THIRTY-SEVENTH WORLD HEALTH ASSEMBLY

COMMITTEE A

PROVISONAL SUMMARY RECORD OF THE SECOND MEETING

Palais des Nations, Geneva
Wednesday, 9 May 1984, at 9h25

CHAIRMAN: Dr K. AL-AJJOUNI (Jordan)
later: Mr R. EDWARDS (Canada)

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Note

This summary record is provisional only. The summaries of statements have not yet been approved by the speakers, and the text should not be quoted.

Corrections for inclusion in the final version should be handed in to the Conference Officer or sent to the Records Service (Room 4013, WHO headquarters), in writing, before the end of the Health Assembly. Alternatively, they may be forwarded to Chief, Office of Publications, World Health Organization, 1211 Geneva 27, Switzerland, before 2 July 1984.

The final text will appear subsequently in Thirty-seventh World Health Assembly: Summary records of committees (document WHA37/1984/REC/3).
GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000: REPORT ON MONITORING OF PROGRESS IN IMPLEMENTING STRATEGIES FOR HEALTH FOR ALL: Item 19 of the Agenda (Resolutions WHA34.36, WHA35.23, WHA36.34, EB73.R3 and EB73.R6; Documents A37/4 and A37/5) (continued)

Dr ORDOÑEZ (Cuba) recalled that two years previously the Health Assembly had adopted the plan of action for implementation of the health-for-all Strategy and countries had been urged to undertake collective action on the monitoring and active evaluation of the progress made. The present review would constitute a first assessment which could then serve as point of departure for future systematic evaluations of the progress made towards the goal of enabling all the citizens of the world to reach, by the year 2000, a level of health that would enable them to lead a socially and economically productive life.

He proposed to single out, among the 12 global indicators approved by the Health Assembly, a few of the aspects most relevant to the development of public health in Cuba. Of fundamental importance was the political decision to give priority to primary health care within the framework of socioeconomic development with the establishment of an integrated national health system and active community participation both in decision-making and in the solution of the health problems of the individual, family and the community. An adequate information system was also vital to the monitoring process and great efforts were being made in the Region of the Americas to increase the capacity and accuracy of national information systems. His country was fully committed to the attainment of success of the health-for-all Strategy.

Dr BORGONO (Chile) welcomed the fact that less than 25% of all Member States had failed to provide information on the implementation of their health-for-all strategy. It was noticeable that some of the countries best fitted to provide information (in the European Region and the Region of the Americas) had failed to do so, thus indicating a certain lack of commitment to inform on their part. The countries of those two Regions had a responsibility to discharge vis-à-vis all the other countries, through WHO in the common quest. That was an important matter as current monitoring was to provide the information for the first formal evaluation of the strategies, which was to take place in 1985. Monitoring was not merely collecting and analysing information - it was a basic element in the evaluation process.

Coming from a country that had before it the health targets of the Americas, which were even higher than those of WHO, he felt that the important point was that such targets had to be achieved not merely in terms of national averages but in every part of every country. Surveillance alone was not enough, it had to lead to analysis and projection of data for evaluation purposes in a rational use of the monitoring process. The regional offices had a part to play as catalysts in obtaining more and better reports on time and in ensuring that the strategies were directed to the promotion of cooperation between developing countries and indeed between countries in general.

He would like the current first review of the monitoring of progress to achieve some simplification of the frameworks and formats, and an improvement of the tools being used to measure the progress made.

It sometimes appeared that there was a sort of schizophrenic gap between the political will to take decisions and their implementation in practice. Although on paper it might appear that many problems could be solved concurrently, what was important was to make a start without delay; the real commitment was to act at the national and regional levels. In that connection he agreed with previous speakers on the need for WHO to provide, at the global and regional levels, more support to countries in improving their information systems so that they would provide the reliable data required for the monitoring and evaluation process. Emphasis should also be placed on the continuing education and training of health workers, in order to provide the essential health infrastructures at the national, regional and, especially, rural levels. The Organization also had an obligation to demonstrate, with examples, the connections and intersectoral and multisectoral linkages between the health-for-all strategies and development in other sectors of national life.

His delegation supported the draft resolution submitted by the Executive Board.
Dr MGENI (United Republic of Tanzania) agreed that the incompleteness and inaccuracy of some of the reports submitted by individual countries on the implementation of the health-for-all strategies seemed to have been due in no small measure to the inadequate information systems and lack of statistical skills and experience in many developing countries. Experience of monitoring progress in his own country suggested that the 12 global indicators, although excellent as criteria of overall progress, had not been altogether appropriately designed to meet the requirement at the national level and that they needed further elaboration to include some complementary factors. Basic standard health status indicators appeared to be required covering at least the 8 components of primary health care since, in their absence, some countries tended to remain faithful to traditional hospital-based standards which might present a biased picture of community health status. It would be misleading, for example, for a country like his own in which the primary health care workers at the periphery consisted of medical assistants and rural medical aid personnel, to use the doctor/population ratio rather than the appropriate allied personnel/population ratio as an indicator of the provision of health care; that would also perpetuate a demand for highly skilled, and in consequence expensive, hospital-based staffs, which were not really required to meet the vital health needs of the community. The standard basic health status indicators covering at least the 8 primary health care components should also clearly state standard targets and objectives and comprise standard supportive indicators relating to resources required for their achievement. In the absence of these primary health care oriented standard indicators, many countries would either revert to the hospital-based, curative health care indicators or over-invest in supportive services without any objective impact assessment. There was a need for a model.

Taking the example of maternal and child health in a community, the health target indicator already adopted would be the achievement of an infant mortality rate not exceeding 50 per 1000 live births annually. The supportive inputs required, i.e., the resources, could then be defined in terms of the number of health personnel required to serve the number of children or number of expectant mothers to be covered, and the number of health worker visits required, and at what intervals, to ensure proper health monitoring at least during the first year of life.

It was also imperative that the indicators that lay within the purview of the health system itself should be identified and clearly defined before an attempt was made to tackle the intersectoral indicators.

His Government would be interested in developing appropriate indicators and would welcome WHO cooperation in so doing, as well as the collaboration of other interested organizations and Member States.

He supported the draft resolution contained in resolution EB73.R6 submitted by the Executive Board.

Dr BENADOUDA (Algeria) agreed that 75% of Member States' having responded to the Organization's request to report on their progress was a factor that made for optimism. The unanimity of political will was also most promising.

The Executive Board's report (document A37/4) was particularly valuable, however, in that it identified some of the obstacles to be overcome. One of the most formidable was the economic recession which tended to intensify the disparity in health standards between countries and within individual countries. That called for the establishment of priorities and the reinforcement of intersectoral cooperation in all fields with an impact on health, both within countries and between WHO and the other international organizations concerned, where necessary to the extent of a genuine mobilization of United Nations resources. For example, there was no point in organizing vaccination programmes in the Sahel if the children had nothing to eat. The second obstacle which arose at the human level was also important, namely shortcomings in the analysis and handling of information, defective planning and management, on occasion a complete lack of intersectoral cooperation, and inadequate operational research capacity at the national level. A further problem sometimes arose with health professionals, whose hospital-based training prevented them from accepting the concept of primary health care, and with the community itself which was conditioned to accept disease rather than to fight it. Nothing less than a reorientation of national systems was required and a change in the attitude towards primary health care, brought about by educating health personnel to the new approach and the population to assume responsibility for their own lives. That was where the real thrust should be directed. The problems enumerated above could all be solved by medical personnel who were realistically trained and conscious of the needs of society. The alternative solution of the periodical detachment of experts did not work; when the experts left the situation reverted to its original state.
Dr EL BERMAWI (Egypt) said that the idea of formulating global indicators was novel and helpful but he wished to comment on some of them.

Global indicator 3 (expenditure on health in terms of GNP) should take into consideration indirect expenditure on projects and activities which might have a more far-reaching effect on health than direct health expenditure, for example environmental health measures, drinking-water supply, sanitation and solid waste disposal. A distinction should be made in global indicator 4 (percentage of national health expenditure devoted to local health care) between coverage and efficiency. It would be wrong, for example, to compare a locality in which a centre of excellence or a university hospital was located with another locality which had only a primary health care unit. When considering global indicator 7 (population coverage with primary health care) where immunization was concerned, a distinction should again be made between reported coverage, real coverage and effectiveness. Global indicator 11 (adult literacy), on the other hand, was closely dependent on the availability of public education and the date on which the policy of literacy for all had been adopted (time had to be allowed for the beneficiaries to reach adult status).

Apart from those specific comments, it would be helpful to quantify global indicators 4, 5, and 7 and its sub-indicators, and to state, for example, the percentage of the population with access to safe water supply and sanitation, the extent of real coverage with immunization and immunization effectiveness, what were the essential drugs and their availability in terms of population served and the availability and distribution of trained personnel for maternal and child health care in terms of categories and rates per population.

He therefore proposed the addition of a further subparagraph to operative paragraph 4 of the draft resolution contained in resolution EB73/R6, which he supported, requesting the Director-General to attempt to quantify global indicators 4, 5 and 7.

Dr GUNJI (Japan) welcomed the Executive Board's report, which gave a clear picture of the actual health situation in the world. He was pleased to note the steady progress made in the past two years in the implementation of strategies at the global and regional levels. However, the common framework and format for monitoring progress would require some improvement if more accurate information was to be obtained in the future. Some of the more difficult questions and indicators could perhaps be refined and amended. Indicators that were more sensitive to the progress being made in developed countries should also be included. The improvement of health information systems was, of course, important in order to strengthen monitoring and evaluation processes. He hoped that WHO would intensify technical cooperation with Member States in order to strengthen their capabilities in that respect.

In Japan, the rapidly aging population and the change in the pattern of illness, with an increase in chronic diseases compared to communicable diseases, had meant that health care expenditure had continued to soar while the increase in national income had slowed in response to the slowing of economic growth. Ways would have to be found of achieving an appropriate balance of health care costs with economic growth.

In accordance with the national plan of action for implementing the strategy, communities throughout Japan were making efforts to set up their own programmes for health promotion. More community health centres had been established and steps were being taken to increase the number of public health nurses at those centres. A law concerning health and medical services for the elderly had come into force in February 1983 and a new comprehensive health programme for the elderly had been introduced.

He pledged his country's continuing efforts to implement the national strategy of health for all.

Dr KIM Won Ho (Democratic People's Republic of Korea) also welcomed the Executive Board's report. The Global Strategy launched in 1979 had passed through the stages of formulation of action plans and initial implementation and was now being pushed forward on a full scale. It would be essential to analyse the successes achieved and the experience gained so far, and to evaluate correctly the strong and weak points, taking measures for improvement. The Organization's proposal concerning the evaluation, in 1985, of the Strategy for health for all was a just and realistic one and he supported the draft resolution proposed by the Executive Board in resolution EB73/R6.

In order to establish an accurate evaluation of progress at the global and regional level it was essential that each country should evaluate carefully its own national strategy. In his own country, President Kim II Sung had stated that efforts should be undertaken to rationalize economic activities by putting them on a scientific basis. To that end, his Government had paid great attention to the setting up of a rational health
information system, based on a careful investigation and analysis of the country's health situation, and with due regard for timely measures for its improvement. In the period under review, the Government had undertaken a series of measures to improve public health services in accordance with needs as assessed by such investigation and analysis. In particular, research groups had been mobilized to investigate the differences in the health services available to urban and rural populations in selected regions. It had been confirmed that the inequalities had been considerably reduced and that the ratio of mortality rates in urban and rural areas had been improved from 1:2 to 1:1.3 in the period 1960-1980. On the basis of such information, primary health care for the rural population would be strengthened further in order to reduce the remaining differences.

Dr MARKIDES (Cyprus) welcomed the Executive Board's comprehensive report. It had been a wise decision, in resolution WHA35.23, to request the Executive Board to undertake monitoring of the progress made in implementing the Strategy for health for all. In preparing their responses, countries had had the opportunity of undertaking national evaluation at a high level. In his own country, that exercise had revealed many shortcomings in the implementation of the political decisions made so enthusiastically at Alma-Ata. The slogan "Health for all by the year 2000 through primary health care" had been received with some scepticism, as nothing new, and in the belief that his country's policies were already being implemented along such lines. However, it had now been realized that for small and poor countries such as his own proper implementation was by no means easy.

He went on to outline the deficiencies revealed by the evaluation of national strategy undertaken in his own country, deficiencies that had existed for some time but that had only become apparent through the evaluation. There was a lack of leaders with a real enthusiasm for primary health care and it was clearly necessary to persuade people of their real needs as opposed to superficial needs. There was a need for leaders in all the health professions, and among other professions, who were oriented towards community rather than clinical or hospital medicine. Experts in public health were needed and those who were available should be better used. It would also be necessary to bring together the Government and the private medical sector so that they worked together rather than competed. For example, while the Government was currently supporting an essential drugs policy, the private sector was not. Doctors from all sectors would have to be brought closer together and ways would have to be found of giving prestige and status to those working in primary health care. Further, satisfactory links would have to be established between primary health care and secondary and tertiary health care levels.

Although his country had all the necessary elements for a good health service, efforts were needed to combine those elements into a cohesive whole. One means of so doing would be to establish good referral and health information systems - present systems, where they existed, were inadequate. It would also be necessary to strengthen managerial capacity, and to pass new laws and regulations and improve existing ones.

WHO's advice and financial assistance in holding seminars, awarding fellowships, and so on, would be needed in order to solve those problems. However, WHO would have to find the right way of giving such assistance in accordance with each country's needs. To send out experts whose reports could be impractical or, though practical, simply shelved, was likely to be of little use.

His delegation supported the draft resolution contained in resolution EB73.R6.

Dr AL-SARRAG (Sudan) welcomed the Executive Board's report and the Director-General's comments as also those of Professor Lafontaine, representative of the Executive Board to the Health Assembly. He agreed with many of the Director-General's comments (document A37/5). The slogan "Health for all" was very attractive from a political viewpoint and was one that could be welcomed by all countries. However, when translated into strategies and plans, the slogan was proving to be an obstacle to activities in all spheres and not just to those related to health. Thus it had been realized that health for all would only be possible if there was active participation of the community and if there was coordination of the activities of all sectors related to health, for example, provision of clear and potable water, food and nutrition, general and public education and housing. Then there were the relatively easier tasks of the health sector itself in the fields of maternal and child health, preventative and precautionary measures against diseases and accidents, as well as curative measures through health centres, clinics and hospitals.

The concept of health for all had met with a great response in his own country. Three years earlier, the President had called for a clear commitment and adherence to the strategy and had instructed the Ministry of Health to meet with other sectors and to coordinate activities into a single strategy to achieve the goal.
The process of evaluation, starting with the questionnaire on the 12 global indicators, had called for a degree of courage on the part of Member States in order to state clearly and frankly the situation in their health services. That some of the replies would be rather weak, inconsistent or lacking in accurate information was only to be expected. A more comprehensive and accurate response might have been obtained if the evaluation had been undertaken within the framework of a workshop held in each country, with the support of the regional office, at which all the important aspects could have been emphasized.

Considerable progress had been achieved in implementing the strategy in Sudan. Primary health care programmes had already been laid down prior to the adoption of the Declaration of Alma-Ata, so that the concept was not entirely new. His Government had realized the need to decentralize administration and there were now eight regional administrations which were further decentralized into local administrative units. At all levels, efforts were being made to achieve the target of health for all.

The realization of health for all would require spiritual support. Since 1983, Sudan had adopted Islamic law in all its activities, with considerable consequences in the field of health. For example, two social scourges - alcohol and prostitution - which undermined the lives of individuals, had been prohibited.

Although considerable efforts were being made towards health for all, the influx of many refugees from countries to the east, south and west of Sudan were proving a considerable burden on the country's limited health resources and it was impossible to ignore such problems. In the evaluation of the effectiveness of the Global Strategy, in two years' time it would be essential to take into account questions of stability, security and peace in all countries in order to contribute to the extension of comprehensive health services in the countries affected and in order to enable them to offer assistance to other neighbouring countries or countries with similar problems within the framework of technical cooperation among developing countries.

His delegation supported the draft resolution contained in resolution EB73.R6.

Mr HADAYETULLAH (Bangladesh) expressed his appreciation for the leadership and sense of direction given by those concerned in WHO to Member States in their arduous task of attaining the goal of health for all by the year 2000.

Bangladesh was one of the least developed countries with many constraints on the implementation of the health-for-all strategy, including overpopulation, high mortality and morbidity, low literacy rates and frequent natural calamities and epidemics, which were accentuated by poor funding, lack of sound planning and programming, and inadequate monitoring, evaluation and accountability. Despite these innumerable economic, social and environmental impediments, his country was trying hard to implement the strategy, keeping in mind the 12 global indicators.

In respect of the endorsement of health for all at the highest official level (global indicator 1), he noted that his country was a signatory to the Declaration of Alma-Ata of 1978 and that his Government had defined an 18-point programme for minimum health care.

A number of measures had been undertaken in Bangladesh for involving people in the implementation of strategies (global indicator 2). Management committees had been formed for most institutions, in order to improve their operational efficiency and accountability. Village health committees had been set up and voluntary health workers trained. A programme for the training of village leaders, imams, traditional healers, teachers and others at the grass-roots level in primary health care was under way. Project committees had been formed with local representatives, for the development of health and family welfare centres covering populations of about 20,000. A restructuring of administration had been introduced with a view to decentralizing power to people's representatives at the upazilla level, who would identify their own problems and undertake planning, programming, budgeting, implementation, monitoring, evaluation and, if necessary, reprogramming in order to determine their own solutions.

With respect to the percentage of GNP spent on the health sector (global indicator 3), he noted that during the financial year 1980-1981, his country's health expenditure had totalled taka 5.65 billions, 49.5% in the public sector, the balance in the private sector, including nongovernmental organizations. That sum represented 2.2% of gross domestic product. The United Nations system had contributed taka 152 millions during the years 1980-1981. The health sector's share of the total public outlay in the second five-year plan, 1980-1985, was 3.72%.

As regards the global indicator 4 (percentage of national health expenditure devoted to local health care) Bangladesh had increased that percentage from over 50% in 1980-1981 to 69% in 1982-1983.
Global indicator 5 referred to the equitable distribution of resources. Bangladesh was making serious efforts to provide health care facilities for the 90% of its population living in rural areas and had established 354 upazilla health complexes there, each covering a population of 200 000 to 300 000. Each complex had 8 doctors, including one physician, one surgeon and one gynaecologist, and one dental surgeon. Each possessed 31 beds for in-patient treatment and maternity and family planning cases and there were also domiciliary staff for domiciliary health and family planning work. About 2000 health and family welfare centres had been established to provide primary health care facilities at grass-roots level and their budget had been recently increased. The medical manpower now available in rural areas amounted to 3500 doctors, 1000 medical assistants, 800 nurses, 3500 female welfare workers, 400 sanitary inspectors, 13 500 male health assistants, 4000 family planning assistants and 30 000 traditional birth attendants.

In regard to global indicator 6 (well-defined strategies, explicit resource allocation for health for all and external support from more affluent countries) Bangladesh had formulated a well-defined strategy for achieving the health-for-all goal, accompanied by explicit allocation of resources. The strategy was being implemented in a phased manner. External resources, for which his people were most grateful, played an important role in the country's health development efforts of this country. Recently a country resource utilization and Health Resources Group study had been carried out by WHO in Bangladesh, which had revealed that there was still a large resources gap for the effective implementation of the strategy in Bangladesh.

As regards global indicator 7 (availability of primary health care to the whole population), in Bangladesh coverage was as follows: 60% of the rural population had access to safe drinking water supplies and there was one tube well for every 150 people in rural areas. 3% of the people had access to water seal latrines. Thanks were due to UNICEF and WHO for providing support for those two programmes. There was, however, much room for improvement in that sector. Widespread immunization, for instance, had not yet been carried out in his country. Efforts were being made in that direction with the establishment of immunization centres in medical colleges, hospitals and health centres and a crash programme to immunize all expectant mothers with two doses of tetanus toxoid during the last three months of pregnancy would soon bring down the infant mortality rate. The present coverage for the various vaccines was about 3%, but for BCG it was 20%.

The nutritional status of children (global indicator 8) in Bangladesh was poor but, due to lack of a proper information system, it was impossible to quantify.

The infant mortality rate (global indicator 9) at 120 per 1000 was high, the major causes of death being tetanus, diarrhoeal diseases, and acute respiratory infections. With effective control of those three diseases, it was hoped to bring down the infant mortality rate to 50 per 1000 with a short period.

In Bangladesh, life expectancy at birth (global indicator 10) was 54.8 years. Separate figures for males and females were not available.

The adult literacy rate (global indicator 11) in Bangladesh was 26%, much below the desired 70%.

Finally, the GNP per head in his country was some US$ 120, a far cry from the aim of US$ 500 expressed in global indicator 12.

In conclusion, his delegation endorsed resolution EB73.R6 submitted by the Executive Board.

Mr Edwards took the Chair.

Dr TOGBA (Liberia) said that his Government had accepted the principle of health for all by the year 2000 but he, personally, was very pessimistic about the possibility of achieving that goal. In Liberia and other countries like it, there were many isolated villages and enormous financial problems. The population lived in remote areas and was difficult to reach and, moreover, the illiteracy rate was high. It was therefore difficult to get health measures, such as safe water supplies, to the people and then difficult to get the people to accept them.

For instance, his country had received help in recent years from the United States of America in the form of a demonstration project for primary health care. He had himself been a member of the committee which had evaluated the project. Clinics had been established and provided with health educators, and latrines and wells had been installed. The committee had visited some of the villages concerned and had found the latrines locked up and no roads leading to them. On inquiry, the people in charge of the clinics had said that they were kept locked up so as to keep them clean. Certain village chiefs had stated that they kept their latrines only for guests.
The Netherlands Government had also sent a team to Liberia to teach primary health care methods in a project which had lasted from three to five years. Among other things, they had established stores where drugs could be bought cheaply. When the project initiators had left, those stores had not been maintained because the Liberian administration could not afford the "cheap" drugs for people to buy. The Federal Republic of Germany had also provided primary health care assistance and the United States would soon initiate a further programme. Liberia was sending students to advanced industrialized countries to study, but he still wondered what would happen when those helpers left the villages.

The vaccination of children who were hungry had been mentioned. If hungry children were vaccinated, severe reactions were to be expected. Moreover, there were problems in keeping the vaccines cool in a country which had only kerosene-fuelled ice boxes. The villages often ran out of kerosene, and, in any case, found it costly to buy. Liberia was, however, making efforts to train workers for rural areas and to get the villagers themselves involved in their own health care. But he still wondered how they would continue to put into practice what they had been taught, in view of their poverty. Even if health for all was attained by the year 2000, what would happen after that? The ideal was wonderful, but he found the reality depressing to contemplate.

Dr CABRAL (Mozambique) said that the Strategy of Health for All by the Year 2000 had already led to an awareness of the need for changes in many spheres where hitherto unquestioned ideas and traditions had maintained inequalities and discrimination in the access to health care.

The report of the Executive Board confirmed the social value of the Alma-Ata Declaration and provided stimulation with the acknowledgement that there was greater commitment among the world health community to solving the basic health problems of the people and that honest attempts were being made. However, some parts of the report, in particular the section dealing with health manpower development, still confirmed his delegation's concern that in a number of countries primary health care was being translated into rural or second-class health care for the poor and underprivileged.

Mozambique's national health strategy had been prepared on the basis of the directives of the FRELIMO Party and the Prospective Indicative Plan for 1980-1990. In 1983, a medium-term plan (1983-1985) had been approved. His country considered that, in the present political situation, it was neither possible nor advisable to divert resources for the elaboration of a long-term plan, extending up to the year 2000.

Mozambique was making every effort to improve its capacity for planning, organization and management at all levels, but particularly at the district level, which was considered as the basic planning unit. Such organization and management, however, and especially coordination with other sectors, was a difficult and complex task in view of the inadequate degree of training of auxiliary personnel. In order to overcome those difficulties, a guide for planning, organization and evaluation for the health centre level had been prepared, containing a set of simple norms for the organization and programming of the main health centre activities, as well as definitions and rules which allowed for the choice of priorities and the evaluation of results. In order to train district level personnel, workshops had been held for the district directors of health throughout the country and it was planned to hold a further workshop on planning and management for provincial and central staff during the present year.

A primary health care project was being implemented in several villages and should provide information for evaluation of primary level activities which would be useful in implementing the strategy of health for all by the year 2000. Thanks were due to WHO for its help in those activities.

During 1982-1983, his country had undertaken studies on the costs and benefits of several activities at different levels of health care with the aim of making the most effective utilization of available resources. Estimated results obtained so far showed that the trend had been consistently in favour of the primary level.

Efforts were also being made to obtain more exact data on which planning and evaluation and possible reformulation of strategies could be based.

Unfortunately, Mozambique's implementation of the strategy had been greatly hampered by the action of armed bandits which had been disastrous in all aspects of life. Personnel training, however, had begun to produce positive results at the primary level.

His delegation agreed with the views expressed in the Executive Board's report and in the comments by the Director-General on the availability and reliability of the data provided by Member States but it was convinced of the need for periodical evaluation. His own country's evaluation had proved a useful tool for tracing gaps in statistical data and for a reflection about the resources allocated to the peripheral level. Mozambique, however,
found it difficult to provide all the information requested. Health coverage only attained 30-60% of the total population, the illiteracy rate was still over 80%, difficulties of transportation were enormous and health workers were few and inadequately trained and working under great shortages of materials, drugs and equipment. In such conditions, it was impossible to provide completely reliable data. It was impossible, for instance, to calculate the mortality rates by age and cause, but the newly established health information system should provide data from hospital mortality and morbidity.

He shared the view that WHO should make a particular effort to provide assistance in the field of data collection. In that connection, his delegation agreed with the views expressed in the managerial framework for optimal use of WHO's resources in direct support of Member States (document DGO/83.1). They regretted that not all the agencies and organizations in the United Nations system appeared to have the same understanding of the problems facing developing countries. Mozambique's experience was that the effectiveness of the support from international organizations was greater if programmes were incorporated more effectively into national plans. External resources should be invested in strengthening the planning and management capacity of the countries themselves and not in imposing isolated projects on them.

In conclusion, his delegation supported the draft resolution submitted by the Executive Board.

Mr SONG Lien Zhong (China) expressed his appreciation of the Director-General's comments in document A37/5 on how the strategy for health for all was being applied with encouraging results.

He said that after China's health strategy and policy had been determined it had been important to ensure that the necessary assistance was provided by central or local government financial and planning institutions. China had adopted a decentralized system of financing so that local support provided an important guarantee for implementation.

Since 1980 China had been strengthening the rural, district and communal bases for public health care, and by the end of 1982 some 16.6% of the total budget was being spent at district level. In order to improve the health infrastructure, attempts had been made to increase cooperation with national and international bodies. Training of health manpower was carried out at various levels: at district level there was a district hospital, a vaccination centre and sometimes a health worker training centre and an institute for traditional Chinese medicine; while at the regional level there were clinics. The current rural level of expertise was very low since most medical staff had had only primary education. Progress was being made in improving the level by recruiting more students of middle and higher educational standard to work in the countryside, as well as by reinforcing the continuing education of existing health personnel.

Difficulties were still being encountered in China in the monitoring and evaluation of the strategy for health for all. That was due partly to the planning and financing system applied and partly to the lack of health management capacity. The intention was to expand the health information capacity by setting up a statistical study for planning purposes.

Professor LUNENFELD (Israel) said he was glad to know that about 75% of Member States had submitted reports on the implementation of the strategy for health for all and he hoped that the documents before the Health Assembly and its deliberations would motivate others to do likewise. Constant monitoring of health strategies was essential, and discussion of the problems involved would make it possible to modify health indicators and adopt sub-groups and reference values specific to national situations and needs. It should also enable many countries to adopt their own upgraded regional reference values for standard indicators.

Intercountry cooperation in the sharing of information and transfer of technology through the coordinating role of WHO would be an important factor in the success of the programme.

Systems for the assessment, planning and monitoring of strategy were only useful if they were based on reliable health information, and greater intercountry and WHO collaboration could help to ensure the quantity and quality of health-related data.

He was proud to inform the Health Assembly that Israel's health system had achieved nearly universal coverage of health insurance (95%) and that health services were provided to all citizens irrespective of sex, religion or ethnic group through organized public agencies. Preventive and curative health services were heavily utilized. Curative services included primary health care centres, including maternal and child health, basic and specialized services at the community level, specialized referral services, hospital services, long-term care and rehabilitation services. The easy availability of such services had in some cases produced over-use (there were 12 visits per capita per annum). Thought must be given to devising a method of preventing over-use, distinguishing it from high effective use and ensuring that the underserved population groups were not deprived.
In Israel, nearly 90% of children had had full immunization by the age of one year, including mumps vaccination since the beginning of 1984. The immunization programme had been strikingly successful throughout the country. Eradication of measles should be achieved by 1989, of rubella in the female population by 1990 and of hepatitis by the year 2000.

Public drinking-water systems provided safe water for domestic use to almost the entire population. Israel's target for the International Drinking Water Supply and Sanitation Decade included: fluoridation of all public water systems by 1988, continuous monitoring of bacterial and chemical water quality, revision of water standards in accordance with WHO standards, and development of re-use of used water.

Special attention was being given to improved housing, recreation, education, and social and health programmes for poor urban areas, through "project renewal", which featured a large element of community participation and had been effective in improving life-styles and changing community attitudes. It was an example of projects and expenditures having an indirect positive effect on health but not included directly in the national health budget.

Considerable progress had been made in reorienting health programmes towards emphasis on disease prevention and health promotion, as was shown by the increased commitment of government and public organizations at all levels, by changes in laws regarding health issues, by budgetary trends and programme development. Allocation of resources and health services administration had been modified in response to changes in epidemiology as well as to technological and research advances.

Several preventive initiatives had led to an improvement in prenatal care, with a significant decrease in the number of high-risk pregnancies; a decrease in accidents and injuries; and the full coverage of children with immunization against preventable childhood illnesses. The national infant mortality rate had dropped from 17.8 per 1000 live births in 1979 to 12.8 per 1000 in 1982, and the aim was to achieve an average of 9 per 1000 by the end of the decade, with no region or population group having an infant mortality rate higher that 12 per 1000.

Mortality from strokes had decreased by 21% and that from coronary heart disease by 28% in the past six years, and it was expected that increased attention to diagnosis and management of hypertension, together with expanded health education, would further decrease mortality from the two commonest causes in Israel. A nationwide network of mobile coronary units would be fully operational by 1987, and basic cardio-pulmonary resuscitation courses for the public had been initiated.

High priority was being given to meeting the needs of a rapidly aging population in ways, such as home care and assistance, that the State could afford. Careful planning was required to avoid creating an over-supply of other kinds of health facilities.

Programmes to reduce environmentally induced cancer by 50% by the year 2000 were in progress, including a recent one to ban smoking and one to remove carcinogenic substances in food, cosmetics and the environment. Israel was collaborating with many countries in active research programmes for the identification of carcinogens.

In spite of an ample overall supply of physicians, real shortages in specific health fields were hampering the development of services. Intermediate health planning indicated the need to upgrade expertise in specific health-related fields, including highly qualified managers and administrators, nutritionists, etc. The WHO fellowship programme and bilateral agreements continued to have a real impact on Israel's health manpower development, which was an integral part of its national strategy for health for all.

In conclusion his delegation endorsed the Executive Board's resolution EB73.R3.

Dr KOOP (United States of America) said that the issues outlined in documents A37/4 and A37/5 were critical for the achievement of the global and national goals of health for all by the year 2000. Considerable progress had been made in focusing international and national attention on the policies, strategies and resources necessary to achieve the goal established in 1979.

The United States had supported that goal since its inception and considered it as significant for industrialized as for developing nations. In 1980 the United States had established a plan of action and health-for-all strategies and in 1983 had submitted its report to WHO on monitoring progress in implementing those strategies, which were based on certain disease prevention and health promotion objectives with specific goals to be achieved by the year 1990.

Progress had been significant. One of the objectives, for example, had been to immunize 95% of school-age children against the seven vaccine-preventable diseases of childhood by the year 1990. Over 95% coverage had already been achieved, and the incidence of the seven diseases had dropped 71% in three years. Indeed, a number of those diseases were on the verge of being eliminated entirely in the United States.
The Director-General in his comments in document A37/5 had outlined some early achievements of Member States and had been candid in acknowledging the problems. He believed it was time for all delegations to speak as frankly as Dr Mahler and the members of the Executive Board. He agreed with the Director-General that the monitoring process had been started barely in time. It was clear from the documents before the Health Assembly that to a large degree the Secretariat had met its responsibilities. However, it was the Member States which had collectively decided on the Global Strategy and it was the Member States which must shoulder the most important responsibilities for achieving that goal. That would not be done without careful monitoring and evaluation of progress, which would be meaningless if it was not taken seriously at the national level.

The "Common framework and format" had been a useful tool in facilitating reporting but he agreed, as indicated in paragraph 146 of document A37/4, that in view of the difficulties experienced by some countries, it was necessary to improve and refine the monitoring tools. An analysis of the problems should be carried out with a view to improving approaches to monitoring and evaluation.

His delegation was seriously concerned by the reporting deficiencies that still remained in the monitoring report. Specific technical needs existed in national capacities to manage implementation of the policies and to monitor progress. His delegation commended the Executive Board for its recognition of those needs and urged that Member States fully support WHO's efforts to intensify its technical cooperation with them in strengthening national capabilities for health management, including information support. Regional offices and Member States must cooperate; the United States would share its information and expertise and continue to provide support in improving monitoring and management through its development assistance programme for primary health care.

He also urged the Secretariat to continue to enhance management of WHO's capabilities through strong coordination at all levels and through upgrading of technical abilities in areas relevant to health for all; staff should be encouraged to give more specific support to Member States in pursuit of health for all; new staff should have technical expertise in primary health care and health management.

Member States clearly recognized the significant benefits that health for all embodied and stood ready to reaffirm their commitment to its achievement. By adopting the Director-General's suggestions and the resolution before the Committee he was confident that they would move ever closer to fulfilling their goal.

Dr WESTERHOLM (Sweden), speaking on behalf of the Nordic countries, said that health developments, like economic development should be analysed continuously since it was one of the most important components of a country's welfare. The 12 global indicators established at the Thirty-fourth World Health Assembly provided a nucleus of methodology but WHO should further develop simple methods. It was essential to determine the changes in the health status of the population, the "risk panorama" and the organization and activities of the health care system by evolving progress indicators according to national disease profiles, risk profiles and care profiles.

The disease profile was the obvious foundation on which to follow up health development. The global indicators of average longevity and infant mortality constituted a minimum level. Special efforts should be made to elucidate the distribution of disease between various socioeconomic groups and between population groups in different geographic regions. The essence of the health-for-all strategy was to reduce differences within and between countries, and WHO should support Member countries in the development of disease statistics facilitating the identification of high and low risk groups in the health sector.

The health policy targets for the European Region gave the Nordic countries a point of departure for analysing changes in the health of various groups of the population. Strategic importance should be given to a direct follow-up of circumstances favouring or threatening the health of various groups of the population, i.e., monitoring of the risk profile.

The global indicator relating to economic development was one example of that type of progress indicator since most disease was connected with poverty. Other basic factors in the risk profile were the proportion of the population having access to pure water and decent sanitary conditions. In addition to the global WHO indicators, every country should try to elucidate developments in various sectors as they affected health, the most important being agriculture and food production, housing, employment and transport. Health policy in those sectors had a critical bearing on public health, elucidating the differences between men and

1 Document DGO/80.1
women and between various socioeconomic groups in avoiding health hazards and opting for a healthier life. National adult literacy rates for men and women should therefore be separate for WHO's purposes, being of direct relevance in view of the effects of education for women on family health.

The follow-up - like the planning - of a country's health development must therefore be intersectoral, and WHO's work to encourage intersectoral action for health should be given even greater priority.

That holistic view of health policy had become increasingly dominant in the Nordic countries; health policy aspects of living and working environments and unemployment, and agricultural policy and food policy had been highlighted in several projects. But it was essential to follow up hazards more directly related to the life-style of the individual, as in the use and abuse of tobacco, alcohol and narcotic drugs.

The health care system constituted a third subject of health development analysis, and the goals of the national primary health care strategy provided an obvious point of departure for it. Special attention should be paid to changes in financial and personnel resources for health and medical care for rich and poor, town and country, large hospitals and local health centres, and prevention and cure. In most countries care was least available to those who most needed it. Indicators of coverage and accessibility must therefore play a prominent part in the follow-up of primary health care strategies.

Primary care strategy and increasing emphasis on preventive measures constituted the cornerstone of health planning in the Nordic countries. However, changes usually took place less rapidly than planned, necessitating follow-up and analysis of factors impeding development, and stimulation of the various decision-making bodies, informal groups, voluntary organizations and individuals to participate more actively in local health promotion.

Thus, the follow-up of the strategy for health for all should elucidate as far as possible the extent of present and future participation by the population in the realization of that strategy, both through the political process and through direct local action.

The Nordic countries supported the draft resolution recommended by the Executive Board in its resolution EB73.R6.

Dr. CHIORI (Nigeria) commended the report and the Director-General's comments. The initiation of the monitoring process should provide the opportunity to learn from deficiencies, and he would therefore support continuous monitoring on progress with the Global Strategy until the goal was achieved.

His country recognized the importance of evolving a national health policy based on equity, and any review of existing policy should take into account the needs of the underserved majority of the population and seek to ensure a shift of resources in their favour.

It was now two years since Nigeria had instituted a mechanism for intersectoral action in favour of health. The requisite perseverance to introduce new measures aimed at improving the existing system was assured, as Nigeria was totally committed to the development of realistic policies at federal and local levels in the discharge of its responsibilities for health care delivery. The consequent reorientation of the health system would need to be based on adequate information at all levels. Accordingly, workshops and seminars had been held with a view to improving the national information system. Another vital component was the development of health manpower, and reorientation of personnel had been initiated with increasing emphasis on the training of new cadres and community-oriented health workers.

A review of the material and financial resources for the delivery of primary health care, reappraising their availability and use, was being carried out prior to assessment of the need for additional resources.

His delegation supported the draft resolution recommended by the Executive Board.

Dr. BRAMER (German Democratic Republic) commended the comprehensive report by the Executive Board and the Director-General's valuable comments.

His country's experience with its health system over the past 35 years supported the emphasis in the Global Strategy on the fundamental role of primary health care in achieving health for all by the year 2000, and indicated that primary health care should be developed as part of concerted health measures, ensuring a network for quantitative as well as qualitative extension of care. Basic health care should even extend to specialized disciplines; for example, the follow-up of hepatitis patients could be entrusted to primary health care physicians. In the German Democratic Republic, prophylactic care, treatment and rehabilitation were all integral parts of a complex free health care system for all citizens.
Experience had also pointed to the need for caution in decentralization, mentioned in paragraph 45 of the report by the Executive Board; a certain degree of centralization with regard to the responsibility for resources, and to activities to motivate and mobilize the community, was desirable.

His delegation would continue to support WHO in the achievement of its Global Strategy in the spirit of United Nations General Assembly resolution 38/188 concerning initiatives for peace, disarmament, détente and social justice, as it was gravely concerned about the growing danger of nuclear war. The delegation would support the draft resolution recommended in resolution EB73.R6.

Dr BANKOWSKI (Council for International Organizations of Medical Sciences), outlining the activities of CIOMS bearing on the moral issues involved in the Global Strategy of Health for all, recalled that for some years CIOMS had focused on the ethical implications of advances in the biomedical sciences. Although health for all necessarily presupposed the development of tactics and methods adapted to different contexts, the ideal itself was rooted in non-material and moral considerations, such as the universality of human rights, social justice, and the brotherhood of man irrespective of race or creed, and it was those very considerations which provided the main motivation of the strategy, involving as it did concerted efforts by health workers in vastly different cultural, philosophical and economic circumstances.

Most health decisions had inherent ethical components and, since different national, cultural and religious traditions yielded different ethical value systems, their interactions with health policy-making would consequently vary from country to country. CIOMS would be convening an international conference on health policy, ethics and human values in Athens in October of the current year, which would provide a forum for discussions between health policy-makers and health ethicists, philosophers and sociologists from different cultural and ideological groupings on selected health policy issues and their ethical implications, such as allocation of resources for primary health care, public policy and hereditary disease, care of low-birth-weight infants, health care of the elderly, and organ substitution therapy.

The main objectives of the conference would be: to identify and compare the ethical content of selected health policy issues for different national and cultural settings; to examine the interaction of ethical factors and other determinants of health policy in those different settings; to explore activities and arrangements which could assist interested countries in enhancing their capacities for dealing with the interaction of ethics and health policy-making; and to consider the usefulness of that kind of dialogue, which drew upon the roots of human values in each culture, in promoting better international understanding across cultural, economic and political lines. It was hoped that an international dialogue of that type could contribute to the achievement of the goal of health for all.

Dr NJIE (Gambia) said that the wide range of comments pointed clearly to the need for reviewing the action WHO had pledged itself to undertake. Using the indicators provided, it was difficult to assess exactly the progress actually achieved. His own country had had some difficulty in replying to the questionnaire since it was hard, for instance, to ascertain expenditure as compared with allocations. He was aware that workshops were being arranged to assist in the monitoring process, and he was convinced that simplified indicators could be established to assist in making realistic assessments rather than to reflect declarations of intent.

What WHO had already achieved towards the implementation of its Global Strategy since its initiation was, however, cause for congratulation. Most of the goals of the five-year health plan in his own country had already been achieved at the end of three years. Experience had shown the need to maintain maximum flexibility.

Improvements in the health system enjoyed high-level backing in Gambia, but intersectoral cooperation had been disappointing. A review had been made of existing systems, including even such points as whether intersectoral bodies should be called "health coordinating committees"; other countries' experience with certain problems would be welcome. The time seemed ripe for a meeting of Heads of State to consider the introduction of a primary health care system.

While all would agree that health action should go beyond merely curative aspects, the real need in rural areas for essential drugs could not be overlooked. Consequently, more attention should be paid to the supply of developing countries since their situation was grave, particularly in view of financial constraints. The efforts being made through the action programme on essential drugs must be coordinated with primary health care action; otherwise, confidence in that whole system might be undermined.
The results of using the media to publicize action under the expanded programme of immunization in Gambia had been gratifying. The basic issue in suiting projects to real needs was one of ensuring that the requisite funds, both from national and international sources, were available. The review of country resource utilization provided a useful exercise for possible remodelling of the resource pattern. He appealed to donor agencies to be flexible when certain sudden trends, such as an increase in the price of fuel, for example, affected the development situation. He urged countries to follow Gambia's example in seeking to ensure that all projects proposed really did conform to the actual needs of the situation.

The meeting rose at 12h40.