

INTERNATIONAL AND REGIONAL ACTIVITIES

53. The purpose of this section is to give a selection of examples of activities at the international and regional levels in connection with health status indicators. Where possible, emphasis will be placed on the selection and use of these indicators to evaluate the impact of PHC programmes.

International activities

54. Three international organizations which have actively contributed to the health indicator movement will be considered here: the United Nations Statistical Office (UNSO), OECD, and WHO. Other agencies involved include the Council for Mutual Economic Assistance, the European Economic Community, the United Nations Research Institute for Social Development, and the Food and Agriculture Organization of the United Nations. Hansluwka (1985) has presented a useful summary table of the indicators of health status advocated by these agencies.

55. The UNSO provided one of the initial stimuli to the health indicator movement, as noted earlier in the report (para. 12). Since the mid-1970s the UNSO has been promoting the use of indicators as tools for the formulation, implementation and evaluation of social policies and programmes. Thus the emphasis has been on 'social indicators' of which health - widely defined - is one component. The contribution of the UNSO has been in terms of supporting the principle of integration, and recent reports explore the problem of making information sources in the socio-economic field mutually supportive (UNSO, 1978; UNSO, 1981). The broad classification of health-related indicators adopted by the UNSO is basically three fold:

1. State of health: a) mortality and length of life
b) morbidity, impairments and handicaps
2. Availability, use and performance of health agencies
3. Nutrition

Table A in Appendix III gives a more detailed breakdown of the health status indicators together with the key variables by which these may be sub-divided.

56. A further activity sponsored by the UNSO in conjunction with several other agencies which is relevant to the information sources for the construction of indicators, is the United Nations Household Survey Capability Programme (UNHSCP). As the name suggests, the objective of this ambitious ten-year programme is to strengthen abilities for conducting regular national household surveys on a variety of topics, including health, in eighty-five countries (Carlson, 1985; UN Secretariat, 1979). The important role of health-interview surveys in providing community-based information was mentioned previously (para. 52).

57. The second international initiative to be considered here is the OECD Social Indicators Development Programme, launched in 1970, with the following objectives:

- a) to identify the social demands, aspirations and problems which are, or could become in the decade ahead, major concerns of the socio-economic planning process;
- b) to measure and report changes in the relative importance of these concerns;
- c) to better focus and enlighten public discussion and government decision-making.

The first major achievement of the Programme was to publish, in 1973, a List of Social Concerns Common to Most OECD Countries (OECD, 1973). The list included 24 'fundamental social concerns' distributed among eight 'primary goal areas', one of which was the 'area of health'. This area covered two 'fundamental social concerns':

- a) the probability of a healthy life through all stages of the life cycle;
- b) the impact of health impairments on individuals (Jazairi, 1976).

Following this initiative there were several years of complex development work designing indicators to measure these concerns. In 1980, this activity was brought together in a report, published two years later, which discusses the selection criteria for an international list of social indicators, together with specifications, statistical guidelines and disaggregations, and an assessment of data availability at the national level within the OECD countries.

58. In terms of the social concern for health, the OECD recommended indicators are as follows:

- 1. Length of life: a) life expectancy
 b) perinatal mortality rate
- 2. Healthfulness of life: a) short-term disability
 b) long-term disability

59. There are several important issues which need to be emphasized in connection with the OECD Programme:

- a) the selected indicators are designed to measure trends in **individual** well-being rather than the health status of the **population** (OECD, 1982);
- b) the list should be viewed as a framework which member countries could use to guide implementation appropriate to their needs and circumstances;
- c) the selected indicators are output-orientated in the sense of describing final social outcome, rather than inputs or operational aspects;
- d) the emphasis is on the 'final impact' on the individual of the complex interaction between government policies and the changing social environment.

e) one of the concerns is to develop an operational definition of disability as a standard, person-based measure of morbidity (Jazairi, 1976). This focuses on disability as a deviation (long or short-term) from an individual's usual level of functioning as measured by ability to perform essential daily tasks.

60. Clearly, the OECD proposed list is aimed at the richer countries with well-established statistical systems. The relevance to the less privileged nations lies perhaps in the systematic approach adopted to selecting indicators, the integration of information from several sectors, the emphasis placed on the importance of policy-relevance as a selection criteria, and the need for flexibility in developing statistical definitions to suit existing data collection activities.

61. The World Health Organisation has taken a leading role in the development of **health** indicators as opposed to **social** indicators, which are emphasized in the UNSO and OECD programmes described above. Several authors have reviewed the activities of WHO in this area (Deliege, 1983; Hansluwka, 1985; Murnaghan, 1981). WHO's involvement has essentially taken place in the context of the efforts to monitor and evaluate the progress towards the goal of 'Health for All by the Year 2000' (HFA/2000), as mentioned previously (para. 17). Earlier work by WHO on indicators tended to be carried out for the purposes of specific control programmes (Baylet, 1979; WHO, 1971, 1976, 1979a).

62. In 1981, the Thirty-fourth World Health Assembly approved a minimal list of 12 global indicators for monitoring and evaluation of the global strategy of HFA/2000. Table 2 indicated earlier the broad classification of health indicators adopted by WHO. Three of the global indicators fall within the category called health status indicators:

- a) nutritional status of children
(birth-weight and weight-for-age)
- b) infant mortality
- c) life expectancy at birth.

It is important to note the absence here of any indicators of morbidity or of disability. The other nine global indicators include those specifically concerned with the coverage or provision of PHC.

63. An important resource document was published by WHO in 1981(a) in the Health For All Series, which aims to 'help Member States of the WHO to decide which indicators to use, particularly at the national level but also at the regional and global levels for monitoring progress towards HFA/2000'. Thus, in addition to the 12 global indicators, the volume refers to 10 other health status indicators, shown - together with possible data sources - in Table B of Appendix III, as a selective list which countries may use as a 'starting point' for identifying those most relevant to their situation. Hansluwka (1985) provides a useful table of some of the most important considerations in the use of the three global health status indicators.

64. The 1981 publication from WHO discusses the various functions of indicators and the criteria for their selection, but pays particular attention to information requirements, the principal sources of data, and the alternative methods of data collection and appropriate analysis. This represents an important contribution to the field of health indicators, especially relevant to the developing countries. Although

the contents of this publication cannot be discussed in any detail here, three particular points may be emphasized:

a) the recommendation of indicators for use at the global level implies the commitment of all countries individually, as well as collectively in regional groupings, to use at least these indicators and to provide the necessary information for the construction of a global indicator. Moreover, in recognition of the problems of international comparisons and aggregations, the global indicators are constructed in terms of numbers of countries which attain 'pre-determined norms' for certain indicators; for example, the number of countries with an infant mortality rate below 50 per 1000 live births;

b) the selection of indicators in a particular country setting should not only be governed by their relevance for policy, but also by the organizational, technical and financial feasibility of collecting and analysing the information required;

c) although the tendency is to emphasize the use of indicators at the national scale, their relevance, utility and feasibility at the local and district levels are also important, especially in connection with the objective of reducing health differentials within the country.

65. The first round of monitoring of national, regional and international progress towards HFA/2000 using the 12 global indicators was carried out in 1982-83. The main emphasis in this initial round was on the monitoring of operational aspects, with a particular focus on indicators of the provision of health care and population coverage by PHC. This was justified on the grounds that there had been insufficient time since the implementation of HFA strategies to detect any major impact.

66. In addition to the initiatives taken in conjunction with the HFA/2000 strategy, the WHO Divisions with responsibility for specific health programmes have been concerned to develop appropriate indicators. Some of these programmes have reached a point in their implementation when they need to demonstrate effectiveness at the sub-national and national levels. Operational indicators are still regarded as necessary but no longer sufficient. Thus, for example, the Maternal and Child Health (MCH) Programme has been concerned to develop suitable outcome indicators which not only contribute to evaluating the effectiveness of the programme but also to the overall monitoring of progress towards HFA/2000 (WHO, 1983b). The MCH Programme is focusing on two priority areas - maternal and perinatal mortality and is collaborating with UNICEF, UNFPA, universities and bilateral agencies in the search for appropriate impact indicators. Similarly, the Nutrition Programme has been promoting anthropometric indices as measures of nutritional status for evaluating health impact. A resources document was published in 1983 on measuring change in nutritional status, providing guidelines for assessing the nutritional impact of supplementary feeding programmes for vulnerable groups (WHO, 1983c). The Expanded Programme on Immunization (EPI) and the Programme on Control of Diarrhoeal Diseases (CDD) have also been actively developing methodologies and measures for evaluation purposes (Lemeshow and Robinson, 1985; WHO, 1985b). Finally, the Leprosy Control Programme has developed the OMSLEP Recording and Reporting System which provides details on the important indicators for monitoring and evaluation (Sundaresan, 1984).

67. Whilst there is obviously considerable overlap in the interests of these individual programmes in terms of evaluation and indicators, there has until recently been comparatively little co-ordination. However, within the last year or so, a more concerted and integrated focus on this topic has been promoted under the Health Situation and Trend Assessment Programme (HSATAP) (WHO, 1985a). This activity has been directed towards the needs of countries which have expressed a commitment to assess the impact of programmes carried out as an integral part of PHC, and in which suitable information is being gathered but not utilized. In addition, the emphasis is on countries which have infant mortality rates in excess of the 'norm' set for the WHO global indicator (50 per 1000 live births). The scope of activities was narrowed further by concentrating on a selected group of programmes which address similar target populations, are aimed at severe health problems, have clearly defined strategies, and a strong evaluation element (WHO, 1985a). Attention has therefore been directed towards components of national health strategies particularly aimed at the prevention and control of childhood diseases, including acute diarrhoea, acute respiratory infections, malaria, malnutrition, and diseases amenable to immunization.

68. The Informal Working Group convened by HSATAP in mid-1985 which proposed the above focused approach, developed a limited set of health indicators (Table C in Appendix III), selected on the basis of how well they reflect the chosen problem areas and on the likelihood that they might show changes associated with specific programmes and the implementation of national health strategies. Recognising the need to measure impact at local, district and national levels, appropriate methods were developed for fulfilling the information requirements of these indicators. A plan of action was proposed for a trial of the proposed indicators and methods to be carried out in a small selection of countries (WHO, 1985a). The ultimate objective is to produce general guidelines for distribution to the WHO Regions where they may be adapted and applied by more countries.

Regional activities

69. The previous discussion mentioned the emphasis placed by WHO on the need for the selection and use of indicators to be tailored to the specific requirements and priorities of individual countries. At the regional level, efforts are being made to co-ordinate these activities.

70. Within the WHO Regions, the countries have met to develop their own strategies for achieving HFA/2000 and to select indicators which are appropriate for assessing progress through out the Region. These regional indicators tend to be more detailed than the global indicators, but on the other hand, leave more freedom for interpretation - whilst sacrificing comparability. Like the global indicators, they represent measures of performance and are presented as the number of countries within the Region attaining a specific level of health development (WHO, 1983b).

71. Each performance indicator necessarily implies a commitment to construct the indicator at the national level. Table D (Appendix III) presents the regional indicators related to health status for the Americas, Eastern Mediterranean, European, and Western Pacific Regions. In addition to these health status indicators, certain Regions have issued directives on other measures essential to the monitoring and evaluation process. Musgrove (1984), for example, discusses the eight

socio-economic indicators considered mandatory in the Pan-American Health Organization's Plan of Action.

72. In the South-East Asia Region, there do not appear to be any agreed regional indicators additional to the recommended global measures (Ministry of Health and Population Control - Bangladesh, 1985). Similarly, at a recent meeting of the Member States of the Africa Regional Office (WHO/AFRO, 1985) the focus was on the national level, with the selection of indicators for three priority areas: MCH, EPI, CDD; it remains to be seen whether these will also be accepted to construct indicators for the Africa Region.

73. This discussion, however, is not meant to give the impression that regional initiatives on health indicators stem solely from the approval of global measures by the World Health Assembly in 1981. Prior to this, WHO had long been collaborating with governments through the Regional Offices in developing health information systems and strengthening statistical services, and the subsequent more focused attention on indicators must be seen as an extension of these earlier activities. Thus, for example, the South-East Asia and Western Pacific Regional Offices sponsored the Sixth Workshop of the South-East Asian Medical Centre in 1979, the topic of which was the development of operational, performance and impact indicators with special reference to community health (Noordin, 1979). Nine countries participated in the Workshop, including five which are members of the Commonwealth: Australia, Fiji, India, Malaysia, and Singapore.

74. The objectives of this Workshop were as follows:

- a). to draw the attention of participating countries to the declining relevance of conventional health indicators in the present era;
- b). to emphasize the need for collaborative effort among participating countries:
 - identifying health and health-related indicators relevant and useful in the present day context;
 - in the development of new indicators relevant to planning, management and evaluation of health activities,
- c) to develop a basis for the formulation of projects to implement the recommendations of the Workshop.

The proceedings of the Workshop include an overview of the needs and problems related to indicators and provide country reports on the relevance and use of statistical measures in the context of community health programmes. A selection of health status indicators are put forward for the evaluation of a variety of programmes, including MCH, immunization, environmental health and nutrition. Mechanisms are suggested for the collection of the information necessary to construct these indicators at the local, district and national levels, as now to be discussed for the four country studies.