WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

A31/A/SR/3

15 May 1978

THIRTY-FIRST WORLD HEALTH ASSEMBLY

COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE THIRD MEETING

Palais des Nations, Geneva
Monday, 15 May 1978 at 09h30

CHAIRMAN: Dr A.-R. A. AL-AWADI (Kuwait)

CONTENTS

Note: Corrections to this provisional summary record should be submitted in writing to the Chief, Records Service (Room 4012, WHO headquarters), within 48 hours of its distribution. Alternatively, they may be handed in to the Conference Officer.

THIRD MEETING

Monday, 15 May 1978 at 09h30

Chairman: Dr A.-R. A. AL-AWADI (Kuwait)

PROGRAMME DEVELOPMENT: Item 2.5 of the Agenda (continued) (Resolutions EB61.R24, EB61.R25, EB61.R26 and EB61.R32; Documents A31/8, A31/9, A31/10 and A31/11)

Country health programming: Item 2.5.2 of the Agenda (continued) (Resolution EB61.R25; Document A31/9)

Mr KWON Sung Yon (Democratic People's Republic of Korea) said that the success of public health depended on health programming, and that a correct health plan made possible the systematic development of public health and the solving of all health practice problems. In the Democratic People's Republic of Korea, the State was directly responsible for health programming and had devoted great attention to it. Programming in all branches of the national economy, including health, was carried out by the State Planning Board; there were also programming departments attached to all health agencies and institutions. Those departments, guided by the Planning Board, drew up the national health plan aimed at fulfilling the national health programme, in harmony with the plans for the other branches of the national economy. The health plans covered health services and institutions, including the construction of such institutions, the distribution of health workers, and the provision of the necessary medical supplies and equipment. On that basis, the objectives set by the State had been achieved, the initiative of health centres and health workers fully utilized, internal reserves mobilized, and epoque-making changes in the level of health achieved.

In developing country health programming, experience had been gained in national health planning and in planning methodology. In the light of that experience, his delegation greatly appreciated WHO's efforts in the field of country health programming and supported the draft resolution. He hoped that WHO would press on vigorously with country health programming.

Dr SANKARAN (India) said that his delegation supported the draft resolution. Country health programming was largely dependent on available economic and manpower resources, transfer of technology appropriate to rural areas, training facilities, the priority given to health in national development, and the proportion of the budget allocated to urban areas as opposed to the development of rural infrastructure. It was therefore country-specific.

It had become apparent in India since independence that, even with a vast increase in medical manpower, a highly developed drug and surgical instrument industry, and a large increase in the number of hospital beds, 80% of resources were devoted to the 20% of the population living in urban areas, little was being done at the periphery, and health care was reduced essentially to curative medicine and primary health care, while preventive and promotive care lagged far behind.

Since 2 October 1977, India had embarked on a major programme to ensure the provision of a modicum of basic health care in the areas of neglect, putting 30 000 community health workers and some 60 000 indigenous midwives (dais) into the field. It was planned, by 1981-1982, to provide one community health worker and one dai per 1500 of the population.

In addition, the Minimum Needs Programme had provided over 5000 primary health centres and nearly 40 000 subcentres in 5247 community development blocks, but had failed to induce medical personnel to serve in the primary health centres, to establish rural referral hospitals, to provide 30 beds in every primary health centre, to provide functional mobile units, and to remedy the concentration of resources in urban areas.

Community health workers received a three-month training at the primary health centres, and were given a manual and a basic kit of drugs. It was the community health worker's responsibility to teach villagers preventive health, sanitation, antimalarial operations, etc. He gave simple first aid, provided basic drugs, and prepared slides for identification of malaria parasites. The community health worker was chosen by the village and went back to it. He was taught to realize his limitations, and in his own language, and was a servant of the people, not the Government. There were also health visitors and auxiliary nurses.

Such a vast programme called for critical evaluation, and an initial six-monthly evaluation was now in progress, carried out by six national institutes; the funding of the programme would be based on that assessment. Of the health allocation in the Plan Budget, 70% would be assigned to rural health care.

In spite of the difficulties, deficiencies, and the resistance and criticism of the medical profession, it was hoped that the programme would lead to a movement away from the disease palaces created in the past. India appreciated the assistance given by UNICEF and the support of the Regional Director for South-East Asia, and welcomed suggestions and offers of collaboration.

Dr HOWARD (United States of America) said that his delegation was pleased to note the growth of country health programming, especially in the developing countries, and endorsed resolution EB61.R25. Country health programming was at a very early stage; as the Director-General had said, there was as yet insufficient operational experience in the execution of all stages of the country health programming cycle. The operative paragraphs of the draft resolution were therefore of considerable value.

The comments of some delegates already showed a certain confusion as to the meaning of country health programming; they had asked why national health planning and methodology had been excluded. It was stated in paragraph 4 of the Director-General's report on country health programming that national health planning had never fully succeeded in developing overall health programming. Would country health programming be fully successful? His delegation agreed entirely with the multisectoral approach of country health programming. The level of health of a population was the end result of many economic, social and political factors, and not merely of the health services. Thus, it might depend equally on employment, transportation and education. It was therefore confusing to say that country health programming was uniquely different from national health planning. Was not national health planning a part of national development planning? Improvements in the health of the population therefore depended on the health planner's understanding of national planning.

Country health programming was not intended to be an internal WHO programming procedure, but the Programming Committee of the Executive Board had correctly recognized the importance of country health programming as the basis for the development of WHO's overall medium-term programme, since country health programming identified national priorities. There was a risk, however, that a Member State might be superficial in analysing its own health problems, and country health programming would then fall short of the requirements of national institutions and manpower development without which self-reliance was difficult to achieve. Country health programming did advocate a continuous long-term planning process, but it was not clear what methodology should be used for that purpose. Thus the country health programming group was asked to use the data already available and assess their suitability, but such an assessment might show the need for additional data, since in many countries the data available were insufficient to permit analysis of the relation between health and development status. Underlying causes of ill health were then difficult to identify. Country health programming might then yield a traditional health service programme with little insight into the social and economic changes needed.

Reference was made in Annex 3 of the report to activities in sectors other than health that might help in solving health problems, but the analysis of health in relation to development was a complex problem. How could training, research or teaching in that field be provided by universities? Only two did so, and unless the number was increased, how did WHO propose to train enough planners for that purpose?

At the Interregional Seminar on Country Health Planning held in the Regional Office for South-East Asia, it had been recommended that at least one research and training centre should be established in each region to promote research and training in country health programming and to act as a repository of accumulated experience. That was one approach to providing leadership, but that recommendation was missing from the draft resolution.

Country health programming was critical for the health of the developing countries and in achieving WHO's objective by the year 2000. To that end, the United States of America was prepared to mobilize extrabudgetary measures to help the developing countries to achieve self-reliance.

Dr HASSOUN (Iraq) said that Iraq, in collaboration with the Regional Office for the Eastern Mediterranean, had already completed the first stage of country health programming. Preparations were now being made for the second and third stages to begin at the end of August 1978. His delegation supported the draft resolution and endorsed the remarks made by the delegate of Pakistan as to the participation of faculties of medicine.

His delegation would like to add a paragraph to the draft resolution contained in EB61.R25 to the effect that Member States should be urged to include country health programming in the curricula of faculties of medicine and in postgraduate courses on preventive medicine in these faculties as well as in institutes of health in order to train specialists in the field, since there was currently a shortage of such personnel.

Dr SAMBA (Gambia) said that a multisectoral country health programming exercise had recently been undertaken in the Gambia with WHO help. That had shown that previous health plans had amounted to little more than tinkering with the health machinery. For the first time, health planning had been carried out in depth and related to overall national development.

In the Gambia, however, country health programming was no more than a statement of intent. If its ultimate objectives were to be achieved and full use made of available facilities, further help from WHO was needed, not only in planning and programming, but also in implementation, evaluation and monitoring. A delegate from a developed country had stated that, to make full use of a WHO staff member, a country should have at least two or three counterparts. Gambia could not provide even a single counterpart; that was an embarrassing situation. Resources were available for the developing countries but they needed help in utilizing them rationally. Without such help, those resources would be misused or not used at all.

Dr BEAUSOLEIL (Ghana), referring to paragraph 5 of the Director-General's report, said that projects of all kinds were presented by bilateral and private agencies to Third World countries; inevitably, those projects did not fit into national health plans and socioeconomic goals. No such project had ever been successful. That problem should be tackled locally at the national level but WHO also had a duty to perform in that connexion. He hoped, therefore, that WHO would vigorously pursue policies and measures aimed at achieving the objectives mentioned in the report.

His delegation supported the draft resolution contained in EB61.R25, but wished to amend subparagraph (2) of paragraph (3) to read as follows: "to promote training in the country health programming process, as well as the research required for its development and application, in national as well as selected international collaborating centres".

Dr HIDDLESTONE (New Zealand) said that his delegation applauded WHO's work on country health programming and supported the draft resolution. While country health programming was particularly relevant to the developing countries, it did have considerable relevance for the developed countries as well.

The work must have a multidisciplinary framework. In line with the emphasis given by WHO to primary health care and community services, the New Zealand Government had established a Special Advisory Committee on Health Services Organization. That Committee included representatives of the major health professions, two economists, a sociologist, a hospital board chairman and representatives of private and voluntary bodies. It was beginning its work with pilot projects which were subject to consumer discussion for at least two years.

An important new concept was that of the development of service development groups relating to nine major aspects of health services. Each such group included representatives of the public and private health sectors, voluntary agencies and consumers, and was serviced by a team of epidemiologists, administrators and research workers. The groups' function was to review existing services, identify areas of overlap and deficiency, seek out areas of unmet need, and decide how the requirements could best be met. It was often found that the voluntary agency was best suited to investigate new areas of service development and to initiate a service which, when it was sufficiently well established, could be passed over to the public or private sector. In his view, the concept of special development groups was worthy of serious consideration.

Dr MARKIDES (Cyprus) said that, several years ago, his country had introduced a five-year plan for health, officially accepted as the health sector plan for the Cyprus five-year development plan. On the basis of that experience, he stressed the excellence of country health programming as a tool for technical cooperation, since it provided first-hand information to WHO on the health problems of countries and therefore a good basis for the development of WHO's medium-term programme. It also enabled country health officials to make use of WHO's experience.

Country health programming required a good information system to enable problems to be identified, and it was therefore necessary for each country to establish a satisfactory statistical and information system. There should be trained personnel capable of recognizing the country's true needs and priorities. Country health programming also needed to be flexible so that it could easily be adapted to new situations. It must be an integral part of socioeconomic development planning as a whole.

Health was not purely a medical problem, but involved education, economics, agriculture, etc. Cooperation with other disciplines was therefore necessary. As an example, a few years ago Cyprus had the third highest incidence of hydatid disease in the world. The Ministry of Health had tried to eliminate the disease but with little success. Three or four years ago, however, a joint eradication programme with the Ministry of Agriculture had been started, with the result that the country was now almost completely free of hydatid disease.

His delegation supported the draft resolution.

Dr SMITH (Nigeria) explained that the Third Nigerian National Development Plan, which covered the period 1975-1980, envisaged a threefold increase in annual per capita expenditure on health. The objectives were to expand health services and correct the distribution of health facilities in the country, to train health personnel, to develop communicable disease control programmes, to create State health management boards and district management committees, to control environmental hazards, to coordinate medical research, and to develop health planning coordination and evaluation.

A country health programme exercise had been carried out in 1976 to elaborate the basic health services programme and to establish new perspectives for future WHO collaboration in contributing directly to the national health plan. Two priority programme areas had emerged from the planning process, namely health manpower development, and primary health care in its broadest sense.

The development of front-line health care delivery and the concept of health services development as an integral part of overall community development have been facilitated by new legislation providing for local self-government and community participation, and a more balanced distribution of resources and services for both rural and urban areas. The National Health Services Panel had made proposals for decentralization and the involvement of local councils in front-line health care delivery.

The National Health Plan provided for a basic health services programme, which was deliberately biased in favour of the rural areas, increasing coverage from 25% to 60%, where "coverage", as proposed by the National Formulation Team, included accessibility, protection of populations at risk, services directed towards prevalent diseases, and availability of beds. WHO was involved in the development of the basic health services units and would cooperate with the Government in the provision of an expanded programme on immunization, malaria control, family health, etc. There would also be technical cooperation with a number of countries in the region.

Initial efforts had been concentrated on the training of auxiliary health workers, as well as on training the trainers. To that end, a Basic Health Implementation Agency had been established in 1976. That Agency was also performing a number of other functions, such as carrying out a health manpower audit, establishing a skills inventory, etc.

Every State Ministry of Health had been asked to designate a project manager for the purpose of executing the basic health services scheme.

The Federal Military Government had approved the establishment of new categories of health personnel, namely community health officers, supervisors, assistants and aides, so as to make good the shortage of health manpower. Such personnel could perform the routine primary health care functions hitherto performed by doctors. A continuous training scheme had been designed for such personnel so as to provide a career structure.

The Federal Military Government had approved contributions of 70% by the Federal Government, 25% by the State governments, and 5% by local authorities to the capital cost of the basic health services scheme, while State governments would bear 100% of the recurring costs.

He acknowledged the cooperation of WHO in those developments, and hoped that there would be a systematic reorganization or review of the curricula of medical schools so as to produce personnel capable of dealing with basic health services in a manner consistent with the objectives of those services.

The Nigerian delegation endorsed the report of the Director-General and, bearing in mind the amendment proposed by the delegate of Ghana, supported the draft resolution.

Professor KRANENDONK (Netherlands) said that his Government took great interest in the development of country health programming, the acceptance of which involved a systems-oriented approach. It represented a considerable improvement over earlier experiences in traditional health planning and health project formulation. Over a period of five years no less than 23 countries had initiated the country health programming process and it was extremely important to learn from their experiences in order to judge whether the working guidelines given in Annex 3 of the report of the Director-General needed further amendments and a more practical reorientation to varying country situations. In relation to present and subsequent General Programmes of Work, it was essential that WHO and its Member States should be encouraged to promote further the concept of country health programming, not only for attaining national self-reliance in planning for health development but also for securing maximum benefit from technical cooperation. In that connexion, he wished to stress the importance of training related to country health programming. The Belgian-Netherlands International Course in Health Development, which was held annually, had from its start in 1964 emphasized health management and planning and it was quite prepared to share its experiences with other countries wishing to strengthen their managerial capacity in health development.

Dr GALEGO PIMENTEL (Cuba) said her delegation fully supported country health programming and resolution EB61.R25. The working guidelines given in Annex 3 of the Director-General's report were of great importance in providing flexibility with regard to the application of country health programming to different countries. One example concerned the collection of data. Many developing countries did not have national coverage in regard to medical services and would therefore scarcely be in a position to build up a national information system for the collection of data. Nevertheless the guidelines made it possible to reach a conclusion regarding the best use of the available resources in those countries.

Another question that she considered of great importance in country health programming was the identification of programmes already being carried out in the country. The support of WHO for such programmes was of vital importance because it would encourage countries to make the best use of their natural resources. On the other hand much has been made of the difference between country health programming and national health programming. There certainly was a possibility of confusion but when she referred to the National Health Programme of Cuba she was speaking of the national policy of the country. That had led to health planning and to the development of an information system. That system in her country had links with primary health care at the regional, provincial and national levels. There was also an institute of health development which was engaged in research on epidemiological problems where staff were trained in health planning, in data collection, and in health administration. During the past year the institute had received grants from other countries in the region and it was also open to all those countries that had helped in that way.

Dr GUNARATNE (Regional Director for South-East Asia) emphasized the continuing nature and flexibility of the country health programming process. One of the lessons that had been learned in Bangladesh, which was the first country to introduce country health programming in 1973, was that before the process was started it was desirable to establish a workshop where national health personnel, WHO staff and the staff of other interested agencies could meet together to discuss the aims to be pursued. At the Interregional Seminar held in February 1977 in New Delhi, unprecedented enthusiasm for country health planning had been shown by the participants representing national governments and various

agencies, including WHO. Among the major benefits of country health planning emphasized at that seminar was the improvement in national health plans when they were based on actual needs and were problem oriented and programme based rather than project based. There was also a better allocation of both internal and external resources and with the improvements in country health planning WHO collaborative activities became more meaningful.

Attention had been drawn to the interregional consultation in Bangkok which took place late in 1977. It had been attended by nationals and by WHO staff from regions and had reviewed the recommendations made at the New Delhi seminar as well as producing a report on the latest situation in regard to the implementation of country health programming in the 23 countries that had so far undertaken the process. One of the very important observations made by the Executive Board in its review of the subject was recognition of the role of WHO representatives in promoting country health programming and it recommended that steps should be taken to increase the understanding and motivation of WHO representatives with respect to country health programming. In order to further the excellent experience with country health programming in the South-East Asia Region, a regional panel had been appointed and the relevant governments had been requested to participate in it. It therefore consisted not only of WHO staff but also of nationals who have participated in country health programming and who have become conversant with the concept and methods involved. That was another example of technical cooperation among developing countries.

The delegate of Indonesia had pointed out that her country was not mentioned in Annex 2 of the Director-General's report but that was probably because it was not one of the countries with which WHO had been closely associated and which had actually carried out the process of country health programming. What Indonesia had done was national health planning, although he agreed that the two concepts were very similar and it might be that the Director-General would consider the addition of Indonesia and perhaps some other countries to the list of those that had successfully carried out country health programming. The delegate of Yugoslavia had asked who the focal point would be. In countries with a WHO representative, he would act as the focal point but in other countries the focal point would presumably be the Regional Director. In any country that had gone through the process of country health programming it was the responsibility of the WHO representative to report to the Regional Director who would then report back to the Director-General.

The delegate of Thailand had given a detailed account of how country health programming had been carried out in his country. It should be stressed that the Regional Office had already established a training centre for country health programming and although it was at present called a national training centre, it could be used as a regional training centre. The centre not only made possible the exchange of experiences among countries but also acted as a repository of knowledge accumulated with regard to experiences in carrying out country health programming. The delegate of Nepal had stated that after carrying out country health programming and project formulation over a period of two and a half years, his Government had just completed a medium-term evaluation which was very interesting and had enabled them to find out whether the programming had been successful, whether the identification of projects had been satisfactory and in what ways country health programming and project formulation needed to be amended. The delegate of the Union of Soviet Socialist Republics had also referred to his country's experience with regard to national health planning during the last 50 years. There was much to be learned from that experience and no doubt the Regional Director concerned would be able to tell the Director-General to include the USSR as also having carried out the country health programming process. The delegate of the Soviet Union had also said that more nationals should have taken part than WHO staff in the country health programming process in Thailand. In fact, five times as many man-months were spent by national staff as by Regional Office and headquarters staff together. There had been much more involvement of nationals in carrying out the process. The delegate of Burma had also referred to the need for community involvement. In Burma, in addition to national staffs and Government officials there had been considerable community involvement, which had greatly contributed to the success of the country health process.

Dr BIDWELL (Secretary, Headquarters Programme Committee) said that in future the Secretariat intended to emphasize the intrinsic national character of country health programming. It would be presented as a simplified form of national health planning and

programming that could be used by the nationals themselves largely within the limits of their own resources to plan for the solution to or reduction of their own health problems within their own national setting. With the aim of achieving a significant multiplier effect in a short time, it was planned to establish two national institutes in two regions for training and research in country health programming within the next year. By the end of the 1980/81 biennium it was hoped that similar institutes would have been established in the other regions.

Another important preoccupation of the Secretariat was to promote country health programming as an instrument for technical cooperation among developing countries, so that nationals from one country would help in the initiation of the country health programming process within another country in the region. In its report, the Programme Committee of the Executive Board requested the Director-General to arrange for the publication of the guidelines for country health programming, medium-term programming and health programme evaluation in one booklet. The preparation for the publication of the booklet was now far advanced and it was hoped that it would be available for distribution to Member States by the end of 1978 or early 1979. In the foreword to the booklet an attempt would be made to underscore the important interrelationships and interlinkages between country health programming, medium-term programming, health programme evaluation and information systems development.

Dr CASSELMAN (representative of the Executive Board) thanked the delegates on behalf of the Executive Board and the Headquarters Programme Committee for the statements they had made indicating their views on country health programming and presenting their experiences. The comments had been most valuable and would contribute to a better understanding of the objectives.

The CHAIRMAN drew attention to the draft resolution proposed by the Executive Board in resolution EB61.R25 and recalled that several amendments had been proposed.

Mrs BRUGGEMANN, Secretary, said that the amendments proposed did not change the substance of the draft resolution but suggested useful additions to it. The delegation of Czechoslovakia had proposed the addition, at the end of the last preambular paragraph, of the words ". . . and to develop efficient national health systems as called for in resolution WHA23.61".

Decision: The amendment was approved.

The SECRETARY recalled that the delegation of Chile had proposed amending operative paragraph 1, subparagraph (3) to read "to establish national centres or structures of other types that countries may consider appropriate, for the development of, and for research and training in, country health programming;".

Professor HALTER (Belgium) said that the addition of the word "structures" without definition might be dangerous. He suggested that, as there was no rigid definition of the term "centres", the original wording of the resolution might be adequate.

Dr BORGNO DOMINGUEZ (Chile) thought that the word "centres" referred to specific structures and that the resolution, as worded, did not permit sufficient flexibility. The proposed amendment also permitted flexibility in translation.

Professor HALTER (Belgium) could not agree. He suggested that, for the French version at least, the terms should be defined more clearly.

The CHAIRMAN suggested the replacement of the word "structures" by the word "institutions".

It was so agreed.

Decision: The amendment, in its revised form, was approved.

The SECRETARY recalled that the delegation of Iraq had proposed amending operative paragraph 1 by the addition of a further subparagraph (6) to read "to introduce, where this has not already been done, the subject of country health programming into the curricula of faculties of medicine and public health institutes, as well as into postgraduate courses on preventive medicine, in order to increase substantially the number of well trained personnel in this field".

Dr BATU (Burma) felt that the amendment did not permit sufficient flexibility to countries wishing to adapt it to their own needs. He suggested the replacement of the words "as well as" by the words "and/or".

Dr TATOČENKO (Union of Soviet Socialist Republics) had no objection to the substance of the amendment, since it was necessary to increase the number of specialists trained in the field. It might, however, be premature to recommend that country health programming be included in the curricula of faculties of medicine. He therefore suggested that the words "faculties of medicine" be deleted from the proposed amendment.

Dr HASSOUN (Iraq) could not agree. Country health programming should be included as soon as possible in the curricula of medical students.

The CHAIRMAN suggested that a working group be set up to discuss further the amendments to the draft resolution. The working group would include the following delegations: Belgium, Burma, Chile, Czechoslovakia, Ghana and the Union of Soviet Socialist Republics; and any others interested.

Development of health programme evaluation: Item 2.5.3 of the Agenda (Resolution EB61.R26; Document A31/10)

The CHAIRMAN, introducing the item, drew attention to the Director-General's report on health programme evaluation and to the draft resolution proposed by the Executive Board in resolution EB61.R26. He hoped that discussion would be directed towards the use of evaluation as a tool in programme development rather than towards the technical details of evaluation.

Dr CASSELMAN (representative of the Executive Board) said that health programme evaluation had reached the stage at which it could be applied equally well by WHO and by national administrations. The Director-General's report summarized recent developments in health development evaluation and gave an account of the Executive Board's review of the report of its Programme Committee on the subject. The Board had noted that evaluation was a multifaceted process, including political, technical, social and personnel aspects. Consequently, a proper appreciation of the process and an appropriate attitude to it were very important. The provisional guidelines contained in Annex 3 to the report stressed the importance of the evaluation by all concerned with the activity and of their intimate involvement in the evaluation process. The Executive Board had endorsed the guidelines and had emphasized that evaluation, since it was an integral part of the health development process, should be built into all health programmes. The Board had recognized the importance of verifying the social relevance of programmes before undertaking evaluation of their performance and results. It had also recognized the further need for development of positive health indicators and evaluation criteria, taking into account socioeconomic and cultural conditions, and the need to develop health information systems to support evaluation, as well as planning, at the country level. The Board had recommended that the guidelines be tested as soon as possible and had emphasized the need for flexibility in their application. Dr Casselman hoped the Committee would present its views on the place of evaluation in health programme development and how that might contribute to the improvement of health care delivery. He drew attention to the draft resolution proposed by the Executive Board in resolution EB61.R26, which requested the Director-General to continue to develop health programme evaluation and urged Member States to progressively introduce evaluation and to collaborate with WHO.

Dr KHAZEN (Canada) recognized the importance of programme evaluation as a part of overall health management rather than as an isolated procedure. Programme evaluation was probably

the most difficult step in country health programming. A differentiation should be made between basic or traditional evaluation of programmes, which was the responsibility of managers, and evaluation of a project or projects in a health plan. The former might prove difficult, especially where the quality of life was to be measured. The latter, especially for cost-benefit reasons, might be easier, for example, evaluation of screening programmes for unborn errors or of immunization programmes. However, the evaluation of health promotion and health education programmes, which required measurement of the effect of a health message on lifestyle or behaviour, necessitated more sophisticated tools. He hoped the Secretariat would make efforts to develop specific and practical assistance for health managers in that area.

Dr SANKARAN (India) said that his delegation supported the draft resolution proposed in resolution EB61.R26. Evaluation in the health field had been undertaken in his country since 1948, by means of the performance budget of the Central and State Ministries, the Planning Commission's assessment, evaluation of health manpower development by the Institute of Applied Manpower Research, and individual assessments of projects by bodies such as the All-India Institute of Medical Sciences and the Indian Council of Medical Research. However, there had never been a detailed countrywide evaluation of the cost-effectiveness and delivery of health care services or of the community's reaction to the way funds had been allocated in recent years. The most recent evaluation of consequence had been in 1961, when the Mudaliar Committee had recommended the extension of primary health care services. An evaluation of mechanisms outlined for the community health workers scheme was being planned and would involve the National Institute of Health and Family Welfare, the All-India Institute of Hygiene and Public Health, the Indian Institute of Management, the Institute of Rural Medical Sciences, the National Institute of Applied Economic Research, the Institute of Manpower Development and, ultimately, the evaluation cell of the Planning Commission. It was also hoped that the Institute of Medical Sciences in Wardha and the All-India Institute of Medical Sciences in New Delhi would be able to participate in a prospective assessment if necessary. The South-East Asia Regional Office would provide feedback to headquarters on the performance of the programme.

Professor KRANENDONK (Netherlands) said that his Government took great interest in the development of and in experiences gained in health programme evaluation. Although there was a place for independent assessment of projects and programmes, the main task of evaluation should be given to those responsible for programme development, be it at the local, national, regional or global level. He agreed that evaluation was a systematic way of learning from experience and using the lessons learned to improve activities and promote better planning. The provisional guidelines for programme evaluation contained in Annex 3 of the report, merited serious consideration and testing but should be considered as flexible guiding principles rather than as a formal manual. Indicators and criteria for evaluation should be adjusted according to the socioeconomic and health conditions of the country or region concerned. However, components of evaluation in respect of relevance, progress, efficiency, effectiveness and impact might form a framework for global acceptance. Close collaboration should be maintained throughout the United Nations system in order to achieve comparable and interchangeable approaches and methods of evaluation. That was particularly important in country health programming, where the basic principle was the placing of health in the broader perspective of total socioeconomic development. He supported the draft resolution proposed in resolution EB61.R26.

The meeting rose at 12h05.

* * *