



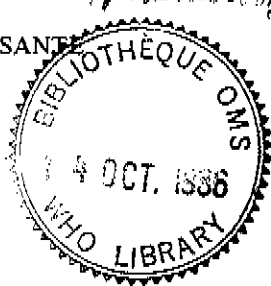
WORLD HEALTH ORGANIZATION
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REPORT OF THE HEALTH SITUATION

AND TREND ASSESSMENT PROGRAMME

TEAM MEETING

Geneva, 16-20 June 1986

Table of contents

	Page
1. Background.....	3
2. Aims and Objectives.....	3
3. Opening Address by Dr J. Hamon, ADG.....	3
4. Regional and HQ Reports.....	5
5. Inter-programme Collaboration.....	6
6. Target 1: Strengthening of Information Support to National Health Management..	8
7. Target 2: Training.....	9
8. Target 3: Development of Methodology and Standard Tools.....	11
9. Target 4: Monitoring and Evaluation of Regional and Global Health Situation and Trends, including Epidemiological Surveillance.....	13
10. Annexes.....	19

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Explanation of Symbols

CDD	Diarrhoeal Diseases Control
CDS	Communicable Diseases
CVD	Cardiovascular Diseases
DAP	Drugs and Biologicals Procurement
DTR	Diagnostic, Therapeutic and Rehabilitative Technology
EHE	Environmental Health
EPI	Expanded Programme on Immunization
HMD	Health Manpower Development
ISS	Information Systems Support
LAB	Health Laboratory Technology
LEP	Leprosy
MAP	Malaria Action Programme
MCH	Maternal and Child Health
MNH	Mental Health
MPN	Managerial Process for National Health Development
NCD	Noncommunicable Diseases
NUT	Nutrition
PDP	Parasitic Diseases Programme
SCH	Schistosomiasis and other Snail-borne Trematode Infections
SHS	Strengthening of Health Services
TDR	Special Programme for Research and Training in Tropical Diseases
TRI	Tuberculosis and Respiratory Infections
VBC	Vector Biology and Control
VDI	Programme of Sexually Transmitted Diseases

1. Background

1.1 The first Team Meeting of the newly organized Health Situation and Trend Assessment Programme (HSATAP) was held in Geneva from 12 to 16 December 1983, and was followed by a meeting on programme development from 4 to 8 February 1985. Their reports were issued as documents HST/84.1 and HST/85.1.

1.2 The GPC agreed that "a second meeting on programme development be held after the World Health Assembly in 1986 in order to review the action required in countries to strengthen their health situation and trend assessment programmes, by taking into account the full experience of the preparation of the Seventh Report on the World Health Situation". It also agreed that "again all regional advisers would participate in the second meeting" (GPC/MIN/15, page 40).

2. Aims and Objectives

2.1 These were:

1. To review the progress towards regional and global targets;
2. To develop an agreed framework for action which makes optimum use of the resources available throughout the programme to achieve the regional and global targets.

2.2 This report should be read with reference to the Global Medium Term Programme of Health Situation and Trend Assessment (HST/MTP/83.1), which gives details of the targets and objectives of HSATAP.

2.3 The list of participants is given in Annex 1.

3. Opening Address by Dr J. Hamon, ADG

3.1 This meeting was called for by the WHO Global Programme Committee to ensure the exchange of experience between regional offices, as well as with headquarters, and the cost-effective use of WHO resources when cooperating with Member States in this field, or when developing additional investigation tools for this purpose. At present this technical cooperation places great emphasis on the monitoring and evaluation of the HFA2000/PHC strategies, but it is obvious that the periodic production of national reports on this topic is far less important than the continuous use of relevant and timely information for the management of all levels of the national health system.

3.2 Indicators have been developed by the Secretariat as well as by Member States to facilitate the monitoring and evaluation, and comparison within and between countries. Some of the proposed indicators are straightforward but this is not always the case. The WHO Programme Development Working Group has therefore suggested that during the present interregional meeting some time be devoted to the manner in which these indicators should be presented to Member States for eliciting meaningful national assessments and unambiguous reporting.

3.3 When looking back at the work achieved by Member States, with the Secretariat's support, in improving the information base for health systems management, one is impressed by the rapid progress made at the national level in all matters related to

the monitoring and evaluation of the HFA2000/PHC strategies. In spite of many flaws, the quality of the evaluation reports is much higher than that of the monitoring reports produced two years ago. At the same time one cannot help wondering whether such periodic reporting has any influence on the daily management of the national health systems, and whether it is genuinely geared to the implementation of these strategies.

3.4 The strategies aim at improving the average health status of people, first and foremost by focusing upon the needs of the most underserved geographic areas and social groups. To achieve this, a country must first locate such areas and groups, identify the most likely causes of that situation, determine what remedial actions would be economically feasible and socially acceptable, and proceed with their implementation. There is at present little evidence that such a course of action has been adopted by the majority of Member States.

To improve the health status of the people

- the most underserved geographic areas and social groups must be located,
- the causes of their situation identified, and
- economically and socially acceptable remedial actions must be determined and implemented.

3.5 The above course of action calls for an intelligent use of the indicators at hand, and the selection of those which, under the prevailing socioeconomic and epidemiological conditions, would be sensitive and easy enough to use to make a snapshot of local health conditions, and which, subsequently, could be used to determine the causes of such a situation, as well as for monitoring and evaluating the impact of remedial actions. Has the Organization been forceful enough in inducing such investigations at the country level, in supporting the presentation of the findings to national policy-makers, and in contributing to the planning and implementation of remedial actions? Has WHO technical cooperation been effective in guiding the selection of the investigation tools, the identification of the remedial actions required, and the evaluation of these actions when implemented? Are the investigation tools at present available suitable for such purposes?

3.6 Another essential element of WHO technical cooperation in this field is that of the social and economic relevance of the diagnosis made and the remedial actions proposed for coping with the most unacceptable health inequalities. Is the Organization only contributing to post mortem investigations to determine what remedial actions were required 20 years ago, so as to encourage and support their implementation now? Or is WHO contributing to social and economic projections which could be the basis for forward-looking remedial actions geared to the future conditions and needs of the people? Are the investigation tools at present available suitable for this purpose? Does HSATAP promote their use as forcefully as we should? Are we satisfied by the outcome?

3.7 Last but not least, a few words about the present international atmosphere. Many influential people seem to have lost faith in "development", and there are many more vocal advocates for short-term emergency relief operations than for support to sustainable development activities. One of the side-effects of such attitudes is that there is a growing disregard for the UN system, and within this system a special disregard for the Agencies which promote long-term development activities.

This has direct implications for the HFA2000/PHC strategy at country level, as well as for the effective functioning of WHO itself.

The WHO governing body has given a clear mandate that WHO funds are not allocated to Member States to be used entirely as they wish, but to be used for the implementation of their HFA2000/PHC strategy.

3.8 The present financial liquidity crisis is serious, but not yet dramatic; however, it could become dramatic over the next few years. Some of the elements which could enable Member States and the Secretariat to successfully implement remedial actions are in the hands of the HSATAP Team. No politician can ignore the presentation of unacceptable health inequalities at the country level, and many international politicians continue to be willing to fund actions aimed at decreasing the magnitude of gross health inequalities between countries. But, to achieve that, national health authorities should present convincing situation analyses, propose socio-economically acceptable remedial actions, and prove beyond any doubt their ability to implement such actions. And what is done in this field within a country, as well as between countries, should be publicized in a timely manner, in a place where it matters, in a language that decision-makers can understand, accompanied by economic analyses that economists and development bank officials can endorse. Enabling Member States and senior officials of the Organization to achieve this result is also HSATAP's duty.

4. Regional and HQ Reports

4.1 Each region and HQ gave a brief report on the highlights of its activities over the past biennium and plans for the current biennium. These were based on Working Papers Nos. 1-7 of the meeting (listed in Annex 2). Common concerns included lack of restructuring and staffing at regional level to match the reorganization at HQ, leaving responsibility for major parts of HSATAP in the hands of other programmes and staff; how to promote action based on the results of the country HFA evaluation reports; and the need to identify those countries which have demonstrated their real commitment to a national HFA strategy, so as to have a chance of success for HSATAP collaboration in strengthening information support, and to plan collaborative activities with those countries and monitor their implementation. Further details of these concerns are given below.

4.2 In several regions, HSATAP still has not been assigned the responsibility for epidemiological surveillance and training, which is handled by the regional equivalent of CDS/HQ. However, as of 1 April 1986, AMR has merged all units relevant to HSATAP into one.

4.3 In the area of regional/HQ collaboration, SEAR proposed that mechanisms should be established to avoid duplication of work between the regions and HQ, and stressed the need for coordination of the dissemination of national health information in the intervening years between the monitoring and evaluation reports (in future 3 years between successive monitoring/evaluation reports).

4.4 Country reports on the evaluation of their HFA strategies in 1985 appear to show improvement over their monitoring reports, received in 1983. However, we should not be content with that. The critical point is whether countries are going to use the information which formed the basis of their national evaluation reports to reprogramme their health plan of action. HSATAP staff should try to find ways to promote action in countries based on the results of countries' evaluations. Current financial constraints mean we must be creative in the search for alternative sources of funds to support this action.

4.5 The question was raised of whether it is still useful to commit scarce WHO resources to training in hospital records, and in response the importance of health records (all records, not just hospital records) was stressed by several participants. It was agreed that HSATAP would continue to collaborate effectively with Member States in developing and improving effective and suitable recording and reporting systems in support of health care delivery and its management. Such recording systems would take into account the need to facilitate data collection as an integral part of health activities, and reporting systems would make available the information needed for the monitoring and evaluation of health strategies including health situation analysis.

4.6 Many countries paid lip service at the World Health Assembly to their commitment to national HFA strategies and the need for information support to implement them, but how many are serious about meeting that need? HSATAP has to identify those countries with which it is possible to achieve some real results. We also need to look at WHO's commitment; if some HSATAP offices are understaffed, it may be difficult to accept that WHO is really committed to the Programme.

4.7 As a reflection of our own commitment it would be justifiable to go back and look at the recommendations of the previous HSATAP Team Meetings, and for those activities that were not implemented we should evaluate the reasons. If they concern lack of manpower, HQ staff and consultants should be called upon. If they concern lack of progress in spite of the sending of staff or consultants, we should ask if the country's requests for consultants reflected the actual needs of its PHC development.

4.8 When HSATAP goes into a country to collaborate in improving its capability for information support to health management, we should plan a schedule of activities, and then monitor its implementation.

5. Inter-programme Collaboration

5.1 Inter-programme collaboration involves not only direct links with technical units at HQ and in the regions, but also joint programme reviews and evaluations in which HSATAP staff have been requested to participate. It was agreed that it is important to continue to strengthen the existing extensive contacts with other units/programmes. The problem of conflicting data from different sources was also closely linked with the question of inter-programme collaboration, and it could be that attempts to solve that problem could provide an opportunity for HSATAP collaboration in other areas as well. Further details of these discussions follow.

5.2 As an example of the extensive inter-programme links of HSATAP, at HQ there is collaboration in:

- (a) Situation analysis - with HSC, MPN;
- (b) Training - with CDD, EPI, HMD, LEP, MAP, SHS, TDR/PDP, VDT;
- (c) Design, assessment and strengthening of national health information systems - with MCH, MPN, NUT, SHS;
- (d) Design and conduct of evaluations and reviews - with CDD, DAP, EPI, MCH, NUT, SCH, SHS;
- (e) Research and development, development of standard tools - with CDD, CDS, EHE, EPI, ISS, LAB, MCH, NCD, NUT, SCH;
- (f) Statistical support - to DAP, DTR, EHE, EPI, HSC, MAP, MNH, NCD, NUT, PDP, TDR, TRI, VBC.

5.3 As the HSATAP cuts across all technical programmes, in the regions there is also active collaboration both directly with the other technical programmes as well as through interprogramme GEAs (group educational activities) and country activities. However, the disparity in the structure and availability of professional expertise at HQ and Regional Offices is apparent. No Regional Office (except perhaps AMRO) has such a large number of experts for virtually every target activity of the HSATAP as does HQ. At Regional Office level, the RAs (often alone) are responsible for all aspects of the programme, largely through their own technical unit but also through collaboration/coordination with other technical units.

5.4 Nevertheless, greater efforts need to be made in coordinating with the different programmes at all levels, and the services available from HSATAP needed to be more widely publicized.

5.5 Collaboration in the regions is necessarily limited by resources. An increasing number of programmes are collecting, analysing and disseminating information, and problems exist with the release of conflicting information from different sources. It was felt that some guidance on how to proceed could be given to the regions based on headquarters experience, and giving details of success. It was emphasized that collaboration must be both ways; HSATAP should not be a passive partner but should seek the involvement of other divisions and units in its projects, where this was appropriate. Experience with the preparation of Health Conditions of the Americas, 1981-84, the Evaluation of the Strategy - Seventh Report on the World Health Situation and individual country analyses of their health situation indicates that we will have to tolerate for some time to come many minor and major discrepancies in data. This is due in large measure to the many different sources of data from many different national and international agencies and institutions. In fact, discrepancies are a possible opportunity for dialogue with national counterparts to identify sources of the problem. Inevitably, such discussions will reveal deficits in data collection systems and other problems which could be potentially corrected through technical collaboration. Internally, within WHO, it would help if all technical programmes used the same denominator for calculations involving rates. U.N. Population Office estimates are the obvious source for official population denominators.

5.6 Programme evaluation activities:

5.6.1 HSATAP staff have been involved in a range of reviews and evaluations of programmes. These fell into six broad groups:

1. Review of national and international statistics for HFA;
2. Programme specific reviews (MAP, EPI, CDD, MCH, etc.);
3. Joint PHC reviews;
4. WHO Programme Management Information Study (with WRs);
5. Financial audit in policy and programme terms;
6. Joint policy and programme reviews.

5.6.2 Policy and programme audits (no. 5 of previous paragraph) had made slow progress and it would be necessary to carry out between 80 and 120 in a 6-8 year period to cover the perceived need. One programme management information system (no. 4 above) had been developed in Sri Lanka. The next step would be to look at the flow of information through the country up to the Ministry of Health. A problem that had emerged was that those responsible for the preparation of the national HFA strategy evaluation had not always been aware of the existence of PHC reviews, and vice versa. Analysis of the effect of these activities was ongoing, and special attention should be paid to their impact on government policy and thinking, the health situation, and on development. The possible effect on the attitudes and actions of bi- and multilateral donor agencies should also be borne in mind.

6. Target 1: Strengthening of Information Support to National Health Management

6.1 Discussion of activities undertaken under Target 1 focussed on the need for national commitment by countries, the assessment of country information needs, and support to health management at the district level. Outside reviews of national health information support capabilities are useless if the country concerned does not feel the need to have the situation reviewed and then to follow up on the findings. There is also a tendency for country information needs to be defined from the top down, whilst the collection of information is organized from the bottom up, and the middle, or district, level gets forgotten in the process. These points are elaborated below.

6.2 To accelerate the implementation of activities to strengthen information support to health systems development and management, the need for commitment by Member States to improve the mechanisms and procedures to generate and use information is a sine qua non. Such a commitment may vary from locating the information focus in the highest level of the health systems organization, to preferentially allocating resources for information system development and maintenance. Though any meaningful measurement of national commitment for improving information is difficult, it was agreed that a statement or provision in the national health development plan to develop and implement national health information as an integral part of such a plan, might be a useful beginning.

6.3 The first stage in any plan of action must therefore be to promote and develop this commitment, emphasizing as a priority the interest of senior decision makers.

6.4 Though national commitments may not be explicit, there are various entry points in the spectrum of WHO collaborating activities with the Member States for information system development. Whatever the entry point may be, HSATAP staff at regional and global levels should promote the consideration of the WHO response to the Member States' requests in the broader framework of information support to health systems management. WHO responses should not be considered as isolated or ad hoc activities but as opportunities to develop, establish and maintain effective and efficient mechanisms to generate and use information. In this regard, such initial responses could well be the beginning of a more comprehensive multidisciplinary approach with MPN, PHC, and HSR, including informatics components.

6.5 There can be no fixed list of entry points for activities to strengthen national health information support, but they could include the following:

- Formal events such as the HFA monitoring and evaluation process have proved useful in several regions.
- Support to national and subnational planning provides a valuable opportunity to identify gaps in information.
- Programme and PHC evaluations have also proved valuable for this and should be promoted by HSATAP.
- Joint reviews of WHO collaboration in some regions may also provide entry points.
- HSATAP should also be aware of the planning cycles of the Member States so that effective collaboration could be promoted at this sensitive phase of the management process to identify solid information needed to solve critical issues.
- Country analyses of the health situation may prove to be a very fruitful entry point. It is felt that it is important to establish an analytical capability and process in each country whereby the health situation is periodically reviewed, gaps in information and knowledge are identified, and epidemiological and operational research are undertaken to fill those gaps. This approach requires a multidisciplinary effort involving the many different technical programmes in WHO.

6.6 The identification of information needs can be based on individual programme activities or on broad managerial reviews. Formal evaluation of needs for defined functions, tasks and activities can be carried out by field reviews. Assessment of information needs is an essential step in developing information support mechanisms and procedures. This does not necessarily imply that "minimum data sets" should be internationally established. National characteristics of such "minimum data sets" are much more critical, and methods should be developed or adapted to identify and arrive at a minimum set of essential data.

6.7 The World Health Assembly has recently placed emphasis on strengthening the management of services in the district, defined as the most peripheral level at which basic health services and first level referral exist and where resource planning can take place. When all criteria are taken into account, the district corresponds to an area with a few hundred thousand people, a governing body, representation of various sectors, resource generation and allocation, and training facilities. As a point of focus, this level has the advantages of being small enough and sufficiently well defined for information needs to be clearly identified, while being a useful building block for national information support systems.

6.8 Follow-up of the HFA strategy evaluation:

6.8.1 The evaluation reports confirmed that there are "persistent deficiencies" in information support in most countries. The question is to what extent the evaluation itself has led to reprogramming in countries for the 1986/87 budget years, whether it will have any effect on budgeting for 1988/89 and whether it suggests any changes in WHO structure or activities that might be accommodated in the 8th General Programme of Work. Unfortunately, many evaluation reports contain mainly subjective, non-quantified answers to the questions asked, and it is not clear that the process of evaluation has stimulated serious consideration of the country's health problems and their management.

6.8.2 There is some evidence that the evaluation reports are influencing national budgeting for 1987 onwards. This can be aided by ensuring that the reports become part of the country profile information.

6.8.3 Most Regions had organized some sort of national or regional follow-up meetings or reviews, but it was recognized that:

1. The problem identified requires action from different programmes and that a joint review of the evaluation is essential.

2. The monitoring and evaluation should be geared to ensure that the information is directly useable by national programmes.

6.8.4 HSATAP has a role in maintaining and updating the information arising from the monitoring and evaluation processes. HSATAP must be active in helping countries to use disaggregated data for national monitoring and evaluation, taking the HFA monitoring and evaluation of the strategy as an opportunity to start or strengthen this process.

7. Target 2: Training

7.1 The meeting considered the role of HSATAP in training in the field of epidemiology and statistics and, more generally, in information support to management for senior, mid-level and peripheral health managers. It was pointed out that in some regions there is no training infrastructure, such as schools of public health, so that WHO is their only training resource. Also, that sending personnel on short training courses without followup is not very productive.

7.2 It was noted that there is a wide variety in approaches to training in different countries depending on individual country needs. It was stressed, however, that in most developing countries training for health workers should not be aimed at producing specialist epidemiologists. Public health staff, at all levels, should be introduced to the skills of applying epidemiological techniques to health management.

7.3 Training in information for management should be concerned with "quantitative thinking" rather than the traditional theories of statistics and epidemiology per se. Such training should ideally be carried out within the countries or regions of the trainees. The role played by established institutions in training in epidemiology and statistics, especially in the European and American regions was noted. It was also noted that short (summer) courses in epidemiology cannot provide epidemiological expertise to health workers who lack basic training in that area, unless they are followed by practical field training under close supervision.

7.4 It was noted that the science and technology programmes of the Organization are increasingly including training in epidemiology in their activities. This was welcomed as an expression of programme recognition of the importance of the field.

7.5 Field epidemiology training: this type of training was accepted by the meeting as part of the answer to the problem of training epidemiologists. The fact that this approach was not a course in epidemiology but a programme was regarded as an advantage. A career structure has, however, not been well defined in all the countries which have these training programmes, and the results of the work of the trainees in clarifying the national health situation are not yet taken into account by policy-makers. Such training should always be complementary to the type of epidemiological training for all health workers referred to in paragraph 7.2 above.

7.6 The Directory of the Schools of Public Health has been updated by HMD and is available. Concerning a directory of epidemiology and statistics courses, regions were equally divided for and against compiling one. On the question of whether to attempt to update the Global Directory of Health Statistics Courses, 2 regions felt it would be useful, the rest said that they only needed access to their own regional directory plus those of AMR and EUR for fellowship purposes. It was thus decided not to undertake the updating of the Global Directory at this stage.

7.7 A set of six training modules for mid-level personnel have been developed in AMR and are available in English, French, Spanish and Portuguese. A new version, reflecting the experience gained so far, is to be produced.

7.8 Discussions on the preparation of training material in information support for peripheral health workers had led to the conclusion that this could not be developed centrally due to very country-specific differences in requirements. Therefore a Collaborating Centre had been designated to produce such material for India, and it was hoped that this material would serve as a model for other countries.

7.9 The group stressed the need for training in the use of data available through routine health data collection systems. The possibility of collecting health data through surveys and particularly in conjunction with the U.N. National Household Survey Capability Programme was noted. Concerning the set of six booklets on conducting Community Health Surveys, booklet number 1 is now available in English, French and Portuguese, numbers 2, 3 and 4 in English and French with the Portuguese versions in preparation, and the draft of number 5 has been reviewed. The distribution of these booklets has varied from region to region.

7.10 ICD training: what is needed is not only training for coders but training in the use of the coded results. Medical students and graduates need training on the ICD and on how to complete death certificates correctly. Regions cannot afford to continue running international courses for ICD coders; national trainers should be trained and national training centres established.

7.11 Staff training: AMR has a specific plan for staff development and training in epidemiology and informatics. A number of HQ staff have also attended courses in epidemiology and in microcomputer use. It was agreed that it is important for HSATAP personnel to update their skills where necessary in the light of the orientation of the Programme.

8. Target 3: Development of Methodology and Standard Tools

8.1 Changes in the orientation of country health strategies in the direction of health for all, notably those involving community participation, imply that health care operations need to change and thus the managerial process for national health development must also change. This implies the need for new types of training, as discussed in the last section, which in turn require new types of methodology, and the standardization of the tools used so that programme monitoring and evaluation can be carried out effectively. This last is the point of Target 3.

8.2 It was proposed that for countries with a high turnover in information support personnel, methods should be devised for technical cooperation and training to compensate for the problem.

8.3 National household survey capability programme (NHSCP) and other issues related to sampling: in the past, WHO has acted as consultant in health surveys. More recently, NHSCP has been adding health-related modules to regular periodic surveys. HSATAP was asked to design and develop health and nutrition modules. Nutrition (FHE/NUT) and ESM have developed such a module on nutritional status, which has been tested in Zimbabwe and will be used elsewhere. There was concern that both Westinghouse Demographic and Health Surveys (WDHS) and NHSCP leave little behind for the country, due to lack of collaboration and communication between national central statistical offices and ministries of health. HQ was asked to help the regions to know early enough which countries are going to carry out such national surveys so they can alert ministries of health and urge them to collaborate. A revised document on Sample Size Determination: a User's Manual, has been issued as document WHO/HST/ESM/86.1. Some good work on qualitative (non-quantitative) methods has been carried out in AMRO by a consultant.

8.4 Small area studies and other sampling methods: HST/HQ has been involved in small area studies for the past few years. The US National Center for Health Statistics is pursuing the development of synthetic estimates. The National Institute for Drug Abuse introduced synthetic estimates to study rare occurrences. HSATAP used these methods in Botswana and India and the results will be published as part of the proceedings of a meeting held in Ottawa last year. Modified Delphi techniques, where experts are interviewed to determine such statistics as health service utilization rates, rather than using random sampling of the general population, were used in Lesotho recently and gave reasonable rates.

8.5 Measurement of impact and effectiveness of programmes: HSATAP has a particular contribution to make to the development, testing and promotion of indicators and methods for evaluating effectiveness and impact of health programmes in countries. The desire was expressed that regional programme managers be consulted during this process and be fully involved in decisions taken in this area. It was suggested that where coverage is already high HSATAP try to get away from proposing yet more coverage indicators, and expend more effort towards developing indicators of quality and effectiveness of health care.

8.6 Computer software development: it was pointed out that many countries were spending considerable sums on computing equipment without a matching effort to improve the quality of the data which are to be processed. SEARO and WPRO are

equipping WHO Representatives with microcomputers, and training them in their use. They hope to use a standard set of programmes for all WRs. AMRO has the intention of working towards making the WHO country office the basic unit of data storage for country data in that region. In this way information can be obtained from the WR without needing to bother the government with questionnaires, etc.* HQ staff have developed some expertise with relevant software, and a list of those areas on which they can advise is given in Annex 3.

8.7 ICD:

- 8.7.1 A second draft proposal for ICD-10 will be circulated to countries by 15 July 1986. All countries' needs should be satisfied as much as possible; therefore the inputs and desires from countries should be transmitted to HQ by the regional offices by 15 January 1987. Regional offices are invited also to make suggestions, by 15 January 1987, for short lists to be developed in conjunction with ICD-10. There will be a meeting of the heads of WHO Collaborating Centres for the Classification of Diseases in June 1987, followed by an Expert Committee meeting in November 1987. The international revision conference is now scheduled for 1989.
- 8.7.2 It appears that there is no hope of establishing an Arabic Centre for ICD at the present time.
- 8.7.3 The Basic Tabulation List and other short lists should be promoted in those countries unable to adopt the provisions of the full ICD. The List provides useful information and is not too detailed.
- 8.7.4 Some persons still have difficulties in making comparisons between ICD revisions. It was agreed that the Basic Tabulation List and other short lists to accompany ICD-10 will be constructed to facilitate comparisons between ICD-9 and ICD-10.
- 8.7.5 Reorientation training materials will be required for ICD-10. These should be made available in good time and show the salient features and major changes in the new ICD.

8.8 Lay reporting: This is an important information gathering tool which is useful in situations where appropriate health resources (health manpower or facilities) are either not available or are inadequate. The term refers to the method used for information generation and not to the generator of information. It should be remembered that what is needed is to make the information available for use in decision-making at the peripheral level, as well as to permit the analysis of the health situation and trends centrally. In the context of health systems based on primary health care, it is considered more as a "community based information mechanism" than as a simple device for classification of diseases and health problems. In this broader scope, lay reporting is used to reorient and introduce desirable changes in the existing epidemiological and statistical services to make available relevant health and health-related socioeconomic and resource information for management decision-making for health development at local, intermediate and national level.

* This, of course, presupposes that the country has been able to collect and analyse its data, with WHO collaboration if necessary.

9. Target 4: Monitoring and Evaluation of Regional and Global Health Situation and Trends, Including Epidemiological Surveillance

9.1 The discussion on Target 4 covered the question of the Global Indicators, their validity and availability; morbidity, mortality and health-resources reporting, data processing, consistency checking and software development. Sections on the global indicators contained in the draft Common Framework for Monitoring 1988 (CFM) were reviewed. Regions were invited to become more active contributors to HSATAP/HQ publications, and to make suggestions for further enhancing the relevance of those publications to countries. Further details of the discussion follow.

9.2 Global Indicators:

9.2.1 Global Indicators are politically valid measurements, but some of them are extremely difficult to quantify on a rigorous scientific and technical basis. The definitions of the global indicators (and sub-indicators) need to be modified in future to make it more feasible to obtain quantitative information. Countries will need additional, more sensitive indicators to monitor the implementation of their strategies.

9.2.2 Global indicator data should be easily derivable from information mechanisms already functioning in the countries, and should not require specific WHO-oriented activities. The periodic monitoring and evaluation of the HFA strategies should be used as a stimulus to the development of national capability for information support to health management.

9.2.3 Most countries do not have the capability, at least in the Ministry of Health, to produce the figures for the economic indicators. Where countries have difficulty in obtaining economic data related to health, special studies should be conducted where feasible. Regional differences in the amount and quality of economic information available should be recognized. In AMRO, there appears to be a considerable amount of economic data available within the countries. In most cases where data appear to be lacking, the first effort should be to consult other sources within the country rather than to provide consultants for this purpose.

9.2.4 Primary health care is an approach, not a separate subdivision of the national health system, and therefore it is difficult to allocate expenditures between PHC and the rest of the health sector. However, the PHC approach results in activities which can be costed. Each country should describe what is meant by PHC in the context of its own health system.

9.2.5 In response to the request made by the Programme Development Working Group (PDWG/REP/14, paragraph 5.4), the sections on the global indicators contained in the draft Common Framework for Monitoring 1988 (CFM) were reviewed. The suggestions made at the present meeting will be sent to regional offices for further review, scrutiny and comments. Since the CFM is for national use, it should be adapted to suit the conditions of each country and used in a flexible manner. Each country should give the national definition of "urban" and "rural". Countries should be encouraged to use other relevant indicators, such as those recommended for monitoring the International Drinking Water Supply and Sanitation Decade, as well as the global indicators.

9.3 Reporting on morbidity and health resources:

- 9.3.1 The discontinuation of the Annual Questionnaires from HQ on New Cases of Certain Infectious and Parasitic Diseases, Hospital and other Medical Establishments with Beds, and Health Personnel throws greater responsibility on regional offices to collaborate with countries to ensure that the information related to these areas that is collected will directly assist national health administrations in the implementation of their HFA strategies.
- 9.3.2 The information on these and other required areas for national and WHO use should develop as a consequence of improvement in national information brought about by HSATAP collaboration with Member States.
- 9.3.3 Every effort should be made to coordinate the mechanisms that regional offices use to collect data on morbidity and resources, which will clearly involve close collaboration between HSATAP and individual technical programme staff, to ensure the greatest degree of comparability in the processing and presentation of these data at global level. Member States should be kept informed of the progress made in improving the quality of information related to morbidity and resources.

9.4 HSATAP publications: all regions designated their HSATAP Regional Advisers as focal points on HSATAP publications, to work with HQ to improve the utility of these publications to Member States.

9.5 Mortality reporting: regional advisers were requested to help fill in the gaps in country series, and advise HQ on the coverage and quality of the mortality data collected in their regions.

9.6 Data processing: Data on cholera, plague and yellow fever reported to HQ have been transferred to a microcomputer. A mainframe programme to identify "outliers" in newly entered mortality data has been developed, so that requests for verification of doubtful figures can be sent to the countries concerned.

9.7 Inventory of health and health-related statistical information available in WHO: a questionnaire has been circulated to many programmes asking for information (but not the actual data) on programme databases, both conventional and computerized. A first draft of the replies is attached as Annex 4. If found useful, this inventory will be updated and disseminated to regional offices.

RECOMMENDATIONS

1. General

- 1.1 HSATAP should contribute to the development of WHO technical cooperation with Member States in such a manner that essential quantifiable elements of the country health system, country health situation and its trends, could be confidently presented to Parliament, Cabinet, or equivalent bodies, for favourably influencing the development of national health policy and strategy.
- 1.2 HSATAP should contribute to developing WHO "country databases" so that they could:
- serve as one of the essential elements of the WHO dialogue with Member States, bilateral and multilateral agencies and organizations,
 - facilitate the work of WHO Representatives, and
 - be used by the Organization for its advocacy for health activities.
- 1.3 HSATAP should continue to collaborate as fully as possible with relevant infrastructure and technical programmes in working with countries. In particular, HSATAP should work closely with SHS/PHC and MPN programmes in developing approaches to meet country needs.
- 1.4 HSATAP should establish a set of criteria by which the WHO collaborative programme on HSATAP can be meaningfully monitored and evaluated, starting with the rest of the period covered by the Seventh General Programme of Work.

2. Target 1: Strengthening of Information Support to National Health Management

- 2.1 As the first stage in any plan of action in direct support to countries, HSATAP should promote and develop national commitment to developing information support to health management, with priority being given to the interest of senior decision makers. The term "health management" includes health planning and priority setting as well as administration of services.
- 2.2 HSATAP should grasp every opportunity to identify national problems of information support to management (defining "management" as in 2.1 above), and entry points for collaborative action, including the time of the preparation of national and subnational health plans.
- 2.3 HSATAP should place emphasis on developing with countries a process for identifying the minimum information that must be recorded by health workers and managers in order to support their activities. This may include information from other sectors. Although there are likely to be common information recording requirements in different countries, the basic record design instruments must be developed to suit local needs.
- 2.4 In keeping with the WHA39 Technical Discussions on the importance of strengthening PHC management at the district level, HSATAP should work in collaboration with infrastructure and technical programmes in countries to decentralize the analysis and utilization of health information in support of decision-making at the different levels of the health system.

3. Target 2: Training

- 3.1 Through collaboration with established institutions and other programmes of WHO, HSATAP should place the immediate emphasis on training of public health workers in epidemiology, statistics and informatics rather than on the production of specialists in these fields. In this process, HSATAP efforts should be directed to the training of trainers and to the promotion of alternate training methods. This does not imply the exclusion of the preparation of specialists in these fields at levels such as the masters and doctorate level. Many schools of public health in the Region of the Americas (even excluding USA and Canada) are capable of preparing people at these levels, and the countries certainly have not only the need for them but also the capacity to absorb them.
- 3.2 HSATAP should provide support to countries in orienting training towards the generation, analysis and use of information, thereby applying "quantitative thinking" to decision making and health management, and in reorienting training according to changing needs and resources. The AMRO first level modular course, "Principles of Epidemiology", might be suitable training material for peripheral level health workers with very little background in epidemiology or medical sciences.
- 3.3 Recognizing the increased development of epidemiological capability within a number of science and technology programmes of WHO, and the resulting expansion of epidemiological training activities, HSATAP should establish or strengthen practical mechanisms of collaboration with these programmes. In doing so, the aim should be to streamline technical cooperation with Member States in this field in order to ensure a coordinated action at the country level in strengthening their health system infrastructure.
- 3.4 Although it was agreed that preparation of a global directory of epidemiology and statistics courses is not a high priority for immediate action, regional offices should increase their awareness of training activities in Member States and exchange this information with the other regional offices and headquarters.
- 3.5 The mid-level personnel training materials in epidemiology and statistics developed in the American Region should be made available to the other regions for suitable modification to suit national needs, and to stimulate the production of training materials for this broad category of health workers.
- 3.6 When the entire series of booklets on Community Health Surveys has been published and field evaluated, HST/HQ should work out appropriate and economic mechanisms for production and distribution in order to make them available to their intended target users without drawing on global or regional financial resources. Field evaluation should include the use of the booklets both as a teaching aid and as manuals for conducting health surveys.
- 3.7 Training material for peripheral level workers should be developed specifically to meet country needs and situations. In collaboration with SHS/PHC, HSATAP should assist in this process by working with selected countries to produce material for their own use that can subsequently be used as examples in other countries.
- 3.8 HSATAP personnel should maintain a high level of technical excellence in epidemiological and statistical disciplines and their many applications. HSATAP staff should periodically update their skills through formal and

informal programmes for professional training and career development. In collaboration with Staff Development and Training, HSATAP should also contribute to the development of epidemiological and statistical expertise within the Organization as a whole.

4. Target 3: Development of Methodology and Standard Tools

- 4.1 HSATAP should request the UN Statistical Office to provide it with reports of the first project formulation missions to countries by its National Household Survey Capability Programme (NHSCP) Central Coordination Unit, so that WRs and national health ministries can be alerted. HSATAP should also invite UNSO to contact WRs' offices when their representatives visit countries in conjunction with the NHSCP.
- 4.2 For small populations (either national or sub-national groups) HSATAP should continue to devise or adapt methodologies to compensate for the random fluctuations in rates obtained due to small denominators.
- 4.3 The Basic Tabulation List and other short lists should be promoted by regional offices in those countries not ready to adopt the full ICD.
- 4.4 Provision should be made by HSATAP/HQ to facilitate future comparison between ICD-9 and ICD-10.
- 4.5 HSATAP should promote and support the use of lay reporting in the broad context of a community-based information mechanism to make available critical information for the management of the health system at local (including community), intermediate and central levels.
- 4.6 Research should be encouraged to develop methodology for producing morbidity estimates from symptom and/or reason for health encounter recording, for example by following a sample of patients for which symptoms have been recorded to diagnosis (including laboratory diagnosis) within the health system.

5. Target 4: Monitoring and Evaluation of Health Situation and Trends

- 5.1 HSATAP should make a greater effort to stimulate countries to improve the quality, coverage and timeliness of cause of death reporting as an integral component of their health information systems.
- 5.2 HQ and regional offices should improve their collaboration with regard to using standard computer software for all aspects of data gathering and analysis. ISS and GES/HST should prepare a listing of epidemiological and statistical software being developed at HQ, along with a brief description of objectives and potential uses. This should be distributed to regional offices.
- 5.3 Following the discontinuation of the Annual Questionnaires on New Cases of Certain Infectious and Parasitic Diseases, Hospital and other Medical Establishments with Beds, and Health Personnel, regional offices should make use of other sources, in particular technical programmes, and develop other mechanisms to provide this information for regional and global use. The information should flow naturally from improvements in reporting brought about by country/HSATAP collaboration. Member States should be informed by HQ of the progress in obtaining better morbidity and health resources data.

- 5.4 WHO should be aware of the magnitude and nature of the major health problems in the world as part of the assessment of the regional and global health situation and trends. Although much of this information is obtained by particular programmes, HSATAP should ensure it is aware of the availability of the data, and develop mechanisms for collaborating with the programmes concerned in the improvement of data handling and analysis as required.
- 5.5 In case of unusual health-related events, such as outbreaks of communicable diseases, chemically contaminated food products or serious accidental environmental pollution, regional offices should make every effort to ensure that countries provide information as promptly, accurately and completely as possible (indicating information on any restrictions on dissemination), and that HQ is kept informed.
- 5.6 HSATAP should more forcefully exploit its contacts with the statistical programmes of other international agencies and organizations to facilitate intersectoral action at country level for strengthening the information support to national health system management.

LIST OF PARTICIPANTS

REGIONS

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MPW*

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PDP Dr Z.S. Pawlowski, Dr R. Morrow

SHS Dr C. Montoya-Aguilar, Dr H.M. Kahesay, Mrs M. Thomas

TDR*

VDT*

Dr J. Hamon, ADG
HST Staff

* Invited but did not attend

Annex 2

LIST OF DOCUMENTS

Schedule (HSATAP86/Schedule)

1. Annotated Agenda (HSATAP86/Annotated Agenda)
2. Provisional List of Participants (HSATAP86/Participants)
3. Health Situation and Trend Assessment, Evaluation of the Programme, 1984-85: African Region (HSATAP86/WP/1)
4. Evaluation of PAHO/WHO Activities, Health Situation and Trend Assessment Program (HSATAP86/WP/2)
5. Health Situation and Trend Assessment - Programme Activities in EMR by RA/HST EMRO (HSATAP86/WP/3)
6. HST/EURO Programme, 1984-85 (HSATAP86/WP/4)
7. SEAR Health Situation and Trend Assessment Programme (HSATAP86/WP/5)
8. Health Situation and Trend Assessment, WPR Programme Overview (HSATAP86/WP/6)
9. Review of HSATAP Activities (HSATAP86/WP/7)
10. Review of Global Indicators for Monitoring and Evaluation of the Strategy for Health for All (HSATAP86/WP/8)

DRAFT

October 1, 1986

LIST OF TOPICS ON MICROCOMPUTER APPLICATIONS
ON WHICH INFORMATION IS AVAILABLE WITH HST/HQ

Data Collection, Analysis and Storage Techniques

(Contact)

1. Delphi Techniques (J. E. Dowd)
2. Establishing, maintaining and evaluating health data bases (J. Duppenhaller)
3. Health Interview and Examination Surveys (J. E. Dowd)
4. Life Table Techniques (Y. Fushimi)
5. Estimation of Small Area Statistics (J. E. Dowd)
6. Determination of Sample Size (S. Lwanga)
7. Use of Computerized Simulation Models (J. Duppenhaller)

Personal Computers in Public Health

(Contact)

1. Map-linked data bases (J. Duppenhaller)
2. Personal computer applications in developing countries (J. Duppenhaller)
3. Personal Computers in Health Management (Presentation to European Scientific Society) (J. Duppenhaller)

Software Development

(Contact)

1. List of Persons (IBM PC) (J. Duppenhaller)
2. Electronic Book (e.g., Drugs for the Elderly) (IBM PC/Macintosh) (J. Duppenhaller/
D. Macfadyen, HEE)
3. Computer Assisted Presentation (CAP) (IBM PC/Macintosh) (J. Duppenhaller/
D. Macfadyen, HEE)
4. Mathematical Models of Typhoid and Hepatitis B (IBM PC/Macintosh) (J. Duppenhaller)

Graphics on Personal Computers

(Contact)

1. Lotus 123 (IBM PC) (P. Pachner)
2. BPS Business Graphics (IBM PC) (J. Woodell)
3. Microsoft Excel (Apple Macintosh) (J. Duppenhaller)
4. MacPaint/MacDraw (Apple Macintosh) (J. Duppenhaller)
5. Cricket Graph (Apple Macintosh) (J. Duppenhaller)

Statistics on Personal Computers

(Contact)

1. SPSS PC+ (IBM PC) (Y. Fushimi)
2. Stat View 512+ (Apple Macintosh) (J. Duppenhaller)
3. Microstat (IBM PC) (Y. Fushimi)

October 1, 1986

Inventory of Health and Health-Related Statistical Information Maintained by WHO

<u>DIU/Unit</u>	<u>Contact Person</u>	<u>Title</u>
CDD	D. Salmon	CDD Research Proposals and Letters of Intent
CDD	J. Tulloch	Management Information System Data Base
CDS/EAM	K. Esteves	AIDS Case Count
CDS/EAM	K. Esteves	AIDS Epidemiology
CDS/LEP	J. Gembke	Latest Available Statistics on Leprosy
CDS/MIM	J. Esparza	Dengue/Dengue Haemorrhagic Fever Occurrence
CDS/PBL	B. Thylefors	Blindness Data Bank
CDS/SME	J. Wickett	Expenditure for Smallpox Eradication
CDS/SME	J. Wickett	Worldwide Smallpox Incidence
CDS/YDT	G. Antal	Yaws Occurrence
CDS/YPH	K. Vogel	Rabies Surveys
COR/ERO	O. Eio	Emergency Relief Operations
DTR/PHA	J. Dunne	"UN Consolidated List of Products whose Consumption and/or Sale have been Banned, Withdrawn, Severely Restricted or not Approved by Governments"
DTR/RAD	E. Lehtinen	TLD Intercomparison
EHE/CWS	G. Watters	Country External Support Information (CESI) System
EHE/CWS	G. Watters	National and Global Water Supply and Sanitation Monitoring System
EPI	C. Chan	EPI Information System
FHE	E. Royston	Coverage of Maternity Care
FHE	E. Royston	Maternal Mortality Rates
FHE/MCH	M. Belsey	Infertility
FHE/MCH	R. Guidotti	Low Birth Weight
FHE/MCH	M. Carballo	Prevalence and Duration of Breast Feeding
FHE/NUT	W. Keller/A.Pradilla	Anthropometry
FHE/NUT	A. Pradilla/W.Keller	Percapita Energy Availability and Family Consumption
HMD/HMI	F. Mawson	World Directory of Medical Schools
HMD/HMI	F. Mawson	World Directory of Schools of Public Health
HST	L. Roy	Global Indicator Data Base
HST/ESM	J. Duppenhaler	List of Persons
HST/GES	A. Lopez	Health Personnel and Hospital Establishments
HST/GES	A. Lopez	Morbidity by Age and Sex
HST/GES	A. Lopez	Morbidity by Seasonal Period
HST/GES	A. Lopez	Mortality
HST/GES	A. Vessereau	Diseases Subject to International Regulations
HST/GES	A. Lopez	Demographic Data Base
HST/GES	A. Lopez	Vital Statistics Data Base
MAP/EME	J. Hempel	Areas where Resistance of <i>P. falciparum</i> to Chloroquine is Reported
MAP/EME	J. Hempel	Detailed Status of Antimalaria Activities
MAP/EME	J. Hempel	Follow-up of Official Register

NOTE: This inventory was carried out by the HST Working Group on Data Bases, WHO Headquarters, June 1986.

The Working Group does not maintain a file of the statistical information listed above. Requests for this information should be directed to the individual programmes as shown.

October 1, 1986

**Inventory of Health and Health-Related Statistical Information
Maintained by WHO**

<u>DIV/Unit</u>	<u>Contact Person</u>	<u>Title</u>
MAP/EME	L. Molineux	Global Monitoring of Susceptibility of Malaria
MAP/EME	J. Hempel	Imported Malaria in Europe
MAP/EME	J. Hempel	Malaria Country Information
MAP/EME	J. Hempel	Malaria Risk in International Travel
MAP/EME	J. Hempel	Official Register of Areas where Malaria Eradication has been Achieved
MAP/PAT	V. Ivorra Cano	Global Inventory of Malaria Personnel
MAP/PAT	R. Kouznetsov	Malaria Country Information
MNH	W. Gulbinat	Mental Health Statistical Information System
NCD/CAN	K. Stanley	Maintained at IARC, Lyon
NCD/SMO	R. Mesirani	Tobacco and Health
OCP	J. Marr	OCP Aquatic Monitoring
OCP	J. Marr	OCP Entomological Data Base
OCP	J. Marr	OCP Epidemiological Data Base
ORH	J. Sardo-Infirri	WHO Global Oral Data Bank
PDP/FIL	B. Duke	Global Prevalence of Filarial Diseases
PDP/IPI	Z. Pawlowski	Prevalence of Ascariasis in Africa
PDP/SCH	K. Mott	Distribution of Schistosomiasis
PDP/TRY	P. Cattand	PHC Approach to Control and Prevention of Sleeping Sickness
SHS/MIE	C. Montoya-Aguilar	"Analyzed Information on Accessibility, Coverage and Use of Services in 40 Developing Countries"
SHS/MOE	D. Smith/E. Webster	SHS Programme Information
TDR	K. Hata	Management Information Systems (MISTR)

NOTE: This inventory was carried out by the HST Working Group on Data Bases, WHO Headquarters, June 1986.

The Working Group does not maintain a file of the statistical information listed above. Requests for this information should be directed to the individual programmes as shown.

13/5/86

Inventory of Health and Health-Related Statistical Information

Maintained by WHO HQ

Title: Global Indicator Data Base

Description: The global indicators for HFA monitoring
and evaluation reported by countries

Division/Programme/Unit: HST

Contact person: L. Roy

Documentation available: Operational manual under preparation
For indicator definitions see: HFA Series
No. 3, chapter VII, paragraph 6

Contents:

Main data items: 12 global indicators, country name, year
of data reference, population group
covered

When established: 1983

How often updated: Every 2-3 years after HFA monitoring/evaluation

Principal data sources: National reports on HFA monitoring/evaluation

Other Comments: Runs on IBM PC/XT, using dBASE III