

CONCLUSIONS

172. This study reflects two inter-related issues which are currently of concern to ministries of health in many developing countries: namely, the evaluation of the impact of their strategies and programmes on the health status of the population and the inadequacies of the existing information and methods with which to achieve this. The actual and potential contribution of indicators to progress in these two areas has been the major theme of this report.

173. A 'state of the art' review traced the origins of the so-called 'health indicator movement' and its continuing links with the parallel concern for 'social indicators'. The recent literature reveals a divergence in the objectives, interests and approaches involved in the selection and use of health indicators between developed and developing countries. In the context of the former, attention has tended to focus on conceptual issues surrounding the phenomenon called 'health', on the growing irrelevance of mortality-based measures for evaluation of impact and the search for alternatives, and on the scientifically desirable qualities of indicators. In contrast, the concern of the developing countries has been more practically-oriented, raising questions about policy relevance and the feasibility of particular indicators given limited financial, technical and manpower resources. This difference of emphasis is perhaps not surprising given the contrasts in the statistical systems and health services between developed and developing countries which are obviously relevant to the selection and use of health indicators. This is not to imply that the two groups cannot benefit from sharing their experiences in this field, but it does challenge the recent emphasis on constructing 'global' indicators, and draws attention to the all too familiar gap between more theoretical concerns and practical applications.

174. The report has attempted to describe some of the international and regional initiatives in the field of health indicators, looking in particular at the contributions made by UNSO, OECD, and WHO. Four illustrative country studies were presented as examples of activities in the context of different health profiles and information systems. The final section of the report should be regarded as exploratory, comprising preliminary checklists of relevant questions to guide the selection and use of health status indicators. The application of these questions was demonstrated for the case of the Commonwealth developing country - The Gambia.

175. The contents of the report lead to a number of conclusions which will now be summarized.

176. First, it is difficult to envisage the development of a universally applicable and relevant set of health status indicators, using common operational definitions and procedures. This is as much to do with the differences in the constraints on the collection of adequate and reliable information to construct the indicators between countries, as to do with the differences in their needs, health situations and statistical systems. Thus, for example, although the infant mortality rate is a key indicator for many countries, the wide inter-country variations in the levels of accuracy, availability and representativeness of the information on which it is based, have led some authors to question whether in fact the same phenomenon is being

measured. Moreover, a global recommendation to adopt the infant mortality rate as an indicator has very different implications in terms of feasibility in different country settings. The report therefore reiterates the need for countries to identify their own requirements for particular health status indicators, both at the national and sub-national levels, and to regularly reassess these requirements and the extent to which they are being met. The selection of health status indicators is not a once-and-for-all procedure; there is a need to review their continuing relevance and feasibility.

177. Second, the fact that countries are not necessarily using exactly the same health status indicators does not obviate the need and value of sharing their experiences. In particular, there is much to be gained by the regular exchange of problems encountered and solutions sought, especially at the sub-national level.

178. Third, the broadening of the interpretation of 'health', which so clearly finds expression in the PHC approach now being adopted throughout the Commonwealth, necessarily implies greater inter-sectoral collaboration. This applies as much to the needs and uses of health information as it does to other aspects of the national development strategy. The country studies presented here bear witness to the multiple demands and uses for this information which require a greater degree of co-ordination and pooling of the limited resources than is currently found.

179. Fourth, this report has highlighted the situation commonly faced in the developing countries of the Commonwealth, namely the lack of basic information to guide the selection of relevant health status indicators. The case-studies have revealed that for some parts of these countries there is virtually no reliable, recent data and, in these circumstances, the value of establishing a network of sentinel reporting areas throughout the country is clear. Moreover, the emphasis on national-level indicators stimulated by some of the international organizations has tended to divert attention away from the importance of identifying and monitoring internal differentials, the reduction of which forms an essential part of 'health for all' strategies. Many of the so-called 'national' indicators are in fact constructed using information for only a proportion of the total population and often for one of the most privileged proportions - socially, economically and with regard to health services. This is not altogether surprising and is a situation unlikely to change in the near future despite the considerable progress many developing countries have made in strengthening their statistical systems. However, the value of these 'national' indicators to actual and potential users, is likely to be improved if some estimate is given of the proportion of the population represented in these key statistics. Alternatively, this sort of qualifying figure could also be employed as an aid to interpretation where sub-national figures are available by presenting, for example, national indicator values together with the range at the district level. These types of refinement represent one of the areas requiring further research within the field of health status indicators.

180. Fifth, the setting-up of PHC reporting networks has brought about an important change in the health information systems of many developing countries, namely the potential for providing a continuous source of community-based data. This is particularly relevant to the evaluation of impact. A major drawback to the use of information from fixed health facilities has always been the question of selectivity. In other words, the events recorded at these facilities represent an often unknown

proportion of all such events occurring in the community. This has obvious implications for assessing the impact of programmes on the health status of the general population and not just those in contact with these health services. Many factors help to explain selectivity, including differential access, availability and uptake of both curative and preventive health care. PHC aims to improve this situation by providing village-level services and, whilst the reporting of village health workers may still be selective, there is the potential to collect information which more closely reflects the health status of the community. For this potential to be realized, greater efforts are needed to control the quality of the information gathered and to assess the possible selection biases in the reporting. It hardly needs to be stressed that the data-gathering role assigned to these community-level health workers should be consistent with the integrated nature of their activities and that the feedback of results from higher levels in the information system needs to be improved.

181. Sixth, the selection and use of health status indicators clearly cannot be considered in isolation from the existing health information system. One does not necessarily have to go out and 'collect' indicators per se since they can often be constructed from the pool of statistics currently being gathered for other intentions, such as patient management, resource allocation, or vital registration. The report has noted, however, that for the purposes of impact assessment there may be a need for specific information-gathering activities, such as baseline surveys. This need may arise not only because of the lack of sufficient detail being collected by the existing system, but also because of inadequacies in the coverage and the quality of the data. On the other hand, in many countries the collection of health information appears to be running ahead of the ability to use it. Under-utilized information often exists at all levels in the system. The co-existence of efforts to collect more information together with neglected sources is characteristic of many developing countries, partly as a consequence of the frequent (and sometimes conflicting) revisions and the lack of integration in their statistical systems. The emphasis must be shifted away from the **quantity** to the **quality** of information. This is consistent with the keenly felt need for a minimal set of selective and mutually-supportive indicators rather than comprehensiveness.

182. Finally, although there may appear to be a multitude of possible health status indicators from which countries have to choose, often causing some bewilderment and confusion, in practice the choice can be simplified by posing certain key questions. This report has attempted to provide preliminary checklists of questions; these lists, however, need to be assessed and adapted using field trials in different country settings and at different levels. In the context of the developing countries, the feasibility of collecting the necessary information - even at the minimum acceptable level of accuracy - for constructing the indicator will often provide one of the most basic guiding principles. Establishing what is in fact feasible is part and parcel of the wider need for countries themselves to have a greater awareness of the operation, coverage, reliability and the problems of their statistical systems. Thus although many developing countries have been 'evaluated' in terms of their current system and needs, these assessments have tended to be carried out by outside experts, but, more importantly, they do not seem to have improved the country's **own** understanding of the situation. In particular, the requirements for information at the different levels do not seem to have been expressed by the users themselves. Understanding and attempting to satisfy some if not all of these requirements is critical to the collection of relevant

information, especially at the village level. Of course, it is unrealistic to expect, say, village health workers to identify their needs without some form of training and guidance, but the importance of establishing the information system from the 'bottom up' rather than 'top down' is entirely consistent with the underlying rationale of PHC.

RECOMMENDATIONS

183. On the basis of this report the following recommendations for action are made.

National

184. Recognition should be given to the need to strengthen the information system as an essential and integral part of the overall health strategy and not as a separate activity; this requires a financial commitment from governments to support at least a minimal information system from domestic revenues.

185. The importance of assessing impact in addition to evaluating the operational aspects of health programmes must be appreciated at all levels; countries will need to decide for themselves whether this requires specific training efforts given the current levels of expertise.

186. Greater intersectoral collaboration is essential to avoid unnecessary duplication of data collection activities, to facilitate the pooling of limited technical, financial and manpower resources, and to improve the quality and scope of health and health-related information.

187. The particular health status indicators which countries finally select as relevant and feasible, given their needs and circumstances, should be subject to regular assessment as a means of controlling quality and coverage and of ensuring appropriate refinements.

188. Consideration should be given to carrying-out field trials of the procedures for constructing and using a minimal set of mutually-supportive health status indicators, at different levels in the health service, **before** these procedures are adopted on a wider scale.

189. The value of routine information from health facilities for the construction of morbidity indicators should be assessed to establish the nature and the degree to which it is representative of the situation in the general community.

190. Assessments should also be made of the quality and the coverage of information arising from village-based reporting networks, especially in terms of births and deaths, with a view to its integration with the existing vital registration system.

191. Greater efforts are needed to improve the feedback of health and health-related information between the central and peripheral levels, and to improve the use of this information in the planning-management-evaluation cycle.

Regional

192. In order to improve and share experience in the selection and use of health status indicators between Commonwealth countries, regional workshops should be held in collaboration with other agencies which are active in this field at the international and regional levels.

193. Consideration should be given to short-term exchanges of health personnel, who are involved in information systems and in the evaluation of the impact of health programmes, between Commonwealth countries for the purposes of training and sharing experience.

Commonwealth Secretariat

194. The Commonwealth Secretariat should promote collaboration between countries in the selection and use of health status indicators for evaluation by :

- a). sponsoring regional workshops and providing the appropriate technical assistance;
- b). providing scholarships or other financial assistance to facilitate further training of nationals and exchange schemes;
- c). providing a central repository for government reports and other relevant publications in the area of health status indicators, and disseminating the key materials to Commonwealth countries.

195. The Commonwealth Secretariat should maintain strong links with other international agencies concerned with indicators and evaluation, and in particular with the current initiatives being taken as part of WHO's Health Situation and Trend Assessment Programme.
