Government of X ***Pan American Health Organization/***
Ministry of Health ***World Health Organization***

Performance Measurement of Essential Public Health Functions at the National Level in Country X

Results of the Workshop on Application of the Instrument
Conducted in X
From x to x, 2001

(Sample Report)

Sponsored by:

The Ministry of Health of the Government of X
and the Pan American Health Organization

EXECUTIVE REPORT

Background

In September 2000, the 42nd Directing Council of the Pan American Health Organization passed a Resolution supporting an initiative aimed at strengthening public health practice in the Americas as well as strengthening the steering role or 'stewardship' of the National Health Authority (NHA) by way of defining and measuring the performance of essential public health functions (EPHF).

Over the past two years, the Pan American Health Organization (PAHO), in collaboration with the Centers for Disease Control and Prevention (CDC) and the Latin American Center for Health Systems Research (CLAISS), and relying on extensive regional consultation, has developed an instrument for measuring the performance of EPHF by the health authority as part of the "Public Health in the Americas" initiative. After having been pilot tested in three countries of the Region –Bolivia, Colombia and Jamaica– this instrument was presented this year to the Directing Council of PAHO, which adopted a resolution for its application throughout the Region[1].

The instrument was submitted for consideration to a group of decisionmakers from the Ministry of Health and to a select group professionals within the public health field in Country X, in order conduct a measurement exercise of the performance of EPHF[2].

The measurement exercise was organized by the Ministry of Health of X, with the collaboration of the PAHO/WHO Representative Office in that country and of the Division of Health Systems and Services Development of PAHO. It was strongly supported by the Minister of Health, who pledged support for this initiative, which seeks to strengthen the public health services infrastructure of the countries of the Region.

Description of the Process

The PAHO/WHO Representative Office in X coordinated and organized the preparatory stage of the application workshop, in conjunction with staff members from the Ministry of Health.

[1] Resolution CD42.R14. Essential Public Health Functions. 42nd Directing Council of PAHO. Washington, DC, 25 to 29 September 2000.

[2] The list of participants in the event is presented as an Annex.

Application of the Instrument

X professionals (including health personnel, academicians, and other specialists) were selected and convened by the Ministry of Health, working virtually nonstop throughout the three days of the effort. The large number of participants meant that the analysis of the functions had to be broken down into two parallel groups, each responsible for discussing specific functions and the measurement of their performance.

Each group was supported by an external facilitator (who helped build a consensus around the group response), a secretary (usually a local facilitator designated by the Ministry) who kept track of the responses and confirmed the degree of consensus in the group, and a technical assistant to record the responses. At the same time, PAHO staff members contributed to the effort by obtaining the comments and suggestions of the participants to refine the terminology or make improvements to the instrument.

The mechanics of the exercise provided for each facilitator to read out loud the definition, standards, measures, and submeasures of each function the group was to discuss. The external facilitator, supported by the local facilitator from the Ministry, ensured that the voting reflected a consensus response by the participating group.

Results of the Measurement

Description of the Scoring and Measurement Mechanism

The score for each indicator that was part of the measurement for each function is based on the score obtained for the so-called "*Parent Questions."* Such questions may be answered with a partial response, since they are based on the average value of "Yes" responses of the measures and itemized submeasures they contain.

The questions for the measures and submeasures allow for only a "Yes" or "No" response. It is therefore important to understand how the collective response to each measure and submeasure is obtained. For the purposes of this exercise, it was determined that if a consensus response could not be obtained in a group discussion through a second round of voting after a tie and has led to another tie, the response will automatically be "No" due to the consistent degree of uncertainty.

In order to record and process the results of the responses, a computer program was used to tally the final score of each question directly, as a function of the responses to its measures and submeasures. This calculation of the final score

of every parent question is essentially the average of the "Yes" responses to the measures and submeasures, given the exceptions mentioned in the instrument.

The score assigned to the indicator is the average of the results obtained for each of the measures within the indicator and the average of the results of all the indicators in a function determines the score for the performance of that particular essential public health function.

The following scale is proposed as a conventional guide for overall interpretation:

76-100%	(0.76 to 1.0)	Quartile of optimal performance
51-75%	(0.51 to 0.75)	Quartile of above average performance
26-50%	(0.26 to 0.50)	Quartile of below average performance
0 - 25%	(0.0 to 0.25)	Quartile of minimum performance

At the end of the workshop, the results of the measurement were shared with the participants. Examples were provided of the types of analysis that can be done when measuring the performance of each EPHF, oriented toward the identification of intervention areas in order to improve the institutional capacity of the health authority in exercising the essential public health functions that pertain to it.

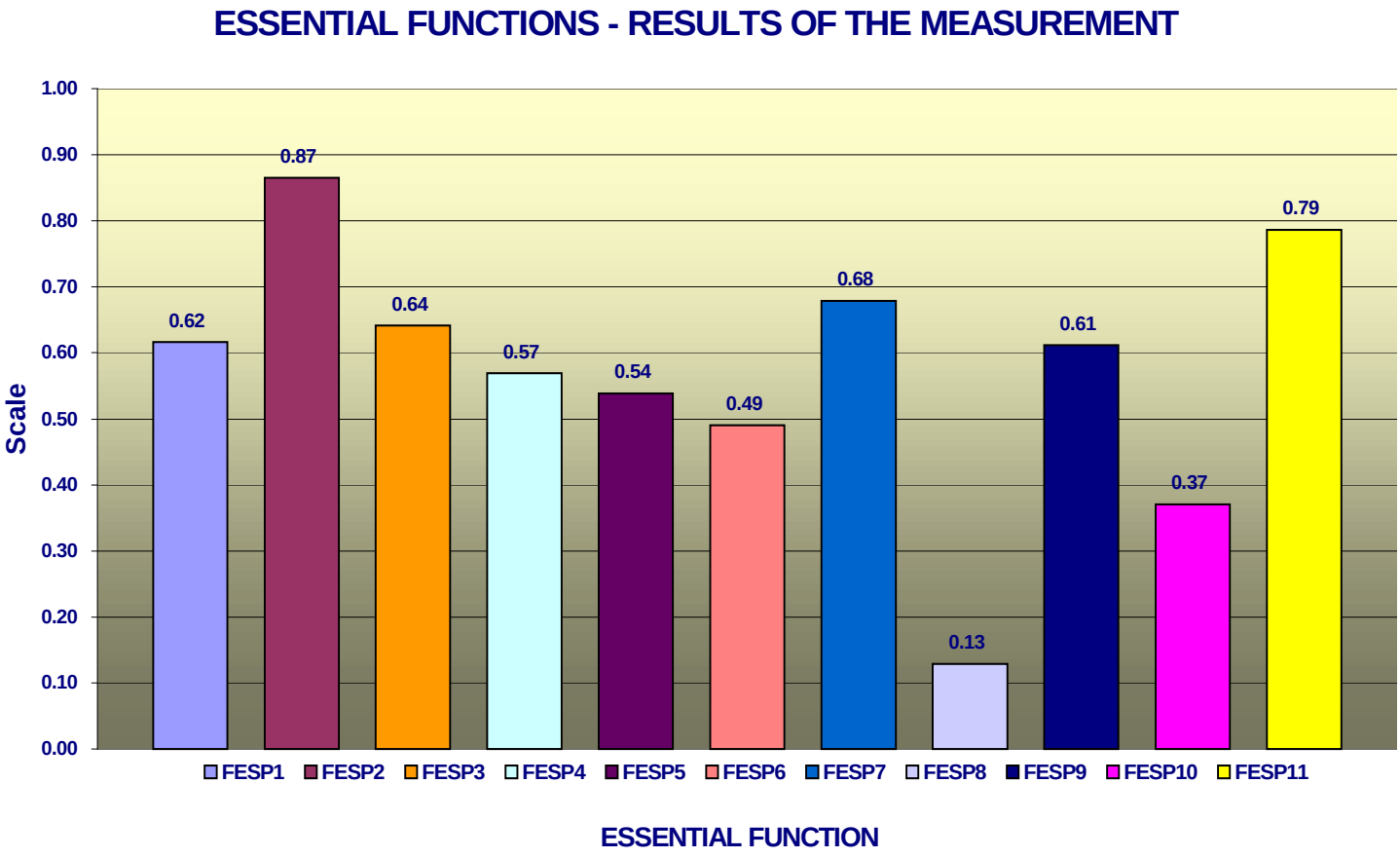
Although it was acknowledged that the criteria for scoring are not yet fully refined, it is accepted that they will suffice to identify the strengths and weaknesses of the public health system. As the measurement effort is applied throughout the Region and the performance of more countries is evaluated, the instrument will gradually develop greater precision.

Successive applications of the instrument will allow for the identification of consistencies between the measurement and gaps in the public health system infrastructure, making it possible to improve the orientation of interventions recommended for strengthening institutional capacity.

Overall Analysis of Results

As noted in the workshop, it is important to underscore that the analysis of the results of the exercise has already been conducted. It is summarized here in order to provide examples of how the results may be interpreted. Obviously, this is the responsibility of the authorities in each country, and is to be done in light of the unique characteristics and circumstances of the authority's fulfillment of the essential public health functions. It should also be noted that in interpreting the results, it may be necessary to compensate for possible biases in the groups analyzing each function. The following figure provides an overview of the performance of each of the eleven EPHF in Country X.

Figure 1: Results of the Measurement by Function[3]



This overview of the performance of the eleven essential public health functions (Figure 1) shows how Function 2 (Public Health Surveillance, Research, and Control of Risks and Harm to Public Health) has the highest score; this could be interpreted as the result of the country's emphasis on surveillance, in terms of both training and operations.

The function with the second highest score was Function 11 (Reducing the Impact of Emergencies and Disasters on Health). The group that analyzed it had little knowledge of the subject, and the evacuation criteria of personnel directly involved in the subject dominated the discussion. This is an example of possible biases, which as noted above, make it necessary to exercise caution in interpreting the results.

At the other end of the spectrum, the lower score in Function 8 (Human Resources Development and Training in Public Health) might reflect a sort of "manifest dissatisfaction" by the group with the conditions for staff development.

[3] The list of the essential public health functions is presented as an Annex.

Function 10 (Research in Public Health) also received a score that places it in the below average performance quartile, which might reflect concerns over the apparently little attention devoted to research.

The low score assigned to each of these two Functions (8 and 10) might reflect neglect of investments in human capital and the scientific apparatus to sustain the development of public health in the country. This hypothesis would warrant a detailed analysis within the context of a process aimed at improving public health, given the medium- and long-term implications of investment in this area.

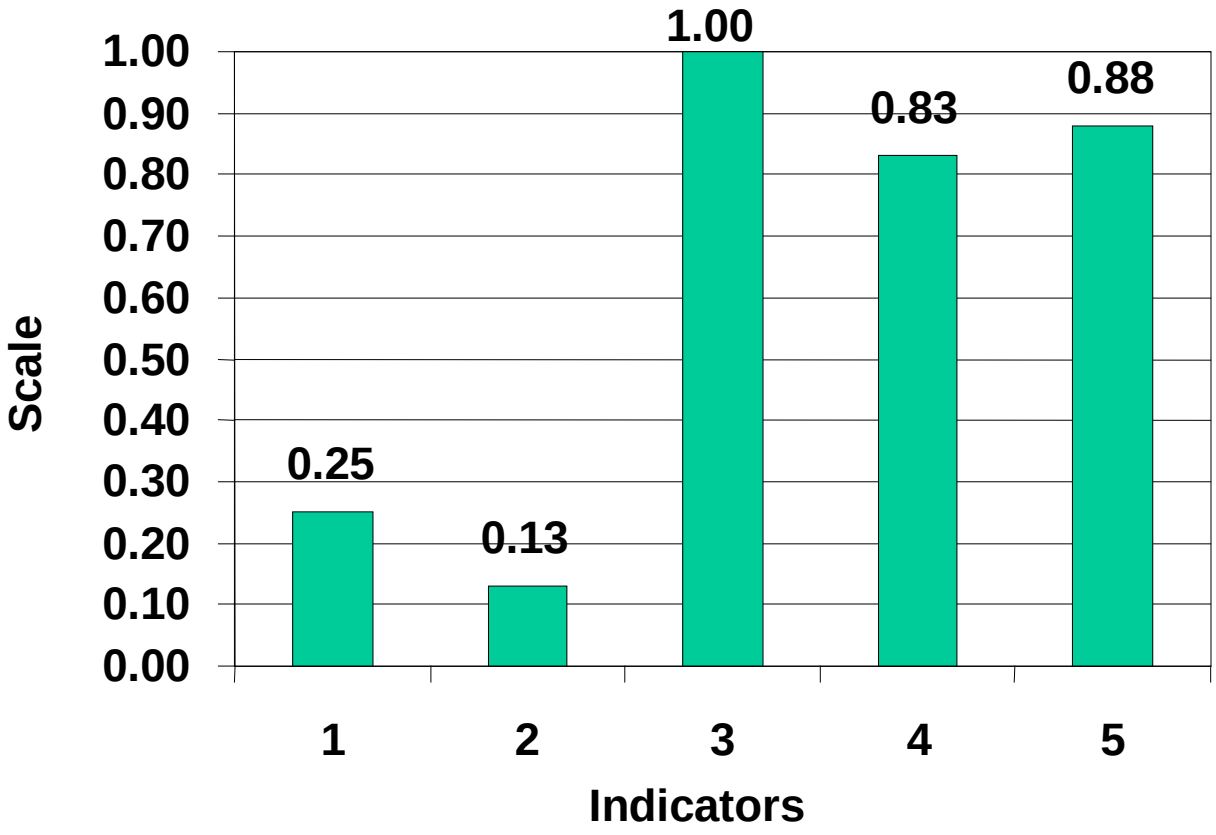
Likewise, Function 6 (Strengthening of Institutional Capacity for Regulation and Enforcement in Public Health) scored in the below average performance quartile. This explains the concern manifested at the beginning of the exercise to include additional aspects on regulation, specifically with regard to insurance companies.

By way of example, the general observation on the scores in these three Functions (6, 8, and 10) is that they suggest the possible existence of gaps or weaknesses that might warrant priority attention from the health authority.

In general, the remaining functions obtained scores that place them in the quartile of above average performance, not the optimum proposed in the objective vision of the process.

In order to delve further into the analysis of the results, the figures on the indicator profiles for each function are provided below, accompanied by comments. It should be noted that the remarks on these results were made at the workshop and are provided as an example of the type of analysis that is possible; under no circumstances are the remarks intended as diagnostic conclusions, since this is the exclusive competence of the health authority, which, of course, provides the criteria and context for interpreting the numerical results.

<u>Essential Function No 1</u>: Monitoring, Evaluation and Analysis of Health Status

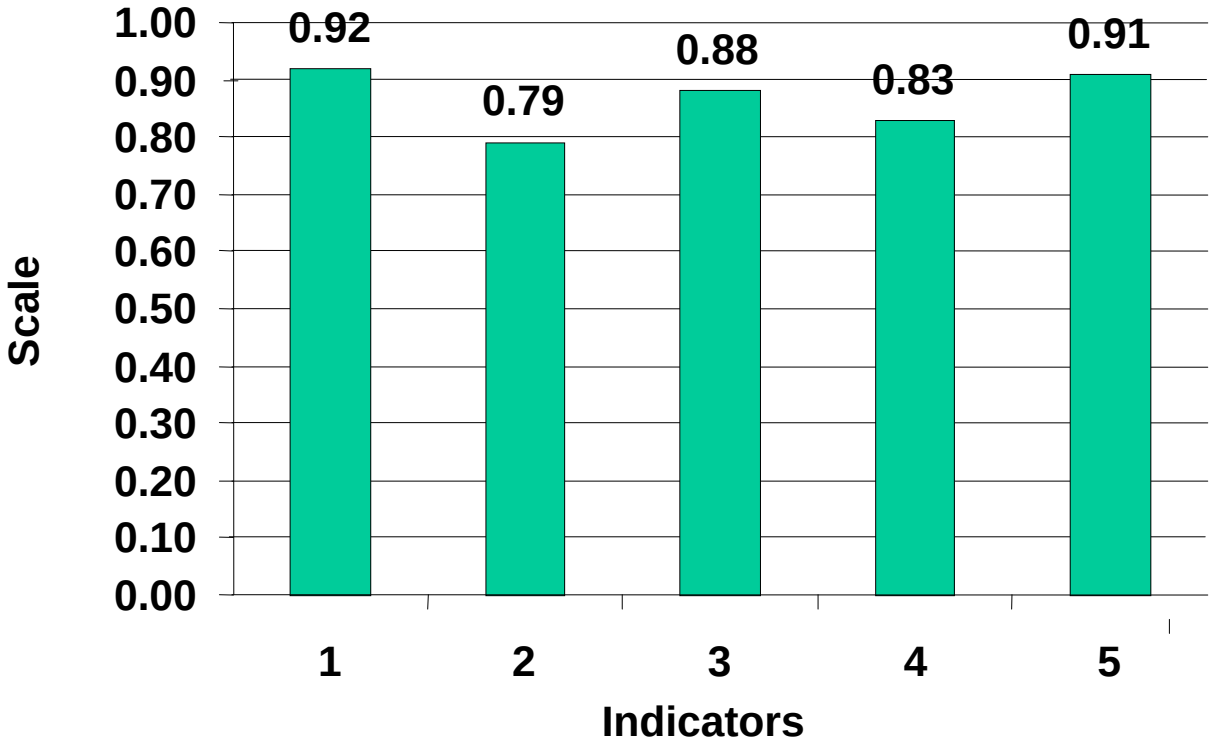


Indicators:

1. Guidelines and processes for monitoring health status
2. Evaluation of the quality of information
3. Expert support and resources for monitoring health status
4. Technical support for monitoring and evaluating health status
5. Technical assistance and support to the subnational levels of public health

Most striking in this function profile are the lower scores of the first two indicators that describe the process and outcome of the monitoring, analysis, and evaluation of the health situation. In contrast, the scores of the next three indicators (indicators 3,4 and 5) are much higher and demonstrate that the institutional capacity to exercise this function is optimal. This could be interpreted as an institutional management problem, rather than one of resources and infrastructure.

Essential Function No 2: Public Health Surveillance, Research, and Control of Risks and Threats to Public Health

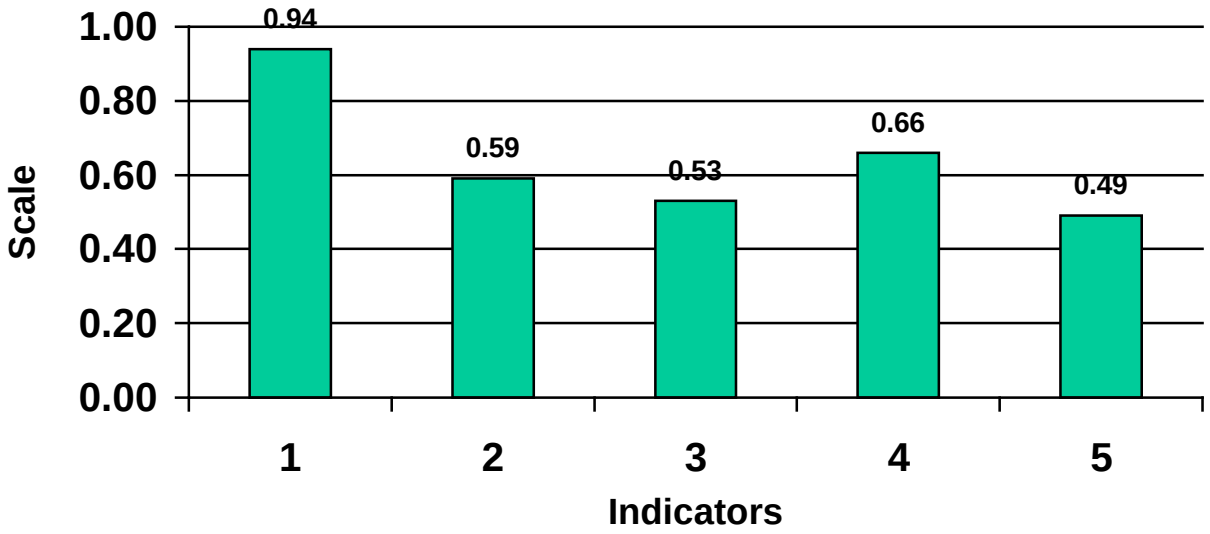


Indicators:

1. Surveillance system to identify threats and harm to public health
2. Capacities and expertise in public health surveillance
3. Capacity of public health laboratories
4. Capacity for timely and effective response to control public health problems
5. Technical assistance and technical support for the subnational levels of public health.

As noted in the overall analysis, the score for this function indicated a virtually optimal performance, which is a result of the high scores for each of the indicators included in the function. It is worth asking whether some degree of bias might have been present in the group that responded to the questions. In any case, there is a marked consistency in the positive results.

Essential Function No. 3: Health Promotion



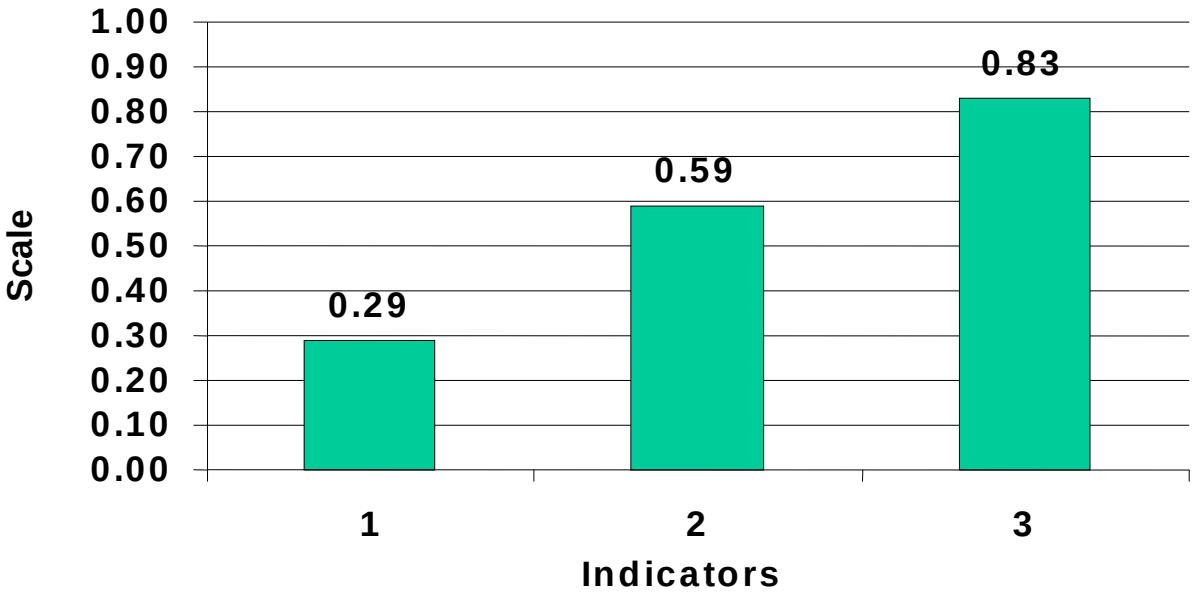
Indicators:

1. Support for health promotion activities, the development of norms, and interventions to promote healthy behaviors and environments
2. Building of sectoral and extrasectoral partnerships for health promotion
3. National planning and coordination of information, education, and social communication strategies for health promotion
4. Reorientation of the health services toward health promotion
5. Technical assistance and support to the subnational levels to strengthen health promotion activities.

Contrary to what was seen in Function 1, it seems that for this function the analysis was favorable to one of the processes involved: that which is carried out within the organization of health services, notwithstanding the recognition that there is little development of decentralized capacity for the exercise of this function (Indicator 5).

It should be noted that the processes involving this capacity of the health authority outside the health sector (Indicators 2 and 3) obtained a moderately unsatisfactory score. This may pose a challenge to the health authority in terms of strengthening its leadership in the extrasectoral dynamic affecting the quality of life; to some extent it explains the interest expressed prior to the meeting to further promote the determinants of the quality of life, which was proposed as a potential area for expansion in the instrument.

Essential Function No. 4: Social Participation in Health



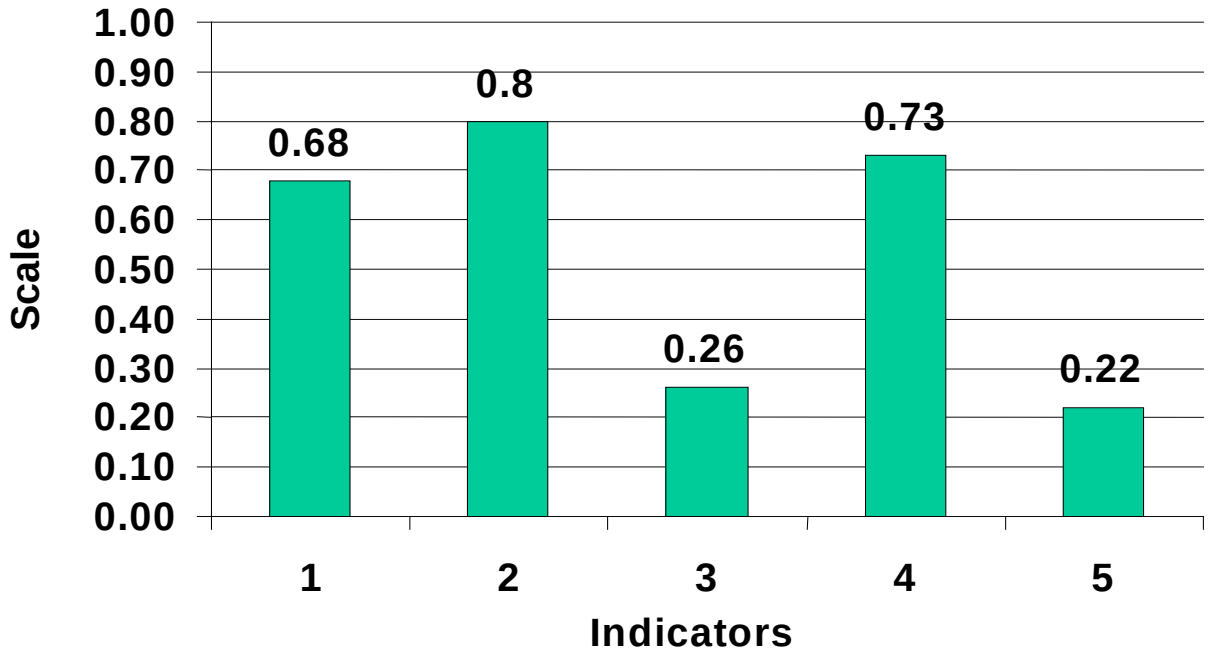
Indicators:

1. Empowering citizens for decision-making in public health
2. Strengthening of social participation in health
3. Technical assistance and support to the subnational levels to strengthen social participation in health.

As with the first function, the exercise reveals a remarkably high degree of dissatisfaction with the performance in fulfilling this function, in contrast to the recognition of the effort involved to improve the decentralized capacity to carry out two processes in this function.

Despite the unsatisfactory performance in both processes, it might be interesting to delve further into the considerable differences in the scores for social participation in health.

Essential Function No. 5: Development of Policies and Institutional Capacity for Planning and Management in Public Health



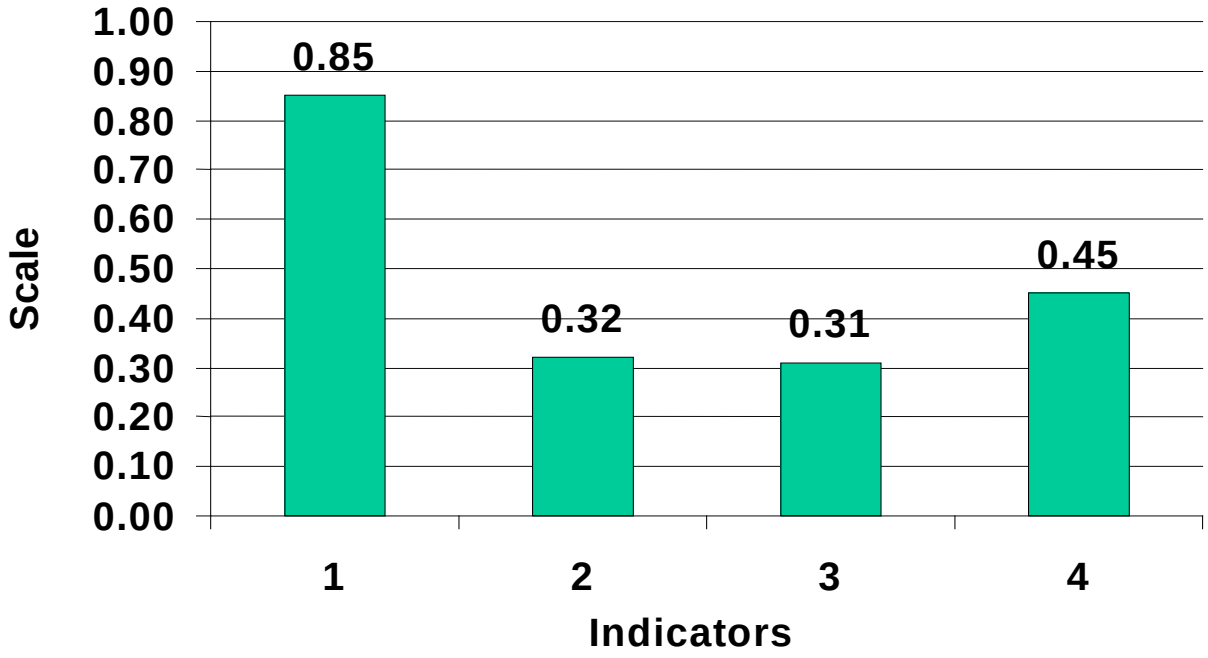
Indicators:

1. Definition of national and subnational health objectives
2. Development, monitoring, and evaluation of public health policies
3. Development of institutional capacity for the management of public health systems
4. Negotiation of international cooperation in public health
5. Technical assistance and support to the subnational levels for policy development, planning, and management in public health.

The profile for this function reveals weaknesses in the development of the institutional capacity for management, in contrast to the moderately satisfactory performance in defining objectives and public health policies; it also reveals a low score with regard to strengthening the subnational levels for decentralized planning and management.

If these deficiencies actually do exist, they might explain the performance gap between some processes and the available installed capacity, as noted in Functions 1, 4, 7, and 10.

Essential Function No. 6: Strengthening of Institutional Capacity for Regulation and Enforcement in Public Health



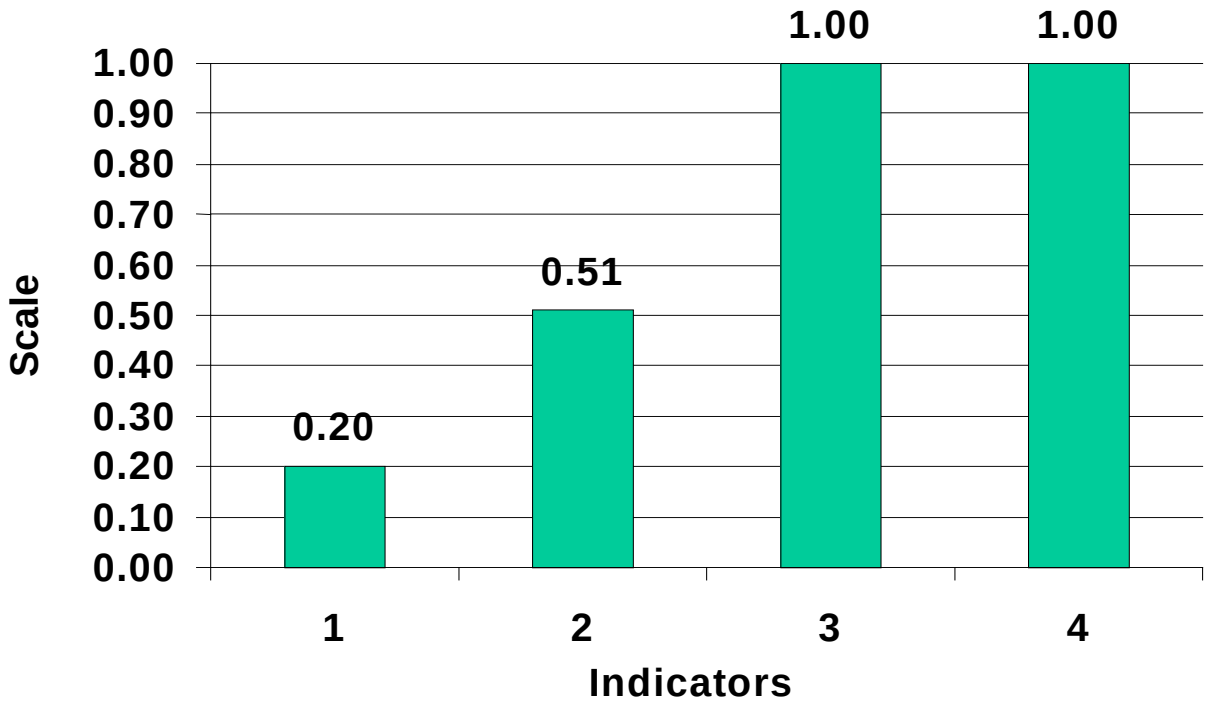
Indicators:

1. Periodic monitoring, evaluation, and modification of the regulatory framework
2. Enforcement of laws and regulations
3. Knowledge, skills, and mechanisms for reviewing, improving, and enforcing the regulations
4. Technical assistance and support to the subnational levels of public health in developing and enforcing laws and regulations.

The deficiencies in this function refer to the health authority's capacities and the exercise of its roles in inspection and enforcement, in tandem with its regulatory role.

The lack of effort to strengthen regulatory and enforcement capacities at the subnational levels is noteworthy as this could warrant an in-depth analysis, given its implications for the exercise of the steering role of health and the territorial expanse and demographic diversity of the country.

Essential Function No. 7: Evaluation and Promotion of Equitable Access to Necessary Health Services



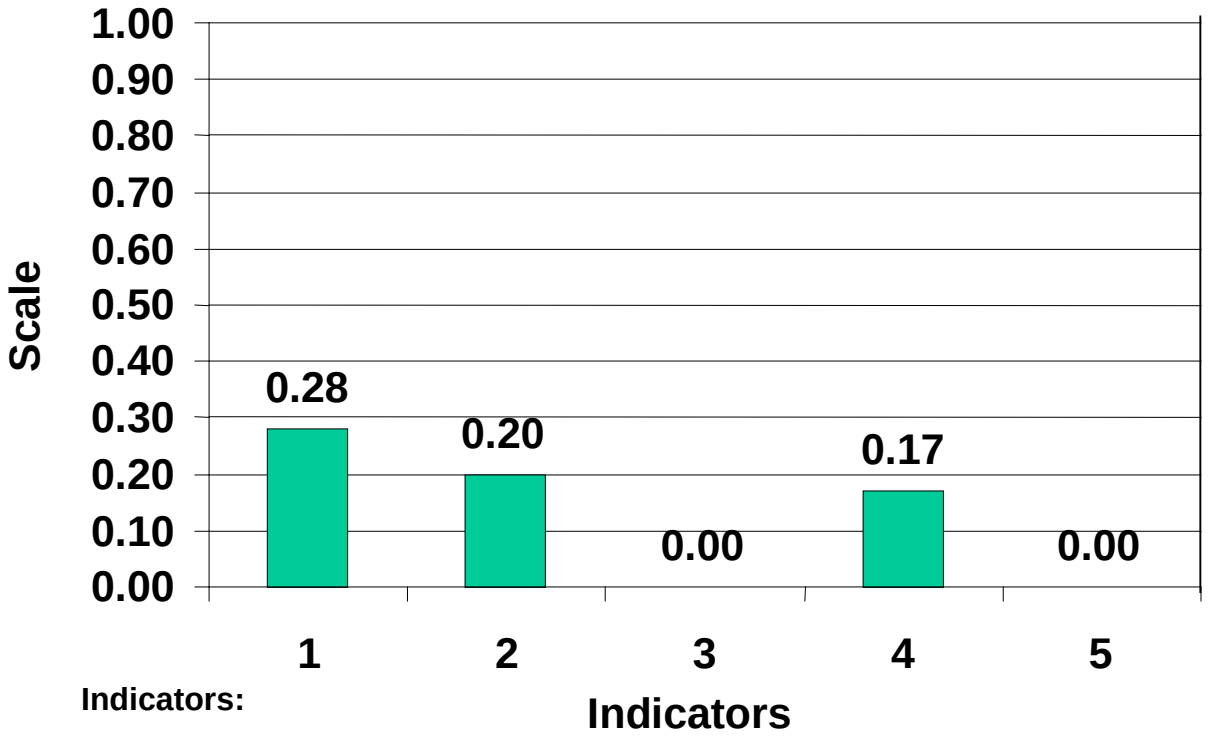
Indicators:

1. Monitoring and evaluation of access to necessary health services
2. Knowledge, skills, and mechanisms for improving access by the population to necessary health services
3. Advocacy and action to improve access to necessary health services
4. Technical assistance and support to the subnational levels to promote equitable access to health services.

This function profile reflects, yet again, the aforementioned gap between the exercise of processes and the capacity to perform them.

Also evident is the remarkable difference between satisfaction with advocacy for improving access and dissatisfaction with knowledge of the conditions of access and possible interventions to improve access. It would be advisable to analyze these in depth. Furthermore, it is evident that the efforts to strengthen decentralized capabilities to address problems of access are regarded as optimal.

Essential Function No. 8: Human Resources Development and Training in Public Health



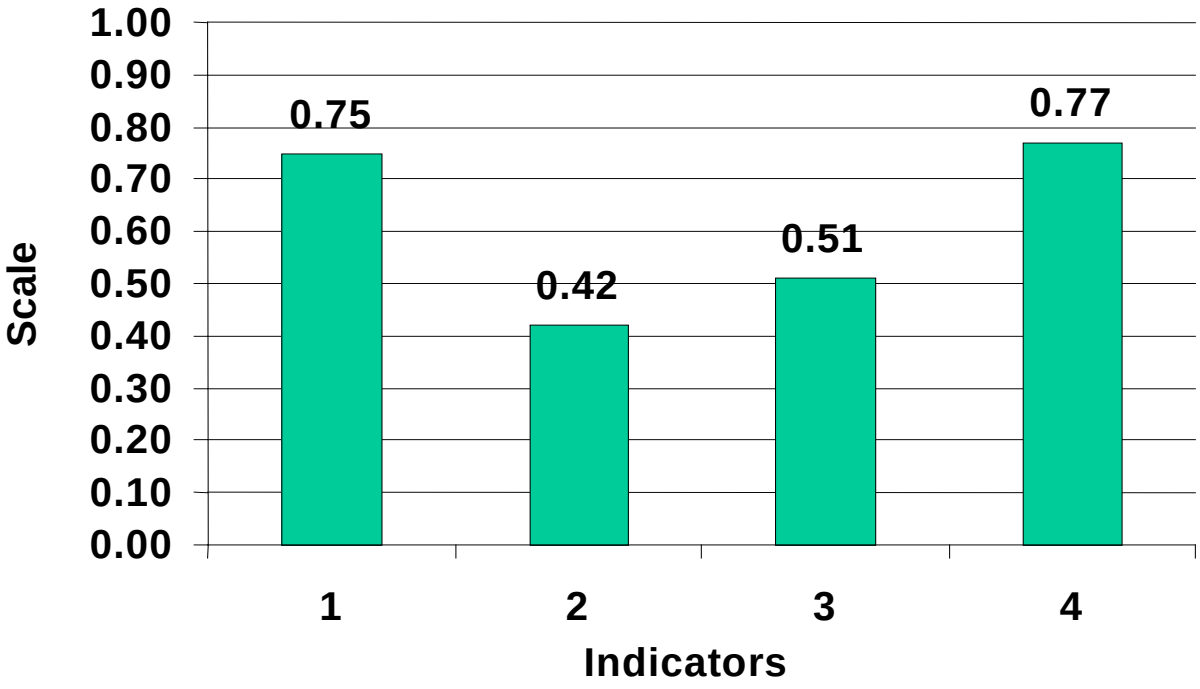
Indicators:

1. Description of the public health workforce
2. Improving the quality of the workforce
3. Continuing education and graduate training in public health
4. Upgrading human resources to ensure culturally appropriate delivery of services
5. Technical assistance and support to the subnational levels in human resources development.

The profile of this function reflects the national evaluation group's strong dissatisfaction with the performance of the health authority in human resource development. There is a remarkably low score for continuing education efforts and for support to the subnational levels.

It would be necessary to provide a context and perform an in-depth analysis of the results in these five indicators in order to validate their objectivity and understand the underlying factors if a pertinent intervention strategy is to be developed.

Essential Function No. 9: Quality Assurance in Personal and Population-based Health Services



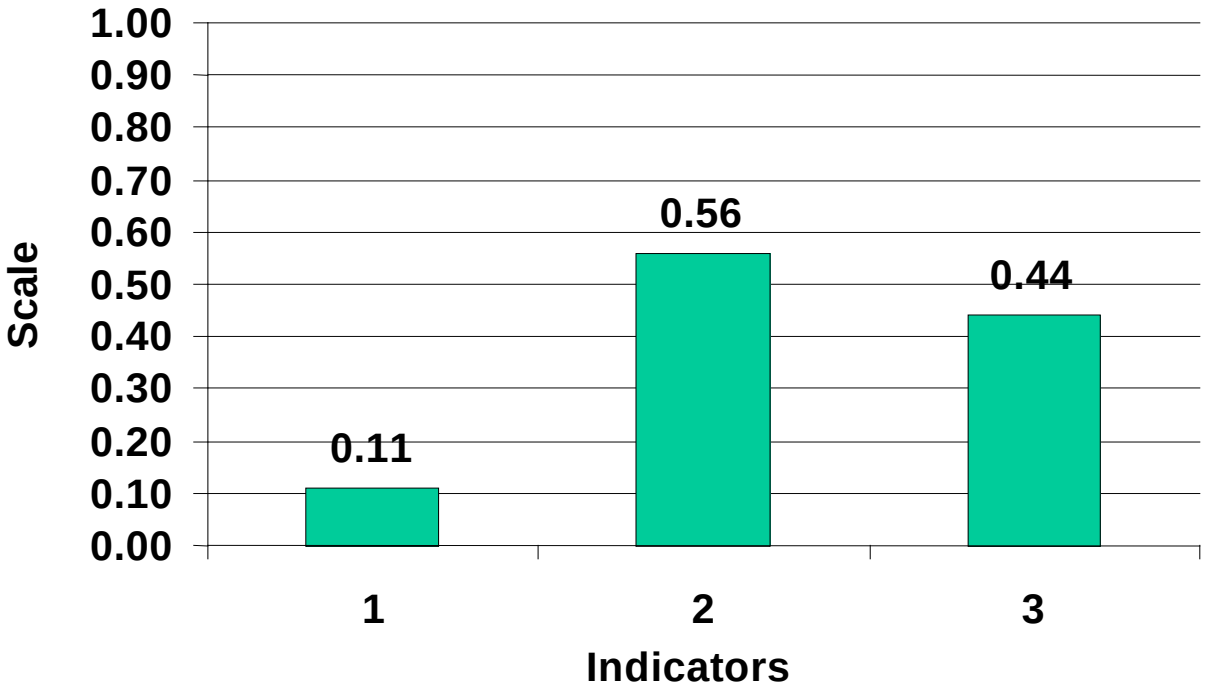
Indicators:

1. Definition of standards and evaluation to improve the quality of population-based and personal health services
2. Improving user satisfaction with the health services
3. Systems for technological management and health technology assessment to support decision-making in public health
4. Technical assistance and support to the subnational levels to ensure quality improvement in the services.

Once more, there is a clear asymmetry between the normative processes (Indicator 1) and the executive processes (Indicators 2 and 3), with the latter lagging behind. Also evident is the occasional disjunction between the quality-assurance capacity at the decentralized levels and the action taken to improve user satisfaction.

These are clear examples indicating that the analysis of the exercise of these functions should rely on in-depth knowledge of the national situation and be geared to identifying determinants for the preparation of pertinent intervention strategies.

Essential Function No. 10: Research in Public Health



Indicators:

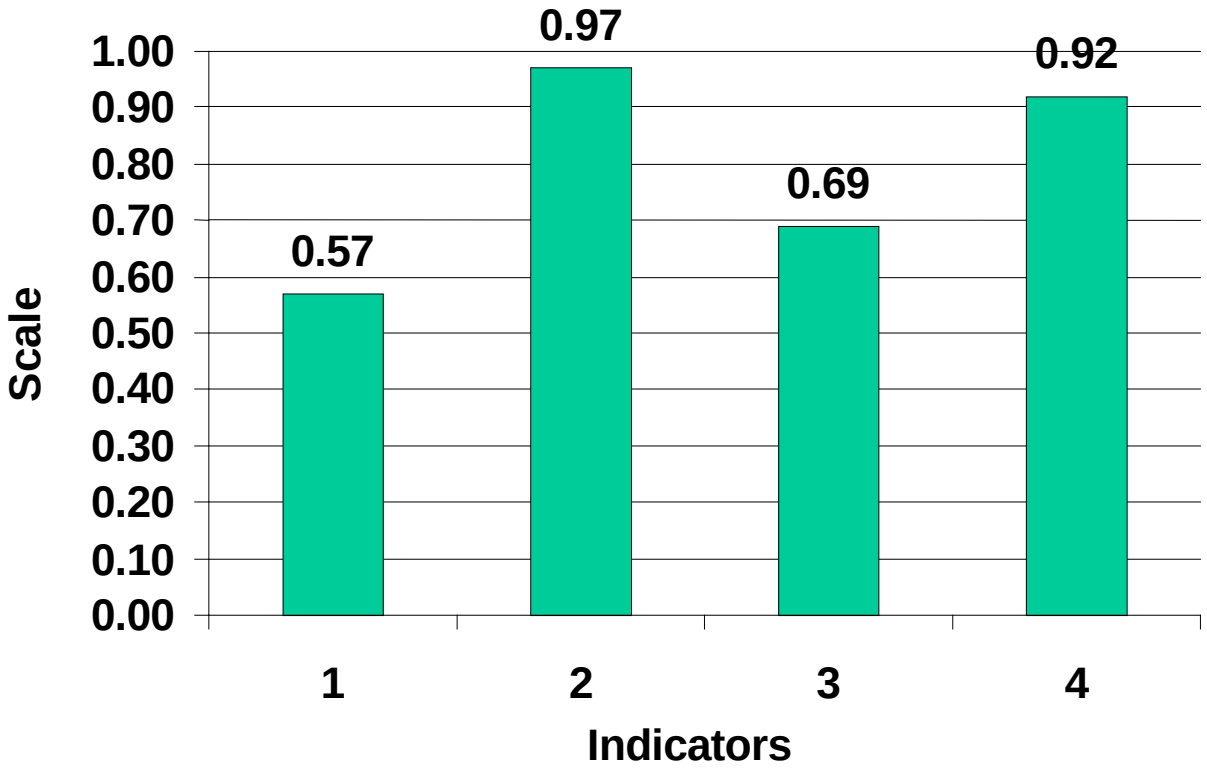
1. Development of a public health research agenda
2. Development of institutional research capacity
3. Technical assistance and support for research in public health at the subnational levels

As noted above, this function yet again reflects the gap between installed capacity and its utilization in research.

The low score for the indicators of this function may reflect limited efforts by the health authority to support the process of generating knowledge, implementing a national research agenda, or making use of the research findings of other actors.

More in-depth analysis may be called for with regard to possible relationships between the low results obtained in Function 8 (human resources development) and this research function.

Essential Function No. 11: Reducing the Impact of Emergencies and Disasters on Health



Indicators:

1. Reducing the impact of emergencies and disasters
2. Development of standards and guidelines that support emergency preparedness and disaster management in health
3. Coordination and partnerships with other agencies and/or institutions
4. Technical assistance and support to the subnational levels to reduce the impact of emergencies and disasters on health.

The profile of this function reflects yet again the gap between the normative (Indicator 2) and executive (Indicator 1) capacities, and between developed capacity and its utilization in work processes. Given the characteristics of the group that analyzed it and the knowledge available to it, a review of the results obtained in previous iterations of the instrument is recommended.

Identification of Priority Intervention Areas for the Institutional Development Plan

In preparing a plan to develop the institutional capacity of the health authorities to improve the exercise of the EFPH pertaining to them (the immediate objective of this exercise in performance measurement), two basic premises have been observed:

1) Development efforts should be institutional in nature. This implies a comprehensive approach, rather than isolated interventions targeting the actors and areas of each function. To this end, all the functions have been merged into three strategic intervention areas:

    - **Final achievement of outcomes and key processes**, the substantive component of the work of the health authority in public health, and thus, the primary goal of interventions to improve performance.

    - **Development of capacities and infrastructure**, understood as the human, technology, knowledge, and resources situation necessary for the optimal exercise of the public health functions appertaining to the health authority.

    - **Development of decentralized competences**, in terms of faculties and capacities directed to supporting the subnational levels or to transferring responsibilities to them, so as to strengthen the decentralized exercise of the health authority with regard to public health, consistent with the requirements of State modernization and sectoral reform.

2) Interventions for institutional development must seek to overcome *weaknesses* by taking advantage of *strengths.* In order to rate performance in the different indicators as strengths or weaknesses, a *reference value* is needed; this needs to be identified for each country at different points in the process, as a function of the level of performance and development goals. The basic criteria for establishing the reference values are: a) that the weaknesses diagnosed not be accepted or consolidated and, b) that they represent an achievable challenge and a reasonable incentive for continuing efforts at improvement.

    Nevertheless, for the purposes of these pioneering applications of the instrument, and in order to facilitate consolidation of the results of all the evaluations in the countries of the Region (with a view to formulating a regional plan of action), as a convention, the reference value has been set as the average of the overall results in the 11 functions. The majority of deficiencies thus remain qualified as weaknesses to be overcome.

The workshop discussed whether the reference value for X should be 50% or more. The view was that on this occasion the country's track record and national public health resources warranted raising the value closer to 70%. In any case, this presentation of results uses the reference value adopted for the regional exercise, without prejudice to the future ability of the national authorities to change it when preparing their development plan.

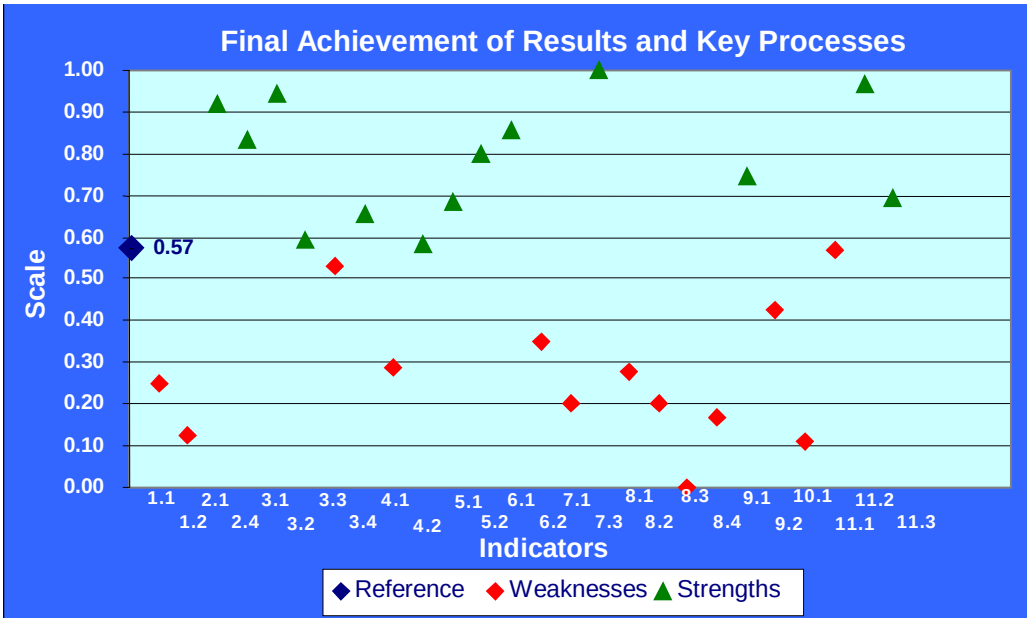
What follows is the classification of the indicators as strengths or weaknesses resulting from the application of the aforementioned reference value, along with comments, for example, on possible areas for priority intervention in the three components of institutional development that have been identified.

Area of Intervention: Final Achievement of Results and Key processes

EFPH	Indicators	Classification	
1	**1.1** Guidelines and processes for monitoring health status	0.25	**W**
1	**1.2** Evaluation of the quality of information	0.13	**W**
2	**2.1** Surveillance system to identify threats and harm to public health.	0.92	**S**
2	**2.4** Capacity for timely and effective response to control public health problems	0.83	**S**
3	**3.1** Support for health promotion activities, the development of norms, and interventions to promote healthy behaviors and environments	0.94	**S**
3	**3.2** Building of sectoral and extrasectoral partnerships for health promotion	0.59	**S**
3	**3.3** National planning and coordination of information, education, and social communication strategies for health promotion	0.53	**W**
3	**3.4** Reorientation of the health services toward health promotion	0.66	**S**
4	**4.1** Empowering citizens for decision-making in public health	0.29	**W**
4	**4.2** Strengthening of social participation in health	0.59	**S**
5	**5.1** Definition of national and subnational health objectives	0.68	**S**
5	**5.2** Development, monitoring, and evaluation of public health policies	0.80	**S**
6	**6.1** Periodic monitoring, evaluation, and modification of the regulatory framework	0.85	**S**
6	**6.2** Enforcement of laws and regulations	0.35	**W**
7	**7.1** Monitoring and evaluation of access to necessary health services	0.20	**W**
7	**7.3** Advocacy and action to improve access to necessary health services	1.00	**S**
8	**8.1** Description of the public health workforce	0.28	**W**
8	**8.2** Improving the quality of the work force	0.20	**W**
8	**8.3** Continuing education and graduate training in public health	0.00	**W**
8	**8.4** Upgrading of human resources to ensure culturally appropriate delivery of services	0.17	**W**
9	**9.1** Definition of standards and evaluation to improve the quality of population-based and personal health services	0.75	**S**
9	**9.2** Improving user satisfaction with the health services	0.42	**W**
10	**10.1** Development of a public health research agenda	0.11	**W**
11	**11.1** Reducing the impact of emergencies and disasters	0.57	**W**
11	**11.2** Development of standards and guidelines that support emergency preparedness and disaster management in health	0.97	**S**
11	**11.3** Coordination and partnerships with other agencies and/or institutions	0.69	**S**

The main weaknesses that the priority interventions should probably focus on in order to improve the processes and results of the exercise of the essential public health functions corresponding to the health authority would be, first, those related to developing human resources and the research agenda and improving the quality of information used in monitoring and evaluating the health situation and access. These were indicated as being in the range of minimum performance. Second would be those involving empowerment of the citizens, communication for health promotion and the improvement of user satisfaction, inspection activities to enforce existing regulations, and management to reduce the impact of emergencies and disasters.

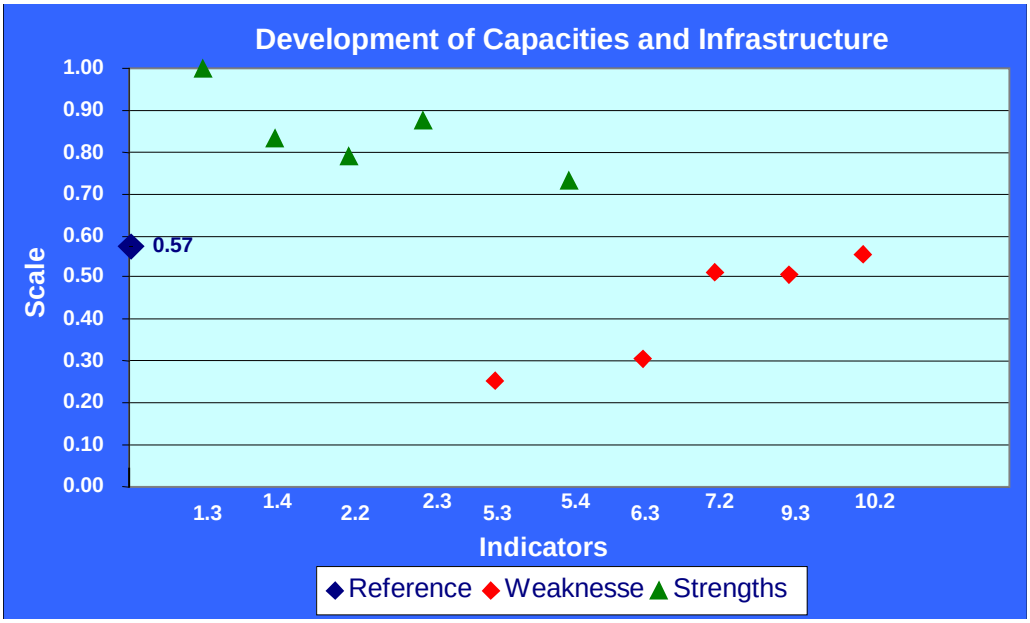
The interventions to improve processes and outcomes are generally of a managerial type. They involve adopting measures for installed capacity to be used more efficiently and to improve operations and results. Such actions can be based on the identified strengths in areas related to these weaknesses, such as: operation of the surveillance and response system for the control of public health problems (this can serve as a reference to improve monitoring and evaluation of the health situation). For example, the development of standards and promotional interventions should serve as the basis for improving communication strategies for promotion; social participation actions could be used to empower citizens in decision-making. Obviously, implementation of the regulations must be the starting point for actions aimed at improving regulatory enforcement.



Area of Intervention: Capacity and Infrastructure Development

EFPH	Indicators	Classification	
1	**1.3** Expert support and resources for monitoring health status	1.00	**S**
1	**1.4** Technological support for the monitoring and evaluation of health status	0.83	**S**
2	**2.2** Capacities and expertise in public health surveillance	0.79	**S**
2	**2.3** Capacity of public health laboratories	0.88	**S**
5	**5.3** Development of institutional capacity for the management of public health systems	0.26	**W**
5	**5.4** Negotiation of international cooperation in public health	0.73	**S**
6	**6.3** Knowledge, skills, and mechanisms for reviewing, improving, and enforcing the regulations	0.31	**W**
7	**7.2** Knowledge, skills, and mechanisms for improving access by the population to programs and services	0.51	**W**
9	**9.3** Systems for technology management and health technology assessment to support decision-making in public health	0.51	**W**
10	**10.2** Development of institutional research capacity	0.56	**W**

The main weaknesses that the priority interventions to develop human, technical and infrastructure capacities should target in order to improve the processes and results of the exercise of the essential public health functions corresponding to the health authority would be, first, those related to increasing the institutional capacity of management, regulation and control, and, second, those related to improving access to the services, technology management, and research. The interventions to increase institutional capacity are more likely to involve investment in training, acquisition of expertise, and procurement of technology resources to improve performance in functions where capacities are deficient.

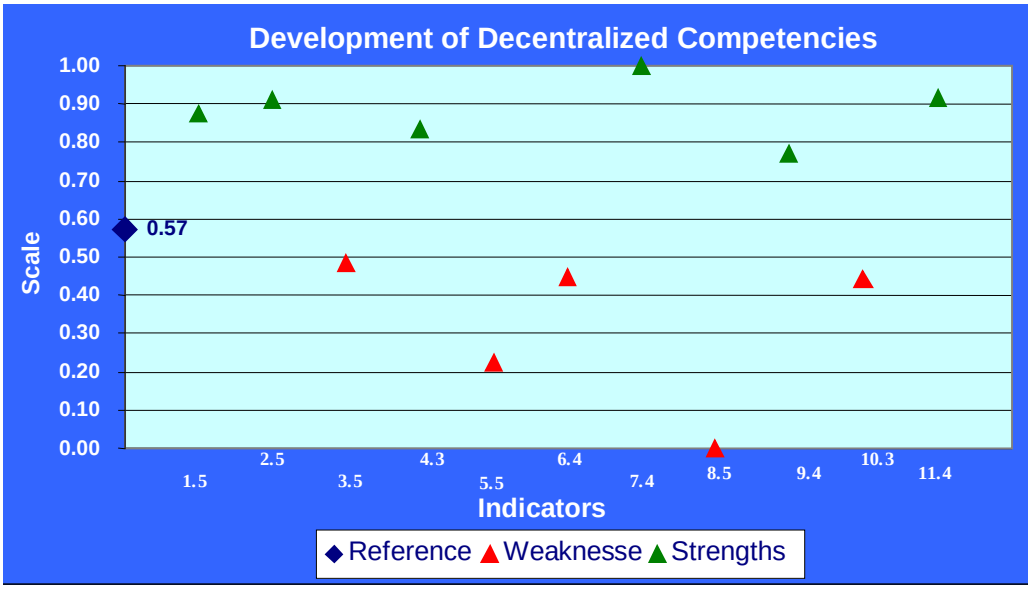


Area of Intervention: Development of Decentralized Competencies

EFPH	Indicators	Classification	
1	**1.5** Technical assistance and support to the subnational levels of public health	0.88	**S**
2	**2.5** Technical assistance and support to the subnational levels of public health	0.91	**S**
3	**3.5** Technical assistance and support to the subnational levels to strengthen health promotion activities.	0.49	**W**
4	**4.3** Technical assistance and support to the subnational levels to strengthen social participation in health	0.83	**S**
5	**5.5** Technical assistance and support to the subnational levels in policy development, planning, and management in public health	0.22	**W**
6	**6.4** Technical assistance and support to the subnational levels of public health in developing and enforcing laws and regulations	0.45	**W**
7	**7.4** Technical assistance and support to the subnational levels of public health to promote equitable access to health services	1.00	**S**
8	**8.5** Technical assistance and support to the subnational levels in human resources development	0.00	**W**
9	**9.4** Technical assistance and support to the subnational levels of health to ensure quality improvement in the services	0.77	**S**
10	**10.3** Technical assistance and support for research in public health at the subnational levels	0.44	**W**
11	**11.4** Technical assistance and support to the subnational levels to reduce the impact of emergencies and disasters on health	0.92	**S**

The main weaknesses that the priority interventions related to the development of human resources and the capacity for planning and management at the subnational levels should focus on in order to improve the processes and results of the exercise of the essential public health functions corresponding to the health authority would probably be, first, those which are in the range of minimum performance; and second, those related to technical support to the subnational levels in health promotion, research, and decentralized oversight.

Interventions in this area of institutional development generally have to do with the delegation of functions, along with the strengthening of the capacity to exercise them, and technical support from the central levels for optimal performance by the subnational levels.



Conclusion

The test application in X was a success, as reflected in the strong interest and motivation of the participants and their contributions to improve the instrument, based on their professional expertise and the shared experience in issues pertaining to the EFPH.

This experience will be of assistance in adapting the measurement instrument and improving the methodology for applying it, pursuant to the resolution of the Directing Council of PAHO. It is furthermore assumed that it will serve the country as a baseline for future implementation and evaluation activities.

Annex 1: List of Essential Public Health Functions

Essential Public Health Functions	
EPHF 1	**Monitoring, Evaluation and Analysis of the Health Situation of the Population**
EPHF 2	**Public Health Surveillance, Research, and Control of Risks and Threats to Public Health**
EPHF 3	**Health Promotion**
EPHF 4	**Social Participation in Health**
EPHF 5	**Development of Policies and Institutional Capacity for Planning and Management in Public Health**
EPHF 6	**Strengthening of Institutional Capacity for Regulation and Enforcement in Public Health**
EPHF 7	**Evaluation and Promotion of Equitable Access to Necessary Health Services**
EPHF 8	**Human Resources Development and Training in Public Health**
EPHF 9	**Quality Assurance in Personal and Population-based Health Services**
EPHF 10	**Research in Public Health**
EPHF 11	**Reducing the Impact of Emergencies and Disasters on Health**[4]

[4] Reducing emergencies and disasters in health includes prevention, mitigation, preparedness, response, and rehabilitation.

Annex 2: List of Participants in the Workshop

NO.	NAME	POSITION AND INSTITUTION
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Annex 3:Results by Function and Indicators

Essential Function Nº 1: Monitoring, Evaluation, and Analysis of Health Status

FINAL SCORE EPHF No. 1	**0.00**
1.1 Guidelines and Processes for Monitoring Health Status	**0.00**
1.1.1 Has the NHA developed guidelines for measuring and evaluating the population's health status?	*0.00*
Do the guidelines or other instruments for monitoring health status:	
1.1.1.1 Have been developed for use by the national level of the health system?	0
1.1.1.2 Have been developed for use by all intermediate levels of the health system?	0
1.1.1.3 Have been developed for use by the local level of the health system?	0
1.1.1.4 Describe suitable methods for data collection and for selecting appropriate sources of information"?	0
1.1.1.5 Describe the role of the national and subnational levels in data collection?	0
1.1.1.6 Provide access to information for citizens and organized community groups while protecting an individual's privacy?	0
1.1.1.7 Include a process to continuously improve information systems that better meets the needs of users at the national and subnational levels (decision-makers, program directors, etc.)?	0
If so, does the process:	
1.1.1.7.1 Include uniform standards at all levels of the information system?	0
1.1.1.7.2 Include procedures compatible with the needs of the national and international agencies of which the system is a part and to which it should provide information?	0
1.1.1.7.3 Include a periodic review of standards and procedures to evaluate their relevance in light of the advances in technology and changes in health policy?	0
1.1.1.8 Describe procedures for conveying information to the mass media and the general public?	0
1.1.1.9 Protect the confidentiality of information through specific protocols for accessing the data?	0
1.1.1.10 Describe the procedures to follow in organizing information in a health status profile that contains information on national health objectives?	0
	0.00
1.1.2 Does the NHA identify and annually update the data collected in a country health status profile?	
Does this profile include:	
1.1.2.1 Social and demographic variables?	0
1.1.2.2 Mortality?	0
1.1.2.3 Morbidity?	0
1.1.2.4 Risk factors?	0
1.1.2.5 Information on lifestyles?	0
1.1.2.6 Environmental risks?	0
1.1.2.7 Access to personal health services?	0
1.1.2.8 Contact with population-based health services?	0

1.1.2.9 Use of population-based and personal health services?	0
1.1.2.10 Cultural barriers in accessing health care?	0
1.1.3 Does the NHA use the health status profile:	*0.00*
Is the health status profile used:	
1.1.3.1 To monitor the health needs of the population?	0
1.1.3.2 To evaluate inequities in health conditions?	0
1.1.3.3 To monitor trends in health status?	0
1.1.3.4 To monitor changes in the prevalence of risk factors?	0
1.1.3.5 To monitor changes in health services utilization?	0
1.1.3.6 To determine the adequacy and significance of the reported data?	0
1.1.3.7 To define the population's priorities and needs in terms of access to services, participation in health promotion activities and resource allocation, with particular emphasis on detecting inequities in access to and utilization of the health services?	0
1.1.3.8 To define national health objectives and goals?	0
1.1.3.9 To evaluate compliance with national health objectives and goals?	0
1.1.3.10 To improve the efficiency and quality of the system to exercise the essential public health functions?	0
1.1.3.11 Can you cite an example where this profile has been used?	0
1.1.4 Does the NHA disseminate information on the health status of the population?	*0.00*
Does the NHA:	
1.1.4.1 Produce an annual report?	0
1.1.4.2 Disseminate this report to all those interested in the information it contains?	0
1.1.4.3 Present it to a group of key decision-makers in the country?	0
1.1.4.4 Regularly organize seminars or other activities to explain or raise awareness among key decision-makers about the implications of the information contained in the annual report on the health status of the population?	0
1.1.4.5 Provide data on health outcomes that are followed over time and compared against standards and goals that are specifically mentioned in the profile?	0
1.1.4.6 Provide communities with a common set of measures to help them make comparisons, prioritize community health problems, and determine the allocation of resources?	0
1.1.4.7 Periodically solicit and evaluate suggestions to improve the content, presentation, and distribution of the health profile?	0
1.1.4.8 Regularly evaluate the use that those receiving the information make of the reports on the population's health status?	0

1.2 Evaluation of the Quality of Information	**0.00**
1.2.1 Is there a unit to evaluate the quality of the information generated by the health system?	*0.00*
If so, the unit:	
1.2.1.1 Is outside the direct control of the NHA?	0
1.2.1.2 Conduct periodic audits of the information system that assesses the country's health status?	0

1.2.1.3 Suggest modifications to the system in areas recognized as weak or in need of improvement?	0
1.2.1.4 Take into consideration the suggestions that the evaluation unit makes for improving the measurement of health status?	0
1.2.2 Is there a national coordinating entity for statistics of which the NHA is a part?	*0.00*
Do the NHA and other national statistics agencies:	
1.2.2.1 Meet at least once a year to propose modifications to the information systems to make them more compatible?	0
1.2.2.2 Take the proposed modifications into account to improve the information systems of the NHA?	0
1.2.2.3 Propose specific measures to improve the quality and usefulness of NHA information?	0
1.2.2.4 Is the percentage of medically certified deaths known?	0
1.2.2.4.1 Does the NHA consider this percentage sufficient to make the mortality data reliable?	0
1.3 Expert Support and Resources for Monitoring Health Status	**0.00**
1.3.1 Does the NHA use or have access at the central level to personnel with expertise in epidemiology and statistics?	*0.00*
Does this personnel have expertise in the following areas:	
1.3.1.1 Training in epidemiology at the doctoral level?	0
1.3.1.2 The design of sampling schemes for data collection?	0
1.3.1.3 The consolidation of data from various sources?	0
1.3.1.4 Integrated data analysis?	0
1.3.1.5 Interpretation of results and the formulation of scientifically valid conclusions based on the data analyzed?	0
1.3.1.6 Translation of the data into clear and useful information by personnel skilled in producing comprehensible and well designed documents for different audiences?	0
1.3.1.7 Design and maintenance of information registries on specific diseases or health problems (e.g. cancer registries)?	0
1.3.1.8 Communication of health information to decision-makers and members of community organizations?	0
1.3.1.9 Research and quantitative analysis?	0
1.3.2 Does the NHA use or have access to personnel with expertise in epidemiology and statistics at the intermediate level?	*0.00*
Does this personnel have training and expertise in the following areas:	
1.3.2.1 Design of sampling schemes for data collection?	0
1.3.2.2 Consolidation of data from various sources?	0
1.3.2.3 Data analysis?	0
1.3.2.4 Interpretation of results and formulation of scientifically valid conclusions based on the data analyzed?	0
1.3.2.5 Translation of data into clear and useful information?	0

1.3.2.6 Design and maintenance of information registries on specific diseases or health problems (e.g., cancer registries)?	0
1.3.2.7 Communication of health information to the population?	0
1.3.2.8 Communication of health information to decision-makers?	0
1.3.2.9 Master's degree programs in Public Health?	0

1.4 Technical Support for the Monitoring and Evaluation of Health Status	**0.00**
1.4.1 Does the NHA utilize computer resources to monitor the population's health status?	*0.00*

Does the NHA:

1.4.1.1 Utilize computer resources to monitor the health status of the country's population at the intermediate levels?	0
1.4.1.2 Utilize computer resources to monitor the health status of the population at the local level?	0
1.4.1.3 Have personnel trained in the use and basic maintenance of these computer resources?	0
1.4.1.4 Does the system used include one or more computers with high-speed processors?	0
1.4.1.5 Does it have programs with commonly used utilities (word processors, spreadsheets, graphic design and presentation software)?	0
1.4.1.6 Is it capable of transforming data from various sources to standard formats?	0
1.4.1.7 Does it have a dedicated line and high-speed access to the Internet?	0
1.4.1.8 Does it have electronic communication with the subnational levels that generate and utilize information?	0
1.4.1.9 Does it have sufficient storage capacity to maintain the databases on the country's health profile?	0
1.4.1.10 Does it meet the design requirements for compiling vital statistics?	0
1.4.1.11 Is there speedy access to specialized maintenance of the computer system?	0
1.4.1.12 Is there an annual evaluation of the need to upgrade the computer resources?	0
1.4.1.13 Can you give an example in which computer resources were used to monitor health status?	0

1.5 Technical Assistance and Support to the Subnational Levels of Public Health	**0.00**
1.5.1 During the past 12 months, has the NHA advised one or more intermediate or local levels on data collection and analysis?	*0.00*

The NHA:

1.5.1.1 Has advised them on the design of instruments for collecting relevant health data?	0
1.5.1.2 Have all subnational levels been informed that provisions exist to advise them on data collection methodology?	0
1.5.1.3 Have the subnational levels been informed that provisions exist to advise them on methodology for analysis of data collected locally?	0
1.5.1.4 During the past 12 months, has the NHA actually advised one or more subnational levels on the methodology to analyze data collected locally?	0

1.5.2 During the past 12 months, has the NHA periodically and continuously disseminated information to the subnational levels and other users?	*0.00*
If so,	
1.5.2.1 Has feedback been sought from the users of this information?	0
1.5.2.2 Have users been advised on how to interpret these analyses?	0
1.5.2.3 During the past 12 months, has the NHA advised those responsible for producing the country's health profile for the subnational levels?	0
1.5.2.3.1 Have those responsible for publishing the health status profile been informed that provisions exist to advise them on this?	0