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TEN-YEAR EVALUATION OF THE
REGIONAL CORE HEALTH DATA INITIATIVE

The Regional Core Health Data and Country Profile Initiative (RCHDI) was launched by the Pan American Health Organization (PAHO) in 1995 to monitor the attainment of health goals and compliance with the mandates of the Member States, in addition to ensuring the availability of a basic set of data to be collected annually, that would make it possible to characterize the health situation and trends in the countries of the Hemisphere. In order to achieve greater validity, harmonization, reliability, and timeliness, the core data have been defined jointly with the Member States and the Interprogrammatic Consultative Group of PAHO. The work of the RCHDI is expected to improve the collection and use of information for management and decision-making in public health.

The availability of core data have made it possible to identify needs and set priorities in health—processes necessary for strategic management and planning in PAHO and the Member States. The RCHDI has made a strategic contribution to the monitoring of compliance with regional and global mandates in health, notably those of Health for All, the World Summit for Children, and the Millennium Development Goals. RCHDI indicators have been used in analyzing the health situation and trends, including the measurement of inequalities necessary for orienting technical cooperation and mobilizing resources towards the populations that need them the most.

Thirty Member States have adopted the Initiative at the national level. Some 24 regularly produce and annually update a pamphlet of basic indicators and use it to identify needs or evaluate programs. Nevertheless, it is important to encourage and support the work with human and financial resources to sustain the Initiative.

This report to the Directing Council presents an accounting of the results and impact of the RCHDI 10 years after its launch, based on the established goal and objectives, and offers recommendations for consolidating and expanding the RCHDI to the national and local levels, requesting suggestions and comments for future action.

CONTENTS

CONTENTS (*cont.*)

Introduction

1.   The Regional Core Health Data and Country Profile Initiative (RCHDI) was launched by the Director of the Pan American Health Organization (PAHO) in 1995 to monitor the attainment of health goals and compliance with the mandates adopted by the Member States and the Pan American Sanitary Bureau (PASB), in addition to ensuring a basic set of data that would make it possible to characterize and monitor the health situation in the Region of the Americas.[1] In 1997, the XL Directing Council of the Pan American Health Organization adopted Resolution CD40.R10[2] on the Collection and Use of Core Health Data to evaluate the health status of the population and health trends, providing an empirical basis for identifying the population groups with greater health needs, stratifying epidemiological risk, determining critical areas, and examining the response of the health services to provide input for policy-making and setting priorities in this field. This resolution, after the diverse resolutions issued on the subject by the Governing Bodies that have formed part of PAHO's institutional memory since 1911, is the mandate for institutionalizing the RCHDI.[3]

2.   The objective of the present document is to report to the Directing Council on the results and impact of the Regional Core Health Data and Country Profile Initiative in terms of its expected goal and the objectives achieved. The document also recommends to the Directing Council that the RCHDI be consolidated and expanded to the national and local levels to strengthen surveillance and monitoring capacity in public health and health situation analysis.

Background

3.   Since the period 1994-1995, in response to decentralization and the new functions and responsibilities assigned to the different levels of the health services, PAHO/WHO has recognized the importance of having data and indicators on the health situation to orient its technical cooperation programs,[4] and it has widely promoted the development

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[1] Organización Panamericana de la Salud. Indicadores de Salud: Elementos básicos para el análisis de situación de salud. Boletín Epidemiológico OPS, 2001; 22 (4): 1-5.
   http://www.paho.org/spanish/sha/be_v22n4-indicadores.htm

[2] Pan American Health Organization. *Collection and Use of Core Health Data*. Washington, D.C.: PAHO; 14 July 1997. (Document CD40/19)
   http://hist.library.paho.org/Spanish/GOV/CD/25287.pdf. and Resolution CD40/R10.
   http://www.paho.org/Spanish/GOV/CD/ftcd_40.htm#R10 .

[3] PAHO Institutional Memory. PAHO Resolutions 1902-2002: 3,186 entries in English; 3,296 entries in Spanish. *Principales Mandatos de los Cuerpos Directivos vinculados a Información y Análisis de Salud*. 2003.

[4] Dr. Alleyne G.A.O. *Perfiles de País y Datos Básicos: Funciones y Responsabilidades*. Washington D.C.: Organización Panamericana de la Salud. Memorandum [HDP/HDA/E8/28/1(986)], 1 August 1995.

of core data as a comprehensive set of basic health indicators to quantitatively characterize the situation of a country or region. It was anticipated that once established, this process would reduce the number of requests to the Member States for health information and facilitate monitoring and analysis of the health situation. At the same time, the technical programs at Headquarters and the PAHO/WHO Representative Offices in the countries were given responsibility for the selection, collection, organization, maintenance, and use of the data and information, putting coordination in the hands of the Program on Health Situation Analysis (HDA), currently the Health Analysis and Information Systems Area (DD/AIS) of PAHO.

4.   In 1996, several meetings were held to discuss the definition, collection process, and categories for the core data, their use in the preparation of country profiles, and the methodologies for health situation analysis. An Interprogrammatic Consultative Group on Core Data and Health Analysis was formed to implement the regional plan of action and stipulate the content, definitions, and sources of the indicators. The Group also set up mechanisms for collecting and validating the data and for studying and monitoring the implementation of the process in general. Visits were also made to all the Representative Offices to consult with and inform them about the Regional Initiative.[5]

5.   In 1997, the Executive Committee and the Directing Council of PAHO/WHO respectively adopted Resolutions CE120.R7 and CD40.R10 on the Collection and Use of Core Health Data and recognized the regional effort to consolidate an automated technical information system in health that would facilitate speedy access to basic information on the health situation of the countries of the Region. They also recommended that the indicators be used in the formulation, modification, and evaluation of health policies and programs.

6.   The RCHDI has the following goals:[6]

(a)   to orient strategic policy management;

(b)   to facilitate the setting of priorities for action in the health sector;

(c)   to improve the evaluation and adaptation of technical cooperation in each of the countries and programs, redefining priorities, strategies for action, and resource allocation;

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[5] Castillo-Salgado C. *Perfiles de País y Datos Básicos*. Washington D.C.: Organización Panamericana de la Salud. Memorandum [HDP/HDA/E8/28/1(1822)], 8 December 1995.
[6] *Ibid,* reference 2.

(d)   to assist the countries in devising investment strategies or special programs for health policy or health services development, as well as the prevention and control of specific health problems;

(e)   to facilitate the mobilization of financial resources;

(f)   to orient research priorities;

(g)   to periodically distribute reports on health trends in each country and the Region as a whole, using the analytical frameworks stipulated in their mandates, such as Health for All and the Renewal of Health for All.

7.   It should be noted that since its revival in 2000, the Regional Advisory Committee on Health Statistics has backed efforts to improve the quality, criteria for validity, and consistency of core data.

Results of the Regional Core Health Data Initiative (RCHDI)

8.   The goal of the RCHDI is to increase the capacity of PAHO/WHO to generate the knowledge that will make it possible to describe and explain the health situation and health status of the population of the Americas and to select health interventions that are both equitable and efficacious.[7] The combined efforts of the Member States and the Secretariat to implement the RCHDI over the past 10 years have been satisfactory in terms of meeting the goal; however, this joint effort must be renewed to expand and institutionalize the initiative at the local level.

Strategic Management and Planning

9.   The RCHDI has shown that it is possible to create a database of essential, standardized, valid, consistent, regular, and timely information, which is critical for health situation and trend analysis. Because they are an essential input, RCHDI indicators have been used in situation analyses for setting priorities within the Strategic Plan 2003-2007 for the Pan American Sanitary Bureau.[8] As indicated further on, the basic indicators have also been used at the country level in the ministries of health to develop national health plans and intersectoral policies.

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[7] *Ibid,* reference 2
[8] Pan American Health Organization. Strategic Plan 2003-2007 for the Pan American Sanitary Bureau. Washington, D.C.: PAHO; 3 May 2002. (Document CE130/12).
     http://www.paho.org/English/GOV/CE/SPP/spp36-04-e.pdf .

10.	The use of these indicators by national authorities and other entities has raised awareness about the need for valid, consistent information for decision-making. It has also led to a critical review of the processes involved in the production, collection, integration, and dissemination of health information in both the Member States and the Secretariat. This awareness is also reflected in a recognition of the need to upgrade systematic national information systems and interconnect and coordinate them to ensure a better response to information needs. In this regard, with respect to indicators and information, Brazil's experience with its Interagency Health Information Network (RIPSA)[9,] based on the RCHDI model, is one of the most successful institutionalized examples of consensus, standardization, collection, coordination, and availability for different types of users, accessible on the Internet. RIPSA brings together national institutions with responsibilities in the production and analysis of health data. This effort has earned the recognition of Brazil's Ministry of Health, which is allocating the additional resources necessary for the coordination, production, and dissemination process. Canada is another successful example of concerted action in the definition, measurement, and use of health indicators in setting priorities and gearing health system plans and programs to respond to needs and decisions in health. To this end it has made public health the frame of reference for selecting the work areas and series of indicators for collecting information and monitoring. The collection, standardization, analysis, and dissemination of information are coordinated by the Canadian Institute for Health Information (CIHI) and serve as a complement to the activities of Health Canada and Statistics Canada[10.]

11.	The creation of health situation rooms in the countries represents a new approach to the strategic use of information. One of the key inputs for their operation in the countries that have set them up has been the core data.

12.	Another strategic aspect of the RCHDI has been its use in monitoring compliance with mandates and commitments and the progress of regional and global health initiatives. One of the most important global initiatives is the Millennium Development Goals (MDGs).[11] The MDGs were adopted by 189 member states of the United Nations in 2000 and are to be met by 2015 in each of the seven designated areas, which include health. In this regard, it should be pointed out that there are 20 MDGs indicators related to health (Annex 1). The RCHDI currently includes 12 of them; it will soon add another one with some program adjustments, and four more could be available in the near future. Finally, the remaining three will require a special data-collection effort. Other important examples of the use of these indicators are the monitoring and evaluation of the Health

[9]	Rede Interagencial de Informações em Saúde (RIPSA), *http://dtr2001.saude.gov.br/sps/ripsa.htm.*
[10]	Canadian Institute for Health Information. *http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=home_e página de Internet* accessed on 10 April 2004.
[11]	United Nations. *United Nations Millennium Declaration*. General Assembly, New York: UN; 18 September 2000 (Document A/RES/55/2) http://www.un.org/millennium/declaration/ares552e.pdf

for All by the Year 2000 strategy and the monitoring of the goals set at the 1990 World Summit for Children.

13.   It is important to note the links between the RCHDI and other global health information initiatives, such as the Health Metrics Network (HMN), sponsored by the World Health Organization, the Joint United Nations Program on HIV/AIDS (UNAIDS), the Department for International Development of the United Kingdom (DFID), the U.S. Agency for International Development (USAID), the Bill and Melinda Gates Foundation, and technical experts from various countries. The HMN was recently set up to increase the availability and strategic use of health information. According to its strategy paper on areas of work for 2004-2009,[12] the HMN has recognized the need for strengthening national health information systems and access to information on AIDS, tuberculosis, and malaria, integrating equity into these systems, monitoring basic demographic events, and conducting disease surveillance. The HMN has identified several key stages for the reform of national information systems, which should be adapted to each country: (a) establishing or strengthening a national mechanism involving the participation of donors and other stakeholders, and spearheading the reform of health information systems; (b) preparing policy guidelines and conceptual frameworks that explicitly consider equity; (c) building consensus on the basic indicators, the standardization of definitions, and the harmonization of data collection instruments; (d) responding to resource- and capacity-building needs at all levels; and (e) preparing, organizing, and disseminating health information modules to stimulate the demand for information and increase the use of information at all levels. The first program component proposed in the HMN is the development and harmonization of standards and regulations for monitoring basic indicators through the national data collection systems.[13] In this regard, the RCHDI and experiences of RIPSA and the CIHI are examples or models of lessons learned for the HMN, with 10 years of documented experience in the Region—initiatives that have passed through the different stages identified.

Technical Cooperation

14.   One of the basic values of PAHO/WHO is equity in health. This first step in the search for equity is to measure and monitor inequalities in health. The RCHDI has made it possible to measure the health situation and the changes in health status through a standardized database. One of the best examples in this regard is the quadrennial publication *Health in the Americas*. During the various phases in the preparation and editing of the 2002 edition, it became clear that, in documenting inequalities in health,

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[12] Health Metrics Network (white paper). *Synthesis of planning stage & proposal for areas of work 2004-2009*. Draft 9 December, 2003

[13] World Health Organization. *Health Metrics Network*. Presentation at the International Roundtable on Better Measuring, Monitoring, and Managing for Development Results. June 5-6, at World Bank headquarters.

countries that participated in the regional initiative and had a national initiative were able to accomplish the task more easily, achieve greater consistency, and obtain the necessary documentation. The basic indicators have been used in the regional health situation analyses for the *Annual Reports of the Director* of PAHO since 1995. The availability of basic indicators disaggregated at the subnational level since 1999 has made it possible to introduce a change of paradigm in data analysis consisting of the exclusive use of national averages in the distributions, making it possible to show health inequalities and their territorial distribution patterns. The dissemination of specific methodologies for documenting inequalities, identifying health needs, and setting priorities through the reports mentioned above has made it possible to boost national analytical capacity, promoting similar efforts within the countries.

15.   PAHO/WHO has decided to intensify its activities, focusing them on the countries, especially those with greater technical cooperation needs. In setting priorities, the core health data and country profiles have been essential for identifying priority countries and areas for cooperation. For example, the current priority countries for PAHO/WHO cooperation—Bolivia, Guyana, Haiti, Honduras, and Nicaragua—are in the group with the greatest health problems and the least resources to address them.[14] The RCHDI indicators are also used in the preparation of the Biennial Program Budgets (BPB) for specific aspects of PAHO/WHO technical cooperation.

16.   The impact of the RCHDI has spread far beyond the Western Hemisphere and the WHO Regional Office for the Americas (AMRO), leading several WHO Regions to request technical cooperation and assistance to develop their own core data initiatives.

17.   Since 1999, the WHO Regional Office for Southeast Asia (SEARO) has published a pamphlet of basic indicators based on the PAHO/WHO model, but with adaptations for the situation, interests, priorities, and availability of information in its region. A significant aspect of that pamphlet is the inclusion of a specific category for gender equity indicators. In late 1999, SEARO identified the RCHDI as one area of collaboration that could be entered into with PAHO. As a result, professionals from SEARO have visited PAHO/WHO and vice versa to transfer the RCHDI table generator to SEARO and adapt it.

18.   In 1999, the WHO Regional Office for the Eastern Mediterranean (EMRO) began publishing its pamphlet of basic indicators, based on the PAHO model. The pamphlet contains country health profiles similar to those of PAHO, and EMRO has requested cooperation in the area of geographic information systems.

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[14] *Ibid*, reference 6, pg. 22

19.   Considering the model and experience of PAHO/WHO through its Department of Measurement and Health Information Systems (EIP/MHI), WHO Headquarters, in a joint effort with all its regions, is working on a framework of basic health indicators for short-term implementation at the global level. A meeting was held in late June to review the initial proposal.

Mobilization and Use of Resources

20.   In the targeting of investment resources, the donor agencies have used the basic indicators and country profiles to identify the areas with the greatest need and priority countries. In many cases, the monitoring of improvements in the basic indicators is used to evaluate the success of programs set up with donor funds.

21.   One of the serious problems that the countries face when conducting situation analysis is the vast quantity of data and information collected, which hinders the rational use of resources. The use of basic indicators, instead of employing an exhaustive approach, allows for better utilization of resources and consolidates the number of indicators needed, which affects the validity and quality of the data included in the RCHDI. Using standardized data and basic indicators collected annually has cut down on the waste of resources, duplication of efforts, and requests to the countries for information.

Results of the RCHDI in the Countries

22.   Between December 2003 and January 2004, with assistance from the focal points in the PAHO/WHO Representative Offices, DD/AIS conducted a special survey to evaluate the impact of the RCHDI in the Region of the Americas. Information was obtained from 37 countries, including the French departments.

23.   The results of the survey indicate the following:

- With respect to adoption of the RCDI, 30 Member States have a National Core Data Initiative, with national groups actively participating in its construction and updating.

- Sixteen Member States indicate that they currently use or have used the RCHDI for measuring inequalities; 21 use them for measuring needs and setting priorities; and 12 for program evaluation, which indicates the wide range of its impact.

- With respect to coherence between RCHDI monitoring efforts and those of other initiatives, 17 countries cite coordination with the MDG.

- Following the regional example, 24 countries indicate that they update and periodically distribute a pamphlet/folder or other printed material with basic indicators, or else use electronic distribution methods (CD-ROM, Web-based information systems, tables in websites, etc.). Between 1995 and 2002, the number of countries with some related product tripled.

- In 25 countries, 90% of the indicator definitions in the last publication of national core data are consistent with the RCHDI glossary, reflecting the impact of the RCHDI and the consensus around it.

- Among the most significant problems mentioned in terms of implementing and maintaining the RCHDI were lack of human resources, limited access to information or data, and an absence of political backing and financing.

24.   Among the countries' most frequent recommendations for strengthening activities in connection with the RCHDI were improving the flow of information between the countries and PAHO/WHO Headquarters and greater promotion and dissemination of information about this initiative in the ministry of health. They also pointed out that DD/AIS can help consolidate the national RCDI.

Specific Products of the RCHDI

Regional Pamphlet "Health Situation in the Americas: Basic Indicators"

25.   In 1994, work began to prepare and assist the Member States and PAHO/WHO Representative Offices in the production of the first regional pamphlet of basic indicators, published in 1995. The pamphlet has been published every year since 1995, without exception. The 2003 version contains 58 indicators (10 demographic, 8 socioeconomic, 15 on mortality, 12 on morbidity, and 13 on resources, access, and coverage). In 1995, more than 70% of the countries had indicators in each category, except mortality, where only 20 out of the 48 countries had them. In 2003, in contrast, this information was available for 40 countries. Between 1995 and 2003, the number of basic indicators in the regional pamphlets increased from 7 to 12 in the morbidity category, while the number of subregional indicators increased from 33 to 51. The 2003 version contained population pyramids for the subregions and a theme map showing the unequal distribution of infant mortality at the subnational level in countries of the Americas that have national core data initiatives; this was the first time that these were included. It should be noted that this pamphlet includes positive health indicators.

26.   It should be noted that several other regional efforts to publish thematic pamphlets have been made with PAHO assistance, covering topics such as gender, maternal and child health, and the health of indigenous populations.

Health Information System: Database and Data Collection Process

27.   The content of the RCHDI database was defined after extensive consultations between the Member States and the PAHO/WHO technical units and Representative Offices and discussions with groups of national experts. A total of 117 national indicators were selected, broken down into five categories:[15] demographic (10), socioeconomic (10), mortality (31), morbidity and risk factors (30), and resources, access, and health service coverage (36). Some of the indicators are disaggregated by age, sex, and urban-rural distribution, for a total of 401 items of data for each of the 48 countries and territories of the Region. Users tap into the RCHDI database through a table generator developed by DD/AIS, which can be accessed electronically on the Web.[16]

28.   In terms of completeness, there is significant variation in the database with respect to the number of indicators available by country and year. A study in early 2004 indicates that the database has barely 49% of them. It has been more difficult to obtain indicators in some categories, especially because national information systems are either not operating in a relevant and timely manner or are not available. This is true mainly for the morbidity, health services, and mortality indicators. At the country level, the median coverage of indicators is 49%, with a range of 12% to 90%. At the regional and subregional level, the average availability of indicators for the period 1995-2003 is 30.9% (48,417 values available), as shown in the table in Annex B. This shows that, notwithstanding the commitment assumed by the countries, there still is room for improvement. It should be mentioned that, after meetings of the Interprogrammatic Consultative Group on Core Data and Health Analysis, it was recommended that nine indicators lacking information for several years not be included.

29.   As additional information and to demonstrate the efforts of the Member States and the Secretariat, this annex includes an table with the current information for the period 1995-2004, with the data taken from the Regional Core Data System, which will be available with this updating during this Directing Council. It should be noted that for the first time, mortality data with a breakdown by sex and age will be available for all the countries that have it.

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[15] *Ibid, reference 2*.

[16] The URL for the table generator is: *http://www.paho.org/English/coredata/tabulator/newTabulator.htm*

Glossary and Technical Notes for Indicators

30.   In 1995, work began on the compilation of a glossary and technical notes for indicators. In 2003, after several revisions, standard definitions were developed, with a glossary for all the indicators that includes a description of the indicator, technical notes, the type and unit of measurement, categories, and subcategories. The definitions are being complemented with additional technical notes on the interpretation, use, and calculation of the indicators. The glossary and technical notes are also available on the PAHO/WHO website.[17]

31.   It should be mentioned that among the countries of the Region, Brazil has made real progress in this direction, publishing *Indicatores Básicos de Saúde no Brasil: Conceitos e Aplicações*[18] (Basic Health Indicators in Brazil, Concepts and Applications), a manual on the use of the indicators that includes technical notes for each of them. Canada's CIHI has done something similar with the indicators contained in its reports.[19]

Atlas of Basic Indicators

32.   In 1996, the first Atlas of Health in the Americas, based on data from the Basic Indicators pamphlet of 1995, was produced and put up on the web. The Atlas was conceived to document the territorial distribution of heath inequalities in the countries through 55 maps, accompanied by graphics showing the countries in the most difficult situation. In 2003, a new, more dynamic version of the Atlas was developed with data from Basic Indicators 2002. Some indicators have maps with graphic overlays to show trends, the distribution in population groups, or a related indicator. The Atlas has direct links to the data and health profiles of each country.

Country Health Profiles

33.   In 1999, taking advantage of the release of *Health in the Americas, 1998 Edition*, summaries from this report, based on the country chapters, were published on the Internet. These were accompanied by a selection of indicators from the core data system. Although they had a somewhat uniform structure, comments from different types of users indicated the need to summarize them even further to facilitate their use. Even though the indicators were updated annually in subsequent years, the summaries were not. In 2003, the profiles were updated and made more uniform and compact. These more selective summaries highlight the health inequalities in the countries. In addition to the indicators

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[17] The URL for the website is: *http://www.paho.org/English/SHA/coredata/tabulator/glossary.htm.*

[18] Rede Interagencial de Informações para a Saúde. *Indicadores básicos de saúde no Brasil: conceitos e aplicações*. Brasília: Organização Pan-Americana da Saúde, 2002.
http://www.opas.org.br/sistema/arquivos/matriz.pdf

[19] *Ibid,* reference 10.

mentioned, this version includes standard graphics for selected indicators. The profiles illustrate the health situation and trends in particular. However, they do not describe special situations that need to be described at particular times. It is felt that this aspect should be updated more regularly (at least every six months) by the PAHO/WHO Representative Offices, in collaboration with the countries and with DD/AIS support.

34.	It is important to note that between the 1999 and 2003 profiles, there has been a marked improvement in the countries' analytical capacity. The next step is to develop health profiles for border areas and subregions, examples of which are the efforts made at the U.S.-Mexico border and in the Central American countries and the Dominican Republic under the Information and Communication for Health project (INFOCOM) initiative.

Web-based RCHDI Information Systems

35.	When the RCHDI was created, the need for developing an information system to support it became clear. Providing interactive access to the data over the Web was made a priority, enabling users to obtain necessary information.

36.	From 1996 to 1997, with support from the regional health library (BIREME), HDA set up a Web-based system to facilitate access to the indicators for the latest available year. From 1998 to 1999, HDA developed a Web-based table generator that works with three dimensions of the indicators (indicator, country, and year), which can be manipulated to produce tables for analyzing the trend of an indicator or the overall situation of a country, or for comparing the indicators of several countries in a single year. This system was launched by the Special Program for Health Analysis (SHA, previously HDA) in 1999 with data from 1990 to 1999 and included the glossary and country health profiles.[20] From 2000 to 2002, new components were developed to facilitate the interpolation of data and the adjustment of rates, as well as the preparation of reports. In 2003, the user interface was redesigned to make it consistent with the PAHO/WHO corporate identity and facilitate use. During this time an instrument was developed to directly generate the Excel grid for the Basic Indicators pamphlet from the database. This made it possible to make corrections and modifications more efficiently than in previous years, with greater control in the production of the pamphlet.

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[20] The various components of the RCHDI can be accessed at the following website:
http://www.paho.org/Selection.asp?SEL=HD&LNG=SPA

Specific Products of the RCHDI in the Countries

Pamphlets and National and Subregional Information Systems

37.   In 1995, only five of the 48 countries—Bolivia, Costa Rica, Guatemala, Honduras, and Mexico—published a pamphlet with national core data. Eight years later, 24 countries have published at least one pamphlet of basic indicators. The countries/territories that have published such pamphlets are: Argentina, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, United States America, Uruguay, and Venezuela. It should be pointed out that 10 of these countries have been publishing pamphlets of basic indicators for over four years.

38.   In 2002, the *Folleto de indicadores básicos de salud de Centroamérica y la República Dominicana 2002* (Pamphlet of Basic Health Indicators for Central America and the Dominican Republic, 2002) was published*,* constituting the first example at the subregional level, with subnational information for 34 indicators. This pamphlet is the product of the joint efforts of the Central American countries under INFOCOM, and it was published after several consultations and subregional workshops with the national authorities.

39.   In 2003, the pamphlet Basic Indicators 2003; Health Situation on the U.S.-Mexico Border was published. This contains a set of basic indicators for the sister communities of the U.S.-Mexico border that was born of the efforts of the PAHO Field Office for the U.S.-Mexico border and the Governments of Mexico and the United States at different levels. It presents information comparing data from the national level with data from the border states and the 29 sister *municipios* along the border.

40.   At least 15 countries have developed information systems or have core data information published on the Internet. Significant among these efforts is the work of Brazil, which has an Internet-accessible system developed by DATASUS[21] that includes a time series of several years for subnational indicators in different categories.

Subnational Health Profiles and Methodological Guides

41.   Some countries in the Region—specifically Argentina, Brazil, Chile, Costa Rica, Cuba, Nicaragua, and Peru—have prepared subnational health profiles, many of which were presented at the II Meeting of National Directors of Epidemiology and SHA Focal

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[21] Ministerio de Salud del Brasil. DATASUS. *Indicadores e Dados Básicos, Brasil – 2002*. http://tabnet.datasus.gov.br/cgi/idb2002/matriz.htm.

Points in Brasília in 2002. In Argentina, for example, the efforts launched in 1997 have made it possible to generate and distribute a variety of information to the country's health sector (e.g, national health situation analyses, and studies on the training provided to subnational and national teams in methods and instruments for epidemiological data analysis) and to distribute nearly 10,000 copies of the pamphlet with the country health indicators nationwide, to both the national and provincial levels.

42.   The National Epidemiology Center of Brazil, in conjunction with SHA, developed methodological guidelines for measuring inequalities in health, with examples based on the country's basic indicators.[22]

Resources Invested in the RCHDI

43.   In order to follow through on the Executive Committee's recommendation to obtain information on the resources invested in the RCHDI, in early July 2004 DD/AIS conducted an ad hoc survey, with the assistance of the focal points in the PAHO/WHO Representative Offices in the countries and the technical units at Headquarters in charge of consolidating different indicators and obtaining an estimate of the budget allocated to the RCHDI, as well as the staffing and percentage of time devoted during the year to this endeavor.

44.   Information was obtained from 19 countries in the Region. The table in Annex C shows the distribution of staff working on both the regional and national component of the Initiative. It should be noted that to support the RCHDI at the national level, the PAHO/WHO Representative Offices provide support to the countries with an investment of a little over US$ 90,000 and the efforts of 34 individuals who participate in gathering, consolidating, verifying, and ensuring the consistency of the data and printing it.

45.   In terms of the regional component of the RCHDI, developed jointly with other technical units at Headquarters, 11 of the 14 units responded. It was found that these units invest $631,100 in the RCHDI (Annex D). It is important to point out that the Expanded Program on Immunization invests a half a million dollars of this figure. In regard to staffing, 12 people collaborate with the RCHDI in administrative posts and 48 in technical posts; these individuals perform various functions in the different technical units devote a portion of their time to this Initiative. It should be underscored that DD/AIS invests $85,000 in direct expenditures for the RCHDOI but is the Area that allocates the most personnel (5 administrative and 10 technical staff) to supporting the ongoing process of collecting, consolidating, verifying, ensuring the consistency of, and

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[22] Duarte EC, Schneider MC, Souza RP, et al. *Epidemiologia das desigualdades em saúde no Brasil Um estudo exploratório.* Fundação Nacional de Saúde. CENEPI OPAS/SHA, Brasilia, 2002

printing all the core data. It is recommended that a permanent post be created for these functions, since they are currently being performed by a multifunctional team.

Outlook and Challenges

46.   The RCHDI is a process that provides valid information for health sector planning and evaluation. This process should be consolidated and expanded to the subnational level in every country in the Region of the Americas. It is the only comprehensive, integrated health information initiative that covers the entire population in the health sector of the Americas. PAHO/WHO's experience with the RCHDI in the Secretariat and the countries has been fundamental for guaranteeing current support and the improvement of the process as a whole in the immediate future and the medium-term. The impact achieved in terms of participation and the use of the RCHDI in its years of operation supports this recommendation.

47.   At the country level, it is recommended that more human resources be allocated to this activity, promoting access to information and its analysis and dissemination, and providing greater political and financial support for the RCHDI. At the same time, efforts should be made to boost national technical capacity in the areas of measurement, information use, and health situation analysis. The aspects of PAHO/WHO technical cooperation necessary to support these processes should be identified, along with the expert resources available in the countries

48.   It is recommended that additional efforts be encouraged and undertaken to collect data and information disaggregated to the country level, in general, as well as information on gender and especially vulnerable groups (e.g., indigenous populations, ethnic groups, the elderly) in particular. This will facilitate better monitoring of compliance with regional and global mandates (especially the Millennium Development Goals), analysis of inequalities in health, and the targeting of selective health interventions to the most disadvantaged groups. Information on successful experiences that emerge from this process should be disseminated to the various levels to encourage their replication.

49.   It is suggested that support be provided for developing and upgrading the countries' health information systems, and that information flows between the countries and PAHO/WHO be improved by promoting and disseminating information to the ministries of health and other sectors connected with health. It is also recommended that the countries use their routine information and records systems for decision-making in health, considering the use of surveys as a complement. At PAHO Headquarters, it is proposed that DD/AIS continue supporting the RCHDI to help consolidate and sustain the initiative in the future.

50.   In order to make progress in developing and undertaking national data collection processes, it is recommended that the countries put mechanisms and instruments in place to foster greater consensus and participation on the part of the institutions responsible for producing and collecting data, indicators, and information in health, with a view to facilitating the validation, harmonization, and dissemination of national core data. The suggested mechanisms include the creation of a General Coordinating Committee for political and administrative matters; an Interagency Task Force for technical coordination; interdisciplinary technical committees for methodological and operational analysis; committees for the production and coordination of indicators; and a Technical Secretariat for determining processes, proposals, and monitoring. Other suggested mechanisms include a Matrix of Indicators and Technical Notes; operational planning of products; a database of common indicators; and interoperational information systems.

51.   Better coordination with government institutions, such as national statistics offices and institutes and civil society organizations, international banks, international organizations, and networks like the Health Metrics Network, is recommended to strengthen international public health on the basis of results, ensuring equity, quality, and effectiveness.

Action by the Directing Council

52.   This document is submitted to the Directing Council to mark the 10 years since the launch of the Initiative, to report on its progress, and to obtain suggestions and comments to guide its future activities.

Annexes

Annex A. The MDGs and the PAHO Regional Core Health Data Initiative

MDG GOAL	MDG TARGET	MILLENIUM DEVELOPMENT GOALS (MDG) INDICATORS	CURRENTLY AVAILABLE AT PAHO	AVAILABLE SOON AT PAHO	COULD BE AVAILABLE AT PAHO	WOULD REQUIRE SPECIAL EFFORT	ALTERNATIVE SOURCE
1	2	4. Prevalence of underweight children (under 5 years of age)	x (D.2.0.9)				
		5. Proportion of population below minimum level of dietary energy consumption		x(B.1.0.0)			FAO
3	4	9. Ratio of girls to boys in primary, secondary and tertiary education					UNESCO, WB
		10. Ratio of literate females to males of 15-24 years old					UNESCO, WB
4	5	13. Under-5 mortality rate	x (C.4.0.9)				
		14. Infant Mortality rate	x (C.1.10.1 and C.2.0.1)				
		15. Proportion of 1 year old children immunized against measles	x(E.7.0.1)				
5	6	16. Maternal mortality ratio	x(C.5.2.0)				
		17. Proportion of births attended by skilled health personnel	x(E.13.2.0)				
6	7	18. HIV prevalence among 15-24 year old pregnant women			x		
		19. Contraceptive prevalence rate	x(E.10.2.0)				
		20. Number of children orphaned by HIV/AIDS				x	
	8	21. Prevalence and death rates associated with malaria	x(D.17.0.0)	x(D.17.0.0)	x(deaths)		
		22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures	x(not in CD)		x		
		23. Prevalence and death rates associated with tuberculosis	x(D.19.0.0 and C.16.0.0)				
		24. Proportion of TB cases detected and cured under DOTS (Directly Observed Treatment Short Course)			x		
7	10	29. Proportion of population with sustainable access to improved water source	x(E.1.0.0)				
	11	30. Proportion of people with access to improved sanitation	x(E.2.0.0)				
8	13	35. Proportion of ODA to basic social services (basic education, primary health care, nutrition, safe water and sanitation)			x	x	
	17	46. Proportion of population with access to affordable essential drugs on sustainable basis			x	x	

Annex B: Availability of Information from the RCHDI for the Region of the Americas and Subregions, 1995-2003

Subregion	No. Countries	All indicators (363) (no. for the period=3267)			Demographic (38) *(n=342)*	Socioeconomic (18) *(n=162)*	Mortality (235) *(n=2115)*	Morbidity (38) *(n=342)*	Resources, Access, and Coverage (34) *(n=306)*
		%	*Total observed*	*Total expected*	*%*	*%*	*%*	*%*	*%*
North America	3	31.8	3116	9801	92.8	36.0	22.4	30.0	28.1
Latin America	22	40.2	28923	71874	99.7	59.7	29.6	37.5	39.8
Central American Isthmus	7	38.3	8770	22869	99.7	61.9	26.4	38.4	39.6
Latin Caribbean	4	38.5	5032	13068	99.7	48.8	29.2	32.8	35.0
Andean Region	5	40.4	6596	16335	99.7	62.8	28.7	41.1	42.4
Southern Cone	4	43.2	5643	13068	99.7	60.5	34.3	35.8	40.3
Non-Latin Caribbean	23	21.8	16378	75141	83.1	23.9	11.0	25.0	22.9
Americas	**48**	**30.9**	48417	156816	**91.3**	**41.1**	**20.3**	**31.0**	**31.0**

The subregions are defined as follows:
- North America: Bermuda, Canada, and the United States
- Latin America: the Andean Region, Brazil, the Central American Isthmus, the Latin Caribbean, Mexico, and the Southern Cone.
- Central American Isthmus: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.
- Latin Caribbean: Cuba, Dominican Republic, Haiti, and Puerto Rico.
- Andean Region: Bolivia, Colombia, Ecuador, Peru, and Venezuela.
- Southern Cone: Argentina, Chile, Paraguay, and Uruguay.
- Non-Latin Caribbean: Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Cayman Islands, Turks and Caicos Islands, Virgin Islands (UK),Virgin Islands (USA), Dominica, French Guiana, Grenada, Guadeloupe, Guyana, Jamaica, Martinique, Montserrat, Netherlands Antilles, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago.

NOTE: The available mortality data are not disaggregated by sex and age, which leads to an underestimation of the degree to which the indicators have been met in the countries.

Annex B (*cont.*): Availability of values for the RCHDI indicators, disaggregated by subregion for el period 1995-2004.
Percentages of availability in terms of the expected value of 100%

Subregion	No. Countries	All indicators (363) (no. for the period =3630)			Demographic (38) *(n=380)*	Socioeconomic (18) *(n=180)*	Mortality (235) *(n=2350)*	Morbidity (38) *(n=380)*	Resources, Access, and Coverage (34) *(n=340)*
		%	*Available*	*Total*	*%*	*%*	*%*	*%*	*%*
North America	3	60.8	5956	9801	100.0	38.3	55.1	30.1	28.4
Latin America	22	55.6	39965	71874	100.0	64.2	44.4	37.9	39.4
Central American Isthmus	7	56.8	12981	22869	100.0	66.5	45.5	39.5	39.6
Latin Caribbean	4	56.3	7357	13068	100.0	51.0	48.0	32.5	34.2
Andean Region	5	48.8	7976	16335	89.7	56.6	25.8	37.0	38.1
Southern Cone	4	59.3	7750	13068	100.0	66.8	49.5	36.3	39.9
Non-Latin Caribbean	23	31.7	23821	75141	91.3	24.5	18.6	24.2	23.8
Americas	**48**	**47.6**	**105806**	**222156**	**95.8**	**43.6**	**32.7**	**30.9**	**31.3**

The subregions are defined as follows:
- North America: Bermuda, Canada, and the United States
- Latin America: the Andean Region, Brazil, the Central American Isthmus, the Latin Caribbean, Mexico, and the Southern Cone.
- Central American Isthmus: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.
- Latin Caribbean: Cuba, Dominican Republic, Haiti, and Puerto Rico.
- Andean Region: Bolivia, Colombia, Ecuador, Peru, and Venezuela.
- Southern Cone: Argentina, Chile, Paraguay, and Uruguay.
- Non-Latin Caribbean: Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Cayman Islands, Turks and Caicos Islands, Virgin Islands (UK),Virgin Islands (USA),
Dominica, French Guiana, Grenada, Guadeloupe, Guyana, Jamaica, Martinique, Montserrat, Netherlands Antilles, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines,
Suriname, Trinidad and Tobago.

Annex C. Recourses Invested Annually in the RCHDI by the Countries at the Regional and National Level. July 2004

Country	Regional					National				
	Annual Budget allocated US$	Posts				Annual Budget Allocated US$	Posts			
		G *		P**			G *		P**	
		No.	%***	No.	%***		No.	%***	No.	%***
Argentina		1	0.1	1	0.2	5000	2	0.1	1	4.2
Bolivia				2	10.0	12000	1	5.0	1	35.0
Brazil		1	7.5	1	7.5	7500	1	7.5	1	7.5
Chile		1	7.5	1	7.5	3000	1	7.5	1	7.5
Colombia				1	5.0	2800			1	5.0
Costa Rica				1	8.3	3000			4	4.9
Cuba		1	3.0	1	3.0	5000	1	3.0	1	3.0
Dominican Republic				1	10.0	3500	1	1.5	1	15.0
Ecuador		1	5.0	1	10.0	2500	1	5.0	1	20.0
El Salvador				1	12.0	5118			3	24.0
Guatemala		1	15.0	1	10.0	2500	1	30.0	1	20.0
Honduras				1	1.0	4000			1	10.0
Mexico						4000				
Nicaragua				1	2.5	16900			1	17.5
Panama		1	4.0	1	4.0	2600	1	4.0	1	4.0
Paraguay		1	0.5	1	0.5	500	1	1.0	1	1.5
Peru				1	5.0	2500			1	5.0
Uruguay				1	15.0	2600			1	15.0
Venezuela						6000			1	20.0
Total	**0**	**7**	**5.3**	**17**	**6.8**	**91018**	**10**	**5.9**	**21**	**12.3**

*   Administrative Posts
** Technical Posts
*** Average percentage per person

Annex D. Resources Invested Annually in the RCHDI by Units at PAHO Headquarters. Julio 2004

Unit	Regional				
	Annual Budget Allocated	Posts			
		G *		P**	
	US$	No.	%***	No.	%***
AD/DPC/CD	5000			4	5
AD/DPC/CD/TB				2	11.1
AD/DPC/NC				1	2
AD/DPC/VP	1100	3	14.0	6	13.7
AD/FCH/AI		1	25.0	1	10
AD/FCH/IM	500000	1	70.0	7	12.1
AD/FCH/WM		1	15.0	2	12.5
AD/GE				1	1
AD/SDE/RA				2	0.8
AD/THS/OS	20000	1	5.0	2	7.5
DD/AIS	85000	5	6.5	15	19.9
DPM/SDH/HP	20000			4	15
DPM/SDH/HR				1	50
Total	**631100**	**12**	**15.7**	**48**	**13.4**

*   Administrative Posts
** Technical Posts
*** Average percentage per person