reasonable to set as a target the eradication of poliomyelitis in the Region by the year 2000.

7. LOCAL HEALTH CARE

The latest available data show that local health care, including a regular supply of at least 20 essential drugs, was available within one hour's walk or travel to the whole population in five countries, and to 90-99% of the population in eight more countries. But coverage was less than 75% in five countries (which account for 30% of the population in the Region, four of them being among the LDCs). The Regional average is 79%, up from 69% in 1982. This indicates that Member States are pushing hard to expand their local health care facilities.

As expected, the urban population has better coverage, as these people are more concentrated within a given surface area. No wonder there are 14 countries that have now achieved full coverage, and five more have achieved 90-95% coverage. Two countries only had a coverage below 75%. However, the picture for the rural population is less bright: coverage was below 75% in nine countries (which account for 35% of the rural population in the Region, and which include all the six Regional LDCs). The Regional average coverage was 96% for the urban population, against 64% for the rural population.

Target 7

One may set the Regional targets for the year 2000 as follows:

(a) At least 98% of the urban population in the Region should be covered by local health care;

(b) All nine countries with 90% or more coverage of their rural population should maintain, or improve, that level to be at least 95%;

(c) The five countries with 75-89% coverage of their rural population should reach at least 90%;

(d) The nine countries with coverage below 75% of their rural population should improve that coverage by at least 25-50% of their present levels, to reach at least 60%, whichever is higher;

(e) The overall Regional average coverage for the rural population should be at least 90% by the year 2000.

8. MATERNAL AND CHILD HEALTH

8.1. Care during pregnancy and at childbirth

The proportion of women cared for during pregnancy by trained personnel varies widely. Latest available data show that it was 90-100% in five countries, while at the other extreme it was a bare 2-10% in three countries (which account for 9% of the live births in the Region, and are all among the LDCs, but excluding one LDC which did not provide coverage data). The latest Regional average coverage was 52%, up from 28% in 1982 (noting that more than half of the countries, including those with low coverages in recent years, could not provide data in 1982).

Data on the proportion of women cared for at childbirth by trained personnel were not much different. Such data were not asked for separately in the First Monitoring Report (of 1982). However, available data show that the Regional average coverage is now about 58%, up from 27% as of 1985. The increasing number of trained traditional birth attendants (TBAs) is probably an important factor. The Regional Office is exerting great efforts in its activities for training TBAs for the rural population.

Figures on the above two indicators reported by some countries seemed to be in the nature of guess-estimates rather than being based on actual studies. Coverage rates at 98-100% were given nine times, and rates rounded in tens (excluding 100%) were quoted ten times. In fact, coverage rates of exactly 60% were given seven times.

It would have been advisable if data on the above two indicators were available separately for urban/rural population. Less than one half of the countries could provide that information; the lower coverage for women in rural areas as compared with their urban counterparts was prominent.

Target 8

The Regional targets for maternal care may be set as follows:

(a) Countries that have by now reached almost complete coverage should maintain that level;

(b) Countries with a present coverage of 75-89% should, and could, reach 95% by 1995, and almost complete coverage by the year 2000;

(c) Those with a present coverage of 25% or less should achieve doubling the present level by 1995, and 3-4 times that level by the year 2000;

(d) All other countries should increase the coverage by at least 50% of the present levels by 1995, to reach a coverage of 90% or more by 2000;

(e) The Regional average coverage should be at least 85% by 1995, and 90% by the year 2000;

(f) Coverage for the rural population should be at least 60% of the level for urban population by 1995, and at least 75% by 2000.

Target 9

All countries should have at least one trained traditional birth attendant per village, if no health personnel of higher levels of qualification/training are available for care during pregnancy and at childbirth.

8.2. Infant care

Data on the proportion of infants cared for, up to at least one year of age, by trained personnel were available for 15 countries only. Though the latest Regional average coverage was 60%, this figure should be taken with much reservation. Out of the eight non-reporting countries, four are among the LDCs, certainly with very low coverage. Besides, one third of the reporting countries gave data for 1985 or earlier. Taking the figures at their face value, seven countries gave a coverage of 90-100%, six of 60-75%, and two of 13-30%.

Target 10

The targets set for care during pregnancy and at childbirth may well be set for infant care also, as applicable.

9. INFANT MORTALITY

The infant mortality rate (IMR) is a basic and sensitive health indicator. The main problem lies in the unreliability of data. Rates based on vital registration are often underestimated. Legislation for birth and death registration is absent in some countries or, if it exists, is not much

enforced. Even in countries of the Region where birth and death registration is said to be "virtually complete" (as defined by the United Nations Statistical Office, i.e. representing at least 90% of the events occurring each year), registration of infant deaths continues to be prone to incompleteness to a higher degree. Legislation usually permits a time limit for registration of births much longer than for death registration. Deaths that occur within days after birth, therefore, often pass unregistered, neither as births nor as deaths, resulting *per se* and according to mathematics in lower IMRs.

In the absence of other information, estimates made by the United Nations or its specialized agencies, based on the application of known mathematical models, were the ones quoted for many countries. Such estimates were sometimes questioned by the countries themselves, which prefer to provide officially rates based on reporting, these being much lower and, hence, more acceptable to them. Limited field studies were carried out in a few countries. In view of known problems inherent in such studies, they often yield lower rates. In fact, some countries now report infant mortality rates of a level so low that they may be about one half of the rates officially included in the first evaluation reports (submitted in 1985). In-depth and large-scale surveys have been carried out lately in Arab countries of the Gulf; the results will be made known shortly. Similar surveys are planned to take place (through the League of Arab States) in five other countries of the Region. It is hoped that more reliable figures for many countries will become available in the near future.

The Regional average IMR came down from 111 in 1982 to 97 in 1985, then in 1987 to 81, per 1000 live births. Taking the latest available data at their face values, one finds that twelve countries (which account for less than 23% of the live births in the Region), have IMRs below 50 per 1000, the target suggested in the Global Strategy. Five more (which account for 57% of the live births in the Region) have rates of 50-100 per 1000. In the upper bracket, six countries have rates exceeding 100 per 1000 live births.

Target 11

The following Regional targets for the IMR may be suggested:

(a) Countries that have gone below the 50 per 1000 mark should be able to achieve, by the year 2000, a further reduction of 25% of their present levels;

(b) The middle-group countries, with rates at 50-100 per 1000, should lower their present levels by one third, or reach rates of 50 per 1000, whichever is lower, by the year 2000;

(c) The high IMR countries should lower their present rates by one half, or reach rates of 70 per 1000, whichever is lower, by the year 2000;

(d) The Regional average IMR should not exceed 50 per 1000 by the year 2000.

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

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MONITORING PROGRESS IN THE IMPLEMENTATION OF HFA STRATEGIES - REPORT ON A STUDY TO IDENTIFY REGIONAL TARGETS

Summary of Recommendations

1. It is recommended that the Regional Committee adopt the targets set in this paper as the EMR Targets Towards HFA. To that list of targets, the following one may be added: "The maternal mortality rate should be reduced, by at least 50% of present levels, by the year 2000."

2. Member States should exert every effort to achieve the set targets, as applicable to each Member State.

3. WHO should mobilize its resources and extend to Member States all possible support in order to achieve the set targets.

4. The Regional Office should continuously monitor progress towards achieving these targets. The Regional Director is requested to present a review of such progress (and any proposals for revision of the targets, if necessary), in conjunction with the periodic reviews by the Regional Committee of monitoring and evaluation of HFA strategies, the next one being the Second Evaluation of HFA Strategies, due in 1991.