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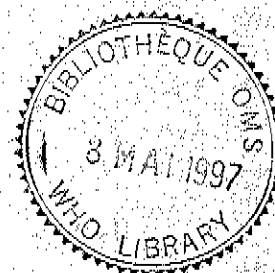
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STRENGTHENING AND SIMPLIFYING THE HFA MONITORING AND EVALUATION PROCEDURE

Report on a WHO Working Group

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1996

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HEALTH INFORMATION SUPPORT

By the year 2000, health information systems in all Member States should actively support the formulation, implementation, monitoring and evaluation of health for all policies.

ABSTRACT

When Member States adopted the HFA strategy, they also agreed to monitor and evaluate progress in its implementation at national, regional and global levels. Since the adoption of the HFA policy and targets for the WHO European Region in 1984, the WHO Regional Office for Europe has continued to coordinate the HFA monitoring and evaluation on behalf of Member States, through a common framework, indicators and procedure to facilitate comparisons and summaries of country reports. The Regional Office has also regularly updated the procedure for HFA monitoring and evaluation with an aim to provide more useful and efficient guidelines to the Member States.

This meeting was organized to support the Office in reviewing the procedure, in preparation for the third (1996-1997) HFA evaluation. The group of experts formulated specific recommendations concerning three main issues:

- simplification of the HFA framework and procedure;
- strengthening of the statistical data collection;
- strengthening of monitoring and evaluation at country level.

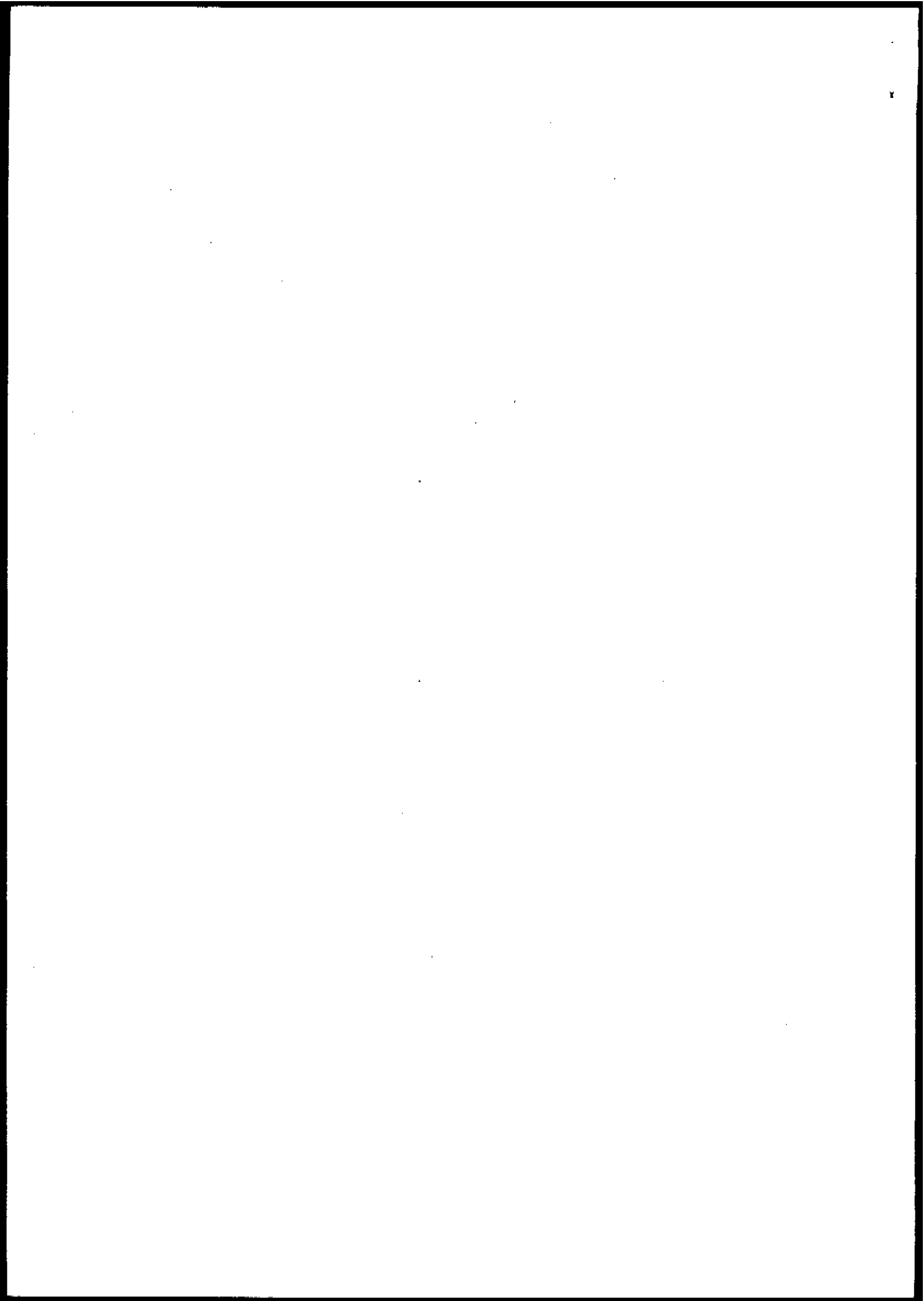
The recommendations of the meeting formed the basis for updating the documentation and procedure for the third HFA evaluation in the WHO European Region.

Keywords

HEALTH FOR ALL
HEALTH STATUS INDICATORS
HFA STRATEGY COORDINATION
EUROPE

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Introduction

1. The meeting was opened by Dr Marc Danzon, Director, Lifestyles and Health and Disease Prevention, who welcomed the participants on behalf of the Regional Director.
2. The opening address emphasized two issues:
 - (a) the need for "active" information, i.e. information deemed necessary for making major decisions regarding a country's future, particularly clearly demonstrated in the countries of central and eastern Europe recently;
 - (b) the decreasing emphasis on the primary intention of monitoring and evaluation of health for all strategies, namely that the countries carry out monitoring and evaluation for their own benefit, and WHO derives the information for monitoring and evaluation at regional and global levels from the respective national information processes.
3. Dr J.-P. Jardel was elected as Chairman of the meeting and Dr J. Devlin was elected as rapporteur. The list of participants, and the list of working papers and background documents are presented in annexes 1 and 2 respectively.

Scope and Purpose

4. "Health in Europe" has become a well established source of knowledge for those involved in public health developments in the WHO European Region. This triennial report is the outcome of the regular monitoring and evaluation of the health for all (HFA) strategies in the region.
5. Since the adoption of the HFA regional strategy, targets and indicators in 1984, the WHO Regional Office for Europe has regularly and systematically pursued the objective of improving the efficiency and efficacy of the monitoring and evaluation process itself. Drawing on the experience and expertise of the Member States and technical experts, there have been numerous innovations in the process and procedure. These have been developed from meetings which precede every consecutive cycle of monitoring or evaluation of HFA strategies in the WHO European Region.

Consequently, after four rounds of evaluation and monitoring exercises, and in view of the immediate experience of the 1993-1994 HFA monitoring and related discussions at meetings of WHO governing bodies (RC44 and WHA 48), there was a need to review the evaluation procedure with the aim of improving efficiency of data collection and processing by WHO and strengthening the respective processes and capacities for monitoring and evaluation at national level. The purpose of the meeting was to assist the Regional Office to that effect and produce recommendations for the forthcoming 1996/1997 HFA evaluation.

6. The following structure of the meeting was adopted:
- an overview was made of the monitoring and evaluation process and feedback of experience at global, regional and national levels;
 - discussions were held regarding proposals for simplification and strengthening of the exercise.

Overview of the 1993–1994 HFA monitoring

The global perspective

7. At global level, the main tool for monitoring and evaluation is the common framework, a document designed to support Member States in carrying out the exercise and reporting their findings to WHO. The first common framework and format was developed in 1982 and it was subsequently revised and improved. It now covers trends in health status, implementation of primary health care, resources for health, trends in healthy environment and lifestyles, and population and socioeconomic trends. It also includes the minimum set of global indicators agreed by the World Health Assembly in 1983. Although the list is short, countries may use additional indicators in keeping with their needs and capacities.

The use of a common framework enables Member States 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 analysis to improve their health plans, reprogramming as necessary. Therefore, this document is not a questionnaire to which responses are required but a tool to assist Member States in carrying out their monitoring and evaluation.

For the WHO European Region, the items and indicators of the global common framework are incorporated into the regional framework document in order to avoid duplication in reporting.

8. The experience at global level with the consecutive monitoring and evaluation exercises has also demonstrated that the process of data collection needs to be simplified and the coverage of indicators and timeliness of reports from countries needs to be improved. The factors identified to potentially increase the usefulness of future HFA monitoring and evaluation at global level are:
- better definitions of some global HFA indicators;
 - more efficient data validation and processing;
 - stronger political support at national level;
 - stronger commitment to use data from monitoring in the managerial process at all levels;
 - streamlining multiple international reporting mechanisms.

Problems with definitions of some global indicators have created particular difficulties in collecting the required data for the countries of the WHO European Region.

The Regional perspective

9. As for the WHO European Regional level, countries were formally invited to initiate the HFA monitoring at the 1993 Regional Committee meeting in Athens where they were provided with the regional framework document. The document followed the structure of the 38 HFA targets for the WHO European Region, as in the previous evaluation exercise. For each target, the framework firstly required a textual "situation assessment" intended to be a short synopsis of qualitative information relevant to the target. Then, the HFA statistical indicators for the target, approved by the Regional Committee, were to be considered in the monitoring exercise and reported on. Details on how to report on the statistical indicators were contained in a set of "dummy" tables enclosed as part of the framework. These dummy tables were supplemented by a diskette and printouts of the HFA database, indicating which data are available at the Regional Office. Only those countries for which data on a given indicator were not already available at the Regional Office were asked to "fill in the gaps".
10. Two steps were recommended to organize the monitoring exercise in each country:
 - a focal point was to be nominated to be responsible for management of the monitoring exercise and for collaboration with the Regional Office staff, and
 - a plan of action was to be drawn up, indicating who would be requested to provide what information to whom, and by what date. This plan included the anticipated timetable for completion and submission of the country report to the Regional Office.
11. The 1991 HFA target update and the changed geopolitical situation in the European Region in particular, presented special challenges for the 1993-94 HFA monitoring. It included 18 "new" Member States, who participated for the first time in monitoring progress towards HFA and therefore needed special support, given their particular problems of health services in transition and requirements for strengthening information systems. Furthermore, existing WHO databases had relatively little information on the "new" countries, as compared to others. The other international data sources used by the Regional Office also had a similar paucity of data. This new situation in the Region therefore required an unprecedented effort to extend the established HFA indicators database to include the "new" Member States while preserving historical trends. This has been largely successful.
12. The number of country monitoring reports submitted to the WHO Regional Office for Europe (Annex 3) remained practically the same for the "old" countries. Twenty five out of 31 "old" countries replied. Seven of the "new" countries also managed to produce their first complete monitoring reports. Eleven of the 18 "new" countries did not formally reply but submitted statistical data as a result of the above-mentioned special efforts. However, all the country reports reached the Regional Office considerably later than the recommended deadline which also means that the managerial process in the Member States would require more time to prepare for and carry out the exercise.

13. Although the regional framework recommended a concise style of reporting, some countries produced voluminous reports. The new facts (policies, action, etc.) were difficult to report on in these reports. Participants at WHO meetings relevant to this subject, in particular the previous meeting of this type,¹ felt that further simplification of the process should be sought by means of reducing the actual reporting of qualitative information to WHO to the most essential new facts, preferably in a structured and concentrated fashion.
14. Furthermore, the experience of the 1993–1994 monitoring showed that separating of the collection of statistical data from the event of the monitoring/evaluation exercise per se was beneficial (in so far as the circumstances in any particular country permit). Examples were the collection of data via the Health Interview Survey (HIS) project, or the special effort to collect statistical data for the “new” Member States. These examples showed that the more data that can be routinely compiled by means other than the HFA evaluation framework, the better the chances of utilizing this data by decision makers, whether during the evaluation or at any other time, whether at country or at international level.
15. The previous monitoring and evaluation exercises showed that in the preparation of “Health in Europe”, the Regional Office needed to involve all technical units and programmes at an early stage. The area specific chapters of the report, e.g. on environment, lifestyles, etc. were drafted by experts in their particular areas and then consolidated. An important decision was to keep separate two related but different issues: informing the Regional Committee about the main thrusts of the monitoring, and the finalization of the report itself as a document of the WHO secretariat. A special effort was made to ensure more timely publishing, and better communication of the report using the mass media. This enabled the report to be published only two months after the Regional Committee after review by an external expert group.

The country perspective

16. HFA monitoring and evaluation at country level were analysed in presentations made by participants and a general discussion followed on the merits and problems encountered. There was general agreement on the value of the HFA monitoring and evaluation exercise. The outcomes provided countries with comparative information on their prevailing health and socioeconomic situation that highlighted the main problems and issues in the WHO European Region. International comparisons provided added value to the country evaluation exercises because almost all European countries participated in the process. It was also pointed out that the HFA monitoring and evaluation exercise facilitated the development of health policies and strategies in many Member States.
17. However, despite the benefits described, the monitoring and evaluation exercises were also perceived to be heavy, largely due to the reasons highlighted in the following paragraphs.

¹ Revision of HFA indicators and monitoring procedures, Copenhagen 29 April - 1 May 1993

18. The benefits of the exercise were not explicit to Member States. It was sometimes viewed as a task undertaken for WHO from which the Member States did not obtain a satisfactory return. This was in spite of the fact that the HFA database and "Health in Europe" (the main products) were highly commended and regarded as useful by all participants.
19. The presence of an operative countrywide HFA strategy created an environment conducive to the monitoring and evaluation exercise. However, it was also noted that in some countries, the presence of a rather country-specific HFA strategy sometimes resulted in different information requirements for national and international HFA monitoring.
20. In some Member States, countrywide monitoring systems were not geared up to providing the wide range of data necessary for the HFA monitoring and evaluation exercise. Data was often compartmentalized and ad hoc extraction required considerable resources.
21. It was noted that there was difficulty on occasion in distinguishing between the statistical indicators that were already reported annually by most of the countries and the remaining indicators required specifically for the monitoring and evaluation exercises. Also, Member States provided data to a variety of national and international institutions via other procedures and it was felt that the data requirements needed to be better coordinated in order to avoid duplication of effort and inefficient use of scarce resources.
22. The problem of definition of the statistical data required to measure the HFA indicators was repeatedly highlighted as a major cause of concern. Consequently, some Member States also expressed concern regarding the validity of the data collected.
23. Member States considered the time-frame for preparation of the country report to be too brief. For future HFA monitoring and evaluation exercises this could be improved upon if advance notice of the expected requirements could be issued by the Regional Office prior to the formal launching of the exercise at the Regional Committee meeting.

Main issues in strengthening and simplifying the HFA monitoring and evaluation procedure

24. Three main issues were proposed for discussion at the meeting:
 - simplification of the HFA evaluation framework for the WHO European Region, and particularly the reporting of qualitative information;
 - strengthening the statistical data collection;
 - strengthening of monitoring and evaluation at country level.

Simplification of the framework

25. The discussion concerning simplification of the HFA evaluation framework was based on working paper no. 9. The paper analysed the reasons for the perception by the Member States that HFA monitoring and evaluation exercises are too heavy and complicated. It reiterated the opening remarks of the meeting that the HFA monitoring and evaluation process at regional and global levels were initially conceived to be based on automatic communication to WHO of the results of regular national monitoring and evaluation at country level. The underlying assumption was that the countries had in place, or would establish in due course, such a HFA oriented monitoring mechanism but seemingly this assumption had not been fully met. Furthermore, the initial assumption was that there would be an explicit distinction between simple and routine monitoring of ongoing activities as opposed to a full-scale, more time-consuming evaluation of the fundamentals of the HFA policies and strategies but this was not realized fully. In addition, attempts at simplification have previously been made by providing more detailed instructions, explanations and examples. These have added to the volume of documents sent to the countries and increased the feeling of complexity of the exercise.
26. Based on the overall experience with HFA monitoring and evaluation, and more specifically, the observations described in paragraphs, 13, 14 and 25, two proposals for simplification were put forward in the paper:
- (a) The request for qualitative information (situation assessments vis-à-vis HFA targets) should be clearly differentiated (separated) from the reporting of statistical data. Also, the instructions and explanations concerning concepts, terms and definitions should be in a separate file or volume in order to emphasize the limited amount of qualitative information being requested.
 - (b) The request for qualitative (textual) information should be streamlined by means of a standardized form to be filled in with headline type notes only on milestones (achievements) in:
 - policy developments
 - strategies and managerial approaches
 - implementation activities
 - information and monitoring.
27. This standardized form for target evaluation would also ask countries to make an overall assessment of progress taking into account trends in the appropriate HFA indicators. The headline type notes mentioned in paragraph 26(b) should justify the overall assessment of progress towards a target. The statistical evidence required should describe the positive/negative trends identified by Member States and considered important for evaluating health policies and strategies.
28. In the discussion, the participants agreed that these proposals would help to simplify the exercise. The separation of the statistical reporting is dealt with later in this section. The proposal for a standardized target evaluation form was strongly supported but there was uncertainty regarding the relevance and feasibility of the areas of

achievement to report on suggested in paragraph 26(b) and the overall evaluation required in paragraph 27. The participants discussed a model of such a form as applied to a concrete country situation (Annex 4). It was agreed that the model will be field-tested in four countries before it is finalized by the WHO secretariat. The participants also pointed out that the standardized form should be regarded as a minimum requirement and the countries should be invited to add any relevant further information.

Countries should also clearly specify the information for restricted use as Member States sometimes include in their reports information intended for use only by WHO and would prefer if this information were not freely available without prior consultation.

Strengthening the provision of statistical data

29. Separating the statistical data collection from the monitoring and evaluation exercises as such, could and should go hand in hand with strengthening of the statistical data collection itself. For practical purposes HFA statistical indicators were subdivided into two groups:

- basic health indicators (e.g. on mortality and infectious diseases) routinely collected and available annually in most countries;
- not routinely available indicators and indicators which are not uniformly measured in all countries (e.g. perceived health).

Strengthening of the data collection related to these two groups of statistical indicators should foster their analysis and impact on decisions, in general, and during the evaluation exercise, in particular.

30. Analysis of the main problems concerning basic health statistics routinely available in the countries, and proposed solutions were presented in working paper 10, as follows:

- (a) A problem arose with the integration and collection of basic health statistics, many of which are HFA indicators, in the formal triennial HFA monitoring and evaluation cycles. It was noted that (i) requests for data are addressed to HFA focal points (not directly to data holders), (ii) the provision of simple annually available data was unnecessarily bureaucratized, and (iii) there were time lapses in data reporting in between monitoring years. Therefore, the separation of the collection of routinely available health statistics from the HFA monitoring and evaluation proper, would simplify the latter and improve the efficiency of the general data collection and dissemination function of WHO. Those indicators which were not routinely collected by most countries should remain to be collected in connection with the HFA monitoring. Special projects or other alternative sources should also be used to collect this data wherever possible, preferably directly from data holders.
- (b) The data reported were, in most cases, not supplemented with descriptions of the definitions used in the countries. The group agreed that (i) working definitions should be offered by WHO to the countries so that they might regroup their data accordingly and (ii) country data holders should highlight the difference between

WHO's working definition and the country definitions so as to make the users aware of possible comparability problems. A related issue is the use of proxy indicators. In the case of some HFA indicators which were hard to measure, proxy indications were considered necessary in practice to monitor progress towards the relevant HFA targets.

- (c) Compartmentalization and difficult access to statistical data at country level were among the main reasons for limited availability and use of routinely collected data – both at national and international levels. The establishment of countrywide databases on health and health-related indicators was considered to be an essential step in resolving this problem. This would improve the communication of statistical data both within the countries and internationally.
 - (d) The exchange of statistical data in computer-readable form was highly recommended. The WHO secretariat was requested to provide a range of more user-friendly tools for data provision, preferably in computer-readable form.
31. HFA statistical indicators not annually available constitute an estimated half of all HFA indicators. A proposal was made in working paper 11 concerning the collection of data to match these indicators. They were divided into two sub-groups, namely indicators that:
- (a) were likely to be frequently measured in population health surveys or available from some other sources. These would be suitable for triennial collection from the survey data holders directly (initially using the Health Interview Survey Project of the WHO Regional Office for Europe);
 - (b) were rarely measured in population surveys, or indicators (mainly environmental indicators) that were only likely to be available from specialized national administrations. These would be requested in connection with a full scale HFA evaluation only once in six years.
32. The group agreed, in principle, with all of the proposals in paragraphs 30 and 31 and discussed their practical application. The group requested that they were sent, at a later stage, detailed proposed lists of indicators for annual, 3-annual and 6-annual reporting. They would review the list with the relevant national experts and provide comments.

Supporting the country level

33. The discussion concerning strengthening of monitoring and evaluation at country level was based on working papers 12 and 13. As mentioned in paragraphs 2(b) and 25, reporting of HFA monitoring and evaluation results to WHO was intended to be derived from, and to stimulate routine monitoring mechanisms at national level. Therefore, it was necessary to also review the fulfilment of the latter function. Two proposals were discussed which involved procedures to:
- (a) support Member States in producing more effective public health reports, and
 - (b) support Member States in the establishment of countrywide integrated statistical databases (paragraph 30(c) refers).

The group considered that priority should be given to developing integrated databases. These were considered helpful and attractive tools (interfaces) for communication between the primary databases (with raw data) and the various users including authorities responsible for monitoring and evaluation of strategies and programmes at different levels in the country. Disaggregated data for the country priority indicators would be easier to retrieve and compare. However, feasibility of the proposal would need to be further studied.

The group noted that public health reports were the national responsibility. WHO should provide guidance to Member States if required when preparing their public health reports, taking into account the usually rather specific situation in each country. WHO could also help by identifying a list of countries who have produced public health reports and making this list known to all countries.

Conclusions and recommendations

34. The health for all monitoring and evaluation has the following two objectives:
- (a) To foster and guide countries in carrying out HFA monitoring and evaluations at country level.
 - (b) To provide information (e.g. on country policies, legislation and programmes) and statistical data (e.g. on global and regional HFA indicators) to WHO to enable regional and global HFA monitoring and evaluations.
35. To achieve these objectives, one instrument (called the "HFA Monitoring or Evaluation framework") had been devised and used since 1985. Prior to each successive HFA monitoring and evaluation WHO had, with the help of experts and Member States, revised the framework with the aim of improving it for use by the Member States. The group concluded that:
- (a) the global and regional outcomes of HFA monitoring and evaluation (e.g. the global report, the regional report – "Health in Europe", the global and regional HFA indicator databases) were beneficial and useful for countries;
 - b) the outcome of the process at country level (i.e. the country reports submitted to WHO) were perceived as of little direct relevance to some countries, although there were examples of innovative use of such country reports (e.g. translations of country reports into local language(s) and wide distribution within the countries, including to the national parliaments);
 - c) the use of just one instrument (the framework) and the process required at country level to meet the above-mentioned two objectives, were regarded as being difficult to carry out and were not fully achieving the objectives. Therefore, the following principles for improvements in the monitoring and evaluation procedure and tools were recommended. The process should be:
 - more focused to Member States individual tasks and purposes;
 - consistent with the existing situation and possibilities in the countries;

- more simple, practical and efficient; and
 - designed to capitalize on the available information from all sectors in countries, thereby furthering the monitoring and evaluation process.
36. The countries in the WHO European Region naturally continue to have rather differing priorities, perceptions and requirements concerning monitoring and evaluation of progress towards the HFA targets. Therefore, it is recommended that
- (a) flexibility in the reporting process by Member States be retained so that the countries themselves and not just WHO benefit from the exercise;
 - (b) WHO develop tools to make regional and global results more directly useful to decision makers in countries, in facilitating international comparisons;
 - (c) WHO enhance the public relations aspects of the exercise and disseminate its outcomes more widely and consider adopting a special logo for this programme.
37. The countrywide monitoring and evaluation capabilities in Member States need to be strengthened. In addition, in order to foster a continuous updating of national policies and strategies, reporting of the monitoring and evaluation results by countries to WHO should be simplified. In order to achieve the former, the following is recommended:
- (a) Member States should establish countrywide databases of health-related statistics (in coordination with the efforts of the EU and other organizations where relevant) to facilitate the use of existing data nationally and internationally.
 - (b) The production of public health reports at different levels in countries should be encouraged. The production of such public health reports is the responsibility of the Member States, the role of WHO being to provide support as requested.
 - (c) WHO should establish a clearinghouse (inventory) of public health reports which can be used by Member States.
 - (d) WHO should seek stronger political support from countries' key decision makers for the national monitoring and evaluation process.
38. The following is recommended in order to achieve simplification of process:
- (a) Reporting of qualitative information to WHO should primarily consist of new facts and the country's assessment of its progress vis-à-vis the European HFA targets. In particular, the countries should use a standardized "target evaluation form" to enter their key observations (Annex 4). However, Member States should also be free to report any other information they may consider relevant. Member States may indicate to WHO if they consider that any restriction should be placed on access to the data by anyone outside WHO. The recommendation is to be field tested in a number of countries prior to implementation.
 - (b) Exchange of statistical data between Member States and WHO should better take into account the properties of the data required, in terms of:
 - periodicity (how often data should be supplied);
 - accessibility (whether it is available);

- relevance (priority nature of the data);
- needs for adjustments (the data should have international comparability).

More specifically, the frequency of reporting of statistical data should be amended as follows:

- annual exchange (for the data that is already produced annually);
- 3-yearly exchange (for the statistical data produced frequently but not annually e.g. survey data);
- 6-yearly exchange coinciding with the large-scale HFA evaluation exercises (for the remaining indicators).

WHO should prepare lists of the above groupings for consideration by Member States represented on this working group prior to finalizing the framework.

- (c) WHO should provide the countries with a more extended and firm timetable for completion of monitoring and evaluation activities and reports. The evaluation exercise should commence as early as possible.
 - (d) WHO should provide more complete definitions to be used in the provision of data, including the use of proxy indicators and suggested "reference definitions", and country variations. These definitions, the country specific definitions and the glossary of terms regarding the monitoring and evaluation procedures should be provided separately from the actual reporting requirements.
 - (e) Information technology should be fully exploited to facilitate the reporting of data in the monitoring and evaluation exercise and Member States should have to report data only once to WHO (for global or regional purposes).
39. There continued to be duplication of effort by Member States in providing data to national and international organizations. Therefore WHO, EU, OECD and other international organizations should undertake more concerted efforts to achieve closer cooperation in the harmonization of health statistics.

ANNEX 1

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ANNEX 2

LIST OF WORKING PAPERS AND BACKGROUND DOCUMENTS

Working Papers

- | | |
|---------------------|--|
| ICP/INFO 01/MT03/1 | Provisional list of working papers and background documents |
| ICP/INFO 01/MT03/2 | Scope and Purpose |
| ICP/INFO 01/MT03/3 | Provisional Agenda |
| ICP/INFO 01/MT03/4 | Provisional programme |
| ICP/INFO 01/MT03/5 | Provisional list of participants |
| ICP/INFO 01/MT03/6 | Health for All monitoring and evaluation – the European perspective by Mr A. Nanda |
| ICP/INFO 01/MT03/7 | A review of the 1993–1994 HFA monitoring in Europe – feedback from the WHO Regional Office for Europe by Dr A. Nossikov. |
| ICP/INFO 01/MT03/8 | Directions for simplification of the 1996–1997 HFA evaluation – main issues for discussion |
| ICP/INFO 01/MT03/9 | Simplification of the HFA evaluation framework for the WHO European Region by Dr A. Nossikov |
| ICP/INFO 01/MT03/10 | Provision of statistical data on the European health for all indicators to the WHO Regional Office for Europe – situation assessment and options for improvements by Dr R. Prokhorskas |
| ICP/INFO 01/MT03/11 | HFA indicators that are presently not readily available – situation assessment and proposals by Dr A. Nossikov |
| ICP/INFO 01/MT03/12 | Strengthening national monitoring and evaluation – national public health monitoring and reporting by Dr A. Nossikov |
| ICP/INFO 01/MT03/13 | National Integrated Statistical Health Databases by Dr R. Prokhorskas |

Background Papers

1. Revision of the HFA Indicators and Monitoring Procedures, Report on a WHO Working Group, Copenhagen, 28 November – 1 December 1989 (EUR/ICP/HST 126).
2. Development of Guidelines for Reports on Public Health, Report on a WHO Working Group, Copenhagen 11–12 December 1990 (EUR/ICP HSC 016).
3. HFA Indicators and Evaluation Framework for the European Region of WHO (1990–1991) (EUR/RC40/9 + Conf.Doc./6).
4. Revision of HFA Indicators and Monitoring Procedures, Report on a WHO Working Group, Copenhagen, 29 April – 1 May 1993 (EUR/ICP/HST 153).
5. HFA Indicators and Monitoring Framework For the European Region of WHO 1993–1994 ICP/HSC 016(1).
6. World Health Organization, Forty-Eighth World Health Assembly, Committee A, Provisional Summary Record of the First Meeting, Palais des Nations, Geneva, Tuesday 2 May 1995 (A48/A/ISR/1).
7. Health in Europe, The 1993/1994 health for all monitoring report, WHO Regional Publications, European Series, No. 56.
8. Guidelines for the provision of national statistical data on health and health services to the World Health Organization, Regional Office for Europe, by WHO's member States of the European Region.

ANNEX 3

STATUS REPORT OF COUNTRY REPLIES ON THE 1990-1991 HFA EVALUATION AND THE 1993-1994 HFA MONITORING

- A full or partial report received covering both statistical and textual elements of progress towards HFA
- B full or partial report received covering only statistical elements
- C some statistical data received due to special efforts, no official report

COUNTRY	STATUS 93/94	1990/1991	STATUS 93/94	1990/1991	93/94 only	1993/1994	1990/1991
	A	A	B	B	C	No Response	No response
ALB					X	X	X
ARM			X		X		not applicable
AUT	X	X					
AZE					X	X	not applicable
BLR	X						not applicable
BEL	X	X					
BIH							
BUL	X	X				X	not applicable
CRO	X						
CZH*	X	X					not applicable
DEN	X	X					
EST					X	X	not applicable

* applies for Czechoslovakia in 1991, and the Czech Republic in 1994.

COUNTRY	1993/1994	1990/1991	1993/1994	1990/1991	1993/1994 only	1993/1994	1990/1991	1993/1994	1990/1991
	A	A	B	B	C			No Response	No response
FIN	X	X							
FRA	X	X							
GEO			X						not applicable
DEU	X								X
GRE	X	X							
HUN	X	X							
ICE	X	X							
IRE	X			X					
ISR	X	X							
ITA	X	X							
KAZ	X								not applicable
KGZ					X			X	not applicable
LVA	X								not applicable
LTU	X								not applicable
LUX	X	X							
MAT	X	X							
MDA					X			X	not applicable
MON				X					
NET	X	X							
NOR	X	X							

COUNTRY	1993/1994	1990/1991	1993/1994	1990/1991	1993/1994 only	1993/1994	1990/1991	1993/1994	1990/1991
	A	A	B	B	C	No Response	B	B	No response
POL		X				X			
POR	X	X							
ROM	X	X							
RUS	X				X				not applicable
SMR				X		X			
SVK	X								not applicable
SVN	X								not applicable
SPA	X			X					
SWE	X	X							
SWI	X	X							
TJK								X	not applicable
TFY								X	not applicable
TUR		X						X	
TKM					X			X	not applicable
UKR					X			X	not applicable
UNK	X	X							
UZB					X			X	not applicable
YUG*		X							not applicable
SSR				X					not applicable
TOTAL	32 (25 old)	24	4	5	11	13	5	13	2

* Refers to the former Socialist Federal Republic of Yugoslavia

ANNEX 4

TARGET 1

EQUITY IN HEALTH

By the year 2000, the differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups.

TARGET EVALUATION FORM

(headline type of entries only)

1. New or reconfirmed policy developments (goals, priorities, main directions): ¹
2. New strategies and management approaches (legislation, structures, agreements etc): ²
3. New activities to implement policies and strategies:
4. New developments in information, monitoring and evaluation of activities underway: ³
5. Statistical evidence of progress (trends in the relevant HFA indicators):
6. Overall assessment of progress: ⁴

¹ Expression of goals for improving the health situation, the priorities among those goals, and the main directions for attaining them.

² Broad lines of action required in all sectors involved to give effect to the health policy. Note: National policies, strategies and plans of action form a continuum and there are no sharp dividing lines between them.

³ Including development and use of indicators of health outcome/gain.

⁴ – good progress: target likely to be achieved or already achieved;

– moderate progress: situation improved, target attainable;

– little or no progress: target unlikely to be achieved;

– negative trends: developments are in a direction opposite to that required by the target.