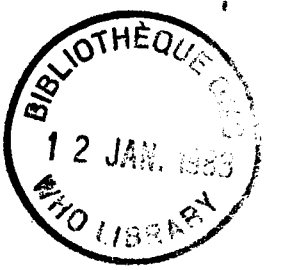
WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

EB71/19

10 January 1983



EXECUTIVE BOARD

Seventy-first Session

Provisional agenda item 12

GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000

Progress report by the Director-General

In conformity with resolution WHA34.36 the Director-General reports hereunder on the steps taken in 1982 towards implementing the Global Strategy for Health for All, following the adoption of the plan of action for the implementation of the Strategy by the Thirty-fifth World Health Assembly in May 1982.

CONTENTS

		Page
I.	Introduction	2
II.	Plan of action for implementing the Global Strategy	2
III.	Monitoring progress in implementing the strategies for health for all	2
IV.	Progress reviews by regional committees	3
V.	Support to national health strategies	4
VI.	Review of developments in primary health care	5
VII.	Training of national and WHO staff	6
VIII.	International flow of resources for the Strategy	7
IX.	Seventh General Programme of Work	8
X.	Proposed programme budget for 1984-1985	8
XI.	Collaboration with other organizations and institutions	8
XII.	Implementation of the study of WHO's structures in the light of its functions	9
XIII.	Concluding remark	10

I. INTRODUCTION

1. In May 1981, when the Thirty-fourth World Health Assembly adopted the Global Strategy for Health for All by the Year 2000 by resolution WHA34.36, it requested the Director-General, inter alia, to report annually to the Executive Board on progress made and problems encountered.

II. PLAN OF ACTION FOR IMPLEMENTING THE GLOBAL STRATEGY

2. In May 1982, by resolution WHA35.23, the Thirty-fifth World Health Assembly approved the plan of action for implementing the Global Strategy. This plan of action, which has since been published as No. 7 in the "Health for All" Series, provides a checklist of activities to be undertaken by Member States, the WHO governing bodies and the WHO Secretariat. It thus facilitates monitoring of progress being made in implementing the Strategy. According to the timetable appearing in the plan of action, the first report on progress is due from Member States in March 1983. This makes it impossible at this stage to prepare a global synthesis based on country information. For this reason, the report that follows will be limited to a few highlights of national progress as well as to action being taken by the governing bodies, the regional offices, and headquarters, in support of the implementation of the Strategy.

3. There are encouraging signs that Member States throughout the world have been active in developing national strategies for health for all in accordance with regional strategies and the Global Strategy as approved by the regional committees and the Health Assembly; but it is difficult at this stage to determine the exact situation. Strategies are sometimes developed and used without formal documents having been issued by governments. Undoubtedly much more will be known when countries begin to monitor and report on progress made.

III. MONITORING PROGRESS IN IMPLEMENTING THE STRATEGIES FOR HEALTH FOR ALL

4. In order to make it easier for Member States to monitor their strategies and subsequently report on them, the Director-General has prepared a "Common framework and format for monitoring progress in implementing the strategies for health for all by the year 2000".[1] This common framework and format had to be developed quickly after the adoption of the plan of action in order to be available to Member States in July 1982, in time for them to initiate a monitoring process. The main purpose of this document is to facilitate the monitoring by countries of progress in implementing their national strategies for health for all. At the same time, it will facilitate subsequent reporting to the regional offices, which will synthesize the information received from countries. This information will be presented to the regional committees at their 1983 sessions to permit them to monitor the implementation of the regional strategies. An analysis of the progress reports from the regional committees will then be made at headquarters, with a view to providing a report to the seventy-third session of the Executive Board in January 1984 so that it can assess global progress. The Board's assessment will then be reviewed by the Thirty-seventh World Health Assembly, in May 1984.

5. In anticipation of this monitoring of the Strategy, any information on primary health care already available from countries has been assembled. A summary of this review will be considered by the UNICEF/WHO Joint Committee on Health Policy following the present session of the Board. The summary has also been issued as an information document for the members of the Executive Board.[2]

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[1] Document DGO/82.1.

[2] Document EB71/INF.DOC./3.

IV. PROGRESS REVIEWS BY REGIONAL COMMITTEES

6. The regional committees reviewed progress in implementing the Strategy for health for all at their 1982 sessions.

7. The Regional Committee for Africa referred to the progress made in implementing the Strategy at its opening meeting. It was stated that all efforts were being made to sustain progress towards the objectives decided upon at the global level, following the Alma-Ata Conference. It was reported that several countries had made progress in the development of primary health care. It was realized that there was no single approach to primary health care; each country would have to develop its own. In reviewing the Health Assembly's resolution WHA35.23, the Committee recalled the decisions it had taken to encourage countries to develop mechanisms for evaluation, and it adopted a timetable for monitoring the progress and evaluating the effectiveness of the strategies. This timetable is in accordance with the plan of action for implementing the Global Strategy, the periodicity of the Seventh General Programme of Work, and the programme budgets. The Committee invited Member States to use the above-mentioned "common framework and format", sent out by the Regional Director in July 1982, for the continuous monitoring of progress in implementing national strategies. It also requested the Regional Director to report on progress to the thirty-third session of the Regional Committee, in 1983.

8. The Regional Committee for the Americas urged Member States to support and promote the implementation of the regional plan of action by initiating further activities at the national level to promote a broad understanding of the process for health for all; to take further action to adjust national health plans in keeping with the regional plan of action and to assure the most effective reprogramming of external cooperation; to set in motion the process of improving national information systems so as to contribute to the effective incorporation of systems of monitoring and evaluation in the managerial process for national health developments; and to ensure effective communication among the different political, social and economic sectors. The Committee appreciated the initiatives taken by the Regional Office for the implementation of the plan of action, particularly a series of "seminar-workshops" on the plan of action (see paragraph 27 below). It also requested the Regional Director to support and increase the measures adopted to strengthen the catalytic role of the Organization in the exchange of experiences and cooperation among Member States and the international community (resolution XII).

9. The Regional Committee for South-East Asia, when reviewing resolution WHA35.23, discussed the progress made in the development, updating and implementation of the national strategies for health for all, and recommended that relevant action be accelerated. It stressed the urgent need to develop national plans of action in order to facilitate the implementation of strategies. Only six countries in the Region had so far developed such plans. It also emphasized that WHO should give attention to the priority areas identified by Member States for the allocation of resources and concentration of efforts (resolution SEA/RC35/R4). It recognized the importance of continuous monitoring of the implementation of the strategies and plans of action, and agreed that the "common framework and format" could be useful for that purpose.

10. During the discussions at the second meeting of Ministers of Health of the countries of the South-East Asia Region, in September 1982, the commitment to achieve the goal of health for all by the year 2000, using primary health care as a key approach, was re-emphasized. It was felt that the immediate need was to select a few areas of common interest and to develop plans of action, and that the availability of trained personnel at all levels was a matter of priority. The meeting resolved to take further steps to improve and strengthen the existing spirit of cooperation among Member States, and decided that TCDC programmes be developed with regard to health manpower training, diarrhoeal diseases control, and immunization.

11. The Regional Committee for Europe expressed satisfaction at the progress made in the implementation of the regional strategy, and noted that a revised version would be submitted at its next session, including targets and indicators. The Committee endorsed the comments made by a subcommittee set up to review the "common framework and format", and urged Member States to ensure that the necessary mechanisms exist at the country level to ensure proper monitoring and evaluation of the national strategies (resolution EUR/RC32/R2).

12. The Regional Committee for the Western Pacific, when reviewing the global and regional plan of action for implementing the strategies, accepted the proposed "common framework and format", with the addition of seven regional indicators. The Committee requested Member States to use the "common framework and format" for continuous monitoring of the implementation of their national strategies (resolution WPR/RC33.R8). It also reviewed the issue of the future direction to be taken to ensure active community involvement in health development in order to implement strategies for health for all through primary health care (resolution WPR/RC33.R4).

V. SUPPORT TO NATIONAL HEALTH STRATEGIES

13. All the work of the Organization is being increasingly geared to support Member States in their endeavours to prepare and implement their strategies for health for all. This is of necessity a gradual process, in view of long-standing practice both in Member States and in the Secretariat. Attempts are being made to learn more about the process of formulating countrywide strategies by working particularly closely with a number of countries. However, not all countries that were approached were ready to have WHO so intimately involved in their internal affairs, and some preferred to take it upon themselves to interpret in the light of their own circumstances the policies they have adopted internationally in WHO's governing bodies. Mention will be made of two countries - with vastly different health problems and national resources for health - which did accept WHO's close involvement: Indonesia and Finland.

14. Cooperation with these countries in developing their health strategies is taking place under the aegis of the internal Health for All Working Group, which was set up by the Director-General as reported to the Executive Board in 1982.

15. As its national strategy for health for all, Indonesia has formulated a long-term health development plan (until the year 2000) with 13 broad programmes. In the next five-year plan (1984-1989), which forms part of the long-term plan, Indonesia will concentrate on the development of the health system infrastructure with appropriate health manpower, and the integration of the relevant elements of primary health care with appropriate technology. Planning, management and information systems with appropriate health legislation will be strengthened. Following Indonesia's agreement to a joint government/WHO policy review of its national strategy at the highest level, the Director-General of WHO and the Regional Director for South-East Asia participated in a three-day workshop with senior Indonesian health officials, including the Minister of Health, in November 1982. The Indonesian Government and WHO have now entered into a "mutual understanding" for collaboration, and a master plan of operations for the period 1984-1989, as well as the documentation for detailed collaboration in joint government/WHO activities during the period 1984-1985, will be formulated by April 1983.

16. Finland has agreed to cooperate with WHO in the further development of its health system as part of the national strategy. Two national seminars for the development of the national strategy have been held with WHO participation. In collaboration with the WHO Regional Office for Europe, draft programmes are being developed by the Government of Finland, covering the activities relevant to the regional strategy and additional issues of specific national importance. Existing national mechanisms for planning and programme development are being strengthened and modified for strategy development. The scenario technique in terms of the year 2000, as developed in the European Region, is being used. As many countries have indicated interest in the national health development process in Finland, a review of this process has been prepared.

17. During its twenty-third session, in 1981, the UNICEF/WHO Joint Committee on Health Policy reoriented its activities with a view to supporting selected countries in developing their national health strategies through primary health care. This support is taking place in a perspective of full national self-reliance. The Committee recommended that substantial support be provided over the necessary periods of time to those countries with clear national commitment to put the primary health care approach into practice. After identifying countries where strategies for health for all have been adopted and where encouraging prospects for the development and implementation of primary health care were evident, dialogues were initiated with Burma, Democratic Yemen, Ethiopia, Jamaica, Nepal, Nicaragua, and Papua New Guinea. The purpose of these dialogues was to discuss the most suitable forms of UNICEF/WHO support. A start was made in Nepal in November 1982 with practical cooperation between the Government, UNICEF and WHO. A report on the above initiatives will be made to the twenty-fourth session of the Committee, in 1983.

VI. REVIEW OF DEVELOPMENTS IN PRIMARY HEALTH CARE

18. The plan of action for implementing the Global Strategy includes the dissemination of material on the organization of primary health care in and by communities. The Alma-Ata report outlined means of approaching such organization, including ways of deciding on the technical content appropriate to the country concerned, but it did not spell out in detail how to do so. To facilitate the organization of primary health care by different types of community, a document[1] has been prepared, illustrating the role of individuals, the family, the community and the health infrastructure in ensuring different aspects of the various elements of primary health care. It has been widely distributed, and feedback seems to indicate that it is proving useful in working out the content of community-based primary health care.

19. One of the essential features of primary health care is community involvement. To support countries in preparing plans for encouraging such involvement, a start has been made in the preparation of a manuscript that will clarify the main issues and trends, on the basis of experiences of countries throughout the world: a report has been compiled on the activities of different WHO programmes in the promotion of community involvement for health development, highlighting similarities and differences in the approaches used and thus making it easier to enhance further integration and strengthening of WHO activities in this area.

20. Since educational activities are essential for mobilizing the involvement of communities in health action, more should be known about the mechanisms and processes used to sustain effective adult education programmes in support of primary health care in countries. The Organization is therefore supporting an international study, initiated by the International Council for Adult Education, on effective adult education programmes in promoting community involvement in primary health care. By the end of 1982, case studies were under way in Canada (the indigenous population), Chile, India, Indonesia, Kenya, Nicaragua, the Philippines, Senegal, the United Republic of Tanzania, and Venezuela. The study is expected to describe patterns and lead to recommendations which will be useful in planning further adult education programmes in support of community involvement in other countries.

21. Another essential feature of primary health care is intersectoral action. Fact-finding inquiries on such action were made in India (in the State of Kerala), Jamaica, Norway, Sri Lanka, and Thailand. The purpose was to identify the critical social and economic development factors that influence health and their interactions; to understand the role of intersectoral collaborative action for improvement of health; to suggest the mechanisms and appropriate strategies necessary to promote, plan and implement intersectoral action at various levels; and to determine the kind of action-oriented research that should be undertaken. A meeting was held in Trivandrum in the State of Kerala in November 1982 to discuss the results to date and to makes recommendations. The meeting reached the following conclusions:

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[1] "Analysis of the content of eight essential elements of primary health care" (document HPC/PHC/REP/81.1).

22. In order to enhance the possibility of successfully achieving intersectoral interventions it may be necessary for the national health sector to make internal adjustments both in its traditional approaches to health problems and in its organizational structure. Such adjustments may include the reordering of priorities and greater decentralization and community involvement. The community is the national centre for intersectoral action, and independent, elected community boards are essential factors in social development. The strengthening of the community capacity necessitates the training of community workers from all sectors, and the provision of technical and material support to enable communities to respond to the major problems they have identified. Nongovernmental organizations are playing an increasingly important role in identifying needs and pursuing intersectoral activities to respond to those needs.

23. The health sector has to develop ways of mobilizing intersectoral analysis and action. It has to do more to encourage the development of a health consciousness on the part of other sectors through the joint identification of the health-related aspects of the policies and activities of those other sectors. It also has to identify ways in which it can contribute to the achievement of the goals of other sectors. Identifying prime movers in those sectors, and providing them with information, training and material support, can help form and strengthen the formal and informal networks. Those prime movers can best operate in intersectoral action when they are either close to policy-makers, are the policy-makers themselves, or are those directly responsible for programme development.

24. If macro-economic policies, major economic development projects and infrastructure investments are to be effective, their health and environmental aspects must be taken into account by the national planning bodies and often the ministries of finance. The Ministry of Health, either directly or through the transfer of personnel to that national planning body, is the appropriate source for an analysis of the health and environmental impact of the macro-economic policies and programmes. The primary constraints on effective intersectoral action are the lack of adequate political commitment, bureaucratic rivalries and the self-protection tendencies of the bureaucracy, ineffective programme design, and deficiency in the human, material and financial resources.

VII. TRAINING OF NATIONAL AND WHO STAFF

25. In order to improve the capacity of senior staff in countries to develop and implement the Global Strategy, and of WHO staff to support them in this, workshops and seminars have been held in various parts of the world. The following examples illustrate their nature and scope.

26. In the African Region a UNICEF/WHO primary health care workshop was held, in English, in Ethiopia with the aim of strengthening the capacity of nationals from health and health-related sectors to work out practical collaborative steps for implementing primary health care; the participants were from Botswana, Ethiopia, the Gambia, Lesotho, Mozambique, Nigeria, Uganda, the United Republic of Tanzania, and Zimbabwe. Twenty-three participants attended a training session in Mali for primary health care instructors, and 35 health service officials attended a similar session in Gabon. Twenty-five participants took part in discussions on the functions of primary health care supervisors at the Dakar Centre for Advanced Nursing Education, and at the Yaoundé Centre 15 participants considered the introduction of primary health care into basic nursing and obstetrical training programmes. Ministers of Health, Directors of Health Services and other Ministry of Health officials from Benin, the Gambia, Ghana, Guinea, Ivory Coast, Liberia, Mali, Mauritania, Nigeria, Senegal, Togo, and Upper Volta participated in intersectoral management workshops held in Nigeria, Senegal, and Togo.

27. In the Region of the Americas it was recognized that the application of an appropriate management process was crucial for the implementation of the plan of action. It was realized that the managerial process must be adjusted to each country's particular situation, health resources, social and economic conditions, and political and administrative mechanisms. It was also felt that a similar adaptation was necessary within the Organization itself with regard to the formulation and execution of technical cooperation activities that will lead to the attainment of this goal. This task, requiring a consistent interpretation of the content

of the plan of action, an understanding of the management aspects necessary for its initial implementation, and a review of methods and procedures for its continuing conduct, led the Region of the Americas to hold a series of "seminar-workshops"; 10 had been organized during 1982, involving nearly 280 senior health professionals from both national health authorities and the secretariat. The first objective of these seminars was to interpret the conceptual and operational aspects of the regional plan of action and to analyse its compatibility with national plans in the health sector. This includes the determination of the implications for national development of the goals, objectives and strategies of primary health care. Another objective was to analyse the steps required to initiate the process of adjusting health policies and plans and monitoring and evaluating them, with a view to attaining health for all by the year 2000. A third objective was to identify the principal implications - sectoral and intersectoral, political, economic and operational - of implementing the plan of action at the national level.

28. In the South-East Asia Region emphasis was given to supporting training activities within countries. Thus, support was given to the training of community health workers, community health leaders and trainers of primary health care workers in Bangladesh, Burma, India, Indonesia, Maldives, Nepal, Sri Lanka, and Thailand.

29. In the European Region the first of a series of annual seminars for senior public health administrators responsible for health policy development and health care was held in Turkey. Its aim was to encourage closer cooperation between Member States in Europe in developing national health policies. A workshop on the managerial process for national health development was held in the USSR.

30. In the Eastern Mediterranean Region particular attention was given to the managerial process for national health development as a means of formulating and implementing policies, strategies and plans of action for health for all; a workshop held in Somalia was attended by 24 top officials.

31. In the Western Pacific Region an interregional seminar on primary health care was held in Yexian, Shandang Province, China. Workshops on the managerial process for national health development were held in China, Fiji, and Samoa. National workshops to promote restructuring of the nursing curriculum to include primary health care involved most of the heads of nursing schools in the Philippines and the Republic of Korea.

32. WHO's staff development and training programmes at all stations laid emphasis on creating a better understanding among both professional and general service staff of the Organization's new policies and the Strategy for health for all that had emerged to implement them.

VIII. INTERNATIONAL FLOW OF RESOURCES FOR THE STRATEGY

33. Part of the assessment of progress towards attaining health for all is related to the measurement of the resources needed to carry out the Strategy; the gap between national resources and the level of resources required by the countries concerned; and the flow of international resources designed to close the gap. As reported to the Board at its sixty-ninth session in January 1982, in the developing countries the average annual resource gap for implementing the Strategy amounts to about US$ 50 000 million. If 80% of this sum could be found by the developing countries themselves, the residual deficit would be of the order of US$ 10 000 million annually, roughly three times the present level of the international transfer of resources for health development. There is no guarantee that massive additional resources will become available to close this gap in the near future. Following intensive efforts at the global level to rationalize the international flow of resources and to mobilize additional resources to support developing countries' strategies, it became clear that action has to take place in countries themselves. Countries have to identify activities that could attract external support. They have to review the distribution of their health budgets and health resources in relation to their national strategies for health for all, and in particular the allocations to primary health care. They have to estimate the order of magnitude of the total financial needs to implement the national strategy, the potential resources available, and the additional resources required from internal and external sources. WHO can support them in this, but cannot act as a substitute for them.

34. In 1982 the regional committees, in reviewing the needs of their Member States for external resources for support of well-defined strategies, adopted resolutions requesting Member States to make studies of the financial machinery in their countries and to adjust their national and international financial resources to their health needs; to undertake resource utilization reviews - which are useful ways of providing a clear idea of the resources needed by the developing countries; and/or to set up a national resource group for primary health care. The regional committees also requested the Regional Directors to take appropriate measures to ensure that the necessary technical and administrative support is provided to carry out these reviews and to continue to examine the international economic environment as well as national and international allocations to the health and related sectors.

35. At the global level, in the course of 1982 the Executive Board discussed the role of the Health Resources Group for Primary Health Care and described it to the Health Assembly as a catalyst for activating the international community's development efforts in support of health for all. The Thirty-fifth World Health Assembly commented favourably on the functioning of the Group. One of its approaches to attract external collaboration is the "Country Resource Utilization Review" (CRU). Such a review is carried out by a developing country itself, involving usually the ministry of health, the ministry of planning, and others concerned, to analyse resources available and opportunities for external fundings. The "CRU" report identifies total estimated budgetary requirements, amounts reasonably expected to be committed or become available from the national government and external sources, and the net shortfall of resources still remaining to be filled. The report is seen by the global Health Resources Group and interested donors. In 1982 "CRUs" were carried out in Nepal, Democratic Yemen, and the Yemen Arab Republic, in addition to those carried out in 1981 in Benin, Ecuador, the Gambia, Sri Lanka, and Sudan.

36. Other opportunities were taken to attract external partners, for example, Country Review Meetings organized by UNCTAD, UNDP and the World Bank, as well as the follow-up of the United Nations Conference on the Least Developed Countries, held in Paris in 1981.

IX. SEVENTH GENERAL PROGRAMME OF WORK

37. The Global Strategy for Health for All prescribes the formulation of the Organization's general programmes of work in such a way as to promote, coordinate and support efforts by countries of the world individually and collectively to achieve the goal of health for all by the year 2000. The Seventh General Programme of Work was therefore prepared in compliance with this principle. The Executive Board finalized its draft of the Programme in January 1982, and after a number of amendments had been introduced the Programme was adopted by the Health Assembly in May 1982.[1] It has since been published as No. 8 in the "Health for All" Series, and has been used in the preparation of the proposed 1984-1985 programme budget.

X. PROPOSED PROGRAMME BUDGET FOR 1984-1985

38. The plan of action for implementing the Global Strategy also envisages that WHO's biennial programme budgets support the Strategy through the translation of the general programmes of work into more specific programme activities. The proposed programme budget for 1984-1985 has been prepared in this perspective both by the regions and at the global level. The Regional Directors submitted their regional programme budget proposals for the biennium 1984-1985 to their regional committees in the second half of 1982, along the lines of the Seventh General Programme of Work. The regional committees reviewed the proposals, and the consolidated global programme budget for 1984-1985 is being presented to the seventy-first session of the Executive Board in January 1983.

XI. COLLABORATION WITH OTHER ORGANIZATIONS AND INSTITUTIONS

39. Collaboration on a wide variety of issues in connexion with the Strategy has taken place with the United Nations and agencies of the United Nations system, in conformity with General Assembly resolutions 34/58 and 36/43. Particularly noteworthy is the collaboration

[1] Resolution WHA35.25.

with a large number of nongovernmental organizations. The value of these organizations within countries has become increasingly evident, and initiatives have been taken to support governments in collating information on them and holding dialogues with them with a view to ensuring their deeper involvement in the national health strategy.

40. Preparations have also been made to mobilize the participation of universities in national strategies for health for all. In an initial consultation, to be held in April 1983, the focus will be on the process that can lead to effective partnership in social development between universities and the communities they serve, the Strategy for health for all being an important component of such development. The preparation for this consultation includes the collection of data on the changing relationships between universities and communities as perceived in different countries of the world. An analysis of these data will identify trends, methods and procedures in the development of collaboration, as well as successes and failures. The issues involved in health for all that have academic implications will then be studied in the light of this analysis. With the support of major university associations, leading figures in the academic world with backgrounds in the humanities and the socioeconomic sciences, as well as the health sciences, have been invited to participate in the consultation. In this way a broad approach will be ensured, in keeping with the nature of the health for all Strategy.

XII. IMPLEMENTATION OF THE STUDY OF WHO'S STRUCTURES IN THE LIGHT OF ITS FUNCTIONS

41. In resolution EB69.R10 the Executive Board requested the Director-General to keep it informed of progress made in implementing the recommendations of the study of WHO's structures in the light of its functions through his reports on the implementation of the Global Strategy.

42. One of the main aims of the study was to ensure that governments assume their constitutional responsibility for the work of the Organization. If they have done so to an increasing extent in the governing bodies, the optimal way in which they can do so individually in their own countries is still an open question. One way is for governments to assume major responsibility for the use of WHO's resources in their countries as allotted in the country planning figure. A study of this is taking place in Thailand following the agreement of the Government. The new approach to programme budgeting of WHO resources at country level, as approved by the Health Assembly in 1977, in resolution WHA30.23, is being intensively applied with a view to providing concentrated support to Thailand's national health strategy. In October 1981, the Director-General and the Regional Director for South-East Asia together undertook a series of frank discussions with the national health leadership about the manner in which Thailand has been utilizing WHO, the effectiveness of WHO's response, the nature of Thailand's strategy for health for all, and possibilities for making even better use of WHO collaboration in the future. A joint government/WHO coordinating committee was set up to manage WHO's 1982-1983 programme budget resources in the country and to plan the use of the WHO resources envisaged for 1984-1985. New approaches to the monitoring of the use of these resources are being studied. Lessons are currently being learned with a view to wider application.

43. In the course of 1982 the Director-General, following consultation with top executive management in the Global Programme Committee, decided on a number of measures aimed at ensuring optimal support by WHO to Member States in their efforts at preparing and carrying out national health strategies. These include measures aimed at making Member States self-reliant in managing not only their own health systems, but also WHO's resources in the country, by giving overriding emphasis to the Organization's activities in countries and ensuring support for these from the other levels of the Organization. The essential aim is to have governments carry out in practice what they have agreed upon collectively in WHO. This can best be achieved through joint policy analysis with a view to supporting the further development of national strategies for health for all, in particular through permanent joint government/WHO mechanisms. WHO's resources in the country will have to be utilized to this end, and intercountry, regional, interregional and global activities will have to be supportive of it.

In consequence, the roles of WHO programme coordinators, regional offices and headquarters staff will be modified, and a certain amount of organizational restructuring will be necessary. Immediately following the seventy-first session of the Board the Global Programme Committee will be considering the managerial implications of these decisions.

XIII. CONCLUDING REMARK

44. This report ends as it began - by emphasizing appropriate interaction between WHO and its Member States, since the Global Strategy can only be fully implemented through the effective preparation and implementation of national strategies.

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