

Conducting policy and
programme evaluation
in **WHO**
overall guidance

• **WHY?**
WHAT?
HOW?
• **WHEN?**



by DPS/NT



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**GUIDANCE FOR CONDUCTING
POLICY AND PROGRAMME EVALUATION
IN WHO**

General principles for the evaluation of WHO programmes, approved by the Executive Board and the Health Assembly, have been applied in WHO since 1980. In the meantime, the theories and methods for evaluating national and international health programmes have evolved. In addition, increased emphasis is being placed at present on accountability for activities financed by public spending. This is why the Health Assembly adopted a number of resolutions (WHA46.35 and WHA48.25) recommending that the Organization develop an evaluation system. It is recognized that evaluation of public spending is a moral obligation, an indispensable managerial approach, and a key to sound policy development.

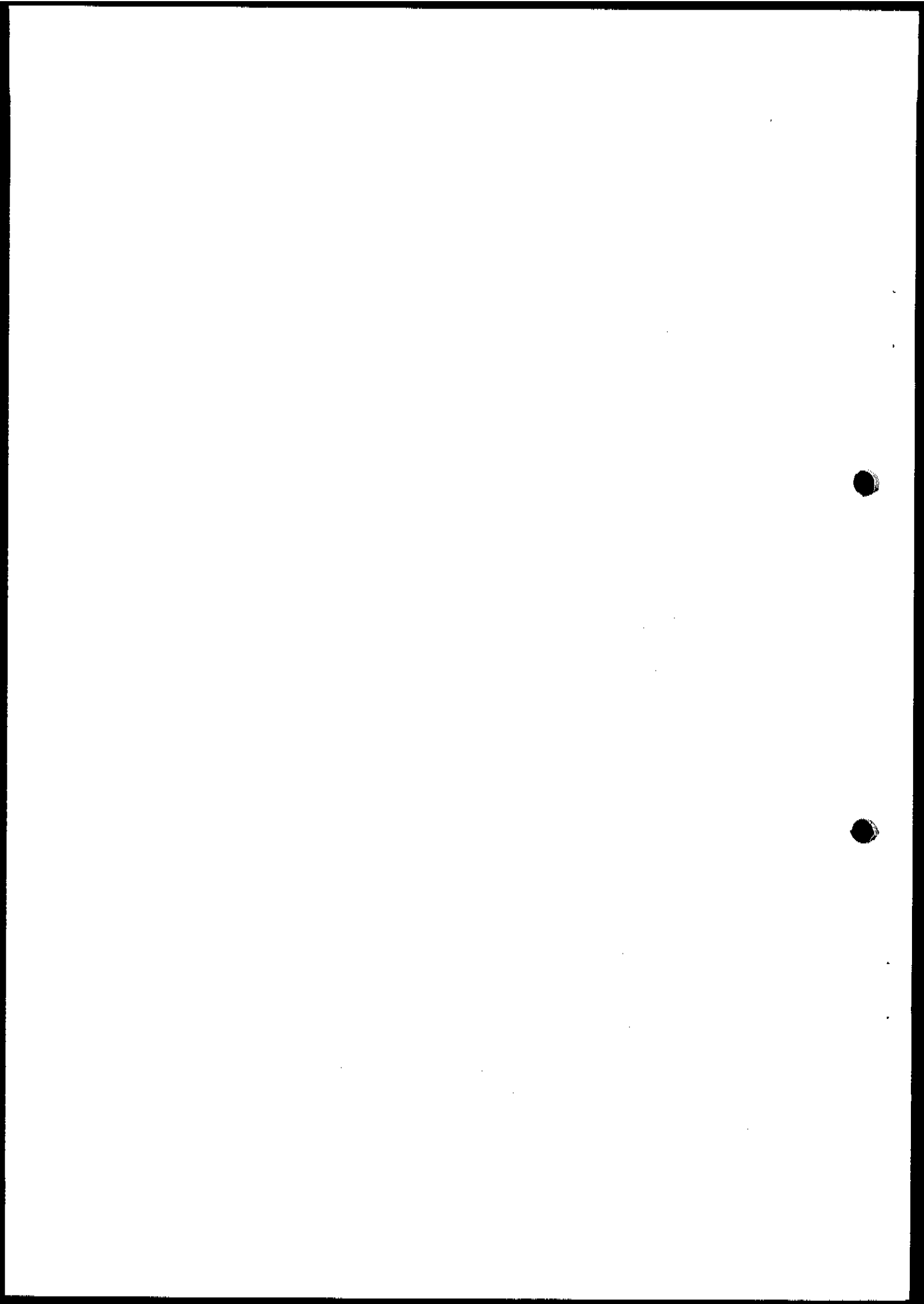
The present guidance is a first step towards the development of a unified system to ensure that objectives are achieved, activities are carried out in a timely fashion, linked to financial expenditures and effectively conducted and documented throughout the Organization. The monitoring and evaluation will be done by the programmes themselves following common standards in line with WHO's principle of self-evaluation. Once a set of procedures has been established and approved, peer reviews and external evaluations can be conducted on the same lines.

The aim of this document is to give practical indications on how WHO staff can conduct policy and programme evaluation on the basis of common methods and definitions and how these efforts can become systematic. The present guidance, therefore, will help to determine whether policies and programmes are appropriate, effectively implemented, and produce the expected results. Furthermore, it aims to assist programmes at all levels to participate in the development of the evaluation system in order to obtain maximum benefit for the Organization as a whole.



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I. WHO'S EVALUATION SYSTEM

I.1 Introduction and objectives

1. While most programmes at WHO headquarters, and in regional offices, approach evaluation systematically, there is no overall system of evaluation with set principles and criteria to cover all WHO activities (financed by the regular budget and extrabudgetary resources). Such a system is indispensable, to ensure comparability and facilitate the setting of priorities.
2. Efforts to strengthen and harmonize evaluation in WHO have four main objectives:
 - (a) to provide essential information for policy, planning, and programme development and reorientation;
 - (b) to ensure effective and efficient use of resources;
 - (c) to ensure that WHO as an organization learns from its experiences and to help focus programmes on outcomes and effectiveness; and
 - (d) to ensure that programme managers provide coherent support to Member States in their efforts to achieve health for all.

I.2 Scope of the guidance and its audience¹

3. WHO's programmes start with countries. It is, therefore, indispensable that the evaluation of programmes be closely linked to the evaluation of national health programmes supported by WHO. In some cases joint evaluations may be useful. There is thus a continuum between evaluation of WHO programmes, evaluation of the health-for-all policy and strategy, and evaluation of national achievements.
4. This guidance is intended to serve as a general "users manual" for WHO staff to evaluate the Organization's work. This includes evaluation of technical cooperation (supporting the assessment of national programmes as required, and assessing WHO's performance and effectiveness), evaluation of normative functions and evaluation of policies. The guidance will help staff at all levels to use an array of standard methods to increase the coherence and transparency of their work, assess its quality and effectiveness, link financial expenditure to activities, ensure timely delivery of products, and learn from experience. A well-conducted evaluation can more than repay the effort expended on it by easing the workload of policy makers, programme administrators and project implementors, and attracting additional resources.

¹ *The present guidance provides a general framework and will be followed by practical guidelines for evaluation of WHO's action at country, regional and global levels and for specific events or circumstances.*

1.3 Definitions, functions and types of evaluation

5. In general, the definition of evaluation given in the Glossary (Annex 8) can be summed up as **the critical assessment, on as objective a basis as possible, of the degree to which policies, strategies and programmes fulfil their stated goals**. WHO's programmes, its governing bodies and Member States, all benefit from the results of evaluation. Figure 1 illustrates the major steps usually involved in WHO's programme management, and shows how evaluation has an input at every stage.

6. Critical analysis is the basis of evaluation. It is useful to approach the whole evaluation process with a question: Does the policy or the programme work? And if so, to what extent does it work? If it is conceived as a way of learning from past performance of policies and programmes, evaluation becomes one of the driving forces for their improvement. Evaluation provides useful input for the decision-making required to set policy, establish priorities and programmes within the Organization, and take decisions on organizational structure and management style.

7. Most of the present guidance deals with **effectiveness analysis** of programmes and an analysis of explanatory factors for success or failure. This analysis of explanatory factors includes **policy analysis** with an assessment of relevance (see Annex 8, Glossary), an analysis of monitoring data and an assessment of staff performance. **Impact assessment**, although crucial to long term planning, is not dealt with in detail.

8. Effectiveness analysis can be used to examine both cost-effectiveness and efficiency. This type of analysis can be used to measure costs of alternative ways of achieving a target. Assessment of costs, both in absolute terms and in relation to the effects of programme or policies, is essential for decision making at WHO. Likewise, evaluation of staff performance is important in order to determine if the main resource of the Organization - its staff - is used efficiently to deliver products (see Section II.3, Step 3).

9. Policy analysis is the critical examination of policy priorities and goals, strategies, and the structure and functions established to achieve existing goals (see Annex 4). Policy analysis should focus first on identifying the institutional arrangements between WHO and countries to foster the attainment of WHO's mission. Second, the priority-setting process and the formulation of strategies need to be examined for logic, soundness and relevance.

10. Monitoring is often considered to be separate from evaluation. Monitoring is concerned with determining how activities are carried out in light of pre-established commitments, and explaining different performance levels and discrepancies between commitments and expected products (see Section II.3, Step 3 and Annex 8, Glossary). The information in monitoring reports can significantly improve the understanding of effectiveness and impact evaluation results.

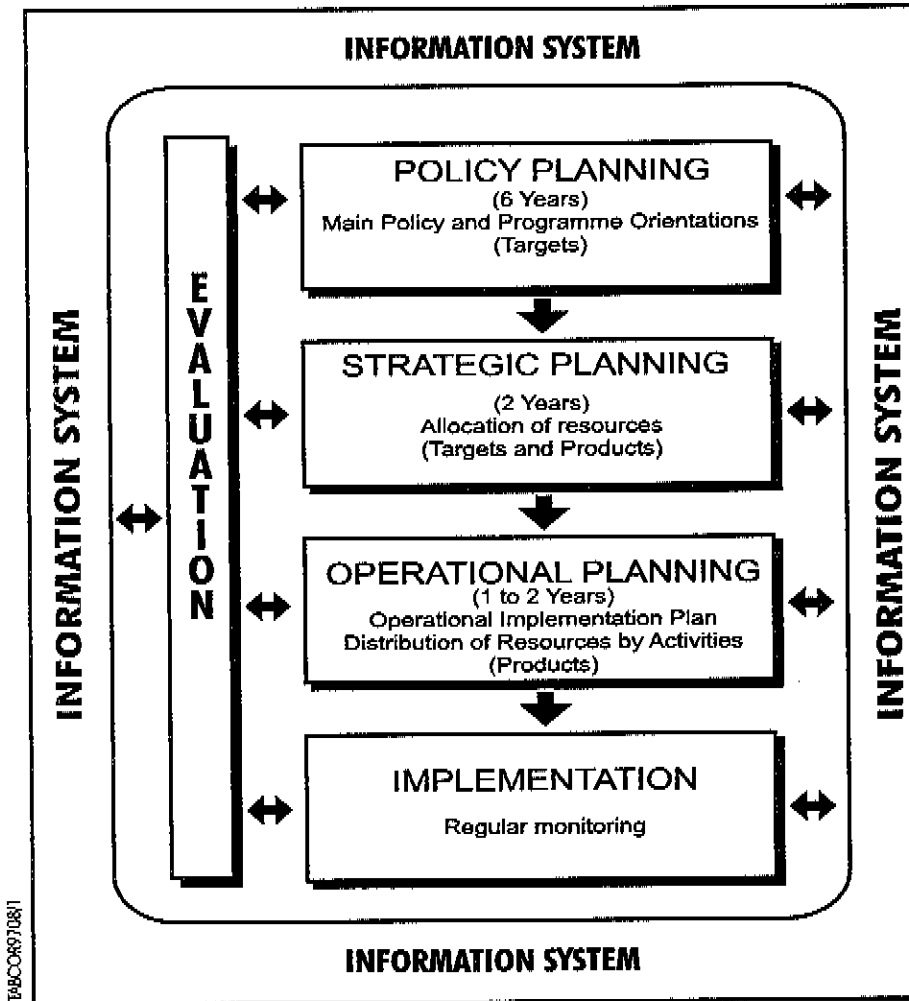
I.4 Evaluation within WHO's managerial process

11. Evaluation is an integral part of WHO's managerial process, which comprises the definition of goals, the development of policy, planning and programming, programme budgeting, and implementation (see Figure 1). The results of evaluation strengthen the managerial process. WHO's managerial process includes evaluation as an integral part. Its main elements are:

- **definition of WHO's long-term goals** - the goals of the Organization define the time horizon and framework of evaluation;
- **policy planning** - policy is elaborated within the framework of the Constitution. It reflects the needs of Member States and embodies a worldwide perspective of WHO programmes; it also includes the selection of priorities;
- **strategic programme budgeting** - setting the overall (macro) programmatic directions and financial resources associated with each of them. In a programme budget, **products** and **targets** (see Annex 8, Glossary) to be achieved in the biennium are specified, which are consistent with the Organization's priorities;
- **implementation** and the detailed planning of activities to achieve products as close as possible to the time of the implementation of **plans of action**;
- **systematic monitoring** of progress and expenditure;
- **evaluation** of the relevance, adequacy, efficiency, effectiveness, and, where appropriate, the impact of WHO's work;
- **accessibility of information at all levels** - the **management information system** will underpin the process and provide comprehensive information to support programme managers in planning and evaluating activities.

12. There are at least three conditions for the successful implementation of evaluation in WHO. First, a system's approach to policy and programme evaluation is to be adopted throughout the Organization to ensure that policy makers and programme managers use similar standardized methods (including appropriate indicators) and the same terminology. Such a system needs to be adapted to all levels of the Organization. Second, a commitment from all levels of the Organization to a "culture of evaluation" is required and appropriate resources need to be allocated for evaluation activities. However, it is usually estimated that the cost of evaluation should not exceed 5-10% of the cost of programme implementation (both in staff and activity terms). Third, training should take place to ensure informed management practices in the Organization.

FIGURE 1:
WHO'S MANAGERIAL PROCESS



13. Evaluation of WHO's work should be closely linked, at least for technical cooperation programmes, to the assessment of national achievements. Therefore, health planning evaluation and health information systems in countries should be sufficiently advanced and WHO will continue to concentrate efforts on supporting these systems.

14. However, as there are a large number of players in the field of health, achievements at the national level cannot usually be directly attributed to any one of them. In order to better understand the mechanisms of improvement and learn from experience, there is a need to focus on evaluating WHO's work.

II. THE CONDUCT OF EVALUATION

II.1 Complementarity of the evaluation processes in WHO

15. The complementarity of the evaluation processes in WHO will be expressed in three different ways:

- **From national programme evaluation to WHO's programme evaluation**

As mentioned earlier (paragraphs 3 and 13), the evaluation of technical cooperation should be based on national achievements. In some cases it may be appropriate for national authorities and WHO staff to jointly evaluate technical cooperation in countries. These evaluation exercises should focus on the role of WHO technical cooperation within the national health plans.

- **Across the various levels of WHO**

Evaluation exercises at each level (country, intercountry, regional and global) of the Organization should be mutually reinforcing. To ensure compatibility, planning and evaluation should be based on common principles and practical orientations, even though they may be undertaken differently in different settings. What is paramount is that a "culture of evaluation" prevails with easy communication links between each level. In this respect the development of a management information system for use across the Organization is essential.

- **From technical evaluation to the evaluation of programme management**

While evaluation within WHO will focus mainly on technical issues (technical cooperation, normative functions and policy formulation), the system will also comprise the financial and managerial components of the Organization's programme.

16. To emphasize this complementarity, Sections II.2 and II.3 address all levels of the Organization and all facets of programmes.

II.2 Preparing for evaluation

II.2.1 Purpose and subject of evaluation

17. It is essential before starting an evaluation to determine the purpose of the exercise and clarify at which level and on what role the evaluation will focus. The purpose can be to improve programme design or to assess the level of success achieved. All levels of the Organization have specific roles, which are complementary and which together aim at implementing the health-for-all strategy. Annex 6 summarizes possible functions of WHO programmes at each level.

18. Careful selection of the evaluation subjects at different times is needed in order to ensure feasibility and appropriate feedback. The following questions are important to guide decisions about the evaluation type and method:

- Is the subject for evaluation a policy (e.g. "Health for All"), a WHO programme (e.g. "Mental Health"), or an institution (such as a Collaborating Centre)? Make sure that the subject is worth evaluating in terms of its size or potential importance. Programme evaluation is the primary focus of this guidance. Such evaluation focuses on the relevance of the programme and its effectiveness by assessing whether objectives have been achieved and products have been completed, are of good quality and are used.
- What are the constraints that could limit the ability to carry out the evaluation or restrict its scope? Will these constraints impair evaluation efforts?
- Once we have answers to the questions we intend to address, will we be able to do anything about the situation?

19. The subject of evaluation, be it a programme or an institution, can usually be characterized by a number of items present in the plan (programme budget and plans of action): **objectives** and **targets** (quantified objectives with a deadline - see below); **products** (see Guidance for the preparation of the proposed programme budget, PPE/97.2); **indicators** (see Annex 1 for the elaboration of indicators); and **criteria** (see Annex 8, Glossary). These elements are the basis for any evaluation. Examples of most of these elements are as follows:

<i>Example:</i>	
<u>Distinction between objective and indicator</u>	
Objective	(one) indicator related to achievement of objective
The Global Programme for Vaccines will monitor trends of all vaccine-preventable diseases on a continuous basis.	The proportion of national surveillance staff in countries and regions trained in surveillance of vaccine-preventable diseases.

Example:**Targets for surveillance of vaccine-preventable diseases**

- a. By 1997, a surveillance function should be fully operational (defined by a number of criteria) at headquarters and regional offices to monitor global and regional incidence trends and distribution of EPI target diseases.
- b. By 1999, support for a standardized and streamlined case surveillance system for EPI target diseases will have been provided to 90% of all countries. Case surveillance should be linked to clearly defined disease control activities.
- c. By 1999, all countries should have a monthly reporting completeness of over 80%.

Source: *Global Programme for Vaccines and Immunization Strategic Plan 1996-2000*

Example:**WHO's objectives, targets and products at country level**

2.3 National health policies and programme development and management

WHO strategic objective: To enable health policy development and its operationalization, in particular, comprehensive decentralization.

WHO targets: By the end of 2001, WHO will have provided analytical and technical support to the Ministry of Health for policy definition, in particular for decentralization in the health sector.

By the end of 2001, WHO will have cooperated with the Ministry of Health and other stakeholders to develop a communications strategy for national health policy consensus-building.

Some possible WHO products: A collaborative document with the Ministry of Health for assessing the long term financial implications of health sector investments and recurrent costs.

A manual with specific communication approaches for various stakeholders to support the Ministry of Health to develop and obtain a consensus on the national health policy, followed by the organization of a national consultation.

Enhanced intersectoral awareness of emerging health issues through continuous efficient operations of the WHO Representative's office.

II.2.2 Timing of policy and programme evaluation

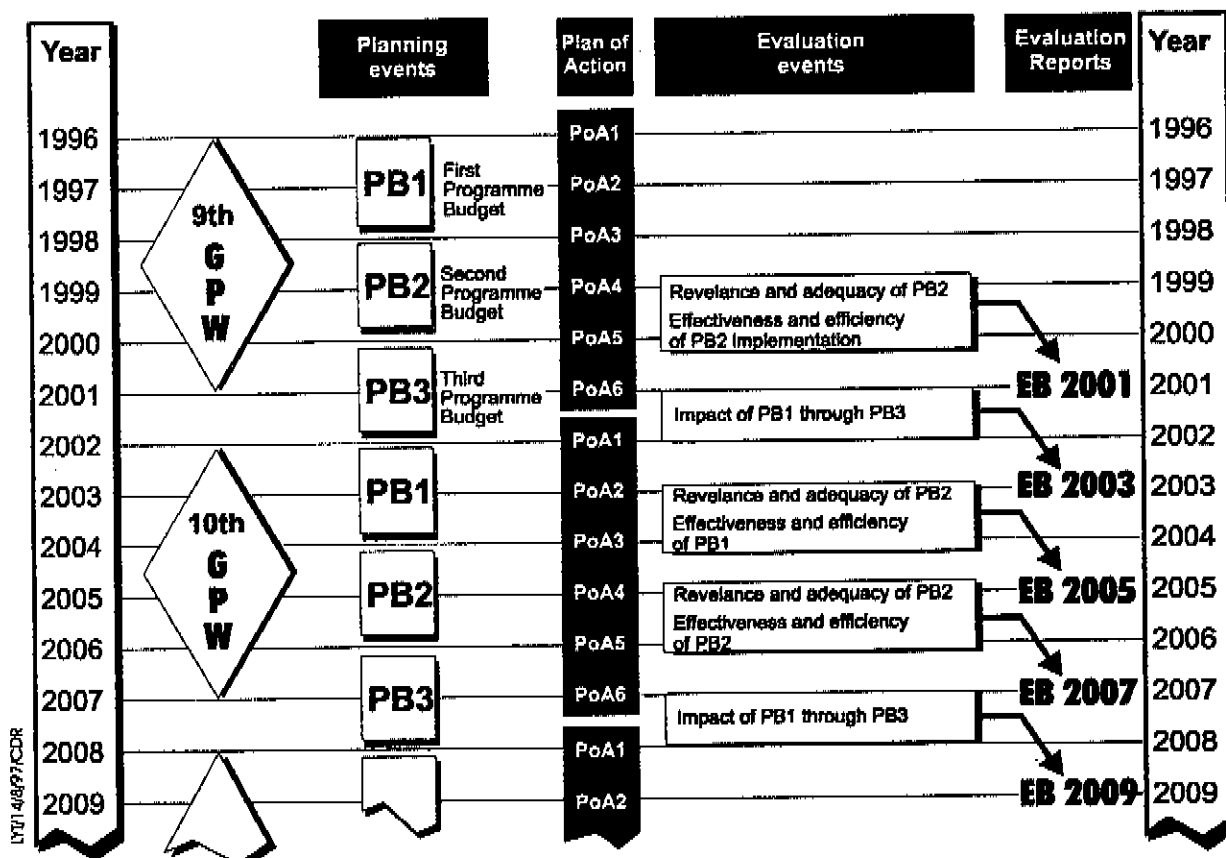
20. While monitoring should be done regularly, it is proposed that Organization-wide evaluation, which can be an expensive undertaking, be carried out as follows:

- Once every third year, on the implementation of the previous programme budget. Because elaboration of the 2002-2003 programme budget takes place in 2000, the lessons learned from evaluating the implementation of the 1998-1999 programme budget will be used mainly for the development of the 2002-2003 budget, although lessons from the evaluation can already be used

to improve the elaboration of plans of action for the 2000-2001 biennium. Because country level evaluation is time- and resource-consuming, it is proposed that one third of WHO collaborative programmes with countries should be evaluated every two years (e.g. one country office out of three). This will ensure that all WHO country programmes are evaluated over a period of six years. Specific guidelines will be developed to describe in detail the processes required to complete such evaluation of programme budget implementation and country level evaluations.

- Every six years as part of a comprehensive evaluation of the General Programme of Work (such evaluation should focus on impact, whenever possible, and overall policy). (See Figure 2.) The lessons learned from preparing, conducting and analysing such evaluation will be used for the development of the following General Programme of Work (e.g. the impact evaluation of 2000-2001 will be used to prepare the Tenth General Programme of Work for 2002-2007). This evaluation will also be closely linked with the evaluation of the implementation of the new health-for-all policy and strategy. Further guidelines will have to be developed and training provided for such a process to take place.

FIGURE 2:
CYCLE OF PROPOSED PLANNING AND EVALUATION EVENTS IN WHO



21. Specific evaluations may be needed at other times: for example, when a programme or programme component is completed or terminated, in national endeavours supported by WHO, or to prepare for an external review.

II.2.3 Participants in evaluation

22. All evaluation, whether conducted by external experts, as a peer review process, or through self-evaluation, must use a **participatory approach**. Consulting and involving all stakeholders during evaluation ensures that optimal and sustainable action is more likely to be taken on the results because they are "owned" by all participants.

23. In WHO, the governing bodies and executive management have suggested that self-evaluation of programmes is a useful principle, without precluding the use of other forms of evaluation such as external or peer review of policies, functions or specific programmes.

24. **At country level**, the WHO Representatives are responsible for conducting evaluation, in line with the established system for programme budgeting. Where there is no WHO Representative, the Country Liaison Officer or the regional office will be responsible for evaluation with the guidance of headquarters/regional offices. Technical specialists from headquarters and/or the regions may often be invited to participate. In addition, as mentioned earlier, national counterparts should be an integral part of the evaluation team. In some cases outside specialists (in a specific technical field) may be invited to join.

25. **At the intercountry and regional level**, evaluation will be done under the guidance of the Regional Director and Director of Programme Management. The staff in charge of the programme or the institution evaluated should be fully involved in the process.

26. **At the interregional and global level**, the programme staff, in collaboration with evaluation experts and/or technical specialists, will be responsible for evaluation under the supervision of the Assistant Director-General or Executive Director.

II.2.4 Sources of information

27. The best way to ensure information support is to specify information requirements at the planning stage. It is also essential to make a good "baseline assessment" of the situation at the beginning of any activity.

28. Decisions about information gathering should be determined by three major factors: the question to be answered, the constraints, and the costs of collecting the information.

29. The background documentation available at headquarters, the regional offices and the WHO Representatives' offices generally falls into the following three broad categories:

- (a) general background information (sociopolitical, economic, demographic, historical and geographical) on the country itself, including the most recent development plans;

- (b) health policy and strategy information highlighting the main thrusts of the national health programme and WHO support to it, and giving an overview of the health situation and trends; national health development plans; national health budget; country and programme profiles; health sector studies; country resource utilization studies; national programme planning, monitoring and evaluation reports; external agency reports; the regional health-for-all strategy; the regional medium-term programmes; the regional programme budget policies; and

- (c) programming, budgeting, evaluative and administrative information such as plans of operation with workplans or plans of action; documentation justifying reprogramming; operating budgets; records of allotments, expenditures and other accounts; WHO evaluation reports (both internal and external); country programme agreements; records of joint policy and programme reviews; records of joint government/WHO evaluation missions; records of the deliberations and decisions of government/WHO coordinating mechanisms; programme budget statements and budgetary tables as proposed and revised; key exchanges between the regional office and WHO representatives' offices, and between WHO and the government concerned; information on programme implementation at the country level such as WHO representatives' semi-annual or annual reports, consultant reports or fellowship evaluation reports.

30. The bulk of the information for monitoring purposes will come from the Activity Management System (AMS) of the WHO Management Information System (MIS). It should be analysed in each programme/division every six months and consolidated every year for the whole Organization.

31. It is necessary to identify the type of **information needed for each component** of the evaluation process. For example, to evaluate the adequacy of programme formulation (see Section II.3), it will be necessary to have an assessment of needs, a list of objectives and target groups; a description of the approaches being used to attain the objectives and meet the targets; a summary of the resources involved, including personnel, and budgeting and financial information; and a schedule of activities, including milestones or checkpoints and their due dates (see also Section II.3). A substantial part of these data need to be regularly fed into the management information system (MIS) so that they are available at the time of monitoring and evaluation.

II.3 How to conduct an evaluation

32. With variations for different types of policies, programmes and activities, evaluation will broadly consist of the following main components:

- (1) Specify the subject for and aims of evaluation (determine indicators and criteria)
- (2) Ensure (during formulation) or assess (during final evaluation) information support

- (3) Verify relevance of policy or programme
- (4) Assess programme's adequacy and sustainability
- (5) Review progress
- (6) Assess efficiency
- (7) Assess effectiveness
- (8) Assess impact
- (9) Draw conclusions, formulate alternative approaches to policies and programmes, and disseminate the information
- (10) Reprogramme with planners.

33. To emphasize the importance of focusing on products and effectiveness in WHO, it is proposed to start with component number 7 for ongoing programmes in WHO, i.e. with effectiveness evaluation, followed by an analysis of the determinants of success or failure. The following four parts outline the steps required for such an approach.

Step 1 - Assessment of effectiveness

34. This step involves an examination of the **current level of achievement** and analysis of effectiveness.

35. As outlined in Section II.2.1, **achievements** are characterized by:

- meeting pre-set targets;
- levels of indicators;
- fulfilment of pre-set criteria; and
- delivery, quality, acceptability and use of products.

36. Targets and indicators are quantified (see Annex 1 and following paragraph). Criteria can be quantitative and/or qualitative. The strategic programme budget of WHO should contain realistic and measurable targets against which WHO's performance can be measured.²

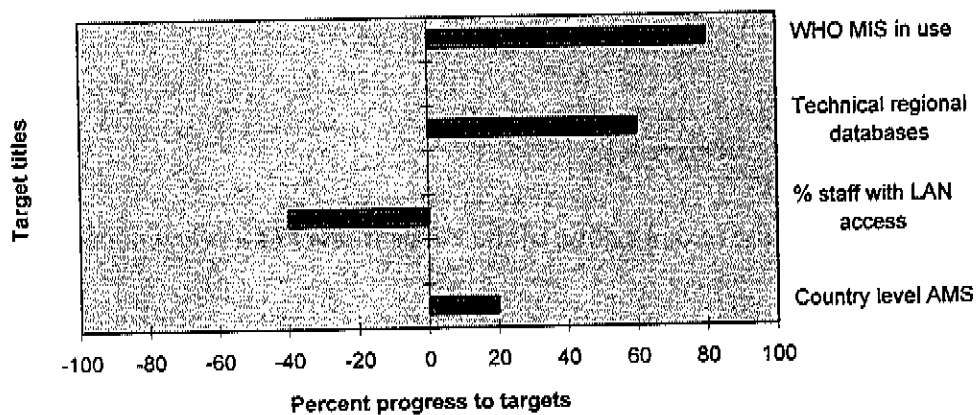
37. **Measurement** methods to calculate indicators, or how well targets were met, include surveys (such as opinion surveys among users of WHO's services and programmes, household and health facilities surveys, coverage data or rapid assessment surveys), vital statistics and sometimes surveillance data. Baseline data are essential as are data collected during programme implementation. Products will be evaluated in terms of their utilization, their quality and, if possible, their effect on the target audience or their ultimate impact. For the sake of simplicity, details are not provided in this guidance on specific evaluation designs and the reader is referred to standard text (see Annex 7b). Whatever the methods selected, they should be valid and reliable.

² See document PPE/97.2, *Guidance for the preparation of the proposed programme budget for the financial period 2000-2001*.

38. The **results** will be expressed in terms of:

- percentage achievement of the targets (see Figure 3);
- the values of indicators supporting the achievement of targets;
- whenever possible appropriate stratification (e.g. by region) of data or indicators;
- a description of the fulfilment of criteria; and
- a description of products delivered, their quality, utilization and effect.

FIGURE 3:
PROGRESS TOWARDS ISM TARGETS



Note: ISM: Division of Information System Management
 MIS: Management Information System
 LAN: Local Area Network
 AMS: Activity Management System

39. Figure 3, (which is for illustrative purposes only), illustrates hypothetical progress towards a set of pre-determined targets from the Division of Information System Management (ISM) as at the end of 1996.

40. It is important to note that "negative growth", that is, not only failure to meet a target but to experience a decrease from the baseline, can take place (for instance, in 1997 less people have access to the LAN than in 1996, despite a target of increasing the proportion of those with access to the LAN). The reasons for this should be explained, as should the reasons for successful achievement of targets.

41. As a further step in evaluating effectiveness and impact, it is important to compare **costs and outcomes**. Annex 2 gives a description of different approaches for such analyses.

Step 2 - Assessment of impact

42. **Impact** is an expression of the overall (direct and indirect) effect of a programme, service or institution on the health and related socioeconomic development of the population concerned. Impact is thus the effectiveness of the interventions on a long-term basis, taking into account the **coverage** of a programme and potential negative effects. Impact evaluation of WHO's action should only take place every third biennium as it requires substantial preparation and impact can often only be detected after a few years. Specific guidelines will need to be developed for impact evaluation in WHO.

Step 3 - Analysis of explanatory factors: relevance, adequacy, monitoring progress and team performance

43. Whether or not all targets are met, there is a need for detailed analysis of the determinants of the results. The analysis should look at four aspects: relevance, adequacy, progress and staff performance (as teams).

44. **Relevance:** this relates to the rationale for adopting particular health policies and supporting programmes in terms of their response to essential human needs, and to social and economic policies. Relevance also requires a process of prioritization between health policies.

Examples:

Questions for relevance

- "Are the health policies relevant to the region's or country's overall social and economic policies?"
- "Are the programmes justified in social and public health terms?"

45. It is assumed that policy analysis (i.e. relevance of the programme to established WHO policies) has been carried out prior to the elaboration of the programme. However, it is necessary to revisit the continuous relevance of the programme in the light of its effectiveness.

46. To determine the continuous relevance of policies and programmes requires the definition of the health status of populations, the target populations and their needs. Broad and flexible qualitative and quantitative methodologies should be used, including the screening of alternative options and their respective priority, analyses of the "returns" which the strategies have produced, an analysis of the degree of "risk" which the strategies have implied, and a renewed continuous feasibility analysis.

47. Qualitative methods include situational appraisal, content analysis and document review, focus-group discussions and in-depth interviews (see Annex 3). The method of observation and scoring falls into two categories: qualitative and quantitative. Annex 4 provides more background on a possible framework for conducting policy analysis.

48. Adequacy implies that attention has been paid to the correct definition of the problem and to designing programmes that address the problem in an optimal way.

<i>Examples:</i>	<u>Questions for adequacy</u>
•	"Are the products and activities of the programme clearly related to its objectives?"
•	"Were alternative (technical/economic) approaches considered?"
•	"Is strategic input of relatively limited monetary value provided at country level acting as leverage and leading to coordinated actions from several national sectors and other agencies to respond to the specified problem?"
•	"Have all functions of WHO been reviewed to ensure that it is the best Organization to deal with the issue?"

49. To determine the adequacy of a programme's formulation implies defining the model of change sought by the programmes and functions and understanding the context (the external factors likely to affect performance) in which efforts are taking place to achieve objectives. Checking adequacy also comprises verifying that appropriate administrative and financial procedures have been planned and followed during implementation.

50. As in any organization in the public or private sector, WHO has to manage both its human and financial resources. WHO's financial resources are entrusted to it by its Member States, donor agencies and ultimately the public at large. WHO, therefore, has an obligation to ensure that its resources are utilized to the maximum benefit of its Member States and interested partners in an efficient and effective manner. Evaluation helps to further strengthen WHO's systematic internal management procedures.

51. The evaluation process should include a review of the adequacy of the three principal components of internal management:

- (1) Human resources;
- (2) Budgeting and accounting; and
- (3) Administration.

52. Criteria and questions for guiding evaluation in these principal components of internal management would include the following:

- (1) Human resources
 - is the staffing structure appropriate/adequate?
 - are terms of reference/post descriptions (TOR/PD) relevant?
 - are all posts filled?
 - are terms of reference/post descriptions being implemented?
 - are staff appraisals being done accurately? and
 - is there appropriate delegation of authority and of responsibility?

(2) Budget and accounting

- is the budget adequate to fund the products and activities in order to achieve the goals and objectives?
- is the budget properly structured to the needs of the entity being evaluated (i.e. WHO Representative's office, regional office programmes, headquarters programmes or divisions)?
- are there sound budgetary controls in operation?
- is the accounting process accurate, reliable and timely? and
- are budgeted costs and actual expenditures compared periodically and are appropriate actions taken where necessary?

(3) Administration

- is the communications system, (internally and externally) both oral and written, adequate and supportive of the work process?
- are the administrative procedures efficient, well-documented and clearly understood? and
- is the informatics system adequate and supportive?

53. **Measuring progress:** or monitoring, is concerned with the comparison of actual with scheduled activities, the identification of reasons for delays or shortcomings, and the proposed remedies to rectify them. The ultimate purpose of monitoring is to learn and allow for the readjustment of programmes as necessary. A progress review also keeps track of milestones achieved, personnel matters, supplies and equipment, and money obligated in relation to budgets allocated in the plans of action.³ It should also include a review of the equity of programme distribution. Two examples of monitoring are provided in Annex 5. The first is taken from the Regional Office for Europe and illustrates the monitoring of product delivery by health-for-all targets. The second example is monitoring of a country community-based rehabilitation programme. In WHO, the recording of information on spreadsheets or using a management information system is ideally done every week or at short intervals. Analysis of the information recorded is done every six months at programme or policy level (as with the AMPES system in PAHO/AMRO). In other words monitoring requires constant attention.

54. Monitoring includes the documentation of **milestones** (a series of key events to occur at a predetermined time; see Annex 8, Glossary), and levels of implementation. Each year, or biannually, the plan of action³ is revised (if necessary) for the next period.

- A regular flow of information is ensured so that programme managers can examine whether activities to develop a given set of products are carried out as planned, are on schedule and are within the budget. Implementation of activities over time is linked with the financial inputs and expenditure in the Activity Management System (AMS).

³ See also *Procedural guidance for the preparation of plans of action for 1998 (PPE/97.1)*.

- Data are for decision-making. Knowing why and where a programme succeeds or is inadequate is more important than knowing whether it is succeeding or failing. Failure or delays may be linked to inappropriate human resource management, to over-ambitious objectives, to inadequate priorities or over-emphasis on a specific programme component. Qualitative methods are used to document the reasons for success and failure.
- A core set of criteria and indicators needs to be developed (see how in Annex 1) to examine the products against their stated objectives. For example, timeliness, appropriateness and quality of technical guidance need to be examined for this purpose. While specific programmes may need a relatively large number of criteria and indicators, it is essential to remember that global indicators are generally intended to give an overall picture of progress and, therefore, their number needs to be small.
- Monitoring is reflected in regular progress reports where an analysis is provided of how the global, regional or national situation has affected the delivery of programmes.

55. **Actual team performance:** a necessary step in developing a systematic approach for evaluation is to link the work of the Organization's staff to financial expenditure, delivery of products and achievement of targets. This is part of the assessment of efficiency. This link is established during the development of the plan of action and professional staff's planned activities (see following paragraph). Assessment of performance and of potential problem areas takes place during the periodic performance appraisal.

56. In WHO, plans of action cover a period of one or several years and apply to a specific area of work; and a plan of activities applies to an individual for a given period (usually a year). Planned activities are established by the individual together with the supervisor during the annual appraisal, and will reflect the activities in the plan of action for the year in question.

57. Programme managers and divisional directors could take this opportunity to, simultaneously, evaluate past activities, elaborate plans of action and plan the future activities of their staff.

58. The performance requirements are specified for each major assignment during the previous year's appraisal or during the process of establishing planned activities. They should include a definition of the standard or level of performance that is expected from the incumbent of a particular post. The performance factors describe in general terms observable work behaviour. They cover task, conduct and relationship elements. One set of factors needs to be assessed for all staff members, another applies only to staff exercising managerial and supervisory functions.

59. Guidance for the elaboration of annual plans of action⁴ has already established a link between the activities planned and the staff appraisal report. In particular they link the planned activities of staff to the activities contained in the plans of action with a view to optimizing the use of WHO staff time and relating work to targets. A number of criteria and questions can guide the evaluation of team performance including the following:

- are work/coordination meetings held routinely with active staff participation?
- is work progress reviewed in a timely and systematic manner?
- is staff training and development appropriate? and
- are staff well-motivated and is there a good working environment?

Step 4 - Action-oriented reporting of evaluation findings

60. The dissemination of the results of evaluation is crucial. Dissemination should be planned early on and the channels to be involved should be identified. The importance of the presentation of the results cannot be emphasized too strongly. Evaluators should tailor their reports to the audience they are addressing - politicians, scientists or the press. The expected use of evaluation results should also influence the way in which these results are disseminated. The report should be made known to all those concerned with the programme. If used well, the report will strengthen team spirit, and if circulated to people working in similar circumstances may facilitate networking.

61. The most evident purpose of evaluation is to prove the worth of, or improve, the programme. It may then lead to the decision to allocate resources for continuing the programme and, if necessary, for improving its management. Thus evaluation reports should contain both positive and negative results. Although evaluation results may be only one of the factors that influence resource allocation, they generally encourage rational decision-making.

62. The evaluation report requires follow-up and alternative strategies need to be formulated, including proposals and decisions by governing bodies.

⁴ Documents PPE/95.1 and PPE/97.1.

III. CONCLUSION

63. The first stage of good evaluation is good planning and identifying a clear statement of the objectives of the policy or programme. The evaluation planning process often further clarifies these objectives, making them more specific, measurable, and with a given time frame.

64. While the above sections have disaggregated the process of evaluation, there is a need to integrate its components into real life. In general, the evaluation of programmes or policies must combine several of the evaluation types discussed above. Evaluators must understand the context in which efforts are taking place to assess their appropriateness. Second, when activities are on-going, there is a need to examine whether they are being carried out as planned, on schedule and within budget. Third, the expected results/products to be attained by these activities should be examined against the stated objectives. Fourth, costing of products must be done and, whenever possible, the costs compared to the outcomes. In practice, however, each of these components is closely inter-linked and the sequence may change over time.

65. "Effectiveness indicators" should relate to the stated overall objectives, while "monitoring indicators" should be more numerous and document the implementation process together with qualitative assessments of facilitators and barriers to programme implementation.

66. Decisions need to be taken on how these assessments or indicators should be conducted or measured, which methods should be used and how often this should be done.

67. Finally, what distinguishes evaluation from other forms of scientific activity is the objective of providing information to decision-makers. The evaluation should be guided by important programme-relevant decisions and policy questions, and should recognize the interests of the various stakeholders in programmes or institutions. The success and relevance of the evaluation process is thus tied to the involvement in the process of programme staff, participants, and other stakeholders. It follows that those conducting the evaluation then have a responsibility to communicate their findings, and inform policy makers about these findings in order to improve programmes.

DEVELOPING MONITORING AND EFFECTIVENESS INDICATORS

Developing monitoring and effectiveness indicators and targets is an essential part of **planning**. If targets and indicators are defined realistically, the conduct of evaluation is likely to be significantly easier.

In the following pages, the most important steps for the development of indicators are provided. Targets definition follows the development of indicators and requires close attention as well. The distinction between monitoring and effectiveness indicators is made to illustrate the difference in periodicity, depth and complexity of the two processes, keeping in mind that monitoring usually precedes and supports evaluation while effectiveness analysis is a subset of evaluation.

The process

- obtain consensus by programme officers on the need for, and uses of, monitoring progress and assessing effectiveness to achieve the objective of the programme
- identify (formulate) indicators that are considered essential for evaluation
- define each potential indicator in order to provide a comprehensive description of data needed
- select a few indicators based on feasibility criteria
- field-test the selected indicators to ensure their applicability
- adopt the indicators and establish a baseline

Obtain a consensus

Identify a list of issues for which indicators need to be developed. A general meeting of staff is held at the beginning of the process, usually when overall planning for the next period is close to completion. All staff must be convinced of the usefulness of an evaluation framework and monitoring rules that include the development of criteria, milestones, indicators and targets. Staff will identify a series of potential areas corresponding to the main objectives of the programme for effectiveness indicators and a list of monitoring indicators and milestones that will assist in making sure that implementation goes according to plan.

Identify (formulate) indicators

This is the most difficult step. The objectives of the monitoring and evaluation system should be clearly articulated. The objectives set during programme formulation should be used as a reference. Indicators specify the performance standard to be reached in order to achieve the goals, objectives and outputs. Indicators should specify:

- . the target population (for whom)
- . the quantity (how much)
- . the quality (how well)
- . the location (where)

Usually the specification of the target population is expressed by using a denominator in order to provide a proportion of the final achievement. Indicators need to be selected that can measure change over time and assist in identifying problems in implementation. Target formulation follows the formulation of indicators by adding the level of achievement and the time dimension (by when) to the above.

Whenever possible, the focus should be on elements whose collection will not require too much additional effort in terms of time and resources. This is not always possible and trade-offs must be discussed. Staff from different levels of the programme should be invited to participate in this process (country, regional, headquarters).

Programme staff should draw up a list of areas where indicators could be developed. The initial list of potential indicators could be as many as thirty. The number of indicators is then reduced, after discussion, to a limited number. The identification of indicators should be guided by the importance of the objective(s) they reflect and the amount of resources devoted to a given area.

Ideally, an indicator is valid when it actually measures what it is designed to measure; it should be **sensitive** to change; be **specific** to the situation concerned; and it should be reliable, i.e. the answer should be the same if measured by different people in similar circumstances. *For example*, infant mortality rate is a sensitive indicator of the level of health of a child population. However, it is not specific, since its reduction can be the result of a large number of factors.

Further considerations in identifying indicators are: How important is the information provided by an indicator to the overall implementation process of the key area? Is it possible for programme staff to respond to operational problems identified by the indicator? How difficult is the method for measuring a particular indicator in terms of time, money and complexity? What is the method to be used to obtain specific information on performance?

Monitoring all aspects of the programme would consume too many resources, therefore, the choice of indicators must be influenced by priority. Such prioritization is not easy but selection of monitoring indicators should be guided by whether or not an indicator will provide explanatory insight to effectiveness analysis.

Define indicators

Each indicator should be defined and described by: intended use, a ratio, a rate or otherwise, sources and methods for data collection, staff involved, timing (periodicity of measurement) and limitations.

Annex 1 (Cont.)

Whenever an indicator is a ratio or rate the **denominator** and the **numerator** of the indicator should be described in detail. This provides a clear understanding of the derivation of the proportion, percentage or ratio that creates the indicator. Once defined, indicators can be formulated as targets by adding the time dimension and an expected level of achievement. This expected level of achievement needs to be gauged as realistically as possible on the basis of existing baseline data. Unrealistic targets are dangerous for progress and policies, as their non-achievement leads to loss of credibility.

Targets need to give a quantified expression of the main objectives of programmes. The person or persons responsible for data collection should be identified together with the method and frequency of data collection. The method used is crucial to the success of each indicator. Sources of data may also vary by programme area and from one region to another.

<i>Example:</i>	Human Resources for Health Programme
Objective	Support countries in creating a favourable legal environment for the development of human resources for health.
Target for end 1998	Increase capacity in Member States with greatest need to develop an effective regulatory framework (legislation) for health care practitioners.
Specify target group	Policy-makers in the sectors of health, education and justice in countries expressing such need.
Set quality	Training and technical advice provided according to guidelines and assessed with follow-up evaluation.
<u>Numerator</u>	Number of countries in need with policy-makers with demonstrated competence in formulating effective regulatory frameworks for health care practitioners.
<u>Denominator</u>	Total number of countries in need.
For targets specify time frame	By December 1998.
For targets set level of achievement expected by given time frame	For example, 40% of countries in need have policy makers with demonstrated competence by end 1998.

The above example illustrates the steps required in formulating a **monitoring** indicator, because this indicator focuses mostly on the process of implementing the programme according to plan. An **effectiveness** indicator would focus more on the result of training policy makers of different sectors to achieve the objective of improving the development of human resources for health. This would require examining the **quality** of training (with an indicator), the changes in those trained sometime after the training (with another indicator) and whether those trained effected changes in the country (with a third indicator).

Select indicators

The process of identifying and describing indicators leads to a large number of indicators that has to be reduced in order to ensure that the process of monitoring and evaluation remains manageable.

Indicators for monitoring purposes have to be closely related to the means available for data collection and processing, and should be gathered as an intrinsic part of the programme in order to be as accurate as possible. While this needs to be a concern for monitoring indicators, it is often not possible for effectiveness indicators.

The following considerations should be taken into account when selecting indicators: How practical and feasible is it to collect data for the indicator? Can data be collected and is the quality of data likely to be good and consistent (validity, reliability and repeatability)? The challenge for programmes in headquarters, regional and country offices is to develop indicators to assess their own work. Such indicators, once developed need to be field tested.

Field-test

Each indicator and its method needs repeated field-testing before finalization. The regions where the test will be conducted need to be identified. Criteria for selecting a test site include the availability and cooperation of personnel, ability to test all the indicators selected, and the willingness of management staff to have the test conducted in their area.

Staff for the field-tests are trained to ensure that the concepts of monitoring are understood and that the sources and methods of data collection are clear. Usually, selection of staff for field-testing is made among those involved in programme implementation. Participants need to be encouraged to suggest changes that fit their own situations. Changes are decided upon after discussion and consultation with the whole group.

The focus should be on whether the methods chosen for data collection are feasible, practical, valid and repeatable. Participants are urged to propose other possible sources of data. Problems encountered while collecting data and possible solutions are discussed. The final adoption of indicators should be based on the following: How easy was it to collect the data? How accessible were the data sources? How useful is the indicator as a tool for evaluation? Does it entail additional work for the data collector? If yes, is it feasible and reasonable?

Adopt the indicators and establish a baseline

Once indicators have been field-tested under various conditions, they need to be used. This is done by establishing a baseline for each of them and repeating measurements at regular intervals. Figure 3, page 12, illustrates the use of trends in indicators to assess progress towards set targets (expressed as % of target achieved) of nation-wide programmes.

COMPARING COSTS AND OUTCOMES

Definitions

There are three basic types of cost that can be measured: direct, indirect and intangible. Direct medical costs are the resources expended on illness. They include drugs, physicians fees, tests, and procedures. Direct non-medical costs include food, travel and lodging associated with medical treatment.

Indirect costs are the resources forgone as a result of illness, and can be measured as lost productivity. There are two ways of measuring indirect costs. The human capital approach measures productivity loss as the value of the future earnings that may be lost due to premature morbidity or mortality from the illness. The challenge with this method is that not everyone works, and some people work for no money, so the human capital approach tends to value outcomes less for women, the elderly, the disabled, minorities and others with low income and children. The willingness-to-pay approach is an alternative method that determines how much people are willing to pay to decrease their risk of illness or death. The results of this method are influenced by how much money the respondent has, so the willingness-to-pay approach yields relatively low estimates for those with low incomes.

Intangible costs are non-financial outcomes such as pain, suffering, or grief. Since intangible costs are difficult to measure, and even more difficult to translate into economic terms, they are often ignored in economic analyses.

One strength of using a cost-of-illness approach to measure the burden of disease is that the outcome is quantifiable (in monetary terms), and can be standardized across diseases. However, the weakness of this approach is that it excludes intangibles, only counts earnings, and is biased because it undervalues some groups in relation to others, thus underestimating the value of the programme. Economic analyses should, therefore, be interpreted with caution, recognizing that they represent the lower bound estimate of the true human cost of illness.

Efficiency¹ is an expression of the relationship between the results obtained from a programme or activity and the efforts expended in terms of human, financial and other resources. The assessment of efficiency is aimed at improving implementation by comparing essential managerial elements obtained through monitoring with the progress apparent in programme implementation. Assessment of efficiency also involves keeping a check on such aspects as the appropriateness of existing plans of action, work schedules, methods applied, personnel used, and the adequacy and use of financial resources. This is done with a view to improving these aspects, if necessary, at the least cost.

¹ *Elements of progress and efficiency are sometimes grouped under the heading "Process evaluation". This is an approach for following up resources used and examining whether planned approaches and methods are applied adequately and whether milestones are achieved. Emphasis has recently been put on process evaluation (which is also closely linked to financial monitoring and quality control).*

Cost-benefit is the relationship between the cost of an activity and the benefits that accrue from it, expressed in monetary terms. Cost-benefit is rarely easy to assess for health programmes since the benefit, although often obvious, is difficult to express in monetary terms. Analysis of **cost-effectiveness** aims to measure the relative costs of alternative ways of achieving an objective. Another term in use is **cost-efficiency**, which is concerned with whether a programme's resources are being used as well as possible, e.g. in terms of the level of services provided in relation to the cost. **Cost-utility** is a form of economic evaluation in which costs are expressed in monetary terms but some of the consequences are expressed in units of utility, e.g. quality-adjusted life-years, or healthy days of life.

Type of questions

Economic evaluations allow comparisons that consider both the costs and the outcomes of alternative strategies to assess whether the benefits gained from a programme are worth the resources expended. Specifically, these evaluations can answer several types of questions that may be of importance to policy-makers: What are the financial resources necessary to establish and run a programme? Do the programme's benefits outweigh its costs? If a programme is not cost saving, how does its cost compare to what society is

Examples:

- "What is the cost of hepatitis B prevention per infection/case averted?" (**cost-effectiveness**)
- "What is the cost (indirect and direct) of the total inputs of WHO (including the WHO Representative's office, advice, facilitation, support and inputs from regional offices and headquarters)?" (**cost**)
- "What is the cheapest option for increasing accessibility of secondary hospitals of given quality in a region with low population density?" (**efficiency**)
- "Assuming no synergy between different strategies, what is the most cost-effective prevention strategy for lung cancer: Mass-media campaign against tobacco (high coverage, medium cost, low effectiveness) and/or face-to-face counselling (low but selective coverage, high cost, medium effectiveness)?" (Decision between **alternative strategies**)
- "What is the cost-effectiveness of distance training for laboratory methods on blood safety compared to other training methods?"
- "Is the influenza vaccine effectiveness going to vary according to whether the vaccination strategy is applied to single individuals (who request it) or to groups (such as students, workers, aged persons)?" In other words, is it enough to vaccinate some of the population to achieve protection of a greater number?

Annex 2 (Cont.)

willing to pay to achieve similar benefits? Even if a programme is beneficial, could the financial resources be better spent by funding a different programme? Which combination among all of the potentially beneficial programmes, funded at what levels, represents the most efficient allocation of resources?

Methods

To answer the above questions, six basic data elements are needed: (1) the programme description; (2) the health outcome averted through the programme; (3) the rates and societal burden of the health outcome; (4) the proportion of this health outcome potentially averted as a result of the programme; (5) the programme's cost; and (6) the cost of the health outcome prevented.

Economic choices are made on the basis of cost and the expected benefits from that cost. Choices will generally be made that optimize the benefits in relation to the cost. Economic analyses will allow the different options to be compared, either in terms of the quality of the outcome for a given cost or of the cost for a desired outcome. When the analysis includes long-term behavioural changes associated with specific programmes, appropriate use of discounting should be made. When calculating the cost of a programme, due attention should be given to all costs involved, direct and indirect, including labour, supplies, training, infrastructure, and time for people to attend.

Calculating the benefits of a programme is more complex. Benefits can be expressed in terms of years of life saved or, even better, years of life saved combined with the quality of those years. Methods include modelling techniques associated with the use of data from effectiveness and impact. Benefit may also be the reduction in health care costs or the avoidance of losses of productivity due to poor health. (See also "Cost Analysis in Primary Health Care. A Training Manual for Programme Managers." Eds. Andrew Creese and David Parker. WHO, 1994.)

SOME QUALITATIVE DATA COLLECTION METHODS FOR EVALUATION

Method	Description	Examples
Focus groups	Small group discussion is held among programme delivery staff or recipients, focused on their reactions to a proposed intervention or their experiences during pilot delivery.	Convene focus groups of programme staff having used technical guidance on evaluation to obtain feedback.
Observation	Evaluator observes actual pilot delivery or video recordings of initial delivery.	Observe health care delivery for complaints of acute respiratory infections and patient reactions. Observe video of physicians trying out a counselling intervention to stop patients smoking.
Open-ended interviews	Evaluator asks probing questions to typical recipients or deliverers, using an interview protocol without preset response categories.	Briefly interview shoppers after their taste tests of new foods for a low-cholesterol diet.
Ethnographic analysis	Evaluator uses methods from anthropology (including observation and interviews) to obtain in-depth understanding of recipients' cultures.	Attend meetings of local hospital officials to learn how they make decisions to purchase new medical technologies.
Message or forms analysis	Evaluator probes pilot recipients for their understanding of and reactions to specified aspects of a written or media communication.	Attend meetings of the governing bodies at the executive and strategic level of the Organization to learn how priorities are selected. Talk to sample recipients about the meaning, acceptability, and likely response to an AIDS-prevention pamphlet.
Expert judgement	Panel of individuals with extensive prior experience in the content area is convened to offer opinions on proposed programme components.	Convene panels of scientists for opinions on the appropriateness of a new strategic plan for evaluation in WHO.
Equipment pre-test	Equipment to be used in intervention is tried out to check its operational use in intended situation.	For a computerized Management Information System for WHO, try out the pilot version of hardware and software in selected countries.

Source: Adapted from S.L. Candle in Wholey J.S. et al (Eds) 1995

POLICY ANALYSIS

Policy analysis is the critical examination of policy goals and the structures and functions established to achieve existing goals. Policy must be understood as the general principles by which a government or an institution is guided in its management of public affairs. In WHO, long-term policies are adopted by governing bodies, e.g. health for all by the year 2000, General Programmes of Work for a specific period (usually 6 years) and Executive Board and World Health Assembly resolutions. Policy analysis will, therefore, follow the same type of periodicity.

Policy analysts have suggested four dimensions of interest in developing a framework for analysis. The **context** describes the environment within which policy decisions take place. The **process** of policy-making includes problem identification and description, policy formulation, implementation and evaluation. **Policy actors** are those who perceive that their interests are affected by the consequences of policies. Finally, the **content** of policy relates to its technical aspects.

All these dimensions should be analysed carefully, as they play a major role in health policy-making and priority-setting, both at national level and in WHO. The **content** of WHO policies and its relevance to the context and problems they address is particularly important, as it shapes WHO's programmes. The content of WHO policies should specify the optimal institutional relationship between WHO and its Member States (e.g. it should evolve from a partnership strictly with ministries of health to a partnership with multiple sectors involved in health). Such an analysis draws concepts from organizational theory and the economics of organization and examines the value of different options (e.g. decentralized planning and management versus centralized planning). The content should also determine which priorities have been selected and in the light of which considerations. Finally, the content should also be related to technical efficiency and the mechanisms put in place by WHO to re-examine its policy orientations and programmes.

A short step-wise approach to policy analysis can be outlined as follows:

- (a) Establish the context. What is the underlying problem that must be dealt with? Explicitly identify the objectives to pursue.
- (b) Lay out the alternatives.
- (c) Predict the consequences of the alternatives.
- (d) Determine how to measure success in each objective.
- (e) Make a choice. Keep it simple.

Methods need to be devised and refined to improve the conduct of policy analysis within WHO.

CURRENT EXAMPLES OF MONITORING

I. Monitoring delivery of products in the WHO Regional Office for Europe

USE OF PROGRAMME FUNDS

EXPENDITURE 1994-1995 PROGRAMME ACTIVITIES			
HFA Target (1-38)	\$ Regular Budget	\$ Other Sources	\$ Target Total
1 Equity in health	27 020	2 336	29 356
2 Quality of life (posteriority)		0	0
3 Disabilities	83 584	1 313 728	1 397 292
4 Chronic diseases	475 941	547 481	1 023 422
5 Reducing communicable disease	559 520	7 176 388	7 735 908
6 Healthy ageing	59 677	47 070	106 747
7 Children/young people	92 343	129 921	222 264
8 Health of women	304 578	401 584	706 162

MONITORING DELIVERY OF PRODUCTS (EURO TARGET 5)

Target 5 Reducing Communicable Disease (extracts)

By the year 2000, there should be no indigenous cases of poliomyelitis, diphtheria, neonatal tetanus, measles, mumps and congenital rubella in the Region and there should be a sustained and continuing reduction in the incidence and adverse consequences of other communicable diseases, notably HIV infection

PROGRAMME STRATEGY 1994-1995	
HFA objective 5.1	To achieve and sustain high immunization coverage for the six EPI target diseases. Proposed output(s) (a) Support to implementation of immunization programme aimed at eradication of poliomyelitis and the other target diseases (of particular relevance to countries of central and eastern Europe)
HFA objective 5.2	To maintain and develop surveillance of AIDS and HIV sero-prevalence and to reduce transmission rates. Proposed output(s) (b) Surveillance of HIV/AIDS, development of national HIV/AIDS programmes and forecasting of the future impact of the HIV pandemic in Europe (of general relevance, with special emphasis on institution-building in countries of central and eastern Europe)

PRODUCTS (extracts)	Doc. Ref.	Lang.
Diphtheria epidemic in Europe: emergency and response: report on a WHO meeting, St. Petersburg, Russia, 5-7 July 1993	EUR/ICP/EPI 038	ENG
Manual for the management and control of diphtheria in the European Region	ICP/EPI 038(B)	ENG
Manual for the laboratory diagnosis of diphtheria	ICP/EPI 038(C)	
Diphtheria: plan of action for the prevention and control of diphtheria in the European Region (1994-1995)	EUR/ICP/EPI 038(A)	ENG
Diphtheria control in the Russian Federation: report on a WHO meeting, Moscow, 20 May 1994	EUR/ICP/EPI 038(D)	ENG
Diphtheria epidemic in Europe: emergency and response; report on a WHO meeting, St. Petersburg, Russia, 5-7 July 1993 Corrigendum (only 1 page)	EUR/ICP/EPI 038 REV.1 CORRI	ENG
Coordination of Operation MECACAR mass vaccination with oral polio virus vaccine: meeting to mark World Health Day, 7 April 1995, Ankara, 29-30 January 1995	EUR/ICP/CMDS 94 03/MT02	ENG

II. Monitoring evaluation at country level

"In a given country, what are the constraints leading to delays in implementing community-based rehabilitation (CBR) programmes at different levels?"

Example

USING MONITORING AND SELF-ASSESSMENT RESULTS IN PLANNING
CBR AT THE NATIONAL LEVEL

INFORMATION	FINDINGS	DECISION/ACTION
Competence of CBR workers	There is no information about the competence and motivation of CBR workers	Coordinator decides to ask supervisors to work out system to get regular information about competence
Resources mobilized	Potential donors are not aware about disability issues and are not supportive of CBR	Coordinator decides to make short video to use in promoting the programme
Cost of programme activities (cost analysis)	Training costs are too high compared to number of people who received support	Coordinator decides to ask supervisors to increase number of people for each training

N.B. CBR: community-based rehabilitation

Source: Adapted from Division of Health Promotion, Education and Communication (HPR) and Unit of Rehabilitation (RHB) guidelines for conducting monitoring and self-assessment of community-based rehabilitation programmes. WHO

FUNCTIONS AT DIFFERENT LEVELS OF WHO

1 Country level

- 1.1 The programme is aimed at solving important health problems specific to the country concerned
- 1.2 The programme is established following a rational process of country/WHO programme reviews

2 Regional and intercountry

- 2.1 Regional Committee requests WHO to run a specific programme
- 2.2 The programme is required for regional health coordination
- 2.3 The programme is required for regional collaboration with other UN agencies
- 2.4 The programme encompasses regional planning, management and evaluation and/or involves guidance, monitoring and control of intercountry or country activities
- 2.5 The pursuit of the programme as a collaborative effort of a number of countries in the same region is likely to contribute significantly to attaining the programme objective
- 2.6 Similar needs have been identified in a number of countries in the same region following a rational process of programming
- 2.7 Considerations of economy in the use of resources favour an intercountry rather than a country activity

3 Headquarters and Interregional

- 3.1 The programme is required for global health coordination
- 3.2 The programme is required for central collaboration with other UN agencies
- 3.3 The programme encompasses global planning, management and evaluation
- 3.4 The programme involves technical support to regions and/or between regions
- 3.5 The programme is intended to stimulate further regional activity in the programme area concerned
- 3.6 Considerations of economy in the use of resources favour an interregional rather than a regional activity
- 3.7 The interregional framework is useful for pooling selected resources, e.g. for the provision of very highly skilled or very scarce advisory services to regions

INVENTORY OF SOME EVALUATION DOCUMENTS IN WHO

(as received by the Unit of Development of Policy and Programme Evaluation)

HEADQUARTERS

Division of Child Health and Development (CHD)

Division of Diarrhoeal and Acute Respiratory Disease Control, *UPDATE*, No. 13, October 1993

Division of Diarrhoeal and Acute Respiratory Disease Control, *UPDATE*, No. 17, October 1994

CDR Interim Report 1994, Annex 2, *Definitions of CDD and ARI programme indicators*
Guidelines for conducting a focused programme review (FPR). *Phase II: Resolving Priority Problems*. Draft, June 1994.

CDD/ARI Programme Management. A training course. *Evaluation*. 1995.

Division of Control of Tropical Diseases (CTD)

Plan of Activities 1996-1997

Action Programme on Essential Drugs (DAP)

Brudon-Jakobowicz, Pascale, Rainhorn, Jean-Daniel and Reich, Michael R. *Indicators for monitoring national drug policies*. A practical manual. WHO/DAP/94.12.

Division of Emerging and Other Communicable Diseases Surveillance and Control (EMC)

Strategic Plan Outline 1996-2000, WHO/EMC/96.1 (Draft 25.3.96)

Division of Food and Nutrition (FNU)

Evaluation Mechanisms, Extract from Programme budget for the financial period 1996-1997

Global Programme for Vaccines and Immunization (GPV)

Expanded Programme on Immunization, *Evaluation and Monitoring of National Immunization Programmes*, WHO/EPI/GEN/86/4 REV 1
Strategic Plan 1996 to 1999, Draft
GPV Catalogue 1995, WHO/GPV/95.04

- Logistics and Cold Chain for Primary Health Care: Evaluation Questionnaire 24*,
EPI/LOG/84/24
- Expanded Programme on Immunization, *Training Evaluation: A guide to the evaluation
of training courses on immunization and other disease control activities*,
WHO/EPI/TRAM/95.3, 1995
- Expanded Programme on Immunization, *Information System: Summary for the WHO
Eastern Mediterranean Region*, WHO/EPI/CEIS/95.2 EM, September 1995

Global Tuberculosis Programme (GTB)

- Tuberculosis Programme, World Health Organization, Geneva and International Union
Against Tuberculosis and Lung Diseases, Paris, *Guidelines for Surveillance of Drug
Resistance in Tuberculosis*, WHO/TB/94.178
- Tuberculosis Programme Review Manual, Draft, TUB/NPS, November 1992

Division of Health Promotion, Education and Communication (HPR)

- Guidelines for Conducting Monitoring and Self-Assessment of Community-Based
Rehabilitation Programmes, *Using Evaluation Information to Improve Programmes*,
Draft January 1996

Division of Organization and Management of Health Systems (OHS)

- Division of Development of Human Resources for Health, *Towards the assessment of
quality in medical education*, WHO/HRH/92.7, 1992
- Division of Development of Human Resources for Health, *Defining and measuring the
social accountability of medical schools*, WHO/HRH/95.7, 1995
- WHO Fellowship Evaluation - Report to Executive Board, January 1997, *Guidelines and
instrument for the evaluation of the WHO Fellowship Programme in the South-East
Asia Region*
- Strengthening nursing and midwifery in support of strategies for health for all, *Monitoring
progress of implementation of World Health Assembly resolution WHA45.5*
- Moore, Frank I., *Guidelines for the Application of Functional Job Analysis*, September
1995
- Hall, Thomas L., *Guidelines for Making a Review of Human Resources for Health*,
September 1995
- Roemer, Professor Ruth, *Guidelines for Legislation Affecting the Development of Human
Resources for Health*, September 1995

Division of Health Situation and Trend Assessment (HST)

- Division of Family Health and Division of Epidemiological Surveillance and Health
Situation and Trend Assessment, *Rapid Evaluation Method Guidelines for Maternal
and Child Health, Family Planning and Other Health Services*, WHO/MCH-
FPP/MEP/93.1, 1993

Annex 7a (Cont.)

- Division of Family Health and Division of Epidemiological Surveillance and Health Situation and Trend Assessment, *District Team Problem Solving Guidelines for Maternal and Child Health, Family Planning and Other Health Services*, WHO/MCH-FPP/MEP/93.2, 1993
- Strengthening Country Health Information Unit, Division of Epidemiological Surveillance and Health Situation and Trend Assessment, *Catalogue of WHO Indicators for Health Monitoring*, First Draft, September 1995
- Lwanga, S.K. and Sapirie, S.A., Strengthening Country Health Information Unit, Division of Epidemiological Surveillance and Health Situation and Trend Assessment, *Rapid Assessment of National Health Information Systems (HIS) including Epidemiological Surveillance (ES)*, September 1995
- Workshop for the Identification of Essential Health Indicators

Division of Strategic Support to Countries (SSC)

- Intensified WHO Cooperation with Countries in Greatest Need, *Evaluation Criteria*, Travel Report, *Evaluation of Intensified WHO Cooperation (IWC) in Cambodia*, July 1995
- Division of Intensified Cooperation with Countries, *Intensified WHO Cooperation: Empirical Analysis and Lessons Learned from Technical Cooperation with the Poorest Countries*, WHO 1996
- Mission Report, *IWC Evaluation in Zambia*, June 1994
- Division of Intensified Cooperation with Countries, *Report on Activities 1990-1994*, WHO/ICO/95.1, May 1995

Division of Mental Health and Prevention of Substance Abuse (MSA)

- Innovative Approaches in Service Evaluation: Consumer contribution to Qualitative Evaluation, Soft Indicators*, WHO/MNH/MND/93.19
- Qualitative Research for Health Programmes*, WHO/MNH/PSF/94.3, 1994

Division of Noncommunicable Diseases (NCD)

- World Health Organization, Regional Office for Europe Copenhagen, Standing Committee of the Regional Committee for Europe, *Guidelines for Annual Reviews of Selected Programmes and Projects by Subgroups of the Standing Committee of the Regional Committee (SCRC)*, Adapted from EB94/INF.DOC./1 "Programme reviews by subgroups of the Executive Board", 7 December 1994

Programme for the Prevention of Blindness and Deafness (PBD)

- Report of the Eleventh Meeting of the WHO Programme Advisory Group on the Prevention of Blindness, New Delhi, 28 February - 3 March 1995, WHO/PBL/95.51, 1995
- Report of the Sixth Meeting of the Nongovernmental Development Organizations Coordination Group for Ivermectin Distribution, Haywards Heath, United Kingdom, 24-25 May 1995, WHO/PBL/95.49, 1995

Ellwein, Leon B., Fletcher, Astric, Negrel, Andre Dominique and Thulasiraj, R.D., *Quality of life assessment in blindness prevention interventions*, International Ophthalmology 18: 263-268, 1995, Netherlands

REGIONAL OFFICES

Regional Office for the Eastern Mediterranean (EMRO)

The joint programme review mission (JPRM), *Working group on evaluation methods. JPRM technical guidelines*, 1995

Regional Office for Europe (EURO)

Products & Services 1994-1995, Ref: PS1

Standing Committee of the Regional Committee for Europe. Fifth Meeting.
Copenhagen, 8 September 1996. *External evaluation of EURO's programmes. Proposed plan of action for 1997*

Standing Committee of the Regional Committee for Europe. Fourth Meeting.
Copenhagen, 12 September 1994. *WHO programme of humanitarian assistance to war-affected populations of the Former Yugoslavia*, Report of an external evaluation

Regional Office for the Americas/Pan American Health Organization (PAHO)

Office of Analysis and Strategic Planning. Technical Report PAHO/DAP/96.3.20.
January 1996

Office of the Assistant Director, Office of Analysis and Strategic Planning.
PAHO/AD/96.01

Standardized format for PAHO project documents and profiles. Office of External Relations. OPS.DEC.94.04

Division of Disease Prevention and Control (HCP). Evaluation Report 1995
Executive Committee of the Directing Council. *Evaluation of the strategic and programmatic orientations, 1995-1998*, 118th Meeting, Washington, D.C.
June 1996

LIST OF REFERENCE DOCUMENTS AND TEXT BOOKS

- Centers for Disease Control. *Prevention effectiveness*. Haddix et al (Eds). Oxford University Press, 1996
- Chollat-Traquet, C. *Evaluating tobacco control activities*. Experience and guiding principles. WHO, 1996
- Cousens, S., Mertens, T., Kirkwood, B., Smith, P., Feachem, R. *Case-control studies of common childhood diseases*. MacMillan, 1995
- Creese, A. and Parker, D. (Eds). *Cost analysis in P.H.C. A training manual for programme managers*. WHO, 1994
- Forss, K., Cracknell, B. and Samset, K. Can evaluation help an organization to learn?. *Evaluation Review*, Vol. 18 No. 5, October 1994 574-591. Sage Publications, Inc.
- Frenk, J., Dimensions of health system reform. *Health Policy*. 1994; 27:19:34
- International Labour Office. *Design, monitoring and evaluation of technical cooperation programmes and projects*. A training manual. Geneva, 1995
- Jamal, Zahir, Capeling-Alakija, Sharon, Lopes, Carlos and Benbouali, Abdenour (Eds). UNDP. *Improving Programme Performance Assessment in UNDP. A concept paper. Lessons Learned*. Coordinated by Tang Tuong, Senior Evaluation and Planning Officer. Office of Evaluation and Strategic Planning (OESP), United Nations, New York
- Janovsky, K. (Ed). *Health policy and systems development. An agenda for research*. WHO, 1996
- Last, J. *A Dictionary of Epidemiology*. Oxford University Press, 1988
- Mertens, T. and Kassler, W. Evaluation of STD/HIV/AIDS programmes. In *Sexually Transmitted Diseases*. Holmes et al. (Eds). McGraw Hill, 1997
- Norwegian Agency for Development Cooperation (NORAD). *The Logical Framework Approach*. Handbook for objective-oriented project planning
- Quinn Patton, M. *Utilization focused evaluation*. Sage, New Delhi, 1986
- Rossi, P.H. and Freeman, H.E. *Evaluation. A systematic approach*. Sage, London, 1993
- Taylor Fitz-Gibbon, C. and Lyons Morris, L. *How to design a program evaluation*. Sage, London, 1987
- United States Government. *Healthy People 2000. Midcourse review and 1995 revisions*. Department of Human Resources. 1995

- Valadez, J. and Bamberger, M. (Eds). World Bank. *Monitoring and evaluating social programmes in developing countries. A handbook for policy workers, managers and researchers.*
- Veney, J.E. and Kaluzny, A.D. *Evaluation and decision making for health services programs.* Prentice-Hall, New Jersey, 1984
- Walt, G. and Gilson, L. A framework for policy analysis. *Health Policy and Planning*, 9: 353-370, 1994
- WHO, *Health Programme Evaluation. Guiding Principles.* 1981
- WHO, *ARI Programme Management. A training course. Evaluation.* Programme for Control of Acute Respiratory Infections. 1990
- WHO, *Innovative Approaches in Service Evaluation: Consumer contribution to qualitative evaluation, soft indicators.* Division of Mental Health and Prevention of Substance Abuse. WHO/MNH/MND/93.19
- WHO, *Ninth General Programme of Work.* 1994
- WHO, *Evaluation of a National AIDS Programme: a methods package.* Global Programme on AIDS. 1994
- WHO, *Measuring the effort levels of family planning programmes.* Rapp. trimest. statist. sanit. mond., 47. 1994
- WHO, *Guidelines for the Elaboration of the Annual Plans of Action.* Document PPE/95.1. 1995
- WHO, *Targets for surveillance of vaccine preventable diseases.* Global Programme on Vaccines Strategic Plan 1996-1999.
- WHO, *Evaluation of the Strategic and Programmatic Orientations, 1995-1998.* Pan American Health Organization/WHO Executive Committee of the Directing Council and Working Party of the Regional Committee. 118th Meeting, Washington DC., June 1996
- WHO, *Useful questions for self-evaluation. Performance Appraisal in WHO - a briefing and reference guide for use during the pilot phase of the new performance appraisal system (PAS).* Division of Personnel (PER)
- WHO, *Guidelines for Conducting Monitoring and Self Assessment of Community-based Rehabilitation Programmes.* Division of Health Promotion, Education and Communication (HPR) and Unit of Rehabilitation (RHB), WHO
- Wholey, J.S., Hertzky, H.P. and Newcomer, K.E. *Handbook of practical programme evaluation.* Jossey-Bass, 1994

GLOSSARY

*Partly based on terminology approved by Management Development Committee (MDC)
pending final approval of the WHO glossary by the MDC.
Other references are in brackets.*

accurate

Exact, precise, correct. (OED)

activity

A task or a set of interrelated tasks aimed at generating a product. (MDC)

activity component

Any element of an activity that may be individually identified and budgeted for (e.g. short-term consultant, fellowship, etc.). (MDC)

adequacy

Quality of an action which is commensurate with the issue it addresses. (MDC)

Note: "Adequacy implies that sufficient attention has been paid to the formulation of the programme -- the setting of objectives, targets and indicators, methods used, etc. -- in relation to the requirements." (PPE)

appraisal report

Document reviewing the performance of staff over a period of time. (WHO, TER)

assessment

An estimation of the value, magnitude or significance of a situation, a programme or an activity, or of certain aspects of these. (MDC)

classified list of programmes

The structure of programme areas and major programmes used for preparing the strategic programme budget. (MDC)

cost-benefit

The relationship between the amount of financial resources (expressed in monetary terms) devoted to a programme or activity and the advantages derived from it. (WHO, TER)

The relationship between the cost of an activity and the benefits that accrue from it, expressed in monetary terms. (PPE)

cost-effectiveness

The relationship between the amount of financial resources (expressed in monetary terms) devoted to a programme or activity and the effect of that programme or activity on a target situation. (WHO, TER)

cost-efficiency

The relationship between the amount of financial resources (expressed in monetary terms) devoted to a programme or activity and the results obtained from that programme or activity. (WHO, TER)

cost-utility

The relationship between the amount of financial resources (expressed in monetary terms) devoted to a programme or activity and the advantages derived from it by a social group. (WHO, TER)

Cost-utility is a form of economic evaluation in which the costs are expressed in monetary terms but some of the consequences are expressed in units of utility, e.g. quality-adjusted life-years, or healthy days of life. (DPE)

coverage

A measure of the extent to which the services rendered cover the potential need for these services in a community. (Last, 1995)

criterion

A standard by which something is judged. (MDC)

deduction

Reasoned argument proceeding from the general to the particular. (Last, 1995)

effective

Showing results in accordance with the objectives and targets for reducing the dimensions of a problem or improving an unsatisfactory situation. (MDC)

effectiveness

An expression of the desired effect of a programme, service, institution or activity in reducing a health problem or improving an unsatisfactory health situation. (MDC)

An expression of the success of a programme, service, institution or activity in pursuing its goals, attaining its objectives, or meeting its targets, producing its results. (WHO, TER)

efficacy

The benefit or utility to the individual of the services, treatment regimen, drug, preventive or control measure advocated or applied. (MDC)

efficiency

An expression of the relationship between the results obtained from a health programme or activity and the efforts expended in terms of human, financial and other resources, health processes and technology, and time. (MDC)

An expression of the relationship between the results obtained from the tobacco control programme or activity and the efforts expended in terms of human, financial and other resources. (PPE)

efficient

Productive of results, with the efforts expended on a programme, activity, task, etc. being as good as possible in relation to the resources devoted to it. (MDC)

equity

The quality of being equal and fair. (OED)

evaluation

A systematic and critical analysis of the relevance, adequacy, progress, efficiency and effectiveness, impact and acceptance of a programme or activity.

Note: It may focus on particular phases of programme development and management, such as programme design (formative evaluation), programme implementation (monitoring) or programme results (outcome evaluation). (MDC)

formative evaluation

Type of evaluation focusing on the design phase of a programme. (after Scriven, 1967)

function

The role assigned to a person or to an organizational entity for implementing a policy or a strategy, for reaching an objective or target, and/or for performing an activity. (MDC)

General Programme of Work

The outline of the global health policy and programme framework used to orient countries' and WHO's work over a specific period of time in pursuit of their common goal. (MDC)

goal

A general objective towards which to strive. (MDC)

health

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (WHO Constitution)

human resource

Reserve of human potential that is available to implement something. (MDC)

impact

The total, direct and indirect, effects of a programme, service or institution on a health status and overall health and socio-economic development. (MDC)

The overall effect of a programme, service or institution on the health and related socioeconomic development of the population concerned. (DPE)

impact indicator

Variable for estimating the change in health or socioeconomic situation brought about by the programme or project activities. (MDC)

implementation

The act of actually undertaking an intended and planned course of action. (MDC)

indicator

A variable with characteristics of quality, quantity and time used to measure, directly or indirectly, changes in a situation and to appreciate the progress made in addressing it.

input

The resources that are actually used in an activity or project in order to generate a product. (MDC)

management

The sum of all measures taken to plan, organize operate, and evaluate all the many interrelated elements of the system. (MDC)

management information system

A system of databases designed to process and exchange information to support decision-making as well as implementation, monitoring and evaluation of programmes, activities and projects. (MDC)

A system of computerized databases designed to process and exchange information to support decision-making. (MDC)

managerial process

The principles, rules and mechanisms that govern the implementation of programmes. (MDC2). As a sequence of interlinked activities, it includes policy formulation, programme formulation, programme budgeting, programme delivery, evaluation, and reprogramming as necessary, with information support throughout. (MDC, PPE)

mandate

Obligations and Authority to act given to the Organization.

material resource

Supplies and equipment available for use in a particular programme, activity or project. (MDC)

milestone

Recognizable achievement toward the accomplishment of an activity. (MDC)

monitoring

The continuous follow-up on health situations and assessment of programme activities to ensure that they are proceeding according to plan.

Ninth General Programme of Work

The third general programme of work since the adoption of the resolution on health for all. It covers the period 1996-2001. (MDC)

normative function

Directing and coordinating international health work. (GPC, 1996)

objective

The end result a programme, a project or an institution seeks to achieve. (MDC)

outcome

The result of a process, such as a policy, programme or activity, which is expected to have an effect on a given situation. (MDC)

outcome evaluation

Type of evaluation focusing on the results of a programme. (after Scriven, 1967)

performance

Measure of the efficiency with which a task has been carried out. (MDC)

planning element *Acronym PE*

Any element of a plan of action in the production of one or several correlated products under a given programme. The types of planning elements are: programme component, product, activity, task. (WHO, TER)

plan of action

An updatable scheme defining activities for generating a product under a specific programme or a programme component by identifying 'who' does 'what', 'when', 'how' and for 'how much'. (MDC)

policy

A set of statements and decisions defining priorities and main directions for attaining a goal. (MDC)

policy analysis

The critical examination of policies themselves, the selected methods of implementation, and policy goals. (DPE, see Annex 4)

policy framework

A structured set of interrelated notions and principles related to policy and providing a suitable environment for programme development. (MDC)

policy planning

The selection of elements of reality and their combination in a consensual description of a situation, the analysis of the goal to be attained in order to bring about some change to the situation, and the outline the orientations that should permit it. (MDC)

product

The identifiable output that a combination of activities is expected to generate. (MDC)

programme

An organized aggregate of technically related activities directed towards the attainment of defined objectives. (MDC)

programme area

A sector of the Organization's work corresponding generally to a policy orientation. It is made up of one or several major programmes. (MDC)

programme component

Part of a specific programme for which a plan of action may be prepared. (MDC)

progress

Stage reached towards the achievement of a product, an objective or goal. (MDC)

Note: "Progress is concerned with the comparison of actual with scheduled activities, the identification of reasons for achievements or shortcomings, and the indication of remedies for any shortcomings." (PPE)

project

A set of activities structured to generate products of particular significance to one or several programmes over a specific period of time, using various resources. (MDC)

relevance

Pertinency to the matter in hand. (OED). Note: relevance relates to the rationale for adopting particular health policies and supporting programmes in terms of their response to essential human needs, and to social economic policies. (DPE)

reliability

Quality of an indicator that consistently returns the same measure of a condition regardless of who is measuring it. (MDC)

repeatable

Capable of being repeated using the same method, although the situation may be different. (WHO, TER)

sensitive

Indicating readily slight change of condition, easily moved or affected by the external forces it is designed to detect or record. (MDC)

sensitivity

Quality of an indicator that readily reflects changes to the condition it measures. (MDC)

The promptness of a programme or an analysis to have different outcomes as one or more input parameters vary. (TER)

Annex 8 (Cont.)

specific

Specially or peculiarly pertaining to a certain thing or class and constituting one of the characteristic features of this thing of class. (MDC)

specificity

Quality of an indicator that only reflects changes to the condition concerned. (MDC)

Quality of a programme to address the issue it purports to address, to the exclusion of others. (TER)

specific programme

A scheme and conceptual framework designed to yield one or several products under a major programme through a number of technically related activities. (MDC)

strategic programme budget

Prospective management tool allocating financial resources for a two-year period to programme areas and major programmes. (MDC)

strategy

The broad lines of action adopted to give effect to a policy. (MDC)

Strategy of Health for All by the year 2000

The guidelines for health action up to the turn of the century adopted in 1981 by the Member States of WHO. (MDC)

sustainable

Capable of being borne or endured. (OED)

target

A quantified specific objective to be reached within a given time frame. (MDC)

technical cooperation function

Helping countries define and achieve their health goals. (GPC, 1996)

valid

Well-founded and fully applicable to the particular matter or circumstances; sound and to the point; against which no objection can fairly be brought. (MDC)

validity of a measurement

An expression of the degree to which a measurement measures what it purports to measure. (Last, 1995)