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منظمة الصحة العالمية

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REVIEW OF THE REPORTS ON MONITORING PROGRESS IN IMPLEMENTATION OF THE STRATEGIES AND PLANS OF ACTION FOR HEALTH FOR ALL BY THE YEAR 2000

NOTE

The part on individual indicators (pages 9 - 18) and the tables in Annex II are being updated. The revised analysis will be distributed at the time of the Regional Committee as Annex IV to this document.

September 1983

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INTRODUCTION

The Plan of Action for Implementing the Global Strategy for Health for All envisages a continuing process of monitoring and evaluation. Member States were required to prepare their first progress report and submit it to the Organization by March 1983. In this first progress report Member States were to concentrate on the monitoring of the relevance of their health policies to the attainment of the goal of HFA, and on the progress made in implementing these. In addition, information was to be collected on at least the twelve global indicators agreed upon by the WHA.

For this purpose a Common Framework and Format was prepared (document DGO/82.1) and sent to the countries. It consists of two parts. The first part is a series of thirteen questions: 1-4 relate to relevance while questions 5-13 relate to progress. The second part is the set of twelve global indicators referred to above.

Two countries in the Region have not yet submitted any report (Qatar and United Arab Emirates). One additional country (Lebanon) reported that no progress had been made because of prevailing conditions. In ten of the countries there is a WHO Representative and Programme Coordinator; of these, two are nationals. Upon request, consultants were sent to four other countries (Iran, Israel, Jordan and Tunisia) to cooperate in preparing their progress reports.

A. THE QUESTIONS

Question 1

The regional health policies, strategies, plans of action and programme directions are based on the constitutional role of WHO as the international directing and coordinating body for all matters related to health. To this end all regional programmes and activities are directed towards the attainment and enjoyment of the highest standard of health by every human being without distinction of race, religion, political belief, economic or social condition. These policies, strategies and plans of action were formulated following the

adoption by the Member States of WHO in 1977 of the Goal of Health for All by the Year 2000, the principles of the Alma Ata Declaration of 1978, and the World Health Assembly's Resolution adopting the Strategy of HFA/2000 in 1979. The strategy was reviewed in October 1979 at the Twenty-ninth session of the Regional Committee of the Eastern Mediterranean Region (Sub-Committee A) which adopted Resolution EM/RC29A/R.7 urging Member States to formulate national policies, strategies and plans of action for HFA/2000, and to collaborate with the Regional Office in formulating a regional strategy. Based on the Constitution and WHA resolutions, a regional strategy for HFA/2000 was prepared in EMR in August 1980. The regional strategy for EMR is largely based on the conclusions of three sub-regional meetings held during 1980 when individual country strategy statements were received and reviewed and subsequently formed the basis of the Regional Strategy.

The broad objectives, targets and approaches for this strategy are essentially founded on a health system based on primary health care, with the eight main components of PHC predominantly stressed. Support measures for the Strategy in the political, economic, social, technical, managerial, health information, research, and public information fields are detailed in the text and ways and means of enhancing them are identified as part of the regional strategy.

Question 2

Special attention has been devoted to the functions and structures of the Regional Office since the launching of the strategy of HFA/2000, with a view to enabling it to provide the necessary support to Member States of the Region. Structural change was made in order to strengthen planning and coordination for the purpose of supporting Member States in their efforts to achieve better planning, organization, implementation, management and direction of their national strategies of HFA/2000. In relation to this development, the Health Statistics and Epidemiological Surveillance units were merged into one unit, namely, Health Situation and Trend Assessment (HST), in line with the new classification of programmes in the Seventh General Programme of Work.

Another important development relevant to the Strategy has been the creation of a Regional Working Group on PHC to advise the Regional Director on the

Regional Office's role and supportive activities for the promotion, implementation, management and evaluation of PHC at all levels.

The Regional Programme Committee at its regular meetings has given increasing emphasis to matters related to national programmes supported by WHO, so that such programmes might be directed in line with the strategy of HFA/2000 and with the primary health care system's eight essential elements.

At country level the WHO Programme Coordinator has been entrusted with greater authority to enable him to play an effective coordinating and executive role on behalf of the Regional Director. To reflect this new role, the title of the position has been changed to WHO Representative and Programme Coordinator (WR & PC). The WR & PC will be expected to act on behalf both of WHO and of the Member State of his assignment as the principal Technical Adviser and coordinator in international health. Briefing about this increasingly important role of WR&PCs was discussed in great detail during the WR&PC meeting held in the Regional Office in June 1983.

Question 3

The progress made by countries of the Region in carrying out their strategies of Health for All has varied from one country to another. In response to question 5 of the Common Framework and Format most countries (15) reported good progress, two countries reported some progress and three countries indicated that progress could not presently be assessed. Only three countries have not so far reported on the progress achieved. It is clear that political commitment is very high in most countries insofar as 13 countries have a clause in their constitutions ensuring the right of every citizen to health. Other countries have political commitments through parliamentary acts, party manifestos or statements by the Head of State. Most countries have founded their strategy and plan of action on a health system based on PHC and its components. Equitable distribution of services and resources has not yet been achieved in all countries. Ten countries claim to have achieved reasonably good distribution, nine countries indicate fair distribution while one country confesses that distribution is still poor. Community participation, in one form or another, in planning and implementation of the Strategy was reported to be good by fifteen countries, fair by three and poor by two. Such

participation took place either through mass organizations, party cadres and organizations, or through local councils. Fifteen countries of the Region have already initiated steps to reorient their training programmes towards PHC. Four countries are still in the process of doing so and have so far achieved fair progress, while one country has not yet taken any steps in this direction.

Most countries of the Region confirm that mobilization of financial and material resources for the Strategy was good or at least fair (18). Only one country stated that there had been no noticeable shift in resource allocation. Coordination within Ministries of Health and intersectoral coordination with other sectors in connection with the Strategy proceeded reasonably well in most countries. Only two countries indicated poor coordination within the Health Ministry and one country indicated poor intersectoral coordination. Most countries also confirmed that health components were included in all socio-economic development projects, particularly those related to agriculture and industry. TCDC and ECDC were quite well implemented amongst countries of the Region. Regional Arab funds have been commended for playing a leading role in this respect. Moreover, bilateral assistance between the more economically fortunate and the less fortunate countries of the Region has shown good progress and is considered to be an important element in the provision of resources for the implementation of the trategy.

Question 4

The Regional Committee for EMR has not met since 1979 and could not therefore undertake any activities in the matter. The Regional Office, through its different mechanisms and structures, has however carried out most of the activities relevant to the Strategy, including the seeking of Government commitment to the strategies, definition of the regional targets through the Regional Strategy and the regional Medium-Term Programme, review of the need for international resources, support from its own budget or through Health Resources Group (HRG) studies in selected Member States from other external sources.

A Regional Health Charter was drafted for adoption by the Regional Committee and its submission for adoption at a future session of the Committee is under consideration.

The Regional programme and budget proposals for 1984/85 were prepared in consultation with Member States which had been requested to prepare country statements indicating national development priorities and the main areas where WHO's support was needed. Moreover, the programme review missions, composed of WHO and national staff, will give further consideration to review of the 1984/1985 Programme Budget and to collaborative efforts between WHO and Member States in line with the Strategy of HFA/2000; it will also discuss preparations for the 1986/87 Programme Budget.

Monitoring progress reports on the implementation of the Strategy at the national level have so far been received from 20 countries out of the 23 in the Region.

Question 5

As the Regional Committee has not met since 1979, no additional activities have been undertaken.

Question 6

In accordance with the replies received from Member States to question 13 of the national Format, it seems that the support provided by the Regional Office to Member States in formulating, implementing, and monitoring the Strategies was satisfactory. Twelve Governments considered such support to have been good and two fair. Four countries, however, indicated that support had been poor or that they did not receive any support at all. This was no doubt caused, at least in part, by the prevailing political situation in the Region. Contacts with United Nations regional organizations on the Strategy were fairly good, particularly with UNICEF and IBRD, and regular meetings were held with the national and regional representatives of these agencies at country and regional levels; resource allocations are already forthcoming. Close cooperation and coordination was also maintained with Regional Arab funds for support to Member States in different parts of the Strategy. Support to countries in preparation of Country Resource Utilization (CRU) studies was undertaken for two countries by the Health Resources Group (HRG) composed of WHO and national staff,

Other countries were assisted in formulating requests for additional resources to organizations such as the World Bank and IDA. Technical support

through experts, fellowships and supplies continued in connection with programme delivery at the country level and in line with the policies laid down by the governing bodies of WHO.

Comments on the 13 questions of the Common Framework and Format for monitoring national strategies

During the analysis of the responses received from Member States it was noticed that the way the questions were answered by States varied considerably, as did the quality and validity of the replies received and the degree of detail. Such variations probably reflected personality differences between those to whom the task of reporting on progress was entrusted in each Member State. Though the explanatory notes on the right hand pages were meant to clarify all the questions, and to make responses from different countries as uniform as possible, many countries responded by a simple answer of "yes" or "no" to many of the questions. The design of some questions was suggestive and had led to such responses. On the other hand, those called upon to answer some of the questions clearly found themselves in a position that obliged them to frame their replies in such a way as to avoid taking personal responsibility and possibly inviting trouble. Questions relating to the policies of a Member State, the degree of attention paid to its population or the degree of participation of the people in running their own affairs, were answered in a way which would imply that the state was very benevolent and democratic. It would have been more informative if questions which invited a "yes" or "no" answer had been further expanded to justify both a "yes" or "no" answer as well as the reasons why one or the other answer had been chosen.

Questions on such matters as the political commitment to the Strategy, the equitable distribution of health services, and the reasonable mobilization of resources will always be answered in a manner to show that the Member States had, as a matter of pride and as an indication of general policy, done its best in the particular area. Member States might be asked to explain the degree and type of political commitment to the Strategy, the ways and means of community participation, and the degree and methods of mobilization of resources to the Strategy as part of the question itself and not as part of the explanatory notes.

It was also noticed that certain elements were repeated several times in many questions as well as in the indicators; those included community involvement, political declaration, training and reorientation of training of health workers. This has led to responses such as "as mentioned before", or "as answered in question so and so", or "please refer to question so and so". Such important issues could be covered in one complete and comprehensive question containing all the subjective information required, in addition to one indicator measuring all the quantifiable elements.

The answers to the questions, when analysed, could not be compared with any baseline data previously available from Member States. In this respect the answers received in the course of this first monitoring report could really be considered as the baseline, even in their present form, as they could not measure any progress from a bench mark set in the past. Progress in the different areas could, therefore, be measured during the coming monitoring exercise even though it may, in respect of some of the questions, be of a subjective nature during the first few monitoring reports.

B. THE INDICATORS

Twelve indicators were included in the Global Strategy for Health for All by a decision of the World Health Assembly. Since these indicators are to be presented at the regional and global levels in terms of the number of countries that have reached certain values for the indicators concerned, the indicators for use at the national level have been presented in a slightly re-worded form.

This section of the present paper analyses the replies in respect of the indicators, examines how the countries dealt with each indicator and contains a regional synthesis of the results. The frequency distribution of the indicator values with respect to quantifiable indicators is shown in the annexed table.

GENERAL REMARKS

The reports undoubtedly contain much important information which is not otherwise available in the Organization. Whatever shortcomings they may

contain, it is hoped that these will be dealt with in the forthcoming Inter-country Group Meeting on Indicators.

Some of the shortcomings can be summarized as follows:

1. For many indicators the proportion of non-response was rather high. In some instances, it was explicitly stated that the data for the components of the indicator were not available. In others, different numerators and/or denominators were used. In a third group, the replies were in the form of unquantifiable general statements such as "reasonably well", "within normal range", "adequate", "being improved", etc.

2. The Common Framework and Format stipulated that "if no data are available for some of the indicators, this should be so stated"; this was often done. Yet there were no replies at all in respect of many indicators or parts thereof. Though in most cases this could presumably imply that data were not available, it is believed they were simply overlooked, in some cases at least, since other parts of the format were carefully commented upon. Some components were not conspicuous in the running text of the explanatory notes.

3. The way in which the format is typed might account for part of the non-response. Indicator 7, for example, is just one sentence. The account on the elements to be considered for this indicator (as presented on the opposite page in the Format) was more detailed and mentioned five indicators. However, these amounted actually to 12-14 "sub-indicators". Consequently many were overlooked; in fact the later "sub-indicators" showed a greater rate of non-response than the earlier ones. If that is the case, and if we expect the countries to report on all these "sub-indicators", consideration might be given to the advisability of changing the Format, so that some of the "indicators" would appear as titles for groups under which each "sub-indicator" should appear as a separate indicator.

4. It seems that the Format for reporting was not as carefully read as it should have been by some of those who were to prepare the report. In one country, for example, replies to almost all the indicators were "yes" or "no" in front of the corresponding explanatory notes without any specific figures being given. Thus the reply was "No" for Indicator 3:"at least 5% of the GNP is spent on health", and so on.

5. The Format stipulates that "the latest available values of the indicators should be provided, together with the calendar year(s) to which each indicator value refers". Yet the reference year was frequently not specified.

6. The French and English systems for writing the decimal point, or for dividing long numbers with several digits, were occasionally inter-mixed, leading to confusion in interpreting the figures.

7. Occasionally the figures reported differed from those available from other published sources; the former were those used in this analysis, unless there were obvious typing mistakes or some misunderstanding could be presumed. Occasionally data from other published sources or from reports of special programmes were used to complement unreported items (or to replace those disqualified), as will be explained later; these were marked with an asterisk(*) in the summary sheets at the end of the paper.

8. In the analysis that follows, the weighted averages for the indicators were calculated, using the population size for the weights.

COMMENTS ON THE INDIVIDUAL INDICATORS

Indicator 1

Health for All has received endorsement as policy at the highest official level

In most countries the Constitution contains a statement on the right of citizens in respect of health. Other forms of endorsement that were mentioned included: the Head of the State (Oman), an Act (Israel), the Party (Afghanistan), and the Council of Ministers or the Ministry of Health (Bahrain, Djibouti, Iraq, Saudi Arabia).

As indicated in the Introduction, three countries (Lebanon, Qatar, United Arab Emirates) did not submit reports; this applies to all the indicators.

Indicator 2

Mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning.

Here, as with the previous indicator, most countries responded favourably. Local people's assemblies or councils, trade unions, professional and group organizations and voluntary organizations were the most commonly mentioned mechanisms for community participation, particularly at the local and operational levels. Decentralization of health services was prominent in some countries (Egypt, Pakistan and Saudi Arabia) and is being introduced in others (Kuwait). At the other end, community participation was described in a few countries (Bahrain, Jordan, Kuwait) as being under discussion or not yet developed.

See also the replies to Question 6.

Indicator 3

The percentage of the gross national product spent on health. (The set landmark is "at least 5%").

Eight countries were able to provide the indicator value, as defined (Afghanistan, Iran, Israel, Jordan, Kuwait, Pakistan, Syria and Tunisia). Three countries (Cyprus, Oman and Yemen) indicated that the numerator related to the Ministry of Health only.

Out of these eleven replies, only two (Iran and Israel) crossed the 5% mark; at the other end three (Cyprus, Oman and Pakistan) were less than 2%, and four (Jordan, Syria, Tunisia and Yemen) were 3-4%. The range was between "around one" (Pakistan) and 7.0% (Israel). The unweighted average was 3.5%, while the weighted average (using the population size for the weights) was 2.9%.

The replies of seven countries were disqualified. A different denominator (e.g., national budget, development budget, public or government expenditure) was used by five countries; one country gave data on expenditures but not enough to compose the indicator and the seventh country only said "No", i.e., not at least 5%. In addition, two countries clearly stated that data were not available.

In the light of the above, it is worth considering the proposal to use under this indicator more than one measure, according to both the numerator and denominator.

Indicator 4

The percentage of the national health expenditure devoted to local health care. (No pertinent indicator value was set, only that it should be "a reasonable percentage", and that the percentage considered "reasonable" would be arrived at through country studies).

Most countries were not able to provide the appropriate indicator value. This was mainly because the national accounting systems could not permit the explicit identification of the components of the indicator, particularly those related specifically to "local health care".

Only two countries (Bahrain and Israel) gave straightforward indicator values. Eight other countries added qualifying statements, such as: of the Ministry of Health budget, of government health expenditure, excluding development budget, excluding external aid, excluding health personnel budget, excluding urban hospital care, etc. Evidently, such reservations affect the indicator values to a varying extent. Accordingly, there was quite a wide range, between 3.5% (Somalia) and 72% (Yemen). Out of these ten replies, five (Afghanistan, Bahrain, Democratic Yemen, Jordan and Kuwait) were between 10% and 30%, four were higher (Djibouti, Iran, Israel and Yemen) and one lower (Somalia) than these two limits. The weighted average was 32%.

Ten replies were disqualified: six were vague or unrelated; three stated that data were unavailable, and no answer was given in one report.

It is clear that differences in inclusions and exclusions in the numerator and/or the denominator render the comparability of the reported indicator values rather difficult. As was mentioned above (Indicator 3), one might have to consider the use of several measures under this indicator, with countries reporting on the measures for which they had the appropriate data.

Indicator 5

Resources are equitably distributed.

This indicator was probably the one least understood, and that to which the responses were the least satisfactory.

A number of countries paid attention to the component resources (viz., per capita expenditure, staff and facilities), disregarding the crucial aspect, namely, the within-country variations. It is likely that the way the explanatory notes were presented contributed to such misunderstanding: the three types of resources were written, each in a numbered line, indented, with extra spaces in between, while reference to geographical areas or population groups was mentioned in the running text that followed.

A few countries could provide within-country distribution of resources, but only as absolute figures without the corresponding population data. More countries, however, simply gave descriptive statements, ranging between "fair" to "almost equally distributed"; one reply was simply "yes". One reply (Sudan) was frank enough to state that "there is maldistribution of resources".

See also the replies to Question 4.

Indicator 6

The Strategy for Health for All has been accompanied by explicit resource allocations and is receiving sustained resource support from more affluent countries.

Unlike other indicators, almost all countries replied to this indicator. Only one country left the space blank.

Generally speaking, there is good mobilization of resources, technical as well as financial. Resort to support from bilateral and international agencies was common. In five "affluent" countries no external resources were received (Iran, Israel, Kuwait, Libya and Saudi Arabia). In one other country (Syria) a complete national strategy has not yet been formulated.

See also the replies to Question 8.

Indicator 7

The proportion of the population for whom primary health care is available. (The global indicator explicitly mentioned "primary health care is available to the whole population").

Five components were identified, namely:

7(a) Safe drinking water in the home or within 15 minutes' walking distance

Fifteen countries were able to provide meaningful data, separately for urban/rural, and/or for the total population. Three countries gave descriptive replies, one mentioned non-availability of data, and one did not give any reply at all. Data from reports for the International Drinking Water Supply and Sanitation Decade were available for two additional countries, and are included in the analysis.

The disparity in the availability of safe drinking water is marked. It was as low as 12% in Afghanistan, up to "all the people" in three countries (Bahrain, Cyprus and Kuwait). The proportion was below 50% in six countries (Afghanistan, Democratic Yemen, Djibouti, Pakistan, Somalia and Yemen) and was 90% and over in six countries (Bahrain, Cyprus, Israel, Kuwait, Libya and Saudi Arabia). The unweighted overall average is 63%, while the weighted average is 52%.

7(b) Adequate facilities for hygienic waste disposal available in the home or immediate vicinity

Fourteen countries provided data. Other replies were disqualified for reasons similar to those mentioned for the preceding component (safe drinking water). However, data from other sources were available for three additional countries and are included in the analysis.

Here, also, the disparity is obvious, ranging between "minimal" (Afghanistan) and "almost all people". For four countries the proportions did not reach 20% (Afghanistan, Pakistan, Somalia and Yemen) while it exceeded 90% in five countries (Bahrain, Cyprus, Israel, Jordan and Kuwait). The unweighted overall average is 54%, while the weighted average is 41%.

7(c-1) Proportion of infants under one year fully immunized

This part of the report was attended to very unsatisfactorily. Rarely was the reply very specific, i.e., to the effect that the data referred to infants under one year fully immunized against the six diseases covered by EPI. Many simply mentioned "immunized", occasionally "adequately immunized". The commonest data presentation was in three figures for DPT, Polio, Measles, and BCG. More or less detail was occasionally the case; one country did not specify the vaccinations. Many mentioned the age of one year, but a few referred to "children under 5" or "at school entry".

Two countries gave absolute figures for vaccination and not percentages of those covered; one described certain vaccinations as "limited" or "not universal". Two countries gave data referring to the capital city only. One country did not reply at all; four did not give any figure; three gave descriptive terms such as "offered","widely available" or "progressively expanding"; one country simply said "yes".

Data from national EPI programmes could provide much of the missing information. It was noticed that, in many cases, data given in the progress report were far above those provided by the EPI programmes; however, the figures given in the official progress reports were the ones used in the analysis.

The summary of data is as follows:

DPT, Polio: Nine countries were below 30% (Afghanistan, Democratic Yemen, Iraq, Oman, Pakistan, Saudi Arabia, Somalia, Sudan and Syria), six exceeded 70% including two (Bahrain and Cyprus) over 90%, and two between the two extremes. The weighted average is 28%. Data were not available for six countries.

Measles Similarly, here, nine countries were below 30% (Afghanistan, Cyprus, Democratic Yemen, Iraq, Oman, Pakistan, Saudi Arabia, Sudan and Syria); two only exceeded 70% (Israel and Kuwait), and six between the two extremes. The weighted average is 29%. Data were not available for six countries.

BCG: Ten countries were below 30% (Afghanistan, Bahrain, Cyprus, Democratic Yemen, Iran, Jordan, Kuwait, Pakistan, Somalia and Sudan); two exceeded 70%

(Egypt and Israel), and four were between the two extremes. The weighted average was 25%. Notably, some countries mentioned that they were not pushing BCG vaccination as tuberculosis was no longer a serious problem. Data were not available for seven countries.

7(c-2) Proportion of pregnant women immunized against tetanus (2 doses)

Rarely were figures given; in fact the majority did not mention anything at all about this item. Data from EPI programmes seemed sketchy. In fact, coverage was 27-31% for three countries only (Bahrain, Kuwait and Oman); while all the remaining twelve reporting countries were 10% or less (of which nine had a coverage of 5% or less). The weighted average is 4%. Data were not available for eight countries.

In general, for the aspect of immunization coverage under Indicator 7, the proposal to refer specifically in the explanatory notes to the EPI national programmes as a source for these data might be considered.

7(d) Proportion of the population to which local health care is available within one hour's walk or travel

Five countries gave descriptive statements without the required percentages; two did not reply to this item at all; one country replied "yes" and another mentioned "low coverage".

Out of the remaining eleven countries, six mentioned that PHC was available for almost all of all the population (Bahrain, Cyprus, Egypt, Israel, Kuwait and Libya). At the other end, the figure was under 20% for three countries (Democratic Yemen, Somalia and Yemen). The weighted average is 71%.

7(e-1) Proportion of women who were attended during pregnancy and at childbirth by trained personnel

More than half of the countries did not provide any reply or figure. For the ten reporting countries, the proportion ranged between 2-5% (Somalia and Iran) and almost all pregnancies (Cyprus, Israel and Kuwait). The weighted average for the ten countries is about 31%.

7(e-2) Proportion of children cared for up to at least one year of age by trained personnel

This element has been reported upon by a smaller number of countries than those replying on the preceding element of maternal care. (For a possible explanation, see General Remarks 2 and 3).

Only seven countries provided figures. These ranged between 1-8% (Somalia and Iran) and more than 90% (Bahrain, Israel and Libya), with an overall weighted average around 23%.

Indicator 8

The nutritional status of children is adequate.

Two measures belong here:

8(a) Proportion of newborn infants having a birth weight of at least 2.500g. (The set landmark is "at least 90%").

Six countries mentioned explicitly that data were not available; two gave general statements viz., "adequate" or "within normal range", and two did not reply to this indicator.

Only ten countries provided data, and these were based on special studies. Of these, six were in the "safe zone", having crossed the 90% mark (Bahrain, Iran, Israel, Kuwait, Syria and Tunisia), while three were in the range 80-90% (Afghanistan, Egypt and Oman). The proportion ranged between 50% (Somalia) and 96.5% (Tunisia), with an overall weighted average around 22%. How far the studies quoted are based on representative samples is another problem.

8(b) The proportion of children under 5 years of age having a weight for age that corresponds to the reference values. (Here, again, the set landmark is "at least 90%").

This measure was the least reported upon. The majority of countries mentioned the non-availability of data; others did not reply at all. Thus only three countries gave figures: between 40% (Somalia) and 92% (Syria), with Libya in between.

It is clear that the Organization needs to make greater efforts in the collaborative programmes with the countries with a view to introducing mechanisms

to obtain data on birthweight and on the weight of children under 5 years, either as part of the MCH service, or through ad hoc studies.

Indicator 9

The infant mortality rate for all identifiable groups. (The stated landmark is "below 50 per 1000 livebirths").

As this is one of the classic basic indicators, only one country (Oman) mentioned non-availability of data; another (Iraq) simply answered "yes".

Data from other published sources were sometimes greatly different from those reported (e.g. 21.5 against 57, or 109 against 152, or being "yes" (i.e., below 50 against 92). However, it must be reiterated that the figures in the officially submitted reports were the ones used in the analysis. In the light of apparent under-registration, some published data are based on demographic estimates, others are based on reported deaths, while for some other countries the reported data seem to represent opinion estimates.

As was to be expected, rates varied widely from 12.8 (Israel) to 182 (Afghanistan). Only five countries fell below the 50 per 1000 mark (Israel, Cyprus, Bahrain, Kuwait and Libya) while, at the other end, eight countries had infant mortality rates above 100, with an overall weighted average of 100 per 1000, a really high figure.

Though the countries were required to report "the rate observed among various population groups", thirteen countries reported the national figure only; two gave figures by geographical region, two by urban/rural, one by sex and one by nationals/expatriates.

Indicator 10

Life expectancy at birth. (Set landmark is "over 60 years").

Reported data covered seventeen countries, some separately by sex, while others were only for the total population.

Life expectancy was in the seventies in two countries (Israel and Cyprus), and crossed the 60 years mark in four other countries (Bahrain, Jordan, Kuwait and Syria). It was still below 50 years in five countries (Afghanistan,

Democratic Yemen, Somalia, Sudan and Yemen). In two countries (Afghanistan and Pakistan), life expectancy among males was somewhat higher than among females. The overall unweighted average is 54 years.

Indicator 11

The adult literacy rate for both women and men. (Set landmark is "exceeds 70%").

One country specified that the data was for "above 6 years", the second for "15 years and over", the third for "adults", while other countries did not specify any age limit. Four countries gave data by sex. Four countries did not provide figures.

Here also the range was very wide, from 12% (Afghanistan and Yemen) to "nearly all adult population" (Cyprus). Only three countries crossed the 70% mark (Bahrain, Cyprus and Israel). Out of the other 13 countries, the proportion was below 40% in seven countries (Afghanistan, Djibouti, Iran, Pakistan, Saudi Arabia, Sudan and Yemen). The overall weighted average is 33%.

Indicator 12

The gross national product per head. (Set landmark: "exceeds US $ 500").

Data from the progress reports, complemented by data from other published sources, were available for 19 countries. This is the only indicator where the picture for the Region is rather bright: twelve out of the 19 countries have GNP per head exceeding $ 500, and the range was really wide, from as low as $ 200 (Afghanistan) to as high as $ 17 200 (Saudi Arabia). In fact it was $ 1000 and over for eleven out of the 12 countries (Bahrain, Cyprus, Iran, Iraq, Israel, Jordan, Kuwait, Oman, Saudi Arabia, Syria and Tunisia). The weighted average is around $ 1 380.

Table 1

Political Commitment

Constitution	Party	Yes(but not defined)	Act	Head of State	Not reported
13	1	4	1	1	3
1. Cyprus	1. Afghanistan	1. Bahrain	1. Israel	1. Oman	1. Lebanon
2. Dem. Yemen		2. Djibouti			2. Qatar
3. Egypt		3. Iraq			3. United Arab Emirates
4. Iran		4. Saudi Arabia			
5. Jordan					
6. Kuwait					
7. Libya					
8. Pakistan					
9. Somalia					
10. Sudan					
11. Syria					
12. Tunisia					
13. Yemen					

Table 2

Strategy Plan of Action
formulated with PHC as Key

Yes	No	Not Very Strong	Not Prepared
17	2	2	2
of which 3 countries have first contact as physician			
1. Bahrain			
2. Egypt			
3. Israel			
1. Bahrain	1. Lebanon	1. Afghanistan	1. Qatar
2. Cyprus	2. Israel (but Health Policy with HFA/2000)	2. Syria	2. United Arab Emirates
3. Democratic Yemen			
4. Djibouti			
5. Egypt			
6. Iran			
7. Iraq			
8. Jordan			
9. Kuwait			
10. Libya			
11. Oman			
12. Pakistan			
13. Saudi Arabia			
14. Somalia			
15. Sudan			
16. Tunisia			
17. Yemen			

Table 3

National Strategy Part of National Socio-Economic Plan

Yes	No	Not Reported
19	1	3
1. Afghanistan	1. Djibouti	1. Lebanon
2. Bahrain		2. Qatar
3. Cyprus		3. United Arab Emirates
4. Democratic Yemen		
5. Egypt		
6. Iran		
7. Iraq		
8. Israel		
9. Jordan		
10. Kuwait		
11. Libya		
12. Oman		
13. Pakistan		
14. Saudi Arabia		
15. Somalia		
16. Sudan		
17. Syria		
18. Tunisia		
19. Yemen		

Table 4

Equitable Distribution of Services and Resources

Good	Fair	Inadequate	Not reported
10	9	1	3
1. Bahrain	1. Afghanistan	1. Sudan	1. Lebanon
2. Cyprus	2. Democratic Yemen		2. Qatar
3. Djibouti	3. Iran		3. United Arab Emirates
4. Egypt	4. Iraq		
5. Israel	5. Jordan		
6. Kuwait	6. Oman		
7. Libya	7. Pakistan		
8. Saudi Arabia	8. Somalia		
9. Syria	9. Yemen		
10. Tunisia			

Table 5

Progress achieved in Implementing Strategy and Plan of Action

Good	Slight	Cannot be Assessed now	Not reported
15	2	3	3
1. Bahrain	1. Djibouti	1. Afghanistan	1. Lebanon
2. Cyprus	2. Syria	2. Iran	2. Qatar
3. Democratic Yemen		3. Iraq	3. United Arab Emirates
4. Egypt			
5. Israel			
6. Jordan			
7. Kuwait			
8. Libya			
9. Oman			
10. Pakistan			
11. Saudi Arabia			
12. Somalia			
13. Sudan			
14. Tunisia			
15. Yemen			

Table 6

Community Participation in Planning and Implementation of Strategy

Good	Fair	Poor	Not reported
15	3	2	3
1. Afghanistan	1. Jordan	1. Bahrain	1. Lebanon
2. Cyprus	2. Kuwait	2. Oman	2. Qatar
3. Democratic Yemen	3. Saudi Arabia		3. United Arab Emirates
4. Djibouti			
5. Egypt			
6. Iran			
7. Iraq			
8. Israel			
9. Libya			
10. Pakistan			
11. Somalia			
12. Sudan			
13. Syria			
14. Tunisia			
15. Yemen			

Specified through

Party	Mass Organizations	Local Councils
3	2	4

Table 7

Reorientation of Training towards PHC

Good	Fair	No	Not reported
15	4	1	3
1. Afghanistan	1. Bahrain	1. Oman	1. Lebanon
2. Cyprus	2. Egypt		2. Qatar
3. Democratic Yemen	3. Kuwait		3. United Arab Emirates
4. Djibouti	4. Libya		
5. Iran			
6. Iraq			
7. Israel			
8. Jordan			
9. Pakistan			
10. Saudi Arabia			
11. Somalia			
12. Sudan			
13. Syria			
14. Tunisia			
15. Yemen			

Table 8

Mobilization of Financial and Material Resources

Good	Fair	No Shift	Not Reported
16	2	1	4
1. Bahrain	1. Afghanistan	1. Jordan	1. Lebanon
2. Cyprus	2. Somalia		2. Libya
3. Democratic Yemen			3. Qatar
4. Djibouti			4. United Arab Emirates
5. Egypt			
6. Iran			
7. Iraq			
8. Israel			
9. Kuwait			
10. Oman			
11. Pakistan			
12. Saudi Arabia			
13. Sudan			
14. Syria			
15. Tunisia			
16. Yemen			

Table 9

Coordination within Ministry of Health

Good	Fair	Weak	Not Reported
17	1	2	3
1. Bahrain	1. Afghanistan	1. Djibouti	1. Lebanon
2. Cyprus		2. Oman	2. Qatar
3. Democratic Yemen			3. United Arab Emirates
4. Egypt			
5. Iran			
6. Iraq			
7. Israel			
8. Jordan			
9. Kuwait			
10. Libya			
11. Pakistan			
12. Saudi Arabia			
13. Somalia			
14. Sudan			
15. Syria			
16. Tunisia			
17. Yemen			

Table 10

Intersectoral Coordination

Good	Fair	Poor	Not Reported
17	2	1	3
1. Bahrain	1. Afghanistan	1. Djibouti	1. Lebanon
2. Democratic Yemen	2. Cyprus		2. Qatar
3. Egypt			3. United Arab Emirates
4. Iran			
5. Iraq			
6. Israel			
7. Jordan			
8. Kuwait			
9. Libya			
10. Oman			
11. Pakistan			
12. Saudi Arabia			
13. Somalia			
14. Sudan			
15. Syria			
16. Tunisia			
17. Yemen			

Table 11

Incorporation of Health Component in Development Projects

Yes	Not very Strong	Not Reported
16	1	5
1. Afghanistan	1. Iran	1. Bahrain
2. Democratic Yemen		2. Iraq
3. Djibouti		3. Lebanon
4. Egypt	Not applicable	4. Qatar
5. Israel	1	5. United Arab Emirates
6. Jordan	1. Cyprus	
7. Kuwait		
8. Libya		
9. Oman		
10. Pakistan		
11. Saudi Arabia		
12. Somalia		
13. Sudan		
14. Syria		
15. Tunisia		
16. Yemen		

Table 12

TCDC & ECDC

Good	Fair	No	Not Reported
15	2	3	3
1. Afghanistan	1. Jordan	1. Iran	1. Lebanon
2. Bahrain	2. Syria	2. Israel	2. Qatar
3. Cyprus		3. Libya	3. United Arab Emirates
4. Democratic Yemen			
5. Djibouti			
6. Iraq			
7. Egypt			
8. Kuwait			
9. Oman			
10. Pakistan			
11. Saudi Arabia			
12. Somalia			
13. Sudan			
14. Tunisia			
15. Yemen			

(of 15 yes: Gulf Council 5
Arab Funds 4
European Countries 2
Not defined 4

Table 13

WHO Support Provided

Good	Fair	Poor or No Support	Not Reported
12	2	4	5
1. Afghanistan	1. Cyprus	1. Iran	1. Lebanon
2. Bahrain	2. Jordan	2. Israel	2. Libya
3. Democratic Yemen		3. Tunisia	3. Qatar
4. Djibouti		4. Kuwait	4. Saudi Arabia
5. Egypt			5. United Arab Emirates
6. Iraq			
7. Oman			
8. Pakistan			
9. Somalia			
10. Sudan			
11. Syria			
12. Yemen			

ANNEX I

COUNTRY SHEETS

Afghanistan Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 31 January 1983

1. Political commitment: In fundamental principles and by party.
2. Formulation of strategy and/or plan of action: February 1980.
3. National strategy forms integral part of national socio-economic development plan: Yes.
4. Review of health systems to reflect characteristics of PHC: Yes.
5. Progress achieved in implementing the strategy and plan of action: By end of current 5 year development plan progress will be measured.
6. Community involvement: Yes: Mass organization, women's associations, trade unions.
7. Reorientation of training of health workers: Faculties of medicine and institutes of health cadres' training supervised by Ministry of Health for better HSMD.
8. Mobilization of material and financial resources: To a reasonable extent.
9. Coordination within Ministry of Health: Yes, establishment of consultative committee in Ministry of Public Health.
10. Intersectoral coordination: Yes, for Water Decade, in drugs policy, in child health, in formulation of public health laws, in curricula development.
11. Incorporating health component in development projects: Yes and under further consideration.
12. TCDC and ECDC: Not systematic.
13. WHO support: Yes through WHO staff.

Bahrain Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 29 December 1982

1. Political commitment: Yes, ministerial.
2. Formulation of strategy and/or plan of action: Yes, February 1980.
3. National strategy forms integral part of national socio-economic development plan: Yes.
4. Review of health systems to reflect characteristics of PHC: Yes.
5. Progress achieved in implementing the strategy and plan of action: Good progress achieved in establishing network of health centres with 80% families registered; good progress in training programmes.
6. Community involvement: Not yet.
7. Reorientation of training of health workers: Very good progress has been achieved through College of Health Sciences.
8. Mobilization of material and financial resources: A good deal of mobilization of resources to PHC.
9. Coordination within Ministry of Health: Good.
10. Intersectoral coordination: Yes, Committee for Control of Environmental Pollution, Health Education Committee.
11. Incorporating health component in development projects: No answer.
12. TCDC & ECDC: Yes, with Gulf Arab States, in committees for PHC and drug control.
13. WHO support: Yes.

Cyprus Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 26 January 1983

1. Political commitment: Yes, in the Constitution.
2. Formulation of strategy and/or plan of action: Yes, 23rd July 1980.
3. National strategy forms integral part of national socio-economic development plan: Yes.
4. Review of health systems to reflect characteristics of PHC: Yes, reviewed and adjusted.
5. Progress achieved in implementing the strategy and plan of action: Yes. especially in provision of good sanitation, provision of medical care, strengthening of rural health centres and community health clinics; 65-75% of population eligible for free medical care.
6. Community involvement: Strong in planning and implementation of strategies e.g. Cyprus Medical Association, trade unions, pharmaceutical associations, and consumers' association.
7. Reorientation of training of health workers: Yes.
8. Mobilization of material and financial resources: To a great extent with assistance from UNHCR, WHO.
9. Coordination within Ministry of Health: Very satisfactory.
10. Intersectoral coordination: Yes, but some difficulties with other ministries associated with provision of health.
11. Incorporating health component in development projects: The question is not applicable to a great extent because no major agricultural or industrial projects in the country.
12. TCDC & ECDC: TCDC yes in form of experts.
13. WHO support: Not specific though some WHO programme activities are carried out.

Democratic Yemen Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 7 March 1983

1. Political commitment: Very high, Constitution; Party resolutions of 1980 and Ministerial Orders of 1979/1980.
2. Formulation of strategy and/or plan of action: 1981/1982.
3. National strategy forms integral part of national socio-economic development plan: Yes. Ministry of Planning works in close collaboration with the Ministry of Public Health.
4. Review of health systems to reflect characteristics of PHC: Yes. PHC first level comprises health guides, TBAs and health units, with good referral system.
5. Progress achieved in implementing the strategy and plan of action: Administrative structure of the Ministry at central and governmental level to be organized to meet PHC requirements. PHC programme being launched.
6. Community involvement: Very strong through mass organizations, women's federation and local people's assemblies.
7. Reorientation of training of health workers: Curricula revised and training of health workers started in all branches of IHMD.
8. Mobilization of material and financial resources: Additional resources required from IBRD/IDA and other agencies.
9. Coordination within Ministry of Health: Very strong and being improved.
10. Intersectoral coordination: Very well developed through People's Council and Executive Office.
11. Incorporating health component in development projects: The health development projects included in big agricultural and industrial projects.
12. TCDC & ECDC: TCDC with socialist countries and Arab countries.
13. WHO support: strong.

Djibouti Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 8 February 1983

1. Political commitment: Not definite; economic and social act.
2. Formulation of strategy and/or plan of action: No.
3. National strategy forms integral part of national socio-economic development plan: Yes, health plan part of national socio-economic development plan.
4. Review of health systems to reflect characteristics of PHC: Yes, plan of operation for PHC being drawn.
5. Progress achieved in implementing the strategy and plan of action: Law for the reorganization of health services being forwarded to the National Assembly.
6. Community involvement: Yes, Red Crescent and other organizations.
7. Reorientation of training of health workers: Yes, retraining of health personnel organized for TBAs.
8. Mobilization of material and financial resources: Good.
9. Coordination within Ministry of Health: Needs improvement.
10. Intersectoral coordination: Committee on hygiene, cleanliness. Establish coordination between Ministries of Defence, Interior and the private sector.
11. Incorporating health component in development projects: Yes, water, agricultural, and sanitation projects planned with health components.
12. TCDC & ECDC: With Arab countries.
13. WHO support: Good.

Egypt Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 3 February 1983

1. Political commitment: Yes.
2. Formulation of strategy and/or plan of action: Yes, formulated and constitute part of 5-year plan, December 1979.
3. National strategy forms integral part of national socio-economic development plan: Yes, part of national health plan.
4. Review of health systems to reflect characteristics of PHC: Yes, and plan adjusted accordingly to include urban population forming 49.2% of the total population.
5. Progress achieved in implementing the strategy and plan of action: Much progress achieved in implementation especially in the control of communicable diseases, diarrhoeal diseases and family planning.
6. Community involvement: Strong through health councils; part of local councils and provincial associations.
7. Reorientation of training of health workers: National planning adjusted and reoriented to PHC. Suez Canal School of Medicine is community-oriented.
8. Mobilization of material and financial resources: Grants in aids are used to strengthen health services.
9. Coordination within Ministry of Health: Progress achieved in coordination within Ministry of Health at all levels.
10. Intersectoral coordination: Association of local government and executive councils promotes intersectoral coordination.
11. Incorporating health component in development projects:
    Health projects considered part of all development projects.

12. TCDC & ECDC: Egypt has been involved in TCDC particularly in research and control of communicable diseases with other countries.

13. WHO support: Yes.

Iran Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 13 March 1983

1. Political commitment: Yes, constitution.
2. Formulation of strategy and/or plan of action: Up to the year 2000/2002.
3. National strategy forms integral part of national socio-economic development plan: Yes, national support considered based on 5-year health development plan. 1983/87 is the latest one.
4. Review of health systems to reflect characteristics of PHC: All health systems have been reoriented towards PHC.
5. Progress achieved in implementing the strategy and plan of action: Progress and implementation cannot be assessed at this stage.
6. Community involvement: At peripheral, district and provincial levels especially in environmental health projects.
7. Reorientation of training of health workers: Various programmes reoriented towards PHC at all levels.
8. Mobilization of material and financial resources: Efforts made to increase allocation for PHC.
9. Coordination within Ministry of Health: Improved.
10. Intersectoral coordination: Through multisectoral health council.
11. Incorporating health component in development projects: Not very strong.
12. TCDC & ECDC: Neither TCDC nor ECDC.
13. WHO support: No.

Iraq Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 6 February 1983

1. Political commitment: Yes, but not specified where and how.
2. Formulation of strategy and/or plan of action: Yes, formulated but not yet adopted, December 1979.
3. National strategy forms integral part of national socio-economic development plan: Yes, but not specified how.
4. Review of health systems to reflect characteristics of PHC: Yes, clause of organizational structure of Ministry of Health and Public Health Law reflect PHC.
5. Progress achieved in implementing the Strategy and Plan of Action: No, because PHC not launched yet.
6. Community involvement: No, planning was intersectoral.
7. Reorientation of training of health workers: Yes, and carried out at different levels.
8. Mobilization of material and financial resources: Good.
9. Coordination within Ministry of Health: Good.
10. Intersectoral coordination: Good.
11. Incorporating health component in development projects: Not necessarily carried out.
12. TCDC & ECDC: Yes, through Arab Ministries of Health councils and the Arab Gulf Council of Ministries.
13. WHO support: Yes.

Israel Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 14 April 1983

1. Political commitment: Yes, Not shown how.
2. Formulation of strategy and/or plan of action: No separate strategy for HFA/2000 but health development is in accordance with the principles and approaches of HFA/2000.
3. National strategy forms integral part of national socio-economic development plan: Yes.
4. Review of health systems to reflect characteristics of PHC: No review made but health care in line with PHC.
5. Progress achieved in implementing the strategy and plan of action: Very good progress achieved.
6. Community involvement: Yes.
7. Reorientation of training of health workers: Yes, training reoriented towards PHC.
8. Mobilization of material and financial resources: Yes, good.
9. Coordination within Ministry of Health: Coordination within health sector is good.
10. Intersectoral coordination: Good.
11. Incorporating health component in development projects: Health components are covering all development projects.
12. TCDC & ECDC: No TCDC.
13. WHO support: No.

Jordan Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 12 March 1983

1. Political commitment: Yes, constitution.
2. Formulation of strategy and/or plan of action: Yes, 1980.
3. National strategy forms integral part of national socio-economic development plan: Yes, health development plan is part of socio-economic development plan.
4. Review of health systems to reflect characteristics of PHC: Yes, PHC directory established in Ministry of Health and training of PHC workers commenced.
5. Progress achieved in implementing the Strategy and Plan of Action: Yes, good progress achieved through the establishment of higher health councils, assessment of health manpower requirements up to 1990, revision of curricula, establishment of additional PHC facilities and establishment of monitoring group.
6. Community involvement: Partly, and is to be strengthened further.
7. Reorientation of training of health workers: Yes, curricula revised; in-service training programmes conducted and 730 auxiliaries trained in PHC.
8. Mobilization of material and financial resources: No significant shift in the proportion of the Ministry of Health budget allocated to PHC.
9. Coordination within Ministry of Health: Good.
10. Intersectoral coordination: Good.
11. Incorporating health component in development projects: Ministry of Health consulted in planning stage of all big investment projects.
12. TCDC & ECDC: Yes, with Arab Health Ministers councils and with other Arab countries.
13. WHO support: Partly.

Kuwait Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: March 1983

1. Political commitment: Yes.
2. Formulation of strategy and/or plan of action: Yes, 1980.
3. National strategy forms integral part of national socio-economic development plan: Yes, national strategy is part of national socio-economic development.
4. Review of health systems to reflect characteristics of PHC: Yes, health systems reoriented towards PHC at 3 levels: primary, secondary and tertiary.
5. Progress achieved in implementing the strategy and plan of action: Targets set for different activities and progress is being measured.
6. Community involvement: Fair but has to be strengthened.
7. Reorientation of training of health workers: Yes, at all levels of medical education.
8. Mobilization of material and financial resources, Yes, good.
9. Coordination within the Ministry of Health: Yes, principally in PHC, secondary in general hospitals and thirdly in specialized hospitals.
10. Intersectoral coordination: Intersectoral coordination with Ministries of Education, Environmental Health control, Information and other Ministries.
11. Incorporating health component in development projects: Yes.
12. TCDC & ECDC: Yes, Arab Ministers' of Health Council and Arab Gulf Council.
13. WHO support: Yes.

Lebanon Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: No progress report has been received due to civil disturbances during the last few years in Lebanon.

1. Political commitment:
2. Formulation of strategy and/or plan of action:
3. National strategy forms integral part of national socio-economic development plan:
4. Review of health systems to reflect characteristics of PHC:
5. Progress achieved in implementing the strategy and plan of action:
6. Community involvement:
7. Reorientation of training of health workers:
8. Mobilization of material and financial resources:
9. Coordination within Ministry of Health:
10. Intersectoral coordination:
11. Incorporating health component in development projects:
12. TCDC & ECDC:
13. WHO support:

Libya Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 12 January 1983

1. Political commitment: Yes, Constitution, December 1969. Public Health Law 1973, and Council of Ministers.

2. Formulation of strategy and/or plan of action: Yes, formulated 1982, and approved by Secretariat of Health.

3. National strategy forms integral part of national socio-economic development plan: Yes.

4. Review of health systems to reflect characteristics of PHC: National health plan is good and reoriented towards PHC with 4 levels: PHC unit, centre, polyclinic and hospital.

5. Progress achieved in implementing the strategy and plan of action: Good.

6. Community involvement: Decentralization and promotion of community involvement well advanced.

7. Reorientation of training of health workers: Training of health personnel reoriented to PHC including nurses, midwives and other rural health personnel; curricula revised and community health workers training programme started.

8. Mobilization of material and financial resources: Not answered.

9. Coordination within Ministry of Health: Good.

10. Intersectoral coordination: Multisectoral health council established; inter-secretariat committee formed through the General People's Congress Supreme Committee for Environmental Health is in operation.

11. Incorporating health component in development projects: Yes, preventive measures are incorporated in industrial and agricultural projects.

12. TCDC & ECDC: Not answered.

13. WHO support: Not answered.

Oman Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 1 February 1983

1. Political commitment: Yes.
2. Formulation of strategy and/or plan of action: National strategy formulated 19 April 1980.
3. National strategy forms integral part of national socio-economic development plan: Yes.
4. Review of health systems to reflect characteristics of PHC: Yes, adapted to PHC with 8 components.
5. Progress achieved in implementing the strategy and plan of action: Very rapid progress in implementing the strategy according to Plan.
6. Community involvement: Not strong.
7. Reorientation of training of health workers: Problem to be overcome because majority of health workers are expatriate with short-term contracts. Nationals are gradually replacing expatriates.
8. Mobilization of material and financial resources: Adequate resources allocated.
9. Coordination within Ministry of Health: Coordination with the Ministry is deficient at certain levels due to the diversity of expatriate staff.
10. Intersectoral coordination: Cabinet assumes intersectoral coordination through committees.
11. Incorporating health component in development projects: Health development project incorporates health components.
12. TCDC & ECDC: Yes, though Gulf Council.
13. WHO support: Yes.

Pakistan Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: May 1983

1. Political commitment: Yes.
2. Formulation of Strategy and/or Plan of Action: Yes.
3. National Strategy forms integral part of national socio-economic development plan: National Strategy for health is part of the socio-economic development plan.
4. Review of Health Systems to reflect characteristics of PHC: Yes, during the formulation of 5-year plan.
5. Progress achieved in implementing the Strategy and Plan of Action: Some progress achieved, but still some constraints remain.
6. Community involvement: Just beginning.
7. Reorientation of training of health workers: Yes.
8. Mobilization of material and financial resources. Yes, but resources to health are allocated to other fields as well.
9. Coordination within Ministry of Health: Fair coordination.
10. Intersectoral coordination: Yes, at national and provincial levels. Such coordination is lacking at field level.
11. Incorporating health component in development projects: Yes.
12. TCDC & ECDC: ECDC yes.

    WHO Support: Yes.

Qatar Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: Not reported.

1. Political commitment:
2. Formulation of strategy and/or plan of action:
3. National strategy forms integral part of national socio-economic development plan:
4. Review of health systems to reflect characteristics of PHC:
5. Progress achieved in implementing the strategy and plan of action:
6. Community involvement:
7. Reorientation of training of health workers:
8. Mobilization of material and financial resources:
9. Coordination within Ministry of Health:
10. Intersectoral coordination:
11. Incorporating health component in development projects:
12. TCDC & ECDC:
13. WHO support:

Saudi Arabia Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: April 1983.

1. Political commitment: Yes.
2. Formulation of strategy and/or plan of action: Formulated September 1979.
3. National strategy forms integral part of national socio-economic development plan: National strategy is part of national socio-economic development plan.
4. Review of health system to reflect characteristics of PHC: Health services have been re-oriented towards PHC coordinating both preventive and curative medicine, with good referral system.
5. Progress achieved in implementing the strategy and plan of action: Good progress achieved in implementing strategy at all levels.
6. Community involvement: Community involvement is very strong especially between Islamic leaders, businessmen and community leaders.
7. Reorientation of training of health workers: Re-orientation of training is good. Expansion of medical school and paramedical institutions as well as fellowships abroad help in reorientation.
8. Mobilization of material and financial resources: Very good resources have been mobilized for PHC and health services in general.
9. Coordination within Ministry of Health: Good coordination between ministry departments.
10. Intersectoral coordination: Good and high levels of intersectoral coordination being established incorporating ministries of education, health, planning and finance.
11. Incorporating health component in development projects: Health components incorporated in all projects.
12. TCDC & ECDC: Good, technical cooperation with Gulf States.
13. WHO support: Not answered.

Somalia Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 31 March 1983.

1. Political commitment: Yes, Constitution.
2. Formulation of strategy and/or plan of action: Yes, May 1980.
3. National strategy forms integral part of national socio-economic development plan: Yes, national strategy is part of national socio-economic development plan.
4. Review of health systems to reflect characteristics of PHC: Health systems re-oriented towards PHC at all levels.
5. Progress achieved in implementing the strategy and plan of action: Yes.
6. Community involvement: Yes, with local health committees, 1982, headed by the Party's chiefs.
7. Reorientation of training of health workers: Country-wide training programme being launched with the assistance of United Nations organizations.
8. Mobilization of material and financial resources: Yes, though foreign and international aid still required.
9. Coordination within Ministry of Health: Coordination committees and councils created at all levels of Ministry.
10. Intersectoral coordination: Yes, national social development committees with representatives from different Ministries.
11. Incorporating health component in development projects: Sugar factory, dam building, and agricultural programme incorporate health component.
12. TCDC & ECDC: Yes, with various countries.
13. WHO support: Yes.

Sudan Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 8 February 1983.

1. Political commitment: Yes, Constitution.
2. Formulation of strategy and/or plan of action: National strategy has been formulated in 1980.
3. National strategy forms integral part of national socio-economic development plan: Yes, national strategy is part of national socio-economic development plan.
4. Review of health systems to reflect characteristics of PHC: PHC project adapted to demographic and geographic coverage.
5. Progress achieved in implementing the strategy and plan of action: Progress achieved particularly in HMD, PHC and information system.
6. Community involvement: Yes, at all levels of planning and implementation.
7. Reorientation of training of health workers: Yes, management courses at all levels were undertaken and topic included in all training institutes and medical schools.
8. Mobilization of material and financial resources: Good mobilization of financial resources.
9. Coordination within Ministry of Health: Coordination within the Ministry of Health is good.
10. Intersectoral coordination: Other ministries and departments participated in planning and organization of meetings held.
11. Incorporating health component in development projects: Health components incorporated in all agricultural and industrial projects.
12. TCDC & ECDC: With Egypt very strong and also TCDC in training health manpower. Financial assistance from other countries.
13. WHO support: Yes.

Syria Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: February 1983.

1. Political commitment: Yes, Constitution and resolutions of the Party.
2. Formulation of strategy and/or plan of action: Yes, March 1980.
3. National strategy forms integral part of national socio-economic development plan: Health strategy is part of socio-economic development plan.
4. Review of health systems to reflect characteristics of PHC: PHC adapted during Fifth 5-year Plan of Action being formulated.
5. Progress achieved in implementing the strategy and plan of action: Progress achieved is very little because plan of action is still being formulated.
6. Community involvement: Local administration ensures community participation.
7. Reorientation of training of health workers: Health personnel being re-trained; curricula strengthened, and departments of community medicine in faculties of medicine strengthened to reflect HFA strategy.
8. Mobilization of material and financial resources: Enough financial resources being mobilized for PHC.
9. Coordination within Ministry of Health: Good coordination within Ministry.
10. Intersectoral coordination: Supreme Health Council ensures proper co-ordination between ministries.
11. Incorporating health component in development projects: Health projects considered as part of development in all other department projects.
12. TCDC & ECDC: Good.
13. WHO support: Yes.

Tunisia Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 1983.

1. Political commitment: Yes, Constitution.
2. Formulation of strategy and/or plan of action: Yes, February 1980.
3. National strategy forms integral part of national socio-economic development plan: Yes, national strategy part of national socio-economic development plan.
4. Review of health systems to reflect characteristics of PHC: PHC system established in Tunisia since adoption of HFA resolution, and covering 4 levels namely: dispensaries, health centres, district hospitals and specialized hospitals.
5. Progress achieved in implementing the strategy and plan of action: Progress achieved and monitoring of basic health care system is recognized as essential.
6. Community involvement: Yes, through health councils. Communities participate in programming and implementation of strategy.
7. Reorientation of training of health workers: Faculty of Medicine re-oriented community medicine programme to PHC. Health institute curriculum includes elements of PHC.
8. Mobilization of material and financial resources: Yes, separate budget allocated for PHC services.
9. Coordination within Ministry of Health: Coordination within Ministry of Health is good.
10. Intersectoral coordination: Intersectoral coordination facilitated through national commissions such as Commission of Environmental Health, Drinking Water and Control of Food Substances.

11. Incorporating health component in development projects:
Health components included in other development projects.

12. TCDC & ECDC: TCDC with European countries and some Arab countries.

13. WHO support: No.

United Arab Emirates Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: Not reported.

1. Political commitment:
2. Formulation of strategy and/or plan of action:
3. National strategy forms integral part of national socio-economic development plan:
4. Review of health systems to reflect characteristics of PHC:
5. Progress achieved in implementing the strategy and plan of action:
6. Community involvement:
7. Reorientation of training of health workers:
8. Mobilization of material and financial resources:
9. Coordination within Ministry of Health:
10. Intersectoral coordination:
11. Incorporating health component in development projects:
12. TCDC & ECDC:
13. WHO support:

Yemen Country Sheet

Progress of Implementation of the Strategy of HFA/2000

Date of preparation of progress report: 8 January 1983.

1. Political commitment: Yes, in Constitution.
2. Formulation of strategy and/or plan of action: Formulated in July 1980.
3. National strategy forms integral part of national socio-economic development plan: National strategy forms integral part of national socio-economic development plan.
4. Review of health systems to reflect characteristics of PHC: Health systems at all levels re-oriented towards PHC.
5. Progress achieved in implementing the strategy and plan of action: Progress achieved in PHC is good.
6. Community involvement: Community involvement is very strong through Confederation of Yemeni Development Associations (CYDA).
7. Reorientation of training of health workers: Re-orientation of training carried out at all levels.
8. Mobilization of material and financial resources: Mobilization of external and internal resources for PHC is very strong.
9. Coordination within Ministry of Health: Good.
10. Intersectoral coordination: Good.
11. Incorporating health component in development projects: Health components included in all other development projects.
12. TCDC & ECDC: Yes, with Gulf countries and Saudi Arabia.
13. WHO support: Yes.

ANNEX II

MONITORING PROGRESS: FREQUENCY DISTRIBUTION OF COUNTRIES ACCORDING TO THE VARIOUS INDICATOR VALUES

MONITORING PROGRESS: FREQUENCY DISTRIBUTION OF COUNTRIES
ACCORDING TO THE VARIOUS INDICATOR VALUES

Indicator 3:

The Percentage of the Gross National Product spent on Health

Interval	C*	P*
Less than 1.0		
1.0 -	3	88.7
2.0 -	1	1.6
3.0 -	3	19.5
4.0 -	2	22.7
5.0 -	1	40.2
6.0 -		
7.0 -	1	4.0
8.0 -		
9.0 -		
10.0 or more		
Data not available	12	100.9
Regional Average**	2.9%	

Indicator 10:

Life Expectancy at Birth

Interval	C*	P*
Less than 40.0		
40.0 -	5	48.6
50.0 -	6	188.2
60.0 -	4	14.9
70.0 or more	2	4.7
Data not available	6	21.2
Regional Average**	54	

Indicator 12:

The Gross National Product per Head

Interval	C*	P*	Interval	C	P
Less than $ 100			$ 4 000-	2	4.7
$ 100 -			$ 5 000-	1	0.3
$ 200 -	2	17.1	$ 6 000-		
$ 300 -	3	110.9	$ 7 000-		
$ 400 -	2	50.6	$ 8 000-		
$ 500 -	1	2.1	$ 9 000-		
$ 1 000-	5	73.3	$ 10 000 or more	2	10.9
$ 2 000-	1	0.9	Data not available	4	6.8
$ 3 000-			Regional Average**	$ 1 379	

* C = Countries; P = Population therein (in millions).

** For the reporting countries, using the population in each country as the weight.

MONITORING PROGRESS: FREQUENCY DISTRIBUTION OF COUNTRIES ACCORDING TO THE VARIOUS INDICATOR VALUES (cont'd)

Interval	Indicator 9: Infant Mortality Rate (per 1 000 live births)		Indicator 4: % of National Health Expenditure devoted to Local Health Care		Indicator 8(a): % newborns with birth-weight of at least 2 500 g.		Indicator 8(b): % Children under 5 with weight-for-age corresponding to reference values		Indicator 11: Adult Literacy Rate (%)	
	C*	P*	C	P	C	P	C	P	C	P
Less than 10.0			1	4.9						
10.0 -	2	4.7	2	5.5					4	32.4
20.0 -	2	1.9	3	18.7					2	106.0
30.0 -	1	3.1	3	44.6					1	40.2
40.0 -							1	4.9	1	44.7
50.0 -	1	9.7			1	4.9			2	7.0
60.0 -	1	3.4							3	14.6
70.0 -							1	3.1		
80.0 -	2	51.2	1	5.9	3	62.4			3	5.0
90.0 -	1	87.1			6	62.3	1	9.7		
100.0 -	4	68.8								
150 -	4	29.7								
200 or more										
Data not available	5	18.1	13	198.0	13	148.0	20	260.0	7	27.8
Regional Average**	97		32		87		74		33	

* C = Countries; P = Population therein (in millions).

** For the reporting countries, using the population in each country as the weight.

MONITORING PROGRESS: FREQUENCY DISTRIBUTION OF COUNTRIES ACCORDING TO THE VARIOUS INDICATOR VALUES (cont'd)

Indicator 7: The proportion of the population for whom Primary Health Care is available

Interval	% Pop. served by:				% fully immunized										% attended by trained personnel			
					Infants under one year						Pregnant women: Tetanus 2 doses		% Pop. with local health care within one hour's walk or travel		Women during pregnancy and at childbirth		Infants up to at least one year of age	
	Safe drinking water in the home or within 15 minutes walking distance		Adequate facilities for waste disposal in the home or immediate vicinity		DPT-Polio 3 doses		Measles one dose		BCG one dose									
	C*	P*	C	P	C	P	C	P	C	P	C	P	C	P	C	P	C	P
Less than 10.0			1	16.8	4	124.9	5	125.8	9	135.7	10	206			2	45.1	2	45.1
10.0 -	1	16.8	3	98.0	2	10.6	3	32.5	1	40.2	2	48	3	12.9				
20.0 -			1	0.3	3	27.8	1	0.7			1	0.9					1	3.4
30.0 -	4	13.2	1	2.1					1	9.7	2	1.9						
40.0 -	1	87.1	2	16.3	1	40.2			1	9.3					1	44.7		
50.0 -	1	40.2					3	48.5					1	40.2	1	6.5	1	6.5
60.0 -			2	84.9	1	3.1	3	48.1	2	4.0					2	6.5		
70.0 -	3	60.8	2	12.4	1	44.7	1	1.6	2	48.7			1	0.3				
80.0 -	1	3.4			3	8.9	1	4.0					1	6.5	1	0.3		
90.0 -	6	19.0	5	9.9	2	1.0							6	54.3	3	6.2	3	7.4
Data not available	6	37.1	6	37.1	6	16.5	6	16.5	7	30.0	8	20.8	11	163.3	13	169	16	215.2
Regional Average**	52		41		28		29		25		4		71		31		23	

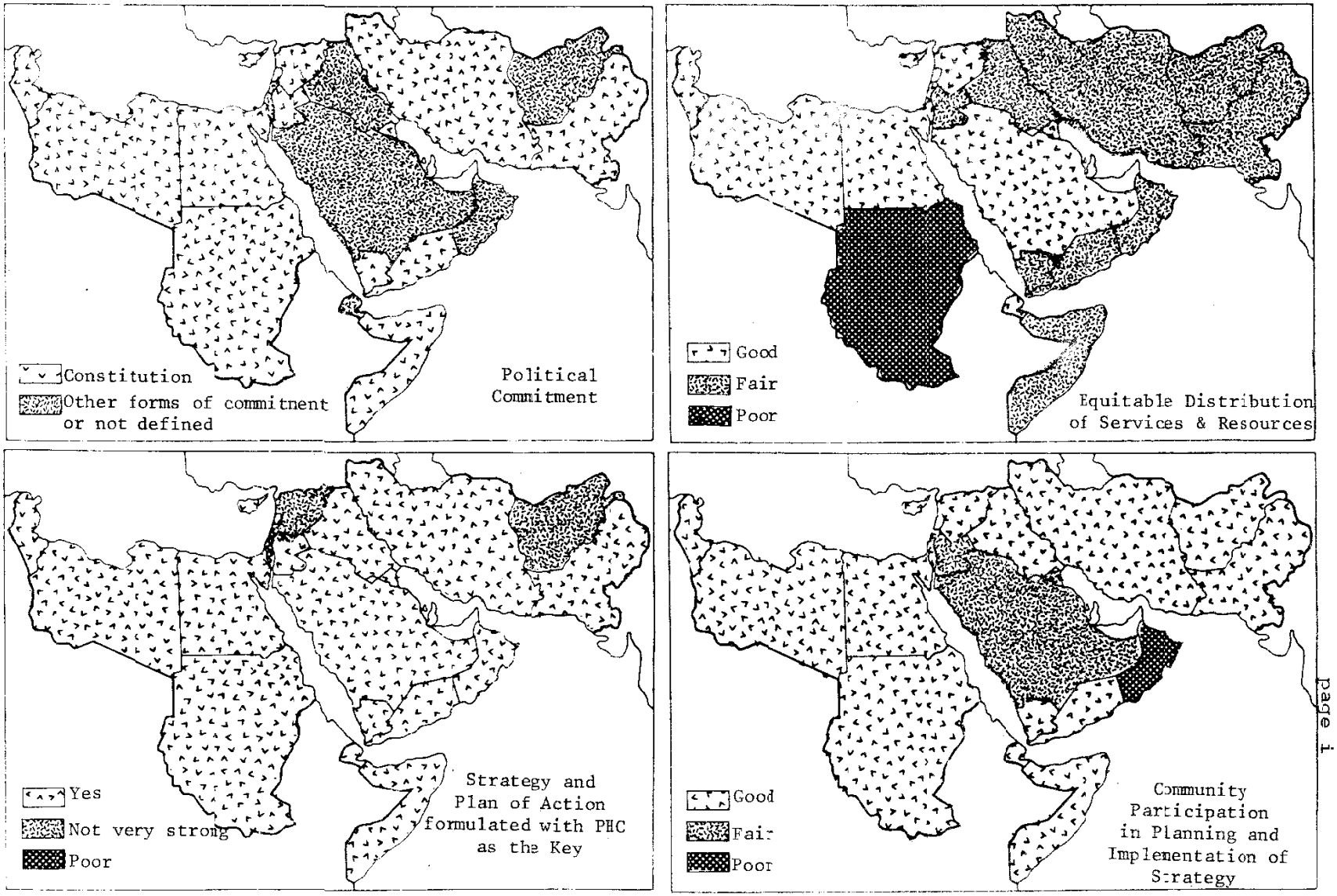
* C = Countries; P = Population therein (in millions).

** For the reporting countries, using the population in each country as the weight.

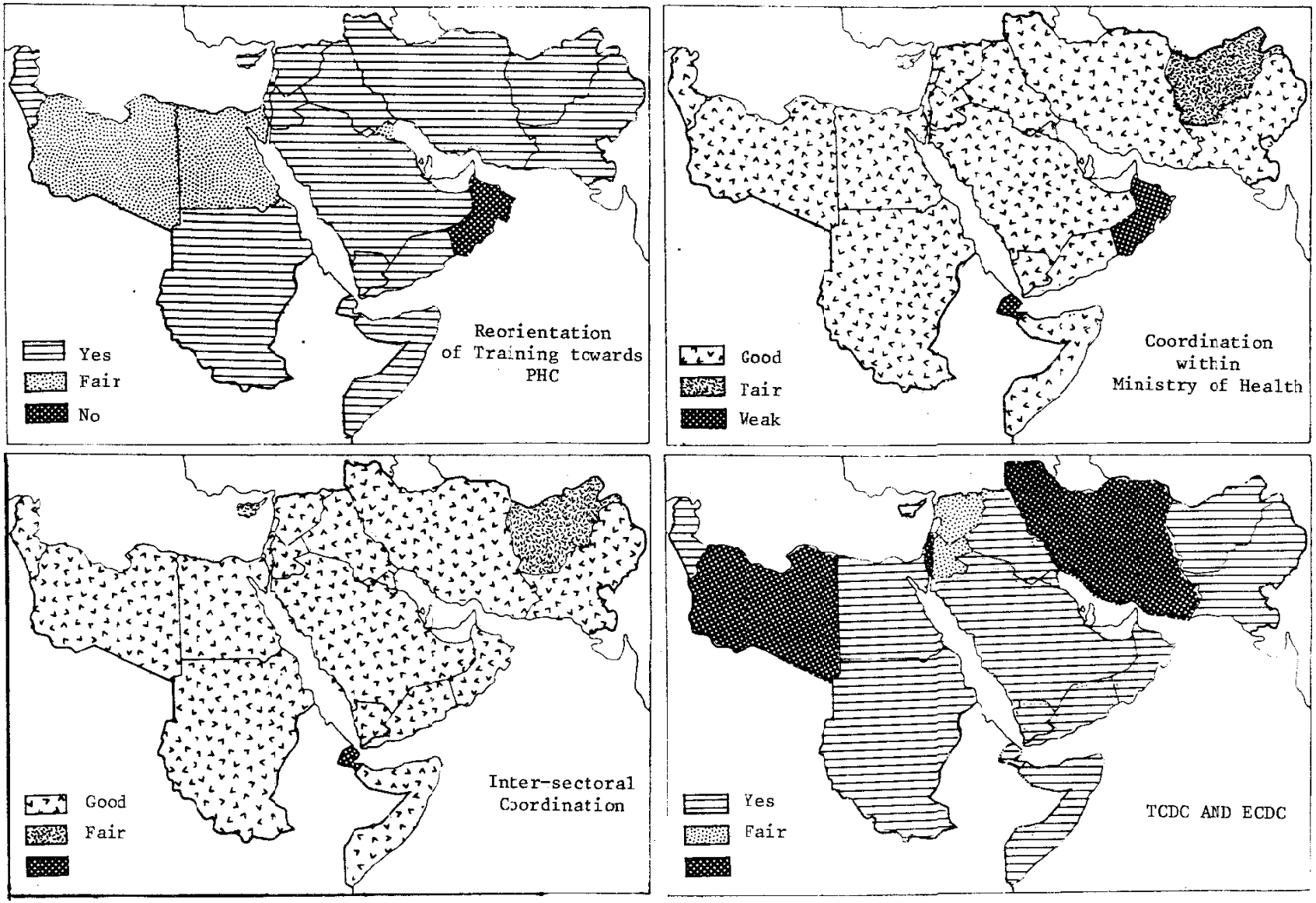
ANNEX III

CHARTS

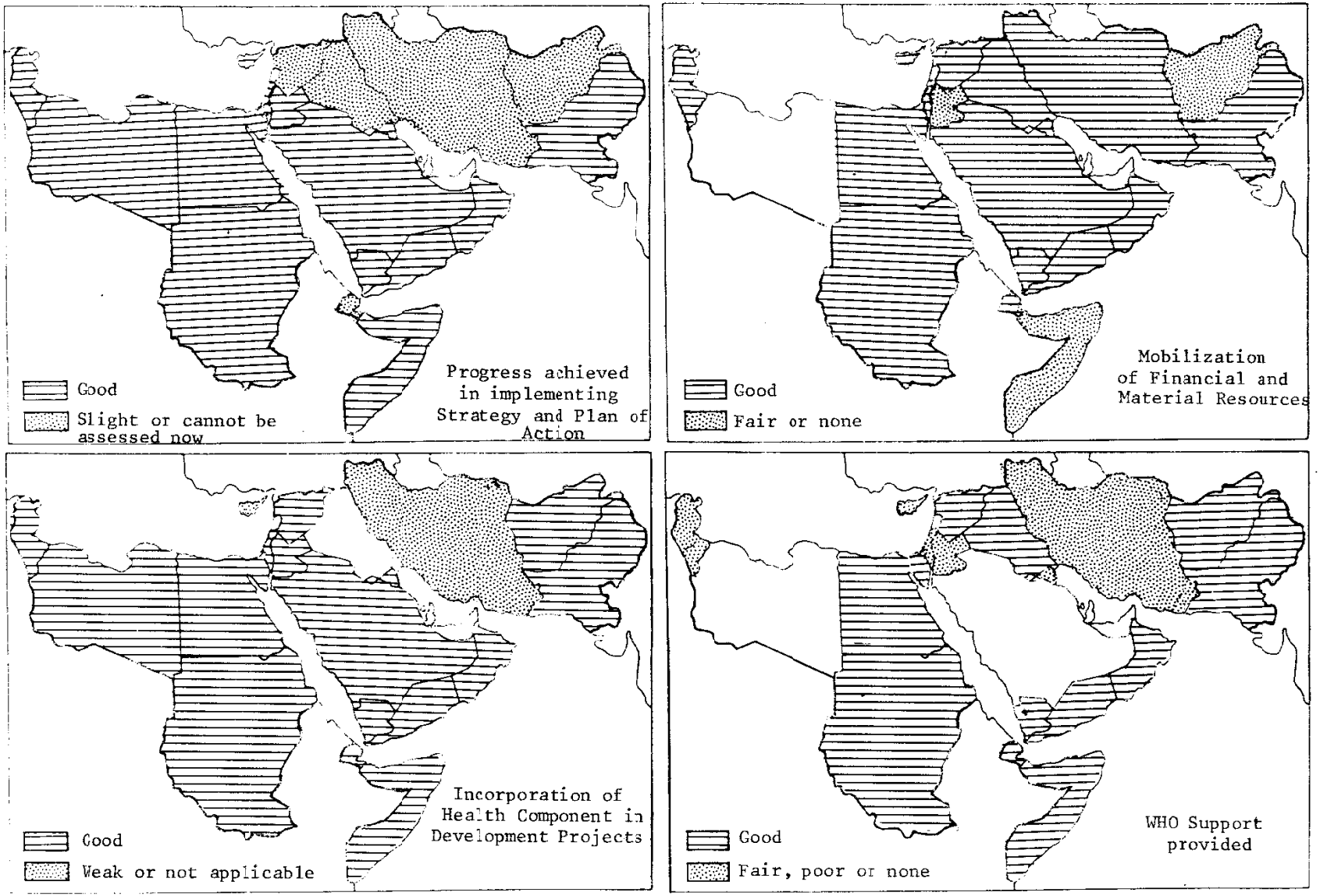
MONITORING PROGRESS FOR IMPLEMENTATION
OF STRATEGIES FOR HFA/2000
IN COUNTRIES OF THE WHO EASTERN MEDITERRANEAN REGION
(Countries not reporting are left blank)



MONITORING PROGRESS FOR IMPLEMENTATION
OF STRATEGIES FOR HFA/2000
IN COUNTRIES OF THE WHO EASTERN MEDITERRANEAN REGION (CONT'D)
(Countries not reporting are left blank)



MONITORING PROGRESS FOR IMPLEMENTATION
OF STRATEGIES FOR HFA/2000
IN COUNTRIES OF THE WHO EASTERN MEDITERRANEAN REGION (CONT'D)
(Countries not reporting are left blank)



WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

منظمة الصحة العالمية

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

EM/RC30(83)/5-Annex IV
September 1983

Thirtieth Session (1983)

ORIGINAL: ENGLISH

Agenda item 7

REVIEW OF THE REPORTS ON MONITORING PROGRESS IN IMPLEMENTATION OF THE STRATEGIES AND PLANS OF ACTION FOR HEALTH FOR ALL BY THE YEAR 2000

ANNEX IV

Revised Analysis of the Part on Individual Indicators (Pages 9-18 of the main document) and of the Tables in Annex II.

COMMENTS ON THE INDIVIDUAL INDICATORS (as of 15 September 1983)

Indicator 1

Health for all has received endorsement as policy at the highest official level

In most countries the Constitution contains a statement on the right of citizens in respect of health. Other forms of endorsement that were mentioned included: the Head of the State (Oman), the Party (Afghanistan), and the Council of Ministers or the Ministry of Health (Bahrain, Djibouti, Iraq and Saudi Arabia). The replies could be classified as "yes" in 19 out of the 20 countries. No reports were received from three countries.

Indicator 2

Mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning

Here, as with the previous indicator, most countries responded favourably. Local people's assemblies or councils, trade unions, professional and group organizations and voluntary organizations were the most commonly mentioned mechanisms for community participation, particularly at the local and operational levels. Decentralization of health services was prominent in some countries, and is being introduced in others. At the other end, community participation was described as being "under discussion" or "not yet developed" in two countries (Jordan and Kuwait) and as "not enough" or "not fully" in two others (Oman and Pakistan). Data were disqualified for two countries, and no reports were received from three others.

Indicator 3

The percentage of the gross national product spent on health. (The set landmark is "at least 5%").

Eight countries were able to provide the indicator value, as defined (Afghanistan, Iran, Israel, Jordan, Kuwait, Pakistan, Syria and Tunisia). Three others (Cyprus, Oman and Yemen) indicated that the numerator related to the Ministry of Health only.

Out of these eleven replies, only two (Iran and Israel) crossed the 5% mark; at the other end three (Cyprus, Oman and Pakistan) were less than 2%, and four (Jordan, Syria, Tunisia and Yemen) were 3-4%. The range was between "around one" (Pakistan) and 7.0% (Israel). The unweighted average was 3.5%, while the weighted average (using the population size for the weights) was 2.9%.

The replies of seven countries were disqualified. A different denominator (e.g., national budget, development budget, public or government expenditure) was used by five countries; one country gave data on expenditures but not enough to compose the indicator, and the seventh country only said "No", i.e., not at least 5%. In addition, two countries clearly stated that data were not available. Thus data were not available for 12 countries, representing 37% of the total population in the Region.

In light of the above, it is worth considering the proposal to use under this indicator more than one measure, according to both the numerator and denominator.

Indicator 4

The percentage of the national health expenditure devoted to local health care. (No pertinent indicator value was set, only that it should be "a reasonable percentage", and that the percentage considered "reasonable" would be arrived at through country studies).

Most countries were not able to provide the appropriate indicator value. This was mainly because the national accounting systems could not permit the explicit indentification of the components of the indicator, more so those related specifically to "local health care".

Only two countries (Bahrain and Israel) gave straightforward indicator values. Nine other countries added qualifying statements, such as: of Ministry of Health budget, of government health expenditure, excluding development budget, excluding external aid, excluding health personnel budget, excluding urban hospital care, etc. Evidently, such reservations affect the indicator values to a varying extent. Accordingly, there was quite a wide range, between 3.5% (Somalia) and 72% (Yemen). Out of these eleven replies, five (Afghanistan, Bahrain, Democratic Yemen, Jordan and Kuwait) were between 10% and 30%, five were higher (Djibouti, Iran, Israel, Saudi Arabia and Yemen) and one lower (Somalia) than 10%. The weighted average was 33%.

Nine replies were disqualified: five were vague or unrelated; two stated that data were unavailable, and no answer was given in two reports. Three reports were not submitted. Thus data were not available for 12 countries, representing 68% of the total population in the Region.

It is clear that differences in inclusions and exclusions in the numerator and/or the denominator render the comparability of the reported indicator values rather difficult. As was mentioned above (Indicator 3), one might have to consider the use of several measures under this indicator, with countries reporting on the measures for which they had the appropriate data.

Indicator 5

Resources are equitably distributed

This indicator was probably the one least understood, and to which the responses were the least satisfactory.

A number of countries paid attention to the component resources (viz., per capita expenditure, staff and facilities), disregarding the crucial aspect, namely, the within-country variations. It is likely that the way the explanatory notes were presented contributed to that misunderstanding: the three types of resources were written, each in a numbered line, indented, with extra spaces in between, while reference to geographical areas or population groups was mentioned in the running text that followed.

A few countries could provide within-country distribution of resources, but only as absolute figures without the corresponding population data. More countries, however, simply gave descriptive statements, ranging between "fair" to "almost equally distributed", one reply was simply "yes", but no supporting figures were given. One reply (Sudan) was frank enough to state that "there is maldistribution of resources"

Indicator 6

The strategy for health for all has been accompanied by explicit resource allocations and is receiving sustained resource support from more affluent countries

Generally speaking, there is good mobilization of resources, technical as well as financial. Resort to support from bilateral and international agencies was common. In six "affluent" countries no external resources were received (Iran, Israel, Kuwait, Libya, Oman and Saudi Arabia). In one other country (Syria) a complete national strategy has not yet been formulated. No supporting figures were given in many replies.

Indicator 7

The proportion of the population for whom primary health care is available. (The global indicator explicitly mentioned "primary health care is available to the whole population".)

Five components were identified:

(7.1) Safe drinking water in the home or within 15 minutes' walking distance

Thirteen countries were able to provide meaningful data, separately for urban/rural, and/or for the total population. Three countries gave descriptive replies, one mentioned non-availability of data, and one did not give any reply at all. However, data from reports for the Water Supply and Sanitation Decade were available for six additional countries, and are included in the analysis. Data were not available for four countries, representing 12% of the total population in the Region.

The disparity in the availability of safe drinking water is marked. It was as low as 10% in Afghanistan, upto "all the people" in four countries (Bahrain, Cyprus, Kuwait and Lebanon). The proportion was below 50% in six countries (Afghanistan, Democratic Yemen, Djibouti, Pakistan, Somalia and Yemen) and was 90% and over in eight countries (Bahrain, Cyprus, Israel, Kuwait, Lebanon, Libya, Saudi Arabia and the United Arab Emirates). The unweighted overall average is 70%, while the weighted average is 52%.

(7.b) Adequate facilities for hygienic waste disposal available in the home or immediate vicinity

Thirteen countries provided data. Other replies were disqualified for reasons similar to those mentioned for the preceding component (safe drinking water). However, data from other sources were available for five additional countries and are included in the analysis. Data were not available for five countries with 13% of the total population in the Region.

Here, also, the disparity is obvious, ranging between "minimal" (Afghanistan) and "almost all people". For four countries the proportion did not reach 20% (Afghanistan, Pakistan, Somalia and Yemen) while it exceeded 90% in six countries (Bahrain, Cyprus, Israel, Jordan, Kuwait and Libya). The unweighted overall average is 59%, while the weighted average is 40%.

(7.c) Proportion of infants under one year fully immunized

This part of the report was attended to very unsatisfactorily. Rarely the reply was very specific, i.e., to state that the data referred to infants under one year fully immunized against the six diseases covered by EPI. Many simply mentioned "immunized", occasionally "adequately immunized". The commonest data presentation was in three figures for DPT Polio, Measles, and BCG. But more, or less, detail was occasionally the case; one country did not specify the vaccinations. Many mentioned the age of one year, but a few referred to "children under 5" or "at school entry".

Two countries gave absolute figures for vaccinations and not percentages of those covered; one described certain vaccinations as "limited" or "not universal". Two countries gave data referring to the capital city only. One country did not reply at all; four did not give any figure; three gave descriptive terms such as "offered", "widely available" or "progressively expanding"; one country simply said "yes".

Data from national EPI programmes could provide much of the missing information. It was noticed that, in many cases, data given in the progress report were far above those provided by the EPI programmes; however, the figures given in the official progress reports were the ones used in the analysis.

The summary of data is as follows:

(7.3a & 7.3c) DPT Polio: Thirteen countries were below 30% (Afghanistan, Democratic Yemen, Djibouti, Iraq, Lebanon, Oman, Pakistan, Saudi Arabia, Somalia, Sudan, Syria, United Arab Emirates and Yemen), six exceeded 70% including two (Bahrain and Cyprus) 90% and over, and four between the two extremes. The weighted average is 29% for DPT and 32% for Polio, otherwise coverage was very close for both.

(7.3b) Measles: Similarly, here, nine countries were below 30% (Afghanistan, Cyprus, Democratic Yemen, Djibouti, Lebanon, Pakistan, Saudi Arabia, Sudan and Yemen); two only exceeded 70% (Israel and Kuwait),and twelve between the two extremes. The weighted average is 31%.

(7.3d) BCG: Thirteen countries were below 30% (Afghanistan, Bahrain, Cyprus, Democratic Yemen, Djibout. Iran, Jordan, Kuwait, Pakistan, Somalia, Sudan, United Arab Emirates and Yemen); three exceeded 70% (Egypt, Iraq and Oman), and six were between the two extremes. The weighted average was 29%. Notably, some countries mentioned that they were not pushing BCG vaccination as tuberculosis was no more a serious problem. Data were not available for one country, representing just one percent of the total population in the Region.

(7.3e) Proportion of pregnant women immunized against tetanus (2 doses)

Rarely were figures given; in fact the majority did not mention anything at all about this item. Data from EPI programmes seemed sketchy. In fact, coverage was 16-39% for three countries only (Bahrain, Kuwait and Oman); while all other seventeen reporting countries were 10% or less (of which thirteen had a coverage of 5% or less). The weighted average is 4%. Data were not available for three countries with 3% of the total population in the Region.

In general, for the aspect of immunization coverage under Indicator 7, the proposal to refer specifically in the explanatory notes to the EPI national programmes as a source for these data might be considered.

(7.4) Proportion of the population to which local health care is available within one hour's walk or travel

Eight replies were excluded, either because they were vague (2), or mentioned "unknown" (1) or no entries were made (5). Three reports were not submitted. Thus data were not available for 59% of the total population in the Region.

Out of the remaining twelve countries, six mentioned that PHC was available for almost all the population (Bahrain, Cyprus, Egypt, Israel, Kuwait and Libya). At the other end, the figure was under 20% for three countries (Democratic Yemen, Somalia and Yemen). The weighted average is 71%.

(7.5) Proportion of women who were attended during pregnancy and at childbirth by trained personnel

More than half of the countries did not provide any reply or figure, representing 61% of the total population in the Region. For the reporting ten countries, the proportion ranged between 2-5% (Somalia and Iran) and almost all pregnancies (Cyprus, Israel and Kuwait). The weighted average for the ten countries is about 31%.

(7.5b) Proportion of children cared for up to at least one year of age by trained personnel

This element has been reported upon by a number of countries smaller than for the preceding element of maternal care. (For possible explanation, see General Remarks 2 & 3).

Only seven countries provided figures. These ranged between 1-8% (Somalia and Iran) and more than 90% (Bahrain, Israel and Libya), with an overall weighted average around 23%. Data wer not available for sixteen countries with 78% of the total population in the Region.

Indicator 8

The nutritional status of children is adequate

Two measures belong here:

(8.1) Proportion of newborn infants having a birth weight of at least 2500 g. (The set landmark is "at least 90%").

Four countries mentioned explicitly that data were not available; five gave general statements, e.g., "adequate" or "within normal range", and one did not enter any reply to this indicator. Data were not available for 13 countries representing 54% of the total population in the Region.

Only ten countries provided data, and these were based on special studies. Of these, six were in the "safe zone", having crossed the 90% mark (Bahrain, Iran, Israel, Kuwait, Syria and Tunisia), while three were in the range 80-90% (Afghanistan, Egypt and Oman). The proportion ranged between 50% (Somalia) and 96.5% (Tunisia), with an overall weighted average around 87%. How far the studies quoted are based on representative samples is another problem.

(8.2) The proportion of children under 5 years of age having a weight for age that corresponds to the reference values. (Here, again, the set landmark is "at least 90%")

This measure was the least reported upon. The majority of countries mentioned the non-availability of data; others did not reply at all. Thus only three countries gave figures, between 40% (Somalia) and 92% (Syria), with Libya in between. Data were not available for 94% of the total population in the Region.

It is clear that the Organization needs to make greater effort in the collaborative programmes with the countries to introduce mechanisms to obtain data on birthweight and on the weight of children under 5 years, either as part of the MCH service, or through ad hoc studies.

Indicator 9

The infant mortality rate for all identifiable groups. (The stated landmark is "below 50 per 1000 livebirths").

Data from other published sources were sometimes greatly different from those reported (e.g., 21.5 against 57, or 36 against 107, or being "yes", i.e., below 50 against 92). However, it must be reiterated that the figures in the officially submitted reports were the ones used in the analysis. In light of apparent under-registration, some published data are based on demographic estimates, others based on reported deaths, while for some other countries the reported data seem to be opinion estimates.

As was to be expected, rates varied widely from 12.8 (Israel) to 182 (Afghanistan). Only six countries crossed the 50 per 1000 mark (Israel, Cyprus, Bahrain, Kuwait, Libya and Lebanon), while, at the other end nine countries had infant mortality rates above 100, with an overall weighted average of 99 per 1000, a really high figure.

Though the countries were expected to report "the rate observed among various population groups", thirteen countries reported the national figure only; two gave figures by geographical region, two by urban/rural, one by sex and one by nationals/expatriates.

Indicator 10

Life expectancy at birth. (Set landmark is "over 60 years").

Life expectancy was in the seventies in two countries (Israel and Cyprus), and crossed the 60 years mark in seven other countries (Bahrain, Iraq, Jordan, Kuwait, Lebanon, Syria and the United Arab Emirates). It was still below 50 years in six countries (Afghanistan, Democratic Yemen, Oman, Somalia, Sudan and Yemen). In two countries (Afghanistan and Pakistan), life expectancy among males was somewhat higher than among females. The overall weighted average is 55 years.

Indicator 11

The adult literacy rate for both men and women. (Set landmark is "exceeds 70%").

One country specified that the data were for "above 6 years", the second for "15 years and over", the third as for "adults", while other countries did not specify any age limit. Four countries gave data by sex. Data from other sources were used for seven countries, but could not be made available for two countries with less than one percent of the total population in the Region.

Here also the range was very wide, from 5% (Somalia) to "nearly all adult population" (Cyprus). Only four countries crossed the 70% mark (Bahrain, Cyprus, Israel and Lebanon). Out of the other 17 countries, the proportion was below 40% in eight countries (Afghanistan, Djibouti, Pakistan, Saudi Arabia, Somalia, Sudan, the United Arab Emirates and Yemen). The overall weighted average is 36%.

Indicator 12

The gross national product per head. (Set landmark: "exceeds US$500").

Data from the progress reports, complemented by data from other published sources, were available for all countries. This is the only indicator where the picture for the Region is rather bright: sixteen out of the 23 countries have GNP per head exceeding $500, and the range was really wide, from as low as $200 (Afghanistan) to as high as to exceed $ 10 000 per head in four countries (Kuwait, Qatar, Saudi Arabia and the United Arab Emirates). In fact it was $1000 and over for fifteen out of the sixteen countries. The weighted average is around $ 1 630.

MONITORING PROGRESS: FREQUENCY DISTRIBUTION OF COUNTRIES ACCORDING TO THE VARIOUS INDICATOR VALUES

Indicator 3:

The Percentage of the Gross National Product spent on Health

Interval	C*	P*
Less than 1.0		
1.0 -	3	88.7
2.0 -	1	1.6
3.0 -	3	19.8
4.0 -	2	22.9
5.0 -	1	40.2
6.0 -		
7.0 -	1	4.0
8.0 -		
9.0 -		
10.0 or more		
Data not available	12	102.7
Regional Average**	2.9%	

Indicator 10:

Life Expectancy at Birth

Interval	C*	P*
Less than 40.0		
40.0 -	6	50.5
50.0 -	8	192.2
60.0 -	7	32.6
70.0 or more	2	4.7
Data not available		
Regional Average**	55	

Indicator 12:

The Gross National Product per Head

Interval	C*	P*	Interval	C	P
Less than $ 100			$ 4 000-	2	4.7
$ 100 -			$ 5 000-	1	0.3
$ 200 -	2	17.1	$ 6 000-		
$ 300 -	3	111.7	$ 7 000-		
$ 400 -	2	50.8	$ 8 000-	1	3.2
$ 500 -	1	2.1	$ 9 000-		
$ 1 000-	5	62.8	$ 10 000 or more	4	12.3
$ 2 000-	1	1.0	Data not available		
$ 3 000-	1	14.0	Regional Average**	$ 1 630	

* C = Countries; P = Population therein (in millions).

** For the reporting countries, using the population in each country as the weight.

MONITORING PROGRESS: FREQUENCY DISTRIBUTION OF COUNTRIES ACCORDING TO THE VARIOUS INDICATOR VALUES (cont'd)

Interval	Indicator 9: Infant Mortality Rate (per 1 000 live births)		Indicator 4: % of National Health Expenditure devoted to Local Health Care		Indicator 8.1: % newborns with birth-weight of at least 2 500 g.		Indicator 8.2: % Children under 5 with weight-for-age corresponding to reference values		Indicator 11: Adult Literacy Rate (%)	
	C*	P*	C	P	C	P	C	P	C	P
Less than 10.0			1	5.1					1	5.1
10.0 -	2	4.7	1	2.1					3	23.2
20.0 -	2	1.9	4	22.2					4	117.1
30.0 -	1	3.2	3	44.6						
40.0 -	1	2.7	1	9.6			1	5.1	3	91.6
50.0 -	3	10.7			1	5.1			2	17.2
60.0 -	1	3.5							4	16.8
70.0 -							1	3.2		
80.0 -	3	65.3	1	6.1	3	62.4			4	7.7
90.0 -	1	87.1			6	62.5	1	9.7		
100.0 -	5	70.6								
150 -	4	30.1								
200 or more										
Data not available			12	190.2	13	149.9	20	261.9	2	1.2
Regional Average**	99		33		87		73		36	

* C = Countries; P = Population therein (in millions).

** For the reporting countries, using the population in each country as the weight.

MONITORING PROGRESS: FREQUENCY DISTRIBUTION OF COUNTRIES ACCORDING TO THE VARIOUS INDICATOR VALUES (cont'd)

Indicator 7: The proportion of the population for whom Primary Health Care is available

Interval	% Pop. served by:				% fully immunized								% attended by trained personnel			
	Safe drinking water in the home or within 15 minutes walking distance (7.1)		Adequate facilities for waste disposal in the home or immediate vicinity (7.2)		Infants under one year: DPT-Polio 3 doses (7.3a & 7.3c)		Infants under one year: Measles one dose (7.3b)		Infants under one year: BCG one dose (7.3d)		Pregnant women: Tetanus 2 doses (7.3e)		% Pop. with local health care within one hour's walk or travel (7.4)		Women during pregnancy and at childbirth (7.5a)		Infants up to at least one year of age (7.5b)	
	C*	P*	C	P	C	P	C	P	C	P	C	P	C	P	C	P	C	P
Less than 10.0			1	16.8	6	128.5	6	128.5	8	119.8	15	221.4			2	45.4	2	45.4
10.0 -	1	16.8	3	98.3	3	29.7	2	15.8	4	58.2	3	49.1	3	13.3				
20.0 -			1	2.1	4	16.5	1	0.7		6.1							1	3.5
30.0 -	4	100.4	1	0.3	1	6.7	3	24.5		9.7	2	1.9						
40.0 -	1	0.3	2	16.3	2	40.5			2	9.9					1	44.7		
50.0 -	1	40.2					3	48.9					1	40.2	1	6.7	1	6.7
60.0 -			2	84.9	1	3.2	6	56.1	2	9.9					2	6.7		
70.0 -	3	61.0	1	9.9	1	3.5	1	1.6	3	62.7			1	0.3				
80.0 -	1	3.5	1	0.8	3	50.3	1	4.0	1	1.0			1	6.7	1	0.3		
90.0 -	8	23.0	6	13.3	2	1.0							6	54.5	3	6.2	3	7.6
Data not available	4	34.7	5	37.4					1	2.7	3	7.6	13	164.9	13	169.9	16	216.8
Regional Average**	52		40		29		31		29		4		71		31		23	

* C = Countries; P = Population therein (in millions).

** For the reporting countries, using the population in each country as the weight.

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

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Agenda item 7

REVIEW OF THE REPORTS ON MONITORING PROGRESS IN IMPLEMENTATION OF THE STRATEGIES AND PLANS OF ACTION FOR HEALTH FOR ALL BY THE YEAR 2000

This Addendum has been prepared following the recommendations of the Intercountry Group Meeting on Indicators for Monitoring and Evaluation of Progress Towards HFA/2000, held in Damascus, Syrian Arab Republic, 24-29 September 1983.

INDICATORS FOR USE FOR THE
REGIONAL MONITORING OF PROGRESS TOWARDS HFA/2000

(A) The twelve Global Indicators already approved by the World Health Assembly (Resolution WHA34.36).

(B) Supplementary Indicators (disaggregated and proxy indicators to the Global Indicators):

1. Proportion of the recurrent (regular) budget and the total government budget which is allocated to the Ministry of Health. (Supplement to Global Indicator 3).

2. Proportion of the total public expenditure devoted to health and health-related services.(Supplement to Global Indicator 3).

3. Annual health budget (or, if available, public expenditure on health, or total health expenditure) per capita. (Supplement to Global Indicator 3).

4. Per capita (or per thousand population) health resources for primary health care, separately for urban and rural areas:

   (a) Financial.
   (b) Personnel (physicians, nurses, dentists, pharmacists, community health workers, traditional birth attendants, etc.).
   (c) Facilities (PHC centres, out-patient services, hospital beds). The national norms should also be indicated, if established. (Supplement to Global Indicator 5).

5. Percentage of population covered by safe water supply, separately in urban and rural areas. (Supplement to Global Indicator 7.1).

6. Percentage of population covered by sanitary waste disposal, separately in urban and rural areas. (Supplement to Global Indicator 7.2).

7. Annual incidence rate of each of the 6 EPI-target diseases for the most recent 5 years. (Supplement to Global Indicator 7.3).

8. Percentage of population covered by local health care, separetely in urban and rural areas. (Supplement to Global Indicator 7.4).

9. Maternal mortality rate. (Supplement to Global Indicator 7.5).

10. Proportion of children having a weight-for-age in relation to reference values at the entrance to the primary school. (Supplement to Global Indicator 8.2).

Introduction

The Intercountry Group Meeting on Indicators for Monitoring and Evaluation of Progress Towards HFA/2000 was held in Damascus, Syrian Arab Republic, during the period 24-29 September 1983. It was attended by twelve participants from twelve countries in the Region.

After discussing the experience of the countries with the twelve global indicators approved by the World Health Assembly (Resolution WHA34.36), the Group proceeded to discuss what indicators could be used to monitor and evaluate progress in the implementation of strategies towards HFA/2000 at the Regional level.

In addition to the twelve global indicators, the Group recommended a limited number of Supplementary Indicators, in the sense that they are disaggregated and proxy indicators to the Global Indicators. There are also two New Indicators. The attached sheet lists these indicators. It was the general view of the Group that providing values for these additional indicators will not constitute a heavy burden on the national authorities.

The Regional Committee may like to review these indicators. The Regional Indicators should be approved by the Regional Committee, inasmuch as the Global Indicators had been discussed and approved by the World Health Assembly. Member States in the Region would be committed to include the indicators, as approved by the Regional Committee, in their progress and evaluation reports in future.

11. Life expectancy at birth, separately for males and females. (Supplement to Global Indicator 10).

12. Gross domestic product (GDP) per head. (Supplement to Global Indicator 12). The annual growth rate should also be computed.

(C) Additional Indicators

1. Average annual rate of natural increase.
2. Unemployment rate.