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Evidence and Information for Policy

ISSUES AND CHALLENGES

In all parts of the world, policy-makers continue to seek ways of improving the performance of their health systems. The growing complexity of health care delivery and changing international conditions, including those linked to globalization, make it essential to base health policy on solid evidence. Although there now exists a rich array of reform experiences in different countries, the evidence of which policies work, and which ones do not, is at best mixed. The mandate of the cluster on Evidence and Information for Policy is to provide health decision-makers with reliable information, analysis and guidance for policy and action, and to help develop the capacity to generate and use this evidence.

There are four areas of work in the cluster. Broadly, they are:

- the provision and analysis of evidence on health system performance, and the assessment, in collaboration with countries, of methods to improve performance focusing on the essential functions of health systems (Evidence for Health Policy);

- the analysis and capacity-building for implementation, in collaboration with Member States, of ways to improve services and their delivery and to generate the resources needed to do this (Organization of Health Services Delivery);

- the collation, organization and distribution of evidence and information, both within WHO and to Member States (Health Information Management and Dissemination);

- strengthening the capacity of countries to generate and use evidence in all areas of health policy (Research Policy and Cooperation).

This document discusses progress during 2000 in each area of work. The document also includes a report on the Commission on Macroeconomics and Health which is working within the EIP cluster during the 2000-2001 biennium.

AREA OF WORK: EVIDENCE FOR HEALTH POLICY

Challenge: Health policy-makers are vitally concerned with improving the performance of their health systems. To do this, they need timely and reliable information on how their systems are currently performing and what types of policies will improve performance. They seek assistance in considering which strategies and institutional options are appropriate to their circumstances and how to implement desired change. The challenge for the Evidence for Health Policy area of work is to work with countries, other parts of WHO and other agencies to meet these needs. This involves development of the tools, capacity and information to assess needs and choose intervention strategies. It involves working with Member States to design health system policy options, and monitor their impact on system performance. The ultimate goal is to improve health, increase system responsiveness and reduce inequalities.

PROGRESS IN 2000

Improving system performance: the framework

Currently available evidence about which policies improve system performance and which ones do not is limited partly because there has not been general agreement about what health systems are designed to achieve. For this reason, considerable attention was devoted to developing a framework for measuring, analysing and monitoring health system performance over time and across settings. It identified a parsimonious set of goals common to all systems. People expect their systems to improve levels of health, to be responsive to the population, and to be financed fairly. It is also important that health policies work to reduce inequalities in both health and responsiveness. This framework was discussed with regional offices, governments and the wider scientific community. It will be the focus of further regional consultations in 2001 and intensive discussion with Member States (see below).

Measuring and monitoring performance

To ensure that policy development is evidence-based, countries need the ability to measure and monitor the performance of their own systems. Methods of measuring system performance in terms of the five indicators – level and distribution of health, level and distribution of responsiveness, and fair financing – were developed and applied to each of the 191 Member States. In addition, the efficiency with which each system is able to achieve its goals with the observed levels of resources was measured. Work is under way with countries to adapt the framework and measurement to the country level, and to build strong links to the development of policy.

Improving population health

The defining goal of the health system is to improve health. Three major themes guided this work. The first was to provide countries with a means of measuring the level of population health in their settings, by producing a new set of life tables for all Member States using new methods and combining this with estimates of time lived in states with less than full health. The new summary indicator of population health level shows how long a child born today could expect to live in healthy year equivalents (healthy life expectancy – previously referred to as DALE or disability adjusted life expectancy). In 2001 we plan to work with regional offices and Member States to develop methods which countries can use to

estimate healthy life expectancy and to monitor changes in the health of their populations. Estimates of healthy life expectancy will be updated and reported annually.

The second theme was to estimate the global burden of disease for 96 causes for 2000, based on extensive interaction with epidemiologists in many settings. This required updating cause-of-death estimates by age and sex for over 130 major causes which in turn required the collection and analysis of partial data sets on causes of death in developing countries, particularly in Africa and Asia. This type of data is critical to governments wishing to identify major health problems as the first step in developing appropriate interventions and policies, so a manual on how to implement a national burden of disease study was drafted and is being revised on the basis of comments received from countries. A training course on burden of disease methods was held with over 70 participants from all regions.

The third theme was to develop preliminary estimates of disease burden attributable to selected risk factors, based on a new conceptual framework for comparative risk assessment. This work will be continued in 2001 to provide impetus particularly for preventive interventions and will be a major input to *The* w*orld health report 2002* on the measurement and reduction of disease burden from health risks.

Other types of basic work allow each of the above policy-relevant strands to be undertaken. Some require the provision of critical pieces of data, and some involve international comparisons and standardization. Activities included the following:

- Preliminary work designed to estimate the prevalence of different health states in Member States and how they are valued involved about 50 countries. This will be scaled up in 2001 so that as many Member States as possible can have access to information critical to their own priority-setting process.

- The development of assessment instruments and methods for cross-population comparison of health information continued, including health status assessment instruments such as the *WHO Survey Health Module, Disability Assessment Schedule* and *WHO Quality of Life.*

- The *International Classification of Diseases* (ICD-10) and *International Classification of Functioning, Disability and Health* (ICIDH-2) were revised in collaboration with a worldwide network of training and reference centres. In 2001, versions of ICIDH-2 for children and adolescents will be developed, as will an application for clinical encounters and surveys. Work is also planned on international classifications of interventions and procedures, and an *International Classification of External Causes and Injury.*

- Terminological work (harmonization and standarization of terms and definitions) for the classifications listed above continued, as well as setting standards for other WHO work in line with ISO standards.

Reducing health inequalities

Reducing inequalities in health was identified as a major goal of health policy. Ideally the extent of current inequalities would be assessed in terms of healthy life expectancy. While for the year 2000 only inequalities in child mortality were measurable, efforts have moved on to measuring inequalities in healthy life expectancy. This will enable policy-makers to better identify and target the groups with the poorest health outcomes, thereby reducing inequalities.

Responsiveness – level and distribution

Responsiveness has two major categories – respect for the person and client orientation. Results of patient satisfaction surveys could not be used to compare responsiveness over settings, largely because of different expectations and experiences of the respondents. For example, it is often found that the poor are more satisfied than the rich with their systems, even though all objective assessment suggests they are not treated as well.

Accordingly, a framework for measuring system responsiveness was developed and applied using key informant surveys. A new instrument is being tested in household surveys. Face-to-face interviews are planned in 41 countries, with self-administered postal surveys in a further 30. Results of this "gold standard" can be compared to results of ongoing key informant surveys.

Fairness of financing

A "fairness in financial contribution" measure was developed to indicate whether the financial burden of paying for the health system was distributed fairly across households. Measurement criteria were based on available household surveys. These data clearly show that higher out-of-pocket payments are closely linked to financing systems that are less fair. In 2001 work shall continue with countries to identify more household surveys and to update the estimates, particularly in countries where reforms have been undertaken and financial fairness can be measured before and after the reform.

Working with countries to measure and improve performance

With the release of the first measurement and analytical exercise (*The world health report 2000*), many countries have expressed interest in developing and implementing the health system performance framework in their settings. Their goal is to develop policies to improve performance. A number of bilateral and international donors have also expressed interest in using the framework to focus their development assistance. To ensure a coherent response to these requests, the Director-General launched the Enhancing Health System Performance Initiative (EHSPI). This includes, as a starting point, capacity-building in data collection and analysis so that countries can measure and monitor their own performance. The overall goal is not measurement for its own sake, but measurement that will aid the development of policies and strategies to improve health system performance. Working with countries to develop these policies and strategies, based on the evidence that is generated, is an integral component of EHSPI. Evidence for Health Policy provides the major input on the methods and techniques, and jointly provides support to countries with the Organization of Health Services Delivery area of work.

Intensive work has been carried out with all countries (both EHSPI and non-EHSPI) to improve methods, data sources and capacity to measure and monitor performance. This work, including the involvement of the regional offices, has led to discussions with countries on ways to improve health systems performance organized around the four essential functions of health systems.

Strategies and policies to improve performance – health system functions

The health system performance framework identified four key functions of the system – stewardship, financing, service provision and resource generation. The first two are the primary responsibility of Evidence for Health Policy and are discussed here. The second two are being led by the Organization of Health Services Delivery area of work.

Stewardship

Stewardship determines the success or failure of all other functions. It places responsibility on government and calls for the strengthening of ministries of health. It does not require government to finance and provide all health services but suggests that it should have the role of overseeing and steering the health system in its entirety. Key contributions in 2001 were:

- Internationally relevant legislation has been collected, summarized, translated and published in the *International Digest for Health Legislation*. *The world health report 2000* contained a review of evidence to date in the area of health financing.

- National health accounts (NHA) and health systems profiles provide both numeric and textual description of a country's overall health system. Both activities were supported in collaboration with regional and country offices and outside organizations. Support was provided to Member States to build capacity to carry out this work; a guide to undertaking NHA in developing countries will be published in 2001.

Financing

This function includes not only revenue collection, but fund pooling and purchasing. Work has commenced to define policy in all areas. Collaborative work continues with the World Bank, the International Labour Organization, and the Commission on Macroeconomics and Health regarding how to increase health coverage for the poor. One outcome is the attempt to combine small community-based insurance schemes with broader pooling schemes to increase their chances of long-term survival. In 2001, a book on health financing that reviews this evidence and the implications for policy will be produced in collaboration with regional offices. Increased support will be provided to countries that wish to link the performance framework with health financing reform.

The world health report 2000 recommended that countries would perform better if they selected carefully the interventions that were provided on the basis of an active assessment of their effectiveness, costs, quality and equity implications. A major effort is under way to estimate costs and effects of critical interventions at subregional level and make them available in a useable form to policy-makers. The first results will appear in 2001. This is based on standardized methods for undertaking cost-effectiveness analysis developed in the cluster and published in the international peer-reviewed literature. Associated tools were also developed for countries to use to undertake this work themselves, including tools for collecting and analysing cost data and a method of modelling the population impact of interventions.

Well-known ethicists were invited to make contributions on the ethical implications of different ways of allocating scarce resources. Preliminary drafts were produced and the final document will be published in 2001. A practical guide to policy-makers based on this information will be produced.

To make the evidence on costs and effects of a large number of interventions more accessible to policy-makers, a training workshop was held on cost-effectiveness analysis with approximately 60 participants from all regions, including many government employees. The costing tools have been shared with the Regional Office for Africa, and they are being tested in collaboration with other parts of WHO, including the Integrated Management of Childhood Illness project.

A framework for defining and measuring quality was developed and published, consistent with the health system performance framework. This can be used at all levels of the health system and will be

expanded in 2001. It is also important to ensure that WHO's own advice to countries is of high quality and based on evidence. Accordingly, a set of guidelines on the process of developing and producing WHO recommendations (e.g. best practice guidelines) was developed in collaboration with a cross-cluster working group. Cabinet is considering a self-assessment kit based on this work. It will be implemented in 2001 and the impact monitored.

Summary

The role of Evidence for Health Policy is to collaborate with countries to provide better evidence on ways of improving health system performance. This requires making better use of scarce resources to improve health, increase responsiveness and reduce inequalities. All activities undertaken in 2000 had that objective – to work with countries to improve system performance based on better evidence of how countries are currently performing, what policies work and which ones do not.

AREA OF WORK: ORGANIZATION OF HEALTH SERVICES DELIVERY

Challenge: Many countries face difficulty in making their health systems respond effectively to the current and evolving needs of the population. Countries have frequently sought to reform their health systems, and health decision-makers and managers continue to seek assistance in considering which policies and institutional options are appropriate to their specific circumstances, and in strengthening their capacity to manage required change.

The defining objective of a health system is to improve people's health, so the delivery of health services is a critical function. The other functions (e.g. stewardship, financing, resource generation) are important in their own right and also influence the way in which services are provided. It is a major failing of the system when effective and affordable interventions do not reach the populations that would benefit from them, or ineffective or inefficient interventions are purchased and provided. This might happen because of failures in training of the workforce and inappropriate investment in physical resources; inadequate provider incentives; unfair financing of services; poorly structured, distributed, organized and managed services; or weak partnerships with the private sector and civil society.

PROGRESS IN 2000

The major focus of the Organization of Health Services Delivery (OSD) area of work is on seeking to determine how to ensure that systems deliver the right mix of interventions to the appropriate people and at the best quality possible for the resources available. OSD also works with countries to find ways to improve the operational efficiency of service delivery by focusing on the resources needed to provide the desired mix of interventions, as well as by improving the quality of health facilities. In 2000, OSD took primary responsibility for providing analytical, normative and technical support to Member States to that effect in relation to resource generation and health service delivery, and worked closely with Evidence for Health Policy on financing and stewardship. OSD also collaborated with disease-focused and life cycle-oriented programmes within WHO headquarters, and with regional and country offices and external partners.

Health services provision: improved responses to health priorities

- An issues paper was prepared and discussions begun with regional offices for the development of a study protocol. Regional workshops are planned for 2001.

- Work continued on development of a conceptual framework for measuring, monitoring and improving performance of health care services; for mapping the elements of health services delivery and assessing their interface; and on a strategy for defining tools for that purpose. These will be finalized in mid-2001 within the context of EHSPI and implemented jointly with Evidence for Health Policy in countries in all regions.

- A strategy for strengthening countries' roles and capacity in using the health technology assessment (HTA) in policy-making and decision-making was delineated in collaboration with the International Society of Technology Assessment in Health Care and WHO collaborating centres for HTA. This will be implemented in 2001 jointly with regional offices.

- Protocols were finalized for a global study with the International Hospital Federation on hospital performance and behaviour in a changing socioeconomic environment. A report describing best practices in managing change in hospital reform and on options in reforming roles and functions of hospitals will be available in 2001.

- Global analytical work commenced with the International Society of Quality in Health Care to assess current practices, methods and tools in quality assurance and improvement (QA/I). This will be completed in mid-2001.

- Support was provided to the Regional Office for Africa, the Regional Office for South-East Asia and the Regional Office for the Easterm Mediterranean in organizing regional consultations on QA/I, and to selected countries, including jointly with the Quality Assurance Programme of USAID in supporting related initiatives.

- A project to identify best practices in quality assurance in technology management and its role in improving quality of care was begun with the World Bank, the United Kingdom Department for International Development (DFID), the German Agency for Technical Cooperation and other partners.

- A draft data-collection protocol was finalized and a pilot country case study initiated in Uganda, to be followed by case studies in six other countries in 2001, on the minimum resource requirements for a core set of interventions for the poor.

- A software-based tool for planning of resources for health interventions (Essential Healthcare Technology Package) was developed; field-testing started in all regions.

- A protocol for a study in Bangladesh, Ecuador, Georgia and Uganda on improving access to health services for the poor was developed with regional offices. Data collection started in Bangladesh in November 2000 and will start in Uganda in April 2001, followed by Georgia and Ecuador during 2001.

- A review of current evidence on the impact of HIV/AIDS on health systems and best practices of health systems' response to the epidemic was completed, as was a literature review on the impact of HIV/AIDS on hospitals.

- Contribution was provided to development of a global health sector strategy on HIV/AIDS with a focus on health systems requirements for the delivery of HIV/AIDS-specific interventions; this work is carried out with the HIV/AIDS department at headquarters, regional offices and UNAIDS.

- Indicators on safe injection and universal precautions were prepared, as was a paper on the influence of HIV/AIDS on health personnel performance. Fact sheets for nurses and midwives were completed and distributed for local adaptation; these will be translated into French and Portuguese in 2001.

- In the area of making pregnancy safer, a strategy, work programme and operational plans were finalized with the Department of Reproductive Health and Research and regional offices. Implementation began in countries in all regions.

Resource generation: physical resources, workforce and knowledge capacities

Physical infrastructure and technology

- Work continued on developing a Health Facilities and Technology Management Toolkit jointly with headquarters departments, regional offices and external partners. Guidelines for formulating and implementing national health care technology policy were finalized and applied in countries in all regions, as were guidelines on health care equipment donations.

- Development of a framework for intercountry comparative analysis on best practices in technology management was initiated, to be completed by mid-2001.

- Support was provided to the Regional Office for Africa and the Regional Office for the Eastern Mediterranean in developing regional health care technology strategies; the regional committees adopted the strategies.

- Several intercountry workshops for decision-makers on capacity-building in technology management were held; more are planned in all regions.

- Analytical work was started with the World Bank and other partners on the "cost of loss" due to mismanagement of technology; a Knowledge and Research Programme was initiated with DFID on "Improving Infrastructure and Technology for the Poor."

- An electronic data bank on infrastructure and technology is being developed, and an internet discussion group, "INFRATECH", was established.

Health workforce

- An agenda for health workforce priorities was initiated, based on a five-year timetable for strategic work with relevant stakeholders; a global conference was held, for which a set of analytical papers was prepared.

- Work was started on a guidebook for optimal decision-making in the development of family medicine at the national level.

- Together with health professional associations, development of an analytical framework to assess needs and help plan the adaptation of health professions was initiated; the framework will be field-tested and implemented in 2001.

- An international advisory council was established on "universities and the health of the disadvantaged", a joint WHO/UNESCO project. A secretariat was established in a collaborating centre, a call for field projects was disseminated, and case studies were prepared.

- A proposal was drafted on creation of a global consortium of international agencies concerned with standards and accreditation mechanisms to improve the quality of medical education and the social responsiveness of medical schools. Indicators to assess capacity development for change in education and practice were identified.

- As part of a programme to develop sound policies and practical approaches to eliminate violence in the health sector, a state-of-knowledge paper is in final revision. It will be the focus of a consultation with partners.

- A meeting of regional fellowship officers will review the global fellowship programme.

- The use of Human Resources for Health (HRH) projection models was reviewed; the French-language version was completed.

- A manual on workload indicators of staffing needs was finalized; it will be applied in francophone countries in 2001.

- HRH performance indicators were finalized and will be field-tested in 2001.

- The world wide web version of the HRH toolkit will be completed in 2001.

Nursing and midwifery

- Global Strategy for Nursing and Midwifery: the situation analysis has been completed based on regional reports, 22 country case studies and a scientific review. The process involved countries, regions, and nurse and midwife experts and leaders, including key professional nursing and midwifery organizations and selected collaborating centres. The report was submitted to the Executive Board at its 107th session, which adopted a resolution on "Strengthening nursing and midwifery".[1]

- A plan of action for nursing and midwifery was developed, including a framework for monitoring progress, for developing mechanisms of enquiry into the global shortage of nursing and midwifery personnel, including migration, and for supporting Member States in developing human resource plans and programmes, including ethical international recruitment.

[1] Document EB107.R2.

- Global Advisory Group on Nursing and Midwifery: the Director-General held the first meeting of this group, which is responsible for advising her on policies supporting nursing and midwifery development.

- A conceptual framework will be completed on health workforce shortage issues, focusing on nursing and midwifery.

- Strengthening nursing and midwifery skills: a prototype curriculum was developed, based on a content area such as Adolescent Health that will be integrated into pre-service nursing and midwifery curricula. This is a joint activity between two headquarters' departments within two clusters, with involvement of the African, American, Eastern Mediterranean and Western Pacific regions and countries. This work is being actively developed with collaborating centres in those countries involved in implementation to ensure twinning and exchange South/South and North/South.

- A systematic review of evidence-based nursing and midwifery practice has been completed by a collaborating centre.

- The work plan on nursing and midwifery will be finalized with partners such as professional organizations and collaborating centres.

Planning and management strengthening

- A systematic review was completed of existing health planning and management approaches, methods and tools, with an annotated bibliography of selected documents for dissemination.

- A toolkit is being developed, giving practical guidance on various approaches and methods for planning of health services delivery and for implementing cost-effective health interventions (to be continued next biennium). This work involves other headquarters departments, regional offices, and the Nuffield Institute for Health in Leeds.

- A framework for improving management capacity in the health system at country level was developed, based on a review of country experiences and a consultation with health management and educational experts. This Management Effectiveness Programme (MEP) was initiated by the Regional Office for the Eastern Mediterranean with OSD support. Outlines for the 10 core learning modules that form the basis of the MEP are currently being developed and will be field tested in Egypt. The Regional Office for the Americas and the Regional Office for Europe are interested in testing and adapting the MEP for their regions.

- A critical-review inventory was carried out of current approaches, methods and tools for strengthening health planning and management information systems at country level. This work requires close consultation with all headquarters departments, WHO regions and other development agencies.

Stewardship strengthening

- A draft workplan was prepared and terms of reference defined for the forum for senior policy-makers and managers of health systems which will have its first meeting in July 2001.

- An analytical literature review on public and private sector relations was carried out.

- Sensitization of developing countries to the potential benefits and limitations of contracting as a mechanism for improving the performance of health services delivery continued. A meeting was organized jointly by the Regional Office for Africa and OSD in Dakar for 10 francophone countries of the African Region, to be followed by a similar meeting for anglophone countries in October 2001.

- A framework for evaluating the effects of contracting on the performance of health systems is being developed in collaboration with other headquarters departments and regional offices.

- A review of WHO's work on local systems and partnerships for health was initiated, and an assessment framework developed.

- Country studies on the role of local government were completed, and workshops held to discuss results; review and consolidation will be finalized in 2001.

- Guidelines for strengthening the role of civil-society organizations in local health systems will be implemented in selected countries in 2001, and a publication on civil society and health completed.

- A multicountry study is being conducted on corruption in health services, jointly with Transparency International.

- A global study is under way to define the state of accreditation of health care delivery facilities and organizations and educational institutions, and licensing of health professionals and its significance in fostering social accountability. It will be completed in mid-2001.

- A consultation on a global approach to accreditation and licensing, including identification of related best practices and standards to promote social accountability, is planned for the end of 2001.

- A working paper entitled, "Towards unity for health: challenges and opportunities for partnership in health development" was disseminated (to be translated into Chinese, French and Spanish in 2001).

- An international advisory committee on activities "Towards Unity for Health" was established, and 12 proposals for field projects in action research were selected.

- Two issues of the *Towards Unity for Health* newsletter were published and disseminated to 3000 readers worldwide.

- Literature on trade and health was reviewed and key issues listed. A review of data that can be used to monitor modes of trade in health services was also completed. Country case studies were initiated, as was work on a web site for trade in health services. Development of a framework to monitor trade in health services is scheduled for 2001, as is development of a database.

Public Health and Rehabilitation Programme (PHARPE)

- This is a joint collaborative programme between the Ministry of Foreign Affairs of Italy, the Government of Eritrea and WHO to strengthen the national health care system in Eritrea.

Discussions were held with the Ggovernment of Eritrea and its Italian counterparts on refocusing the project to provide broader strategic and policy support to the health sector and the priority areas already identified.

AREA OF WORK: HEALTH INFORMATION MANAGEMENT AND DISSEMINATION

Challenge: Reliable information is the cornerstone of effective health policies and forms the basis for raising awareness of health matters, formulating strategies, and building the expertise necessary to improve health. Yet many people either lack access to relevant information or are overwhelmed by too much and cannot make optimal use of it. Easing access to health information that is relevant to people's needs is a priority of WHO.

More specifically, the Health Information Management and Dissemination area of work aims to support WHO's growing information management and dissemination needs. For example, Member States and partners rely on receiving sound and timely scientific advice which has been through WHO's thorough process of expert review. WHO staff in all sectors need ready access to the most recently published scientific data; WHO as a whole needs efficient systems for organizing and publishing its own health content. Effective dissemination of WHO's health information begins with good planning and assessment of the information needs of target audiences, which in turn is supported by good evaluation of the impact of WHO's information products.

This area has strengthened the support provided to Member States and staff through library and reference services, high-quality editorial and other production services, and a marketing and dissemination unit responsible for handling marketing, sales, and free distribution of all publications, in close liaison with regional offices. The two periodicals – *The world health report* (annual) and the monthly *Bulletin of the World Health Organization* – have changed considerably to include more substantive scientific work.

PROGRESS IN 2000

This area of work has evolved considerably over the past 18 months, making better use of advances in technology and strengthening its service-oriented approach to respond better to the changing needs of its partners. It continues to seek the optimal balance of the use of "mature" professions such as library science and editorial services, and newer professional approaches in information and communication science, including information technology.

New challenges in information management

One new challenge is the exponential growth of the internet for information sharing, resulting in a much greater use of WHO's web site (www.who.int). Though the demand for printed books and documents sold through WHO's global network of sales agents has not diminished, the number of people seeking information from WHO's web site has grown dramatically; currently www.who.int has some 15 million "hits" each month, from over 250 000 different users. With an exponential increase in the amount of information on WHO's web site, managing that information becomes more urgent and at the

same time more complex. Added to this challenge are a growing demand for information in multiple languages (including navigation of the web site), the need for information on the site to be kept up to date (in all languages), and the need for users to be able to find easily the information they are seeking. Accordingly WHO has initiated a web project which aims to put in place a content management system for the web site that will enable staff to publish information on the site using standard templates, without the need for special knowledge of web-based publishing. More importantly, the system will result in a well-designed and easy-to-navigate site that includes a pre-defined set of core information and enables the user to find information based on a range of different variables such as geographical area, health topic, population group or organizational structure of WHO. In the meantime, WHO has developed an interim approach for the web site which includes English, French and Spanish language navigation of the pages, content arranged according to health topic as well as organizational structure, and a more flexible "home page" with regularly updated information and links to the main categories of information.

It is probably even more important to put in place systems and processes for managing the ever-increasing collection of health information being generated by WHO's technical programmes, be it country-specific surveillance information, research results, background documentation for meetings, or databases of collaborating institutions, experts, or other partners, to give but a few examples.

WHO's publishing programme

EIP is the focus of WHO's central editorial service for WHO official publications and general editorial and publishing advice and support to technical departments. As of early 2001, 21 books had been published in English, with a further 21 in various states of production. In addition, over 100 technical documents have been issued by headquarters clusters. To complement its small in-house editorial team, WHO is expanding its network of outside technical editors, keeping them informed of changes in editorial style and coordinating evaluation of their work.

In following up a review of its publishing programme, EIP has launched a project to develop a single process for all WHO information products, which includes improved planning, development, production, dissemination and evaluation. This Information Production Chain (IPC) process is being pilot-tested with the CDS and HTP clusters. The IPC project should not only improve the production process of information products, but should also enable monitoring of costs at each stage and identify ways to reduce costs. A key component of the project is to identify the services and support needed by the technical department generating the product and to find ways for EIP to provide the services needed to optimize quality and timeliness.

Marketing and dissemination of information

WHO's Marketing and Dissemination team, largely funded through sales income from publishing, is responsible for all marketing and sales activities of WHO publications, priced technical documents, CD-ROMs for sale, and videos. This includes invoicing and subscription services for periodicals and serial publications (the team achieved its target of no more than five working days of invoicing backlog), a global network of sales agents (new sales agents in 10 Member States were added) and other promotional activities, such as production of catalogues and brochures and participation in book fairs, professional conferences, etc.

Another way in which the widespread use of WHO's information by different target audiences is ensured is by promoting its reproduction (both print and electronic) and translation into national and local languages.

Library and information services

EIP houses WHO's library and information services, serving both partners and WHO staff. The extensive library collections, both print and electronic, are complemented by networks of libraries and information providers around the world, enabling WHO to obtain quickly copies of scientific articles and other material. Increasingly, electronic access to journals, reference material and other information sources form a central part of the library's resources. The library database (WHOLIS) which provides access to the WHO knowledge bank is available to anyone with internet access. WHOLIS is a record of everything that WHO has published, and recently 10 000 technical documents have been linked from this central database in full text. WHOLIS also contains references to health and development material that is published outside of WHO, and acquired by the library. Weekly training is offered for staff on the use of web-based information sources (some 70 different sessions were held during 2000), and the library provides expert assistance for online scientific literature searches.

WHO's library is also responsible for maintaining archives of printed material, as well as important historical collections of published literature on selected public health issues. These archives are scanned and linked electronically to the WHOLIS database in full text, so that scholars can access these resources. Researchers also come in person to use the library's historical collection.

WHO has not lost sight of the fact that internet services remain out of reach for most health care workers and other health professionals in the least developed countries, and has continued activities aimed at meeting their information needs as well. An example is the Blue Trunk Library (BTL) project, consisting of a collection of core health information material – primarily from WHO – developed for health workers at the district level in developing countries. The collection is shipped to the country in a blue trunk and is accompanied by a visit from a WHO librarian who works with district health professionals to ensure that they are trained in using the collection optimally. Both English and French BTLs are available, and some 460 trunks were delivered in 2000.

The world health report

EIP is responsible for the production of *The world health report* (annual). The main theme of *The world health report 2000* was "Improving health system performance." This was issued in June 2000 in English and French, followed soon afterwards by Arabic and Spanish editions, with Chinese and Russian editions published before the end of the year. An international media campaign supported the launch of the report which gained immense media coverage. Work on *The world health report 2001* is well under way, with the theme of "Mental health: new hope, new understanding". Publication is planned for October 2001.

Bulletin of the World Health Organization

The *Bulletin of the World Health Organization: the international journal of public health* is a fully peer-reviewed public health journal published monthly in English, with French and Spanish abstracts for each article and six-monthly digests of selected articles in French and Spanish. In 2000, 12 issues were published, both in print and on WHO's web site, as well as two French and two Spanish digests. The rigorous selection procedures introduced in 1999 have raised both the quality and the quantity of material available for publication. The timeliness and appearance of the journal improved steadily during the year. The *Bulletin* has become a lively forum for scientific debate on issues of major international public health importance.

AREA OF WORK: RESEARCH POLICY AND COOPERATION

Challenge: Research is the systematic process for generating new knowledge, and the knowledge produced from global research efforts underpinned the health revolution of the 20th century. Based on unprecedented advances in biology, the social sciences, and information technology, this “knowledge revolution” will continue to result in conceptual advances as well as novel interventions directly impacting on diagnostic, preventative, therapeutic, ethical and social aspects of human health and disease. It is also clear that advances in knowledge have not fully benefited developing countries. It has been estimated, for example, that only 10% of global research funds are allocated to health problems affecting 90% of the world’s population. With clear disparities in economic strength, political will, scientific resources and capabilities, and in the ability to access the global information network, the scientific and informatics revolution has, in fact, widened the knowledge and health gap between rich and poor countries.

The goal must be to narrow the gap and reduce inequalities between developed and developing countries in terms of access, production and utilization of scientific knowledge. By considering research and knowledge as global “public goods”, WHO has a key role to play in correcting the imbalance and ensuring that the fruits of research benefit the poor in a sustained and equitable manner. Based on the belief that knowledge will be a major vehicle to improve the health of the poor, we must stimulate research in developing countries as a practical realization of our corporate strategy. By focusing on stimulating the overall research process and environment, this objective will be complementary to other areas of work that underpin the corporate strategy – i.e. reducing burden of disease and risk factors, developing better health systems and promoting health as a component of development.

PROGRESS IN 2000

Emerging trends in scientific knowledge have been identified; the potential to improve health is there. The mobilization of the world research community has begun to tackle priority health problems. We are working with countries to stimulate research to reduce the disparity in health services. Development of initiatives to strengthen research and research capacity in developing countries has begun. The ultimate aim of these projects is to enshrine research as a foundation for policy. Close coordination with countries will ensure development of effective mechanisms and actual implementation.

Emerging trends in scientific knowledge

Work in this area has included:

- redefining the role of, and reconvening, the Advisory Committee on Health Research (ACHR);
- convening meetings on scientific developments with health implications;
- creation of a research database and a database of collaborating centres.

Future plans include an ACHR special report on genomics and health (to be completed in 2001), ACHR involvement in the Director-General’s advisory panel to review methodology for health systems performance evaluation, and a meeting on biotechnology in health improvement (Cuba, October 2001).

Mobilization of the world research community

Work in this area has included:

- co-organizing the International Conference on Health Research for Development (Bangkok, October 2000);
- cooperation with other organizations involved in health research (e.g. the Council on Health Research for Development, the Global Forum for Health Research, the Alliance for Health System and Policy Research).

Future directions involve post-Bangkok follow-up activities, an international workshop on national health research systems, planning for the next international conference on health research (2003), and improved coordination and consolidation of international health research activities (governance).

Development of initiatives

Work in this area has included:

- a research pilot project as part of the Health InterNetwork (HIN) initiative to improve access to research information in developing countries;
- international awards to support cooperation in health research for development;
- surveys on health research priorities and structures in developing countries.

Future activities will encompass the extension of the HIN research pilot project to more countries, the Health Research Systems Performance Evaluation initiative, involvement in an initiative to monitor global resource flows for research, the formation of networks of national health research councils, and the mapping of biomedical ethics capacity in developing countries.

AREA OF WORK: THE COMMISSION ON MACROECONOMICS AND HEALTH

Challenge: The Commission on Macroeconomics and Health (CMH) was established in January 2000 as a time-limited initiative in response to the need to place health at the centre of the development agenda. The Commission is chaired by Jeffrey Sachs, Professor of Economics at Harvard University, and comprises 18 commissioners (who include international economic and health policy-makers) and six working groups entrusted with conducting the key analyses for the CMH. At the end of its mandate the CMH will issue a final report consisting of evidence-based recommendations for policy-makers around the world, linking increased investment in the health sector to economic growth and poverty reduction.

The CMH differs from other health development-related initiatives in that it will provide, among other things:

- defensible arguments about how central health is to economic growth and poverty reduction;
- information on the chief determinants of health within or outside the health sector;
- cost-estimates of the full economic impact of the burden of disease and identification of major disease areas which can be feasibly targeted for effective intervention;
- an analysis of the cost of failing to invest in health research that addresses the problems of the poor;
- scenarios and policy recommendations so that globalization can be made to benefit the world's two billion poorest;
- an outline of what else is needed in terms of a supportive framework (not just "more money", although that is the fundamental issue, but more money for health and health systems that can deliver interventions to those who need them, changes in international agreements, etc.);
- evidence of the macroeconomic policy changes needed to ensure that health systems promote health outcomes among the most vulnerable groups of society.

PROGRESS IN 2000

It is hoped that the CMH report will stimulate increased allocation of resources for health outcomes within and between countries (i.e. at the domestic and donor level). The CMH's findings will help decision-makers focus on health priorities and health conditions that can make a difference to the economic scene and to the plight of the poor. The CMH will make a difference in the way policy-makers around the world think and react to the prospect of increasing investments in health as a means towards economic growth.

Although the CMH's work will not be completed until the end of this year, a lot has been achieved to date:

- Major disease areas – such as HIV/AIDS, malaria, tuberculosis, diarrhoeal disease, acute respiratory infections, nutritional disorders, reproductive health and tobacco – have been identified as the most feasible targets for effective intervention.
- Cost estimates have been drawn up for the provision of prevention and treatment technologies.
- New research priorities have been drawn up where new technologies are urgently needed.
- Innovative ways to deliver interventions have been identified.
- Good intermediate products have been provided – e.g. in relation to effectiveness surrounding key interventions for health conditions most affecting the poor with regard to HIV/AIDS and maternal mortality, a framework has been developed for designing financing strategies for middle-income and low-income countries.

- Joint working group efforts are progressing. Two working groups are combining to work together with WHO, the International Labour Organization, the World Bank and the London School of Hygiene and Tropical Medicine on financing health care for the poor. Two others are working together on public and private incentives for research and market access issues. The working groups are also collaborating on the issue of labour market outcomes – i.e. the impact of health shocks on income insecurity and impoverishment and on health insurance/financing.

- Research findings are paving the way for solid evidence-based recommendations – i.e. preliminary work is showing the importance of strengthening the peripheral health system and having an enabling environment (functioning equipment, adequate supplies and drugs, etc. for the interventions to be carried out.

- Public goods have been identified for health improvements of the poor.

- Research is being carried out on the interface between globalization and health care facilities availability to the poor in developing countries. This will lead to evidence-based recommendations on better health care outcomes for developing countries.

- Regional consultations have taken place to find substantive answers to central questions such as: How much and what forms of development assistance are needed to improve health outcomes for the poor? How should aid be channelled? How should aid expenditure be effectively monitored and evaluated?

The CMH is about to enter the crucial phase of collating evidence-based findings into a well structured, clearly laid out, convincing document for decision-makers around the world. The six working groups are processing their findings on their respective subjects – i.e. by submitting commissioned papers to anonymous peer reviews to ensure quality material – and the commissioners are meeting to agree which content issues, policy directions and specific recommendations will form the basis of the final report. Two global consultations are being planned for June and August 2001. A strategic dissemination process is being studied for implementation following finalization of the report in December 2001.

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