WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR SOUTH - EAST ASIA

REGIONAL COMMITTEE

Forty-third Session

Provisional Agenda item 15

SEA/RC43/6

5 July 1990

MONITORING AND EVALUATION OF HFA STRATEGIES: A PROGRESS REPORT ON PREPARATIONS FOR SECOND EVALUATION

1. INTRODUCTION

The thirty-third session of the Regional Committee had adopted the regional and national strategies for the attainment of the social goal of Health for All by the year 2000. At that time, the Committee had urged Member Countries to set up mechanisms at the national level to monitor and evaluate the implementation of the strategies. In September 1981, while endorsing the global strategy, the Committee again emphasized the need for regular monitoring and evaluation. The first monitoring took place in 1983 and the first evaluation in 1985. The results of the first evaluation formed the basis for the Seventh World Health Situation Report. The World Health Assembly had also, in its resolution WHA34.36, urged Member Countries to implement the strategies for Health for All and monitor their progress and evaluate their effectiveness.

At the time of the first evaluation, the periodicity of monitoring and evaluation was changed from the erstwhile two- and four-year cycles to three- and six-year cycles respectively. Consequently, the second monitoring took place in 1988 and the results of the monitoring of the progress and implementation of the strategies were noted by the Regional Committee in 1988.

In 1989, the World Health Assembly, after considering reports on monitoring of the progress, urged Member Countries, in its resolution WHA42.2 to carry out the second evaluation of the strategies in time for the Eighth World Health Situation Report (1992). According to the time-table, the second evaluation is to be carried out by Member Countries during the period September 1990 to January 1991.

In order to assist countries in the evaluation and to have a uniform reporting format that will help intercountry and global comparisons, WHO has prepared a guideline document entitled "Evaluating the Strategies for Health for All by the Year 2000, Common Framework: Second Evaluation" (CFE/2). This document has been pretested in a number of countries of the world, including India and Mongolia from this Region.

The document CFE/2, the final version of which has been sent to all Member Countries, consists of two parts. The first part contains the main items and subjects which Member Countries are requested to explore when evaluating their strategies and which they will include in their national reports. The second part is presented as an annex with brief explanatory notes to clarify the items and subjects contained in the first part to help understanding.

There are a few new elements in the global indicators, including family planning, maternal mortality rate and probability of a child dying before five years of age. Member Countries are to present the information on these indicators for identifiable sub-groups of the population, wherever feasible.

These data may be disaggregated according to sex, age, race, social group, and place of living (urban/rural area, province, state, etc.), wherever feasible. This approach would allow the national authorities to identify those sections of the population who are underserved and underprivileged and may help focus on appropriate measures to achieve equity and social justice.

2. LIST OF REVISED INDICATORS

The list of twelve global indicators, as they stood originally and as revised, is given in the Annex.

3. TIME-TABLE

The time-table for completing some of the important action points by Member Countries, the Regional Office and WHO headquarters is as follows:

1.	*Regional Committees: Review of the evaluation* process for the Global Strategy for HFA.	*Sep 1990*
2.(a)	Member Countries: Carrying out of evaluation of national strategies for HFA and submission of evaluation reports to the Regional Committees.	Sep 1990-Jan 1991
(b)	*WHO Secretariat: Provision of technical support* to countries in the process of evaluation and preparation of evaluation reports.	*Sep 1990-* Jan 1991
3.	WHO Secretariat: Analysis of data on global and regional indicators from country reports and preparation of regional reports on evaluation of the strategy for HFA.	Feb-Jun 1991
4.	Regional Committee: Review of assessment of effectiveness of regional strategies.	Sep 1991
5.	Programme Committee of the Executive Board: Review of the draft global evaluation report and recommendation for adjustment of the global strategy.	Oct 1991
6.	Executive Board: Assessment of effectiveness of the global strategy and submission of report to WHA, including adjustment of the global strategy.	Jan 1992
7.	WHO headquarters: Finalization of the evaluation report based on comments and recommendations of the Executive Board.	Jan-Feb 1992
8.	World Health Assembly: Review of effectiveness of the global strategy and endorsement of adjustment of the global strategy.	May 1992

9.	Submission of the second report on the effectiveness of the global strategy by the Director-General to the Economic and Social Commission of the UN General Assembly.	Jun 1992
10.	Editing, translation and publication of the second global report on the evaluation of the strategy for HFA as the Eighth Report on the World Health Situation.	May-Dec 1992

4. ACTION POINTS

At the seventeenth session of the Consultative Committee for Programme Development and Management (CCPDM), held in April 1990, the country representatives were briefed on the process to be adopted for the second evaluation using CFE/2. The WHO Representatives have also briefed the concerned national authorities in this regard and most of the countries are already in the process of carrying out the second evaluation of HFA strategies. In the majority of the countries, the national authorities have already initiated actions, such as setting up of intersectoral groups, assigning responsibility to individual officers and reviewing national health plans and strategies to identify those parts of country information and management process which might be relevant to the second evaluation of the HFA strategy. For example, in India and Nepal, the usefulness of data obtained during the field-testing of the health management information system at the district level was stressed.

WHO continues to provide technical support, wherever necessary, to countries in carrying out evaluation and in the preparation of the evaluation report.

5. CONCLUSION

The Regional Committee may like to urge Member Countries to proceed with their evaluation of the national strategies using the common framework (CFE/2), and present disaggregated information, wherever feasible, and complete the evaluation process by January 1991, as planned. All Member Countries may also like to report on the use of the results of the evaluation for appropriate modification of the national health plans and national HFA strategies.

Annex

LIST OF GLOBAL INDICATORS

1. ORIGINAL 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 per cent 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 to pregnancy and childbirth, and caring for children up to at least one year of age.

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

- at least 90 per cent of newborn infants have a birth weight of at least 2 500 g;

- at least 90 per cent of children have weight-for-age that corresponds to the reference values[1].

(9) The infant mortality rate for all identifiable sub-groups is below 50 per 1 000 live births.

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

(11) The adult literacy rate for both men and women exceeds 70 per cent.

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

2. REFORMULATED INDICATORS

(1) The number of countries in which Health for All is continuing to receive endorsement as policy at the highest level.

(2) The number of countries in which mechanisms for involving people in the implementation of strategies are fully functioning or are being further developed.

(3) The percentage of the gross national product spent on health.

(4) The percentage of the national health expenditure devoted to local health services.

(5) The number of countries in which resources for primary health care are becoming more equitably distributed.

(6) The amount of international aid received or given for health.

(7) The percentage of population covered by primary health care, with at least the following:

- Safe water in the home or with reasonable access, and adequate excreta disposal facilities available;

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[1]Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000, Geneva, World Health Organization, 1981 ("Health for All" Series, No. 4).

- Immunization against diphtheria, tetanus, whooping cough, measles, poliomyelitis and tuberculosis;

- Local health services, including availability of essential drugs, within one hour's walk or travel;

- Attendance by trained personnel for pregnancy and childbirth, and caring for children up to at least one year of age;

- The percentage of women of child-bearing age using family planning.

(The percentage of each element should be given for all identifiable sub-groups).

(8) The percentage of newborns weighing at least 2 500 g at birth and the percentage of children whose weight-for-age and/or weight-for-height are/is acceptable.

(9) The infant mortality rate (IMR), maternal mortality rate (MMR) and probability of dying before age 5 (q5), in all identifiable sub-groups.

(10) Life expectancy at birth, by sex, in all identifiable sub-groups.

(11) The adult literacy rate, by sex, in all identifiable sub-groups.

(12) The per capita gross national product.