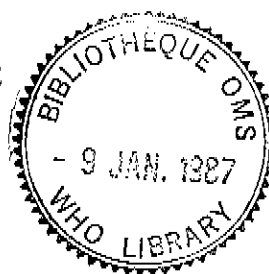




WORLD HEALTH ORGANIZATION  
ORGANISATION MONDIALE DE LA SANTE



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## MONITORING THE STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000

### Common Framework: Monitoring (CFM)

Member States have agreed to monitor periodically the progress in the implementation of their national strategies for health for all and to evaluate their effects in improving the health status of people, using appropriate indicators to this end. Based on a common framework, Member States undertook to report on the monitoring of progress in the implementation of their strategies for the first time in 1983, and to report on the evaluation of the effectiveness of the implementation in 1985. This revised common framework is intended to assist Member States in collecting and analysing relevant information for monitoring further progress in the implementation of their national strategies for health for all and to report to their regional committees in 1988, in accordance with resolution WHA39.7 (1986). The monitoring of progress in the implementation of the Global Strategy for Health for All, which will be based on the findings at national and regional levels, will be reviewed by the Executive Board and the World Health Assembly in 1989.

This document consists of two interrelated parts. The first part contains the main items and pertinent questions which Member States should explore when monitoring their strategy and should address in their national reports. The second part consists of an annex with brief explanatory notes which help to clarify the items and questions contained in the first part. A list of references has also been included on page 6 which may be consulted if further information is needed.

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## INTRODUCTION

1. When Member States unanimously adopted the Global Strategy for Health for All by the Year 2000 (resolution WHA34.36, May 1981), and the Plan of Action for implementing it (resolution WHA35.23, May 1982), they agreed to monitor progress in the implementation of their national strategies and to evaluate their effect in improving the health status of the people, using appropriate indicators to this end. Member States further agreed to establish at the earliest stage a process of monitoring and evaluation that was appropriate to their needs as part of their managerial process for national health development.

2. The World Health Assembly decided to monitor the progress and evaluate the effectiveness of the implementation of the Strategy at regular intervals, proposing that reports on progress be reviewed biennially by the regional committees, the Executive Board and the Health Assembly and that, every six years, an assessment be made of the effectiveness and impact of the Strategy at national, regional and global levels. Member States initiated the process with a first report on the monitoring of progress in the implementation of their national strategies in 1983 and with a first report on the evaluation of the effectiveness of the implementation in 1985.

3. Recognizing the need for Member States to strengthen their national capability in monitoring and evaluation, including the related information support, as part of their overall managerial process, the Thirty-ninth Health Assembly in resolution WHA39.7 (May 1986) decided to institute reporting on monitoring of progress in the implementation of the Strategy every three instead of every two years, maintaining the evaluation of the effectiveness of the implementation of the Strategy on a six-year cycle, starting from 1985.

4. Monitoring, being an integral part of any managerial process, is a continuous activity. Reporting on progress and outcome to be reviewed at national decision-making levels is periodic, and in most cases annual. As described above, countries have also decided to report to WHO on progress in the implementation of their national strategies every three years. This distinction between monitoring at national level as a process and reporting to WHO as a periodic activity is important. For the latter, selected information on the progress concerning the main components of the health-for-all strategy and the global indicators (as well as any regional or national indicators if they exist) has to be collected, analysed and synthesized. It was realized that reporting in a systematic manner and the synthesis of information at regional and global levels would be facilitated by the adoption of a common (standard) framework. Thus in 1982 a Common Framework and Format (CFF) was developed to assist Member States in collecting and analysing relevant information for monitoring progress in the

implementation of their national strategies for health for all, and to report on progress to the regional committees, the Executive Board and the World Health Assembly.<sup>1</sup> Subsequently, an expanded CFF was prepared for reporting on the evaluation of the effectiveness of the implementation of the Strategy.<sup>2</sup>

5. If countries have introduced a process for monitoring progress and evaluating the effectiveness of the implementation of their strategies, it is expected that the reports to be presented to the WHO regional committees will be derived from the information which is being systematically collected and analysed to support their national health development efforts. On the other hand, if such a process has not yet been introduced or is not functioning effectively, countries can use the common frameworks as a tool and as an opportunity to initiate the building up of national mechanisms for the monitoring of progress and the evaluation of the effectiveness of the implementation of their strategies. The results of the monitoring and evaluation process could serve for wider consultation both within the health sector as well as with other sectors, and help decision makers in identifying what key measures need to be taken to accelerate the implementation of their national strategies.

6. This Common Framework - Monitoring (CFM) has been further revised in the light of comments and suggestions made by Member States and the regional offices on the CFF in its application. The reference point now for assessing further progress in the implementation of national strategies is the 1985 national reports. Member States will thus be able 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 resulting analysis to improve their health plans, reprogramming as necessary.

7. At this stage, it should be re-emphasized that the CFM is not "just another WHO questionnaire", but on the contrary an important tool for supporting the monitoring and evaluation process which is essential to the basic functioning of countries' managerial processes for national health development. Final responsibility for the monitoring and evaluation of the implementation of the national strategies for health for all remains with each Member State.

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<sup>1</sup> Document DGO/82.1.

<sup>2</sup> Document DGO/84.1.

8. As in the previous common frameworks, the CFM sets out the broad principles embodied in the Strategy for Health for All and pinpoints pertinent questions which Member States may wish to address when examining progress. The CFM consists of a series of items, subdivided into a number of questions, to be reviewed for the monitoring of progress by government officials as well as a supporting Annex. For each item and/or question reference is made to the appropriate section in the Annex which contains points relating to the questions which need to be considered. These points are extracted from WHO's "Health for All" Series and other relevant sources of information. (A complete list of those references is to be found on page 6.) It is suggested that these references be reviewed carefully to seek further clarification on the pertinent questions or principles as necessary.

9. Each Member State is expected to submit its report to its respective regional committee. This report should be presented as a separate document. In each case the number of the item in the CFM that is being reported on should be indicated in the report. For example, when the report deals with matters related to health manpower the section should contain the heading "Item 8: health manpower". The report should also contain a covering page bearing the name of the Member State, the date of completion of the report, and the period covered (e.g. 1985-1987). Finally, if any further clarification is required it is suggested that the WHO representative or, in the absence of one, the WHO Regional Director, should be contacted.

REFERENCES

WHO "Health for All" Series

- No. 1 - Alma-Ata 1978: Primary health care (1978)
- No. 2 - Formulating strategies for health for all by the year 2000 (1979)
- No. 3 - Global Strategy for Health for All by the Year 2000 (1981)
- No. 4 - Development of indicators for monitoring progress towards health for all by the year 2000 (1981)
- No. 5 - Managerial process for national health development: guiding principles (1981)
- No. 6 - Health programme evaluation: guiding principles (1981)
- No. 7 - Plan of Action for implementing the Global Strategy for Health for All and:  
Index to the "Health for All" Series, No. 1-7 (1982)
- No. 8 - Seventh General Programme of Work, covering the period 1984-1989 (1982)
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Evaluation of the Strategy for Health for All by the Year 2000, Seventh Report on the World Health Situation. Geneva, WHO, 1986. (Document A39/3).

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ITEMS FOR MONITORING NATIONAL STRATEGIES FOR HEALTH FOR ALL:

I. MONITORING AND EVALUATION

Governments will need to know if they are making progress in the implementation of their strategies, and whether these strategies are having the desired effect in improving the health status of the people. To this end countries will need to introduce, if they have not already done so, a process of monitoring and evaluation that is appropriate to their needs as part of their managerial process for national health development. Whatever the precise nature of the process, it should include monitoring progress in carrying out the measures decided upon, the efficiency with which these measures are being carried out, and the assessment of their effectiveness and impact on the health and socioeconomic development of the people.<sup>1</sup>

ITEM 1: MONITORING PROCESS AND MECHANISMS

(see Annex, p. 24)

- 1.1 Has a monitoring process been introduced at all levels of the health system? If not, what are the main deficiencies and difficulties?
- 1.2 For which of the global indicators<sup>2</sup> (and regional indicators, if applicable) is information not easily available? If not, what are the main difficulties?
- 1.3 What have been the main difficulties and obstacles in improving information support for the monitoring of the national strategy? What major actions have been taken since 1985 to overcome these?

<sup>1</sup> "Health for All" Series, No. 3, 1981 (p. 73).

<sup>2</sup> Idem (pp. 75-77).

## II. NATIONAL HEALTH POLICIES AND STRATEGIES

The Strategy for Health for All is based on the concept of countrywide health systems based on primary health care as described in the report of the International Conference on Primary Health Care, Alma-Ata, 1978. It relies on concerted action in the health and related socioeconomic sectors following the principles of the Alma-Ata Declaration. The Strategy is equally valid for all countries, developing and developed alike; at the same time, it lays particular emphasis on the needs of developing countries.<sup>1</sup>

The fundamental policies embodied in the Strategy for Health for All are outlined in the Global Strategy. These policies call for: the political commitment of the state as a whole; coordinated efforts of social and economic sectors concerned with national and community development; an equitable distribution of resources both within and among countries; community involvement in the shaping of its own health and socioeconomic future; and technical and economic cooperation among countries.

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<sup>1</sup> "Health for All" Series, No. 3, 1981 (p. 12).

ITEM 2: NATIONAL HEALTH POLICIES

(see Annex, p. 25)

- 2.1 What are the principal thrusts of the national health policies? In which way are these reflected in the overall national development policies?
- 2.2 What, if any, revisions or additions to the existing policies have been made since 1985? Which aspects require further strengthening?

Global indicator 1 - Health for all has received endorsement as policy at the highest official level<sup>1</sup>

- 2.3 What is the evidence of continuing political commitment for Health for All at the highest official level?
- 2.4 What obstacles, if any, have impeded the development of national health policies for them to be in line with the policy of Health for All, and what measures are being taken to overcome these obstacles?

ITEM 3: NATIONAL HEALTH-FOR-ALL STRATEGIES

(see Annex, p. 26)

- 3.1 Have the national strategy and plan of action been updated since 1985? To which period do they correspond? How are they reflected in the national development plan?
- 3.2 If such a national strategy for achieving health for all had not been elaborated before 1985, has this been clearly outlined now? What are its main thrusts?
- 3.3 What principal obstacles, if any, have impeded the development of a national strategy for health for all? What measures are being taken to overcome these obstacles?

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<sup>1</sup> "Health for All" Series, No. 3, 1981 (p. 75).



ITEM 4: ORGANIZATION OF THE HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE (see Annex, p. 27)

- 4.1 Has a full acceptance and understanding of primary health care been achieved at all levels of the health system? If not, what are the difficulties? What actions are being proposed to overcome these?
- 4.2 What major actions have been undertaken since 1985 for reorienting and strengthening the health system towards primary health care? Review their adequacy in achieving the national health-for-all strategy. Which aspects require further attention?
- 4.3 What further action has been taken to ensure better coordination within the health sector? What obstacles have been encountered and how are they being overcome? Specifically, have adequate referral systems been established between the different levels of the health system? If not, what actions are proposed to improve these?

ITEM 5: INTERSECTORAL COLLABORATION

(see Annex, p. 29)

- 5.1 What policies of other sectors critical to health are contributing positively or negatively to people's health? Give examples. In what way is the health sector collaborating in or attempting to influence the development of these policies?
- 5.2 What institutional mechanism has been established to ensure that health goals are an integral part of socioeconomic development policies and programmes? Do mechanisms exist to ensure that there is a systematic analysis and monitoring of the impact on health of major development projects? Give specific examples and review their adequacy.
- 5.3 What mechanisms have been established for intersectoral collaboration at local, intermediate and central levels of the health system? Review their adequacy.
- 5.4 What have been the main factors which have facilitated intersectoral action?
- 5.5 What are the main obstacles to achieving collaboration with other sectors in health development? What measures are proposed to overcome them?

ITEM 6: COMMUNITY INVOLVEMENT

(see Annex, p. 31)

Global indicator 2 - Mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning<sup>1</sup>

- 6.1 What specific policies and mechanisms have been developed for involving communities in the planning and implementation of the national health strategy? Are these adequate?
- 6.2 In what ways are communities involved in health matters? Give examples.
- 6.3 What measures have been taken to increase people's understanding of their health problems and ways of solving them?
- 6.4 How are the nongovernmental organizations contributing to the health strategy? What steps are proposed to involve them further?
- 6.5 What have been the main obstacles in involving communities, and what measures are intended to overcome them?

ITEM 7: MANAGERIAL PROCESS AND MECHANISMS

(see Annex, p. 33)

- 7.1 What managerial process and related mechanisms have been set in motion to further develop and/or update, implement and monitor the national strategy and plan of action? Describe briefly.
- 7.2 What obstacles, if any, have impeded taking the necessary managerial measures, and what has been done since 1985 to overcome them?

ITEM 8: HEALTH MANPOWER

(see Annex, p. 34)

- 8.1 Is there a health manpower plan in response to the needs of the strategy? What major changes, if any, have been introduced since 1985?
- 8.2 Has progress towards an equitable distribution of health manpower been achieved in urban and rural areas? If not, what are the deficiencies? What measures are proposed to resolve these?

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<sup>1</sup> "Health for All" Series, No. 3, 1981 (p. 75).

- 8.3 What new actions have been undertaken for the education and training of health personnel since 1985?
- 8.4 What new measures have been taken to improve the motivation and commitment of health workers to primary health care?
- 8.5 What have been the main obstacles in the implementation of the health manpower plan, and what measures are proposed to overcome them?

ITEM 9: RESEARCH AND TECHNOLOGY

(see Annex, p. 35)

- 9.1 Is there a national policy concerning the selection and use of health care technology at the different levels of the health system? Describe briefly.
- 9.2 What mechanisms have been established for consultation and coordination with relevant groups and communities on the selection and use of health care technologies?
- 9.3 Has a national research policy focusing on priority health problems been outlined? What are its main thrusts?
- 9.4 What mechanisms have been established or strengthened to facilitate the coordination of health research, to promote the use of research, and to disseminate the research findings?
- 9.5 What principal obstacles have been encountered in developing/implementing the national research and technology policies? What measures are proposed to overcome these?

ITEM 10: RESOURCE UTILIZATION AND MOBILIZATION

(see Annex, p. 37)

- 10.1 Is there a master plan for the mobilization and use of human, material and financial resources in support of the national health-for-all strategy?
- 10.2 What measures have been taken since 1985 to reallocate human, material and financial resources for the implementation of the national strategy?

10.3 What efforts have been made since 1985 to mobilize additional internal<sup>1</sup> material and financial resources?

10.4 What measures have been taken to optimize the use of resources by the health sector?

10.5 Have the above measures (10.2 - 10.4) proved adequate? If not, what have been the main obstacles, and what measures are planned to overcome these obstacles?

Global indicator 3 - At least 5% of the gross national product is spent on health<sup>2</sup>

10.6 What percentage of the gross national product is spent on health?

Global indicator 4 - A reasonable percentage of the national health expenditure is devoted to local health care<sup>2</sup>

10.7 What percentage of the national health expenditure is devoted to primary health care?

Global indicator 5 - Resources are equitably distributed<sup>2</sup>

10.8 Have resources for primary health care been distributed in such a way as to reach socially and geographically disadvantaged and underserved groups?

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<sup>1</sup> The international transfer of resources is dealt with under item 11.

<sup>2</sup> "Health for All" Series, No. 3, 1981 (p. 75).

#### IV. INTERNATIONAL ACTION<sup>1</sup>

International action to support national actions for developing health systems should concentrate on the strengthening of national health infrastructures and on the promotion of the health service and technology that are appropriate to their circumstances. At the international level constant efforts are necessary to influence bilateral and multilateral agencies to channel resources into support for the Strategy in such a way that resources will have a multiplier effect in countries.

WHO's first constitutional function is to act as the directing and coordinating authority on international health work. The Organization's international health work comprises in essence the inseparable and mutually supportive function of coordination and technical cooperation. Accordingly, WHO's role includes coordinating all aspects of the Strategy and cooperating with Member States as well as facilitating cooperation among them regarding the Strategy. In particular, WHO facilitates technical and economic cooperation among developing countries.

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<sup>1</sup> "Health for All" Series, No. 3, 1981 (pp. 49, 57 & 79).

ITEM 11: INTERNATIONAL TRANSFER OF RESOURCES

(see Annex, p. 43)

For developing countries:  
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- 11.1 Has a systematic analysis been made of the needs for external support for the national health-for-all strategy? What priority needs have been identified?

Global indicator 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 resource support from more affluent countries<sup>1</sup>

- 11.2 What proportion of the external resources needed has been received? Indicate areas that have received support since 1985. Which priority needs did not receive adequate support?

For donor countries:  
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- 11.3 What support has been provided for the implementation of the health strategies of developing countries since 1985? Indicate in terms of US dollars and of broad areas supported.

ITEM 12: INTER-COUNTRY COOPERATION

(see Annex, p. 44)

- 12.1 What new priority areas of inter-country cooperation have been identified since 1985, either through TCDC/ECDC<sup>2</sup> or bilateral arrangements, that support the implementation of the national strategy?

- 12.2 What main modalities or mechanisms of inter-country cooperation have been utilized? Give examples.

- 12.3 What are the main factors that have (a) facilitated and/or (b) inhibited such cooperation? What measures have been or will be taken to overcome obstacles?

<sup>1</sup> "Health for All" Series, No. 3, 1981 (p. 75).

<sup>2</sup> Technical cooperation among developing countries (TCDC), Economic cooperation among developing countries (ECDC).

ITEM 13: INTERNATIONAL COOPERATION (INCLUDING WHO)

(see Annex, p. 45)

Cooperation with WHO

- 13.1 In which way is WHO cooperation directly supporting the implementation of the national strategy?
- 13.2 In view of WHO's policy on the rational use of its resources, what measures have been taken since 1985 at national level to improve the efficiency in the use of these resources?
- 13.3 What are the main factors that have (a) contributed to productive cooperation with WHO and/or (b) caused less than optimal cooperation with the Organization? What corrective measures have been, or will be, taken to overcome problems encountered?

Cooperation with other agencies

- 13.4 What other major international (United Nations) or multilateral cooperative efforts and/or nongovernmental activities exist that are health-related and have a bearing on the implementation of the national strategy? What mechanisms have been established for the overall coordination of international support towards the national strategy?

V. AVAILABILITY OF HEALTH CARE

"Primary health care includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs."<sup>1</sup>

Most of the essential elements of primary health care are set out in the definition of global indicator 7, which reads:<sup>2</sup>

"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 pregnancy and childbirth, and caring for children up to at least 1 year of age."

<sup>1</sup> "Health for All" Series, No. 1, 1978 (p. 4).

<sup>2</sup> "Health for All" Series, No. 3, 1981 (pp. 75-76).

ITEM 14: AVAILABILITY OF PRIMARY HEALTH CARE

(see Annex, p. 46)

- 14.1 What proportion of the population has safe drinking water available in the home or within 15 minutes' walking distance?<sup>1</sup>
- 14.2 What proportion of the population has adequate facilities for excreta disposal available in the house or close to it?<sup>1</sup>
- 14.3 What proportion of infants reaching their first birthday has been immunized against the six EPI target diseases; and what proportion of pregnant women has been immunized against tetanus?<sup>2</sup>
- 14.4 What proportion of the population has treatment for common diseases and injuries, and a regular supply of 20 essential drugs, available within one hour's walk or travel?<sup>1</sup>
- 14.5 What proportion of pregnant women are attended by trained personnel?<sup>1</sup>
- 14.6 What proportion of deliveries are attended by trained personnel?<sup>1</sup>
- 14.7 What proportion of infants are attended by trained personnel?<sup>1</sup>

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<sup>1</sup> It is suggested that the coverage be stated separately for urban and rural areas (definition to be provided) and/or by geographical/ administrative subdivisions.

<sup>2</sup> Coverage will need to be stated for all the six EPI target diseases together and separately for each vaccine, and by geographical/ administrative subdivisions.

VI. HEALTH AND SOCIOECONOMIC STATUS

Countries have already agreed on a shortlist of indicators for assessing health and socioeconomic status at global level.<sup>1</sup> Some WHO regions have also established additional regional indicators, while many countries may also be using additional indicators in keeping with the needs and capacities. A periodic review of the indicators at national, regional and global levels will be useful for assessing trends.

ITEM 15: HEALTH STATUS

(see Annex, p. 50)

Global indicator 8 - The nutritional status of children is adequate, in that:

at least 90% of newborn infants have a birthweight of at least 2 500 g; at least 90% of children have a weight-for-age that corresponds to the reference values given in Annex 1 to "Development of indicators for monitoring progress towards Health for All by the Year 2000"<sup>2</sup>

15.1 What is the proportion of newborns with birthweight of at least 2 500 g?<sup>3</sup>

15.2 What is the proportion of children with weight-for-age corresponding to reference values?<sup>3</sup>

Global indicator 9 - The infant mortality rate for all identifiable subgroups is below 50 per 1 000 live-births<sup>2</sup>

15.3 What is the infant mortality rate for all identifiable subgroups?<sup>4</sup>

Global indicator 10 - Life expectancy at birth is over 60 years<sup>2</sup>

15.4 What is the life expectancy at birth?<sup>4</sup>

<sup>1</sup> "Health for All" Series, No. 3, 1981 (pp. 75-77).

<sup>2</sup> Idem (p. 76).

<sup>3</sup> It is suggested that the above proportions be stated separately for urban and rural areas (definition to be provided) and/or by geographical/administrative subdivisions.

<sup>4</sup> It is suggested that this information be provided separately by sex, urban and rural areas (definition to be provided) and/or by geographical/administrative subdivisions.

ITEM 16: SELECTED SOCIAL AND ECONOMIC INDICATORS

(see Annex, p. 53)

Global indicator 11 - The adult literacy rate for both men and women exceeds 70%<sup>1</sup>

16.1 What is the adult literacy rate for women and for men?

Global indicator 12 - The gross national product per head exceeds US \$500<sup>1</sup>

16.2 What is the gross national product per head?

ITEM 17: REGIONAL INDICATORS

17. Provide information on the national values for any regional indicators agreed upon by the Regional Committee.

ITEM 18: NATIONAL INDICATORS

18. In addition to the above, provide information on any other national indicators which have been used.

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<sup>1</sup> "Health for All" Series, No. 3, 1981 (p. 76).

## VII. CONCLUSION

### ITEM 19: GENERAL COMMENTS ON PROGRESS AND FUTURE ACTION

On the basis of the preceding review, a summary assessment of progress in the implementation of the national strategy should be made. This should include:

- the most important achievements and measures taken especially since 1985;
- the adequacy of these measures in achieving the objectives established;
- the main shortcomings;
- the main obstacles being encountered; and
- the measures intended to overcome them.

A few priority areas for future actions may be listed.

ANNEX

EXPLANATORY NOTES ON COMMON FRAMEWORK: MONITORING (CFM)

This annex to the CFM is designed to provide some of the details requested by users to help in answering the questions raised in the first part of the document. Background information and key references are provided for each item, together with guidance on how calculations should be made, where appropriate, and indication that where possible geographical (or urban/rural) breakdown should be given and that information sources should be identified.

## I. MONITORING AND EVALUATION

### ITEM 1: MONITORING PROCESS AND MECHANISMS

#### Points to be considered with respect to item 1

1. A prerequisite to monitoring in health development is national capability to provide adequate information support for the development and appreciation of the managerial processes. While the efficient collection of the most relevant information at all levels of the health system is important, even more critical is the use of such information for planning, management and decision-making purposes. The experience to date indicates that many countries lack adequate information support for monitoring progress in the implementation of their strategies. Even where data are being collected, they are not being systematically compiled, analysed and used.
2. Countries traditionally have many sources of data, such as vital events registers, population and housing censuses, routine health-service records, epidemiological surveillance data, sample surveys, disease registers, etc. But the health sector has tended generally to rely on routine health-service records, which are kept for administrative rather than for monitoring purposes. A commitment to obtain relevant information from all sources to complement health-service data, and to use this information for monitoring progress at different levels, is vital. The health sector in many countries has only recently begun to appreciate the value of information and its role in monitoring.
3. The purpose of monitoring progress in health development is to improve health programmes and the services for delivering them, and to guide the allocation of human and financial resources in current and future programmes. Monitoring should be perceived as a decision-oriented tool, closely linked with decision making, whether at the operational or the policy level.
4. The individuals and groups responsible for the development and application of the managerial process for national health development at various policy and operational levels also carry responsibility for its monitoring. The community itself might eventually undertake responsibility for monitoring progress in the implementation of the strategies. Mechanisms for this will need to be created.

The monitoring of progress in the implementation of national health-for-all strategies should also be an intersectoral responsibility. This is especially crucial for those countries where further improvements in the health status of the

population depend mainly on the effective actions which have to be undertaken by other sectors. Countries need to develop appropriate mechanisms for such monitoring and generate interest and commitment for this from other sectors. Final responsibility for monitoring progress in the implementation of the national health-for-all strategy and the total health system, and for reporting to WHO, rests with the central authorities such as the ministry of health or the national planning and decision-making bodies.

5. With regard to the specific questions, countries may wish to address the following aspects:

- A brief description of the various components of the national monitoring process may be given, followed by a short assessment of its adequacy. The description could consider which levels (central/ministerial, intermediate/district, peripheral/community) lack provision for a monitoring process, and what needs to be done to provide it.
- A brief analysis of the difficulties experienced in generating, analysing and using information for these indicators may be given. Difficulties could be analysed such as (if applicable): data not available in the ministry of health but available from outside sources; data not available anywhere in country; data too out-of-date to be useful; lack of capacity to perform such surveys.

## II. NATIONAL HEALTH POLICIES AND STRATEGIES

### ITEM 2: NATIONAL HEALTH POLICIES

#### Points to be considered with respect to item 2

1. For items 2.1 and 2.2 countries may wish to examine specific thrusts in their policies such as those aimed at: reducing disparities in the health status of people; involving people in the shaping of their health; and reaching disadvantaged and underserved population groups. In addition the health component of socioeconomic development policies and policies of other related sectors should be examined in detail, to identify areas receiving emphasis or requiring further strengthening, for example: education of women, nutrition and agriculture, and environment.
2. For item 2.3, global indicator 1 reads: "Health for all has received endorsement of health for all as policy at the highest official level".

The goal of health for all has already been endorsed by almost all Member States. However, any major changes which have occurred since 1985 will need to be included in the present report such as:

- new or amended legislative measures strengthening the right of citizens in respect of health;
- new commitments made by the cabinet;
- new endorsement of health charters;
- statements made by the head of state and the prime minister on significant changes in health policy;
- new policy or significant changes in the policy for the provision, allocation or reallocation of resources in favour of primary health care and/or underserved populations, including those resources outside the health sector (e.g. agriculture, irrigation, water-resource development, energy, education).

In reviewing the status of political commitment, countries will need to look for evidence such as that cited in the examples above. They will also need to identify the constraints encountered in translating political will into real commitment and action, and suggest measures which would be undertaken to resolve them.

#### ITEM 3: NATIONAL HEALTH-FOR-ALL STRATEGIES

##### Points to be considered with respect to item 3<sup>1</sup>

1. The evaluation of the effectiveness of the implementation of the Strategy carried out in 1985 revealed that while many countries had elaborated or adjusted their national health strategies since the endorsement of the Global Strategy, some had not. Few had been able to project a long-term health development or overall socioeconomic development strategy. While a large majority of countries had indicated that their overall national health strategies reflected the fundamental principles of the Health-for-All Strategy, the main thrusts and emphasis varied according to the national or regional health situation.
2. A national strategy, which should be based on the national health policy, includes the broad lines of action required in all sectors involved to give effect to that policy.
3. A national strategy should encompass a range of political, social, economic, managerial and technical measures to be taken for fostering national health development. It should incorporate ways of: ensuring the involvement of other sectors bearing on health;

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<sup>1</sup> "Health for All" Series, No. 1, 1978.

selection and application of health technologies; involving professional groups, communities and nongovernmental organizations. It should deal with financial implications and broad legislative actions required for achieving the national health policies.

4. In reviewing their strategies, governments need to examine gaps in their national strategies. If a national strategy for health for all has not been clearly formulated, the reasons for this should be critically reviewed.
5. A broad national plan of action has to specify the policies to be followed, the objectives to be attained and the related targets, quantified to the extent possible. In most countries it indicates a time frame (say 5-10 years) during which such objectives are to be achieved. It also specifies technical, economic, and administrative measures to be pursued in relation to these objectives. Broad allocations and ways of financing have to be defined at the initial stages of the formulation of plans of action. Without this, plans remain dreams.
6. In order to formulate appropriate national strategies, active dialogue is required between staff at the many levels of the health system, and the socioeconomic development planners, the community, the private sector and the nongovernmental organizations. Countries should review the mechanisms that are being used for achieving such a dialogue, and identify any obstacles and areas requiring further action.

### III. DEVELOPMENT OF HEALTH SYSTEMS

#### ITEM 4: ORGANIZATION OF THE HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE

##### Points to be considered with respect to item 4

1. The definition of primary health care is contained in Alma-Ata 1978 - primary health care.<sup>1</sup>
2. In fulfilment of the health-for-all policy, concerted efforts are required from countries to develop their health systems of which primary health care is the central function and main focus. While no universal blueprint of a health system can be imposed on countries, the following general principles are applicable to all health systems based on primary health care:<sup>2</sup>

<sup>1</sup> "Health for All" Series, No. 1, 1978 (pp. 2-4).

<sup>2</sup> "Health for All" Series, No. 3, 1981 (pp. 39-40).

- the system should encompass the entire population on a basis of equality and responsibility;
  - it should include components from the health sector and from other sectors whose interrelated actions contribute to health;
  - primary health care, consisting of at least the essential elements, should be delivered at the first point of contact between individuals and the health system;
  - the other levels of the health system should support the first contact level of primary health care to permit it to provide these essential elements on a continuing basis.
3. As countries reorient their health systems to primary health care, many changes are needed in their organization and management, including:
- redefinition and reallocation of the roles and responsibilities of the principal institutions comprising the health system;
  - establishment of mechanisms for coordination within the health sector for the delivery of health care;
  - reorganization and expansion of the health care delivery infrastructure;
  - definition of roles and functions of the different levels of the health care infrastructure;
  - establishment of referral mechanisms between the levels of the health care system; and
  - establishment and strengthening of mechanisms for community involvement and intersectoral collaboration.
4. The development and deployment of health manpower, as well as the planning, designing and equipping of health facilities in response to the needs of the different levels of the health system, are important for efficient and effective functioning of health systems based on primary health care. Countries will need to review each level of their health system (such as local, intermediate, and central levels) with a view to assessing their technical and managerial adequacy to carry out their corresponding functions. They will need to report on specific actions which have led to the strengthening of the capacity of the health system to deliver primary health care, such as actions to strengthen district health systems. Any legislative measures taken to support these actions should to be described. They should also examine the remaining weaknesses or deficiencies in the system.

5. A district health system based on primary health care is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, nongovernmental, private, or traditional. A district health system therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, workplaces and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative, and rehabilitative health activities.
6. The roles and responsibilities of the private sector and the nongovernmental and voluntary organizations in the implementation of the national health strategies may be reviewed, wherever applicable. The mechanisms used to ensure coordination should be described briefly.
7. In addition to the rural areas, the organization of primary health care in the urban areas might require special attention in an increasing number of countries. Action taken in this regard as well as difficulties experienced may be included in the report.

#### ITEM 5: INTERSECTORAL COLLABORATION

##### Points to be considered with respect to item 5

1. Recognizing the multisectoral character of health development, the Alma-Ata Declaration<sup>1</sup> called for the coordination of health-related activities of the different sectors. In response, countries have sought to develop more integrated health policies and programmes embodied in the primary health care approach - and to design institutional mechanisms and administrative structures better able to promote intersectoral action for health.<sup>2</sup>
2. The linkages between health and development have been demonstrated over a number of years in both developed and developing countries. In the former, health gains were mainly due to better living conditions, improvements in nutritional status,

<sup>1</sup> "Health for All" Series, No. 1, 1978.

<sup>2</sup> Document A39/3.

sanitation and health behaviour. Recent studies in some low-income countries have shown that when health development became part of a strategy to satisfy the basic needs of the population (including access to resources and economic opportunities by the less well-off, raising educational levels, availability and distribution of food, improved status of women, and basic infrastructure, such as transport and public amenities), the basic health indicators improved dramatically, particularly for the vulnerable groups.

3. Each country therefore has to continue to identify the key roles and contributions expected from the most relevant sectors for the achievement of its health objectives included in its national strategy for health for all. Relevant policies in other sectors which contribute to or foster health development have to be clearly outlined and coordinated. Countries will need to examine periodically these policies and actions with a view to assessing their adequacy and their specific contribution to health. They will also need to promote further intersectoral policies and actions towards health.
4. To foster intersectoral action, countries are expected to devise ways of ensuring adequate cooperation between ministries of health or analogous authorities and other ministries concerned. Mechanisms such as multisectoral national health councils and interministerial committees for coordination in policy making and planning have been established in some countries. The effectiveness of these mechanisms in achieving intersectoral collaboration at policy, planning and community levels have to be further enhanced. Such mechanisms should also be part of the managerial process in support of the strategy for health for all.
5. Some development actions, such as in the agricultural and industrial sectors, can have side effects that are detrimental to health. It is therefore important to incorporate preventive measures in any development scheme which poses particular health hazards. Appropriate legislation may have to be enacted to support such health measures, for example for environmental control, water quality assurance, and the regulation of the construction of industrial facilities. Other development prospects may provide an opportunity to include a health component, for example for the health protection of industrial and migrant workers. In addition, the industrial sector can support primary health care by establishing industries related to health, in particular for essential foods and drugs. Local small-scale industries are also important, because they create employment and thereby improve the local economic base and earning power. The health sector has to play a spearheading and stronger advocacy role and seek positive collaboration with other sectors to achieve the health goals.<sup>1</sup> However, the incorporation of health as a

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<sup>1</sup> "Health for All" Series, No. 1, 1978 (p. 40); & "Health for All" Series, No. 3, 1981 (p. 83).

development goal of the overall national planning and strategy formulation is of overriding importance.

6. Coordinated planning at the community level will make it possible to link primary health care closely with other sectors in joint efforts for community development. Community representatives in local government can ensure that community interests are properly taken into account in the planning and implementation of development programmes. The desirability of coordinating at the local level the activities of the various sectors involved in socioeconomic development, and the crucial role of the community in achieving this integration, make community participation an essential component of primary health care. Countries will need to give special attention to achieving intersectoral action at the community level and to seeking mechanisms which are effective and developed by the communities themselves.
7. The capability of the health sector to monitor the impact of economic development projects on the environment and on natural resources, as well as to measure changes in health profiles and the impact on socioeconomic development, has to be enhanced.
8. Multilaterally- and bilaterally-funded development schemes should incorporate into their feasibility studies an analysis of potential impact of the schemes on health (e.g. industrial, agricultural, public works and other such projects), and should then be adjusted as necessary to avoid any adverse impact on health. Training in impact analysis for health and other personnel concerned with development may often be necessary to improve skills in this sphere.

#### ITEM 6: COMMUNITY INVOLVEMENT

##### Points to be considered with respect to item 6

1. The desirability of involving the community at large in matters related to individual and collective health is accepted by all Member States implementing the Strategy for Health for All. Health policies and strategies in a large majority of countries emphasize community involvement in the assessment of the health situation and in the planning, execution and evaluation of programmes. Mechanisms and approaches for such involvement, and measures to inform and motivate communities so that they take greater responsibility for their health and wellbeing, have also been outlined in some national health strategies. While promising trends in mobilizing communities for health for all are evident in many countries, sustained community involvement has been difficult to attain. A genuine partnership between the health system and the community has yet to evolve in many countries.<sup>1</sup>

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<sup>1</sup> Document A39/3 (p. 43).

2. Global indicator 2 reads: "Mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning".

The following are some of the measures that may promote community involvement:

- (a) delegation of responsibility, authority and resources to the community, to establish primary health care in the community in a way that is linked to the real-life situation of the people in that community;
  - (b) creation of community health councils, composed of representatives of a cross-section of the people in the community, to develop and control primary health care;
  - (c) fostering individual responsibility for self-care and family care, adopting a healthy lifestyle, and applying the principles of good nutrition and hygiene;
  - (d) delegation of part of the responsibility and provision of human and material resources to communities to carry out agreed components of health programmes, such as vector-control activities to reduce malaria transmission, sanitation, and ensuring adequate nutrition for underprivileged children;
  - (e) developing mechanisms for people to participate at the national level in decision making on the country's health system and health technology through accepted social and political channels;
  - (f) ensuring people's representation in national or intermediate-level decision-making bodies;
  - (g) election of members of the public to the governing bodies of health institutions.
3. In addition to the orientation and training of health workers, other people with community responsibility, such as civic and religious leaders, teachers, community workers, social workers and magistrates, will be provided with information on the national health strategy and the part they could play in supporting it.
4. Ministries of health will need to continue to explore appropriate ways of involving people in deciding on the health system required and the health technology they find acceptable, and in delivering part of the national health programme through self-care and family care and involvement in community action for health. Ministries of health will need to launch countrywide health-education activities

through health personnel and the mass media and in educational institutions of all types, with the aim of enlightening the whole population on the prevailing health problems in their country and community and on the most appropriate methods of preventing and controlling them.

5. Nongovernmental organizations (NGOs) can and do play a crucial role in promoting and implementing the strategy for health for all through resource mobilization (in both human and financial terms) and by planning and executing projects with people. Countries therefore need to recognize the actual and potential contribution of NGOs and find ways and means as well as mechanisms to mobilize them more effectively to pursue national health goals in partnership with governments.

#### ITEM 7: MANAGERIAL PROCESS AND MECHANISMS

##### Points to be considered with respect to item 7

1. The managerial process for national health development is a systematic, continuous process of national planning and programming. It includes policy formulation and the definition of priorities. It involves the preparation of programmes to give effect to these priorities, the preferential allocation of budgets to them, and the integration of the different programmes within the overall health system. It also deals with the implementation of strategies and plans of action, and the programmes, services and institutions for delivering them, as well as with their monitoring and evaluation with a view to modifying existing plans or preparing new ones as required, as part of a continuous cycle. Finally, it outlines the information support required throughout.<sup>1</sup>
2. The evaluation of the effectiveness of the implementation of the Strategy carried out in 1985 revealed that although most countries do have a managerial process for the development of their nation's health, in many of them the components of intersectoral planning and of information support are weak, and the participation of voluntary organizations and the private sector in the formulation of national policy and plans is virtually non-existent. The degree of decentralization is still limited in many countries, and consequently community participation is also limited. The costing of plans and the allocation of resources require more attention in most countries. Countries identified a need to intensify actions in order to strengthen the managerial capacity of the health system at all levels.
3. In reporting on monitoring of progress, particular emphasis will need to be placed on reviewing the following aspects of the managerial process and related mechanisms: policy formulation, the planning process (including the involvement of other sectors and the community), supporting legislation, costing of plans and allocation of resources,

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<sup>1</sup> "Health for All" Series, No. 5, 1981.

decentralization, implementation and information support. In reviewing their progress, countries may address the following aspects:

- the process of formulation and updating of national policies, strategies and plans of action to implement the national strategy for health for all;
- mechanisms of involving other sectors and the community in planning, monitoring and evaluation;
- adequacy of information support to the managerial process;
- costing of plans and allocation of resources;
- new legislation enacted since 1985 to support the management of the strategy; and
- mechanisms for decentralizing planning, management and resources, and for what levels of the health service decentralization has been achieved.

Countries should also identify areas where progress has been achieved, and where deficiencies in the mechanisms still exist.

#### ITEM 8: HEALTH MANPOWER

##### Points to be considered with respect to item 8

1. There is a growing recognition in countries that technical capabilities must be further strengthened if the full potential of health workers is to be mobilized for health for all by the year 2000. Specific policies to direct and coordinate health manpower development as an instrument of health systems development are equally important. The development of primary health care depends on the attitudes and capabilities of all health workers and also on a health system that is designed to support and complement the front-line workers.
2. Among the major issues related to health manpower development and utilization identified during the last evaluation<sup>1</sup> were: unequal distribution of health manpower; low motivation of professional health workers, especially doctors, for primary health care; poor utilization and productivity of health personnel; and the still inadequate social relevance of education and training programmes of the professional health workers. Concerted efforts are required on the part of governments to resolve these issues, including taking measures which are outside the direct influence of the health sector. Governments are particularly expected to examine their progress in achieving a balanced and equitable distribution of health manpower, improving the motivation of health workers, and in resolving difficulties related to manpower utilization and availability.<sup>1</sup>

<sup>1</sup> Document A39/3.

3. Ministries of health, together with other ministries concerned such as labour and education, should plan health manpower in specific response to the needs of the health system, with a view to placing at the disposal of the system the right kind of manpower in the right place in the right numbers at the right time.
4. Governments are expected to give high priority to the full utilization of human resources by defining the technical role, supportive skills and attitudes required for each category of health worker according to the functions that need to be carried out to ensure effective primary health care, and by developing teams composed of community health workers, other developmental workers, intermediate personnel, nurses, midwives, physicians, and where applicable, traditional practitioners and traditional birth attendants.
5. Governments are also expected to undertake or support reorientation and training for all levels of existing personnel and programmes for new categories of health personnel. Such training programmes should be socially relevant and technically sound and aim to increase the motivation of health workers towards serving the communities.
6. Ministries of health and other ministries concerned, such as education, culture, labour, finance and public administration, will need to take further steps to ensure that health workers are socially motivated and provided with the necessary incentives to serve the remote and neglected areas.

#### ITEM 9: RESEARCH AND TECHNOLOGY

##### Points to be considered with respect to item 9

1. An important factor for the success of primary health care is the use of appropriate health technology.<sup>1</sup> It is part of a national health policy to insist on technology that is appropriate, to encourage its local development, to disseminate information about it, and to promote its widespread use. The identification or development of appropriate technology has to be considered when the national strategy for health for all is being formulated.
2. A systematic assessment is needed of the health technology being considered for use in each priority programme, aimed at applying technology that is appropriate for the country or part of the country concerned. The process in determining health

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<sup>1</sup> "Health for All" Series, No. 3, 1981 (p. 50).

technology entails specifying for each programme what measures should be taken by individuals and families in their home and what should be taken by communities, whether by individual or community behaviour or by specific technical measures. Measures to be taken by the health services at primary, secondary and tertiary levels, as well as those to be taken by other sectors, should also be specified.

3. To arrive at the identification of appropriate technologies, the involvement of other agencies and groups such as the ministries of science and education, research and academic institutions, industry and the NGOs in health and its related sectors, and consultations with communities, are important.
4. Governments are also expected to review the scope and content of their activities in the field of biomedical, behavioural and health-systems research, with a view to focusing them on problems requiring solution as part of their strategies for health for all. The allocation of resources to relevant health research, the training of scientists, the development of career structures for health research workers, and the use and dissemination of research results are important features of a national health-research strategy. The coordination and promotion of health-research activities within the country through mechanisms such as health-research councils are also required, as are mechanisms for bringing together researchers and planners to ensure the relevance of research to the needs of policy and decision makers and the application of the results.
5. The evaluation of the effectiveness of the implementation of the Strategy in 1985 revealed that while there was a greater awareness of the importance of research in national health development, very few countries had defined their national health-research policies or had effective mechanisms functioning for the coordination of research activities. Resources allocated or available to research were also limited. The need for research on social and behavioural issues and on the appropriate use of research and technology was stressed. Special attention was also drawn to the appropriate use of research and health care technology at the primary health care level.<sup>1</sup> Thus in reviewing the monitoring of the implementation of the national strategies the following should also be examined: specific actions taken with respect to the aspects mentioned above in the further development and implementation of national strategies, progress achieved and principal obstacles encountered.

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<sup>1</sup> Document A39/3.

ITEM 10: RESOURCE UTILIZATION AND MOBILIZATION

Points to be considered with respect to item 10:

1. One of the recognized major constraints faced by health administrators everywhere is the lack of resources. A related problem is that often the scarce resources available are not managed in the most effective way. Compounding these two problems is a third, that information on existing resources and health expenditure may not be available in sufficient detail to permit rational planning. In the prevailing economic climate there has been a decline in the rate of growth of national economies, accompanied by, in many countries, a reduction in the health budget. This situation calls for creative planning to maximize the use of all available resources.
2. The first step towards the coordinated provision of resources for primary health care is to develop a master plan for the mobilization of not only the financial but also the human and material resources required. In the light of the national goal of health for all by the year 2000, a national strategy should have been formulated and costed, by customary budgetary periods (e.g. 2 years, 5 years) up to the target date. The financing of the strategy, and the provision of the necessary human and material resources, should have been planned using one or more of the alternative options available, such as: the reallocation of existing resources to devote a larger share to primary health care, the generation of additional internal and external resources (external contributions are covered under item 11), and the optimization of the use of the resources obtained.<sup>1</sup>
3. Various initiatives may have been tried for mobilizing additional, extrabudgetary and internal resources. These include community contributions in cash, kind or labour, the participation of business/industry in the health care of their employees, health insurance schemes, etc. Some of these require legal and/or administrative measures to be implemented. A description of such efforts, together with any associated measures, should be given here.
4. With regard to optimization, substantial savings can sometimes be made by improving the effectiveness of the delivery of health services, and of the utilization of equipment and personnel. For example, advantage can be taken of any visit of a mother and child to a health facility to bring the child's (and mother's) vaccination status up to date. Home visits can be made by a single polyvalent health worker rather than by several staff from different programmes. Transport can be shared. Supervision can be targeted to those areas with the most serious

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<sup>1</sup> Planning the finances of the health sector - a manual for developing countries.  
Geneva, WHO, 1983.

problems. Paperwork can be reduced to the minimum required to permit proper programme management. Examples of any such actions which have been tried and which have given good results may be given.

5. Global indicator 3 reads: "At least 5% of the gross national product is spent on health".

The following rate should be calculated:

$$\frac{\text{National health expenditures} \times 100}{\text{GNP}}$$

- (a) As most countries prepare National Accounts reports, the officials responsible for such reports should be closely involved in determining the above rate. If the GDP is used instead of the GNP, this should be indicated.
- (b) All actual health expenditures, public and private, should be assessed.
- (c) Both capital and recurrent expenditures should be considered. The form of tabulation illustrated below should be adapted for the purpose, as some of the expenditure data may not be available in the country.
- (d) The following table indicates the distribution of health expenditures by major areas according to the source of final consumption. This table is not exhaustive and should be worked out based on the national accounting system and policy. Separate tables can be drawn up for capital and recurrent expenditures.
- (e) Other governmental and public agencies outside the ministry of health may have health expenditures, e.g. military and prisons (for medical services), agriculture (for veterinary public health services), education (for health manpower training), social welfare, community development, public works (construction and maintenance of health buildings, maintenance of vehicles).
- (f) To the central government expenditure, the state, provincial and local government expenditures should be added and subsidies from central to other levels deducted.
- (g) Next, the voluntary and private sectors should be added. Employee health services provided by employers, charitable organizations, private health insurance should be included. Any private payments not covered by insurance must also be taken into account. For example, private expenditure on drugs can be calculated by subtracting government drug purchases from the total value of drugs sold. Ideally, an estimate of the value of payments in kind, for example, to traditional healers or to support community health workers, should be made.

Sample country worksheet

Health sector expenditure

Year: 198\_\_

Area of expenditure	Ministry of Health	Other ministries	Other government (e.g. state, local)	Missions, charities	Industry	Health insurance	Direct private payments	Foreign aid	Total
- Hospitals									
- Health centres and posts*									
- Private practitioners									
- Traditional healers									
- Drugs & supplies									
- Disease prevention and control services									
- School health									
- Workers' health									
- Domestic water supply									
- Sanitation									
- Vector control									
- Nutrition programmes									
- Transport									
- HQ administration									
- Training: professional other									
- Research									
- Other services (specify)									
<b>Total</b>									

\* including staff costs but excluding drugs.

(h) Finally, foreign development aid to the health sector, both governmental and private, should be included.

(i) Health activities and expenditures do not include:<sup>1,2</sup>

- food subsidies covering the whole population;
- water for irrigation or industry;
- general education;
- homes for the aged or disabled (but medical care for the inmates is included);
- earnings or production lost due to illness;
- cash benefits paid during illness.

(j) The final total should be accompanied by the following information:

- year to which the data refer;
- sources of the various entries used in the calculation;
- a list of which expenditures are included.

(k) The actual figures used in the worksheet may be kept confidential, if necessary; it is only the final result that is needed for national and international purposes.

6. Global indicator 4 reads: "A reasonable percentage of the national health expenditure is devoted to local health care".

The following rate should be calculated:

$$\frac{\text{National health expenditures devoted to local health care} \times 100}{\text{National health expenditures}}$$

(a) Local health care means first-level contact, including community health care, health-centre care, dispensary care and the like. In some countries, including some highly industrialized ones, a significant amount of local care is provided by the outpatient departments of large urban hospitals. An attempt should be made to estimate the cost of these services. Each country will decide on what percentage should be considered "reasonable".

(b) Fundamentally, the priority a country gives to local health care may be reflected in the share of the health budget given to local health activities. But many national health budgets are not structured so as to show costs for local care separately. Therefore, these costs must be estimated. Detailed guidance on how to do this is given in the references.<sup>1, 2, 3</sup>

<sup>1</sup> Document EB77/INF.DOC/1.

<sup>2</sup> Planning the finances of the health sector - a manual for developing countries.  
Geneva, WHO, 1983.

<sup>3</sup> Document SHS/84.3.

- (c) The principles provided for the calculation of the numerator of global indicator 3 should also be applied to the numerator of global indicator 4. Capital and recurrent expenditures should apply only to activities devoted to local care.
- (d) In the simplest case, costs for local care include capital and recurrent expenditures for health centres and health posts, plus the salaries of the personnel who work in, or are supervised from, health centres and posts, and the costs of their supervision from the next level (e.g. district).
- (e) Supervision costs can be calculated by estimating the proportion of staff time, transport costs, and building construction and maintenance costs at the district level that are consumed by supervision activities. To simplify the calculations, the entire salaries of the district supervisory staff may be considered as a cost for local care, even if they do not work full-time in supervision. The proportion of office space and transport used by them can then be estimated.
- (f) In countries where there is a significant private or nongovernmental sector, the proportion of expenditures on local care from these sources must be estimated. This would include payments to general practitioners, obstetricians and paediatricians (but not to other specialists), to opticians, ophthalmologists and dentists, and to commercial pharmacists for injections and first aid.
- (g) The expenditure on drugs can be obtained from government figures on imports plus local production, and an estimate made of the proportion of these drugs which are used for local care.

7. Global indicator 5 reads: "Resources are equitably distributed".

- (a) This indicator refers specifically to resources for primary health care.
- (b) An equitable distribution of resources means that each subgroup of the population receives primary health care in proportion to its needs.
- (c) While it is recognized that a perfectly equitable distribution of resources for primary health care is extremely difficult to achieve, steps can be taken to ensure that underserved groups receive special attention. The purpose of the indicator is to measure progress towards a more equitable distribution of resources for primary health care.

- (d) It is important to understand that "equitably" does not necessarily mean "equally" in terms of expenditure. For example, it may cost more to deliver a given health care service to a remote mountain village than to provide the same service in a city. On the other hand, WHO studies have shown that some simple diagnostic tests can be performed more cheaply at peripheral than at central laboratories (because of lower overhead costs).
- (e) The distribution of resources for primary health care should be analysed according to population groups, in terms of:
- expenditure
  - manpower
  - facilities.
- (f) The first thing to do is to identify the subgroups in special need of primary health care, whether because of lack of services or facilities, lack of accessibility of existing services, or poor social or economic standing. Such groups are likely to have exaggerated values for indicators of health status, e.g. a high infant mortality rate, low life expectancy, higher incidence of low birthweight and malnutrition. Expenditure on health care for these groups (at the minimum, urban/rural) should be determined as far as possible, and it will probably be found that, in view of their exceptional needs, costs on a per capita basis are higher for the less favoured than for the more favoured sections of the population.
- (g) Manpower engaged in primary health care includes government personnel working from health centres and health posts, and government, voluntary and private personnel delivering services directly to the community, e.g. private practitioners, traditional healers, staff of mobile clinics and preventive health units. It will be useful to tabulate manpower for primary health care according to these three broad groups: professional, technical, other.
- (h) The analysis of facilities should include health centres, health posts and mobile units. It should distinguish clearly between the centres and posts that are fully staffed and operational, and those that are not. Two areas may have the same ratio of population per health post, but if there is full-time staff in one area and not in the other, there is no equity. Or if one area is much larger than the other, although the ratio of population to health facilities may be similar, accessibility may be quite different.
- (i) The combined analysis of the tables for expenditure, manpower and facilities for primary health care in relation to priority groups should give an indication of the degree of equity in the distribution of total resources for primary health care. The government's views on the equity of resource distribution should be stated.

#### IV. INTERNATIONAL ACTION

##### ITEM 11: INTERNATIONAL TRANSFER OF RESOURCES

###### Points to be considered with respect to item 11

Global indicator 6 reads: "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 resource support from more affluent countries".

1. Developing countries receiving support should provide information on the amount of external resources received, both financial and other. The period to which the information refers should be specified. The amount of external resources received should be compared with the total amount required, if such needs have been assessed. An explanation should be given of the kind of support received (for primary health care, hospitals, training, etc.). Countries should try to quantify this information as much as possible.
2. Foreign aid of all categories should be included:<sup>1</sup> grants and loans, bilateral and multilateral (including which UN agencies involved), official and private (nongovernmental), in cash and in kind, as technical cooperation, training activities, or in direct provision of health services. All capital and recurrent expenditures should be shown, even if certain expenditures are not shown on government accounts (e.g. donation of a hospital, organization of training activities, workshops and seminars). Care should be taken to avoid the double counting of aid channelled through the ministry of health; it should be counted as foreign aid and not shown as a ministry expenditure. Only actual expenditure should be considered, not unmet or future commitments.
3. With respect to item 11.3, donor countries should express the resources provided both bilaterally and multilaterally to the national strategies for health for all of developing countries as a percentage of their own (the donor's) GNP, and also as a percentage of the total resources provided as grants and loans for all purposes to developing countries. They should also indicate the broad areas supported such as primary health care (naming the essential element involved), health management, health manpower development, hospitals and the like.

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<sup>1</sup> Planning the finances of the health sector: a manual for developing countries. Geneva, WHO, 1983, pp. 57-59.

## ITEM 12: INTER-COUNTRY COOPERATION

Points to be considered with respect to item 12

1. TCDC/ECDC<sup>1</sup> or inter-country cooperation among the developing countries might take the form of exchange of information and experience on all aspects of one another's national strategies, training, collaborative research, use of one another's experts, joint programmes for the control of certain diseases, production, procurement and distribution of essential drugs and other essential medical equipment and supplies, development and construction of health-infrastructure facilities, and the development and application of low-cost technology for water supply and waste disposal.<sup>2</sup>
2. Cooperative activities with and among the industrialized countries might for example include the areas of assessment of clinical, laboratory and radiological technology and of the usefulness of selective health screening for early detection of disease, research on prevalent noncommunicable diseases and mental health, control of environmental hazards, including the long-term health effects of chemicals in the environment, prevention and control of alcohol and drug abuse, accident prevention, and care of the elderly.<sup>2</sup>
3. Cooperation among countries in health and related matters has increased significantly in recent years in a number of areas such as training, exchange of technical expertise, control of communicable diseases, joint purchase of essential drugs and other materials, transfer of technology, exchange of technical and scientific information and environmental pollution control.
4. Such cooperation has developed through many mechanisms, e.g. through bilateral agreements, through regional or subregional mechanisms which were either already in existence or were established specifically for health, and through established political and economic country groupings.
5. Some of the obstacles to inter-country cooperation identified during the evaluation were political differences, lack of adequate funds, and conflicting policies and priorities of donor and recipient countries. Problems of communication and the lack of political will also constitute important constraints to effective cooperation. Mutual trust and confidence between countries need to be continually fostered. Countries will need to examine in which way inter-country cooperation has facilitated their national strategies and what factors have in particular favoured or inhibited such cooperation.

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<sup>1</sup> Technical cooperation among developing countries (TCDC); Economic cooperation among developing countries (ECDC).

<sup>2</sup> "Health for All" Series, No. 3, 1981 (p. 71).

ITEM 13: INTERNATIONAL COOPERATION (INCLUDING WHO)

Points to be considered with respect to item 13

1. As part of their intimate partnership relations, WHO and its Member States cooperate in developing and implementing national strategies for health for all along the lines described in the global and regional strategies. This includes the investment of resources in reviewing and developing national health systems based on primary health care, and strengthening national capacities to do so. It also includes the transfer of validated information and the facilitation of its use, as well as the joint pursuit of research and development, and support in generating and mobilizing resources. WHO provides international services as well as direct financial cooperation in conformity with defined criteria. The monitoring and evaluating of national strategies as part of the managerial process for national health development is prominent in WHO's cooperative activities with Member States.<sup>1</sup>
2. Each region of WHO has now defined a regional programme budget policy to ensure the optimal use of WHO's resources in countries and at regional level for the attainment of the goal for health for all, backed by the new managerial arrangements<sup>2</sup> which provide a management framework for implementing such a policy. These new arrangements now aim at the joint government/WHO development of countrywide programmes and health systems for their delivery that can be maintained by the country after WHO's direct cooperation with them has ceased. Under the new arrangements, governments assume responsibility for the work of WHO and the use of WHO's resources in their country, particularly those resources provided from the WHO regular budget. This government responsibility implies that WHO's resources are to be used only for activities that are consistent both with defined national policies and with international health policies agreed upon collectively by the Member States of WHO.
3. The United Nations and its specialized agencies have been approached with requests to include in their programmes action relevant to the Strategy, whether to support national action by the sector concerned or to engage the support of people in various social and economic disciplines, particularly through their nongovernmental organizations. Attempts have been made to set in motion action by the United Nations and its specialized agencies in partnership with WHO to support the Health-for-All Strategy in such crucial fields as socioeconomic planning and management, education, agriculture, water supply and sanitation, environmental control, housing and industrial development. Countries should review the efficiency of mechanisms established to ensure overall coordination of international support for health, particularly within their planning and financial institutions.

<sup>1</sup> Document DGO/85.1 (p. iv).

<sup>2</sup> Documents DGO/83.1 Rev. 1 & A38/INF.DOC/2.

V. AVAILABILITY OF HEALTH CARE

ITEM 14: AVAILABILITY OF PRIMARY HEALTH CARE

Points to be considered with respect to item 14

1. Safe water and sanitation (items 14.1 and 14.2)

The following rates should be calculated:

Population with safe water in the home or within 15 minutes x 100

Total population

Population with adequate excreta-disposal facilities at home or close x 100

Total population

- (a) Safe drinking-water includes treated surface waters and untreated but uncontaminated water such as that from protected boreholes, springs and sanitary wells. Other sources of unknown quality should be considered unsafe and not included in the estimate of coverage.
- (b) Among the various elements of sanitation, excreta-disposal facilities are the only ones which are included. They are considered adequate if they effectively prevent human, animal and insect contact with excreta.
- (c) If the above data are available in terms of the proportion of households (for which safe water and sanitation are available), it should be possible to convert this to the proportion of population, using average figures for household size.
- (d) As similar indicators are used for monitoring the International Drinking Water Supply and Sanitation Decade, coordination with those responsible for collecting the data for that project is highly recommended.
- (e) The year of reference and source of data should be given in each case.
- (f) Whenever possible, a breakdown by urban/rural category and also by geographical area and socioeconomic group is desirable. Any groups for which safe water supply or sanitation is deficient should be identified.

2. Immunization (item 14.3)

- (a) For the coverage of infants it is most useful for the management of immunization programmes to estimate the proportion of infants reaching their first birthday who have been immunized. Values should be calculated separately for:
- full immunization against all the six diseases;
  - full immunization against DPT (2 or 3 doses according to the immunization scheme adopted in the country);
  - immunization against measles (1 dose);
  - full immunization against poliomyelitis (3 doses), with a note of whether live or killed vaccine is used;
  - immunization against tuberculosis (1 dose).

Each sub-indicator will be expressed by the following rate:

$$\frac{\text{Number of infants fully immunized}}{\text{Number of infants surviving to age 1}} \times 100$$

If the national schedule provides for immunization in a different age group, such as measles in the second year of age, the value should be the proportion of children immunized in the target age group (if such is the case, it should be clearly mentioned).

- (b) If the national schedule includes immunization of pregnant women against tetanus, the figure to be calculated is the proportion of pregnant women immunized with tetanus toxoid (2 doses). If tetanus immunization is also given to other groups of women, this may be recorded, but for proper programme management it is necessary to know the proportion of pregnant women being protected. For the coverage of pregnant women, the figure to be calculated is the proportion of women fully immunized with two (or more) doses of tetanus toxoid by the end of pregnancy.
- (c) If the figures available are for children in age groups different from those requested, these groups should be clearly indicated. But for the proper management of immunization programmes it is essential to be able to break down the data to show the proportion covered in the first year of life (or the second year for measles immunization).
- (d) As the monitoring of immunization coverage is included in most national immunization programmes, it is desirable to ensure the coordination of data collection and data sources so as to eliminate duplication and discrepancies in reporting.

- (e) The year of reference and source of data should be given in each case.
- (f) Whenever possible, a breakdown by urban/rural category and also by geographical area and socioeconomic group is desirable. Any groups for which immunization is deficient should be identified.
- (g) Where the contribution of the voluntary or private sector is significant, an attempt should be made to estimate it.

3. Availability of health care (item 14.4)

The sub-indicator measures the percentage of the population having treatment of common diseases and injuries, and a regular supply of 20 essential drugs, available within one hour's walk or travel.

The following rate should be calculated:

$$\frac{\text{Population having access to local care} \times 100}{\text{Total population}}$$

- (a) The criteria involved here are:
  - A regular supply of essential drugs. Is an uninterrupted supply assured of the essential drugs designated by the country? To all parts of the country?
  - At least 20 essential drugs. Countries should be encouraged to communicate their list of essential drugs for front-line units (such as health posts). Sometimes these might be less than 20.
  - One hour's walk or travel. If data for time taken is not available, but distance is, distance can be converted into time. For example, under many circumstances 5 km can be walked or 25-50 km travelled by motor transport in one hour, depending on road or track conditions. Countries can calculate conversion factors according to the terrain.
- (b) The year of reference and source of data should be given in each case.
- (c) Whenever possible, a breakdown by urban/rural category is desirable, and also by geographical area and socioeconomic group.
- (d) Where the contribution of the voluntary or private sector is significant, an attempt should be made to estimate it.

(e) If convenient, the availability of local health care and uninterrupted availability of essential drugs may be reported separately. Any groups for which the availability of essential drugs or local health care is deficient should be identified.

4. Care of pregnant women and children by trained personnel (items 14.5, 14.6 and 14.7)

(a) For the proportion of pregnant women attended by trained personnel during pregnancy (item 14.5), the following rate should be calculated:

$$\frac{\text{Number of pregnant women attended by trained personnel}}{\text{Number of live births}} \times 100$$

- For national monitoring, disaggregation by place of care and type of personnel is recommended. The average number of prenatal visits should also be calculated.
- The type of training given to the attending personnel should be described (e.g. nurse, community health worker, trained birth attendants), together with the criteria used for attendance (e.g. minimum number of visits recommended during pregnancy).
- The number of prenatal visits found and the content of care provided at those visits should be reviewed in the light of any national norms to determine whether the situation is satisfactory.

(b) For the proportion of deliveries attended by trained personnel (item 14.6), the following rate should be calculated:

$$\frac{\text{Number of deliveries attended by trained personnel}}{\text{Number of live births}} \times 100$$

- Disaggregation by place of delivery and type of personnel is desirable.
- The type of training given to the attending personnel should be described (e.g. nurse, community health worker, trained TBA), together with the place of the delivery (i.e. home or institution).
- The rate found, together with the data on place of delivery and type of training, should be reviewed in the light of any national norms to determine whether the situation is satisfactory.

- (c) For the proportion of infants (up to their first birthday) cared for by trained personnel (item 14.7), the following rate should be calculated:

$$\frac{\text{Number of infants cared for by trained personnel} \times 100}{\text{Number of live births}}$$

- The type of training given to the personnel providing health care should be described (e.g. nurse, community health worker), together with the criteria used for care (e.g. minimum number of visits recommended during first year).
  - The number of infant visits found and the content of care provided at those visits should be reviewed in the light of any national norms to determine whether the situation is satisfactory. The average number of visits/contacts should be calculated.
- (d) The year of reference and source of data should be given in each case.
- (e) Whenever possible, a breakdown by sex, urban/rural category and also by geographical area and socioeconomic group is desirable. Any groups for which the availability of care for pregnant mothers and infants is deficient should be identified.
- (f) Where the contribution of the voluntary or private sector is significant, an attempt should be made to estimate it.

## VI. HEALTH AND SOCIOECONOMIC STATUS

### ITEM 15: HEALTH STATUS

#### Points to be considered with respect to item 15:

##### 1. Nutritional status of children (item 15.1)

Global indicator 8 reads: "The nutritional status of children is adequate, in that:

- at least 90% of newborn infants have a birthweight of at least 2 500 g;
- at least 90% of children have a weight-for-age that corresponds to the reference values given in Annex 1 to Development of indicators for monitoring progress towards Health for All by the Year 2000".

The following rates should be calculated:

$$\frac{\text{Number of newborns with a birthweight of at least 2 500 g} \times 100}{\text{Number of live births}}$$

$$\frac{\text{No. children under 5 with weight-for-age corresponding to ref. values} \times 100}{\text{Number of children under 5 years}}$$

- (a) It should be noted that birthweight is an indicator of health and nutritional status of the mother as well as a prediction of infant health and development.
- (b) Birthweight should be measured within the first hours of life, before significant postnatal weight loss has occurred. If available, information on preterm births should be provided separately.
- (c) The reference values for weight-for-age measurement are those labelled "median-2 SD (kg)" in the tables in Annex 1 to "Health for All" Series No. 4, Development of indicators for monitoring progress towards Health for All by the Year 2000. The number of children studied and their representativeness should be stated. Breakdown by sex and 1-year age group is recommended. In case "weight-for-age" data are not available, "weight-for-height" data for children under 5 years of age may be presented instead, or in addition. The cut-off point would be "median-2 SD" weight-for-height as given in Annex 3 to the document mentioned in (c).
- (d) The data source (e.g. civil registration, hospital records, sample survey) and the year of reference should be given.
- (e) If the data refer only to a particular geographical area or age group, this should be specified. It is particularly important to identify geographical areas or population subgroups suffering from inadequate nutrition.

2. Infant mortality (item 15.2)

Global indicator 9 reads: "The infant mortality rate for all identifiable subgroups is below 50 per 1 000 live births".

The following rate should be calculated:

$$\frac{\text{Number of deaths under 1 year of age} \times 1 000}{\text{Number of live births}}$$

- (a) The key section of this indicator is "all identifiable subgroups". The national rate should, of course, be given, but in addition it is important to give the rates by sex and urban/rural division, and also, if possible, by geographical area and socioeconomic group. In some countries it may also be appropriate to give the rate by ethnic group. National definitions of urban/rural and other subdivisions should be included.
- (b) For those groups or areas with higher infant mortality rates, measures proposed to counter the problem may be mentioned.
- (c) If there is a national target for the infant mortality rate, this should be given.
- (d) The year of reference, source (e.g. civil registration, sample survey) and data representativeness should be given.

The following tabular presentation may be used:

			Year: 198_
Area/group	No. live births	No. infant deaths	IMR/1 000 live births
Whole country			
Males			
Females			
Urban			
Rural			
etc.			

3. Life expectancy at birth (item 15.3)

Global indicator 10 reads: "Life expectancy at birth is over 60 years."

- (a) A simple procedure for computing life expectancy is illustrated in the publication mentioned in the footnote below.<sup>1</sup> Life expectancy cannot be established with precision for a country with a population of less than 1 million if based on data for a single calendar year. For a country with a population of less than 1 million but more than 200 000, data for 2-5 years should be combined for the computation. For a country with a population of less than 200 000, the average age at death may be used as a proxy indicator.

<sup>1</sup> "Health for All" Series, No. 4, 1981 (pp. 70-74).

- (b) The figure for life expectancy should be reported separately for males and females, if available. Variations in life expectancy by geographical areas and/or socioeconomic subgroups are important, and any areas or groups with lower life expectancy should be identified.
- (c) The year to which the data refer, the data source (e.g. death rate based on a complete count, sample registration, estimate, etc.) and the data representativeness should be described.

ITEM 16: SELECTED SOCIAL AND ECONOMIC INDICATORS

Points to be considered with respect to item 16

1. Adult literacy (item 16.1)

Global indicator 11 reads: "The adult literacy rate for both men and women exceeds 70%".

The following rates should be calculated:

$$\frac{\text{Number of literate males aged 15 years and more} \times 100}{\text{Number of males aged 15 years and more}}$$

$$\frac{\text{Number of literate females aged 15 years and more} \times 100}{\text{Number of females aged 15 years and more}}$$

- (a) The year to which the data refer, the source (e.g. census, sample survey) and the representativeness of the data should be described.
- (b) It is important to identify areas or population groups within the country which have a low female literacy rate.

2. Gross national product (GNP) per capita (item 16.2)

Global indicator 12 reads: "The gross national product per head exceeds US \$500."

The GNP per head should be expressed in national currency as well as US dollars. The year to which the figure relates should be specified. If the GNP is not available, the gross domestic product (GDP) may be provided.