This short account of the work of WHO in 1980 is in no way intended to be a complete description of the Organization’s numerous undertakings. It emphasizes activities that took place in the WHO regions, highlighting questions of particular interest. However, the activities referred to in this report are not necessarily considered to be of greater importance than the many other activities and programmes, including major ongoing ones, that are not mentioned. A more comprehensive account will be provided in the biennial report of the Director-General on the work of WHO in 1980-1981, to be presented to the Thirty-fifth World Health Assembly in 1982.

Abbreviations

The abbreviations used in this report include the following:

ADB - African Development Bank
ACC - Administrative Committee on Coordination
ACMR - Advisory Committee on Medical Research
ASEAN - Association of South East Asian Nations
CIDA - Canadian International Development Agency
DANIDA - Danish International Development Agency
ECA - Economic Commission for Africa
ESCAP - Economic and Social Commission for Asia and the Pacific
FAO - Food and Agriculture Organization of the United Nations
GTZ - Gesellschaft für Technische Zusammenarbeit (Agency for Technical Cooperation of the Federal Republic of Germany)
IARC - International Agency for Research on Cancer
ILO - International Labour Organisation
IPPF - International Planned Parenthood Federation
OAU - Organization of African Unity
OPEC - Organization of Petrol Exporting Countries
PAHO - Pan American Health Organization
SIDA - Swedish International Development Authority
TCDC - Technical cooperation among developing countries
UNCTAD - United Nations Conference on Trade and Development
UNDP - United Nations Development Programme
UNEP - United Nations Environment Programme
UNESCO - United Nations Educational, Scientific and Cultural Organization
UNFPA - United Nations Fund for Population Activities
UNICEF - United Nations Children’s Fund
USAID - United States Agency for International Development
WFP - World Food Programme
WHO - World Health Organization.
Introduction

1. "To ensure implementation, debate has to give way to action." This was what the Executive Board had to say when it submitted its draft of the Global Strategy for Health for All by the Year 2000 to the Thirty-fourth World Health Assembly.

2. 1980 was a year in which the way to action for health for all by the year 2000 was clearly demarcated. For, in that year, tens of countries, developed and developing alike, addressed themselves seriously to the preparation of national strategies for attaining health for all their people. In a world plagued by cynicism, this phenomenon alone would suffice to warrant devoting a whole annual report to it; for it shows that the Member States of WHO are taking seriously their responsibility for the health of their people. Moreover, during 1980 these same Member States approved in their respective regional committees regional strategies to support their own individual strategies. And finally, at the Thirty-fourth World Health Assembly in May 1981 they will be considering a Global Strategy submitted to them by WHO's Executive Board.
3. What are these strategies all about? In spite of wide national and regional variations, which are only to be expected in view of the widely different circumstances of each country and region, certain themes have emerged that are common to them all. Thus, the need has become clear to develop health systems that encompass the entire population on a basis of equality and responsibility. Such systems include components from the health sector and from other sectors whose interrelated actions contribute to health. These systems are based on primary health care as defined in the Declaration of Alma-Ata, delivered at the first point of contact between individuals and the health system. Other levels of the health system support the first contact level of primary health care to permit it to provide these essential elements on a continuing basis.

4. To build up such health systems implies establishing a well-coordinated infrastructure, starting with family and community care, and continuing with intermediate and central support and referral levels. This infrastructure will have to deliver well-defined health programmes that cover the whole population, progressively if necessary. These programmes will have to use technology that is scientifically sound, adaptable to various local circumstances, acceptable to those for whom it is used and to those who use it, and maintainable with resources the country can afford. Health manpower will have to be planned, trained and deployed in response to specific needs of people as an integral part of the health infrastructure. Action will have to be taken not only in the health sector, but also in other relevant social and economic sectors. Such action will have to include measures for health promotion, not the least of which will consist of promoting healthy lifestyles and habits. Measures to make sure that all preventable disease is indeed prevented will also have to be included. Great care will have to be taken to ensure that diagnostic, therapeutic and rehabilitative measures are really appropriate for the country in which they are applied.

5. The above is far from being the conventional way of providing health care in most countries, so the introduction of such health systems will not follow simply from enunciating their principles or planning them on paper. Crucial to the strategies, therefore, is making sure of social control of the health infrastructure and technology through a high degree of community involvement. Such social control will naturally have to be applied by each country in a manner that is consonant with its political, cultural and administrative traditions. As the synthesis of the Global Strategy from the national and regional strategies has shown, political commitment at the highest government level as well as the support of economic development planners will have to be ensured, and professional groups inside and outside the health sector will have to be enlisted. An appropriate managerial process for national health development and the related health systems research will have to be applied, and health research in general oriented to support the strategies. Information will have to be widely disseminated to policy makers, to professional people in the health and related sectors, and to the public at large, to ensure acceptance of the strategies by them and thus encourage their involvement. These measures will have to be supplemented by additional ones to ensure the mobilization of all human resources, not only health personnel. The best use will also have to be made of available financial resources, and additional resources generated, if these strategies are to have a chance of succeeding.

6. As the preparation of the strategies has clearly shown, all the above-mentioned actions in countries by countries will have to be supported by international action. The most important international action will consist of cooperation among countries. The pledges made throughout the year by developing and developed countries alike to cooperate among themselves in support of the health for all movement is, to say the least, highly encouraging. These include pledges of good will to ensure that the international transfer of resources for health from developed to developing countries are channelled into priority activities in the strategies of these latter countries.

7. What are the chances of success of such a Strategy? The knowledge is for the most part available; its application, however, has never been guaranteed until now. Such a guarantee depends on the world's political, socioeconomic and health leaders taking the Strategy seriously, ensuring the intercountry cooperation required, and making available the necessary resources.
8. In the course of 1980, WHO's unique role was identified again and again in connexion with the development of strategies for health for all, their support, their coordination, the monitoring of their progress, and the evaluation of their impact. The Organization has been preparing itself over the past few years to fulfil its heightened role in support of the efforts of its Member States to attain an acceptable level of health for all their people. To this end, a worldwide managerial study of unprecedented proportions was carried out, namely the Study of WHO's structures in the light of its functions. It was summarized in a historical resolution of the Thirty-third World Health Assembly which will no doubt shape the way the Organization will work over the next decade or two. Behind the tidy façade of the Health Assembly's resolution lies a profound reawakening of the original intention of WHO's founders when they adopted a Constitution based on cooperation among Member States to promote and protect the health of all peoples. For the Health Assembly's resolution has restated and reinstated the unique democratic features of WHO's way of life, whereby Member States assume total responsibility for their collective action and undertake to carry out their own health activities in the spirit of the policies and programmes they have adopted collectively in WHO.

9. And now for some of the details. Convinced that through its international health work WHO can be a powerful instrument in helping to reduce international tension, to overcome racial and social discrimination, and to promote peace, the Health Assembly decided to concentrate the Organization's activities over the coming decades on support to national, regional and global strategies for health for all, including the exercise of its influence to channel all available health resources towards this end. This implies strengthening the roles of the Organization in promoting action for health in addition to indicating how such action might be carried out. It was clear to the Assembly that if the Organization was to succeed in fulfilling its tasks adequately, its directing, coordinating and technical cooperation functions would have to be mutually supportive, and that the work of the Organization at all levels would have to be properly interrelated.

10. In adopting the resolution, Member States undertook to strengthen their ministries of health as necessary so that these could fully assume the function of directing and coordinating authority on national health work. They also undertook to mobilize all possible resources in their countries that could contribute to health development, including those of other relevant sectors and nongovernmental organizations.

11. The regional committees were accorded a more active part in the work of the Organization. They were urged to intensify their efforts to support the national strategies of the countries in the region as well as the regional and global strategies for health for all. To foster the unity of conception and action they were also urged to increase their monitoring, control and evaluation functions so as to ensure the proper reflection of national, regional and global health policies in regional programmes and the proper implementation of these programmes. To this end they were requested to include the review of WHO's action in individual Member States within the region. But monitoring and control has to act in more than one direction. Just as the regional committees were urged to intensify their monitoring function within the region, the Executive Board was authorized to strengthen its role in giving effect to the decisions and policies of the Health Assembly, and to monitor on behalf of the Assembly the way the regional committees reflect the Assembly's policies in their work, and the manner in which the Secretariat provides support to Member States.

12. The Health Assembly also defined principles for the provision of support by the Secretariat. Thus, it requested the Director-General and the Regional Directors to act on behalf of the collectivity of Member States in responding favourably to government requests only if these are in conformity with the Organization's policies. The Director-General was requested to redefine the functions of the regional offices and of headquarters in such a way as to ensure that they provide adequate and consistent support to Member States in their cooperation with WHO and among themselves. He was also requested to adapt accordingly the organizational structures and staffing of the regional offices and of headquarters.

13. Immediately following the Thirty-third World Health Assembly a plan of action was worked out for implementing the above-mentioned resolution, and work for putting it into effect was started forthwith. Although greatest attention was paid during 1980 to the two crucial matters of the strategies for health for all and the structures of WHO in the light of its most
important functions, the ongoing activities of the Organization during 1980 were certainly not neglected. The report that follows, which lays greatest emphasis on activities that took place in Member States and in the WHO regions, highlighting matters of particular interest, bears ready witness to the intensity of these activities.

Policies for health

14. The main thrust of WHO's activities in 1980 was towards promoting national, regional and global strategies for the attainment of the main social target for the next two decades: "Health for all by the year 2000, or the attainment by all citizens of the world of a level of health that will permit them to lead a socially and economically productive life".

15. Almost all the countries of the world have collectively pledged themselves to strive to reach that target. During the year they were joined by Equatorial Guinea, Saint Lucia, San Marino and Zimbabwe, all of which became Members of the Organization, bringing the membership to 156 plus one Associate Member.

16. The Executive Board, the World Health Assembly and the regional committees engaged in vigorous discussion to formulate policies for health during 1980; Table 1 lists some programme and organizational topics considered by the Executive Board and the Health Assembly, and Table 2 lists some issues debated by the regional committees. Two themes were common to all meetings: formulating strategies for attaining health for all by the year 2000, and the study of WHO's structures in the light of its functions. In other words, all of WHO's deliberating organs were examining how the Organization's principal objective can be achieved, and how WHO needs to be remodelled in order to contribute to achieving the objective most efficiently. These two themes and some of the other issues are covered in later sections of this report.

17. The subject chosen for the Technical Discussions at the Health Assembly in May was "The contribution of health to the New International Economic Order". The following were some of the points raised:

- There is a need for a complete and harmonious integration of the health sector into the overall development process, at the national as well as the international level; efforts to bring about such integration should be directed towards the goal of health for all by the year 2000 and based on primary health care and the Declaration of Alma-Ata.

- The health sector must be seen as a basic element in a country's socioeconomic development; also the health sector must allow for the participation of all peoples in the formulation and implementation of its plans.

- An essential prerequisite for the establishment of the New International Economic Order is strong political will and commitment at the national and international levels. The health sector can assist in this respect by helping to create the necessary political will and commitment within its own sphere of competence.

- Health must secure a more prominent role in the development process; this can partially be accomplished by creating a greater awareness amongst all national and international planners of the important contribution which health has to make to socioeconomic development.

- The need for a new order is entirely justified given the many disturbances in the global economic situation. The New International Economic Order has provided WHO with a new optic for pushing ahead with social development, with a renewed emphasis on a just and equitable distribution of social goods and services, as implied in the Declaration of Alma-Ata. The health sector has a duty to state clearly (a) what resources it needs, given the overriding importance of health for each individual and each community; and (b) what the health sector can contribute towards economic growth and stability.
<table>
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<tr>
<th>Subject</th>
<th>Resolutions&lt;sup&gt;a&lt;/sup&gt; of the Executive Board (9-25 January)</th>
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<td>EB65.R14</td>
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</tbody>
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<sup>a</sup> For the text of the Executive Board resolutions, see WHO document EB65/1980/REC/1.

<sup>b</sup> For the text of the Health Assembly resolutions, see Handbook of resolutions and decisions of the World Health Assembly and the Executive Board, volume II, 4th ed. (1973-1980), 1981.
### TABLE 2. SOME ISSUES DEBATED BY THE REGIONAL COMMITTEES IN 1980\(^a\)

**Regional Committee for Africa** (Brazzaville, 17-24 September)

- Primary health care
- Charter for the Health Development of the African Region
- Technical cooperation among developing countries
- National liberation and health
- Seventh General Programme of Work
- Development and coordination of research
- Prevention of blindness
- WHO's structures in the light of its functions
- Strategies for attaining health for all by the year 2000
- Information systems for the management of national health programmes\(^b\)

**Regional Committee for the Americas** (Washington, D.C., 22 September - 3 October)

- WHO's structures in the light of its functions
- Malaria control
- Women in development
- Strategies for attaining health for all by the year 2000
- Health assistance in disasters
- Community health education\(^b\)

**Regional Committee for South-East Asia** (Malé, 1-7 September)

- Strategies for attaining health for all by the year 2000
- WHO's structures in the light of its functions
- International Drinking Water Supply and Sanitation Decade
- Health manpower planning and community participation for primary health care\(^b\)

**Regional Committee for Europe** (Fez, Morocco, 7-11 October)

- Strategies for attaining health for all by the year 2000
- WHO's structures in the light of its functions
- Seventh General Programme of Work
- Problems of medical technology\(^b\)

**Regional Committee for the Western Pacific** (Manila, 9-15 September)

- Strategies for attaining health for all by the year 2000
- WHO's structures in the light of its functions
- International Year of Disabled Persons
- Seventh General Programme of Work
- Disability prevention and rehabilitation
- Mental health
- Drug abuse
- International Drinking Water Supply and Sanitation Decade
- Programme of acute respiratory infections
- Development of the regional mental health programme\(^b\)
- Community involvement in health services development\(^b\)

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\(^a\) There was no meeting of the Regional Committee for the Eastern Mediterranean during 1980.

\(^b\) Subjects of technical discussions or presentations.
Strategies for attaining health for all by the year 2000

18. National, regional and global strategies for attaining health for all by the year 2000 need to be continuous, and should avoid inflexibility in formulation. Many countries developed their strategies during the year. The regional committees reviewed these strategies and proposed regional strategies based on them. Now WHO is developing a global strategy based on the national and regional strategies. It is applicable to all countries but particularly emphasizes the needs of developing countries, and is based on the individual and collective commitment of countries to attain the goal of health for all by the year 2000.

19. It has become clear that the attainment of that goal requires political, social and economic reforms, including a more equitable distribution of resources for health. Governments may wish to review their health systems regularly in the light of decisions taken collectively in WHO, to strengthen their ministries of health or equivalent bodies, and to provide the necessary mechanisms to ensure coordinated action on the part of all the sectors concerned. It is also evident that communities should be seriously involved in health work, and for this reason they need information, stimulation, advice and support; then they can participate, for instance, in the control of local endemic diseases.

20. The genuine partnership between WHO and its Member States is the key to attaining the common goal. One role of the Organization, for example, is to provide support in strengthening health infrastructures and in the training of health workers. Developments in the regions, described below, show the sort of action that can be taken.

21. The newly formed African Advisory Committee on Health Development review the regional strategy for health for all. Most of the countries of the African Region have formulated realistic national strategies, and the regional strategy is a synthesis of the national strategies. Specific objectives were taken from the national strategies and classified into three groups: development of comprehensive health services, health science and technology, and promotion and support. There is an implementation schedule including objectives for 1990 related to immunization, water supply and sanitation, and the fight against hunger and malnutrition.

22. The strategy requires an additional US$ 2500 million per year (including US$ 2000 million for drinking-water and sanitation, US$ 55 million for the expanded programme on immunization, and US$ 25 million for malaria control) - US$ 7-10 per inhabitant per year - and extrabudgetary funding will be necessary. An African Regional Health 2000 Resources Group was therefore set up (see para. 30), and this group also met for the first time in June in Brazzaville.

23. The Regional Committee for Africa, meeting in September, considered the subject of strategies for attaining health for all. The Committee invited Member States to formulate detailed national plans of action with emphasis on primary health care, and to put their strategies into effect with the support of WHO, OAU and other organizations and institutions. The Regional Committee approved the regional strategy and requested the setting up of mechanisms to evaluate the progress of the work every two years and the impact of the work every six years.

24. In September the Regional Committee for the Americas considered the question of strategies for attaining the goal of health for all by the year 2000, together with the question of developments in the health sector in the decade 1971-1980 (the period covered by the Ten-Year Health Plan for the Americas). The Regional Committee agreed that primary health care and its components constitute the basic strategies for attaining the goal, and that they include: the extension of health service coverage and environmental improvement; community organization and participation; better mechanisms for intersectoral linkages; development of research and appropriate technologies; and the development of human resources. A regional plan of action is under preparation.

25. In June a regional meeting on strategies for health for all, jointly sponsored by WHO and UNICEF, was held at the WHO Regional Office for South-East Asia in New Delhi. The participants were senior officials from nine Member countries of the Region representing
health, planning, social welfare, rural and community development, and other disciplines. Members of an ad hoc subcommittee on research needs in this field, appointed by the ACMR, also attended. The meeting served as a forum for Member States to exchange information and experience relating to strategies for health for all, and to formulate regional strategies for collective action.

26. The European Region has a Regional Health Development Advisory Council, which advises on strategies for health for all. It is composed of members of the Consultative Group on Programme Development and experts from the Region in the fields of political science, economics and sociology. The Advisory Council proposed a comprehensive, coherent and consistent long-term strategy for the Region as a whole. In this strategy, three main programmes were identified: the promotion of lifestyles conducive to health; the reduction of preventable conditions; and the reorientation of the health care system. Of these, the first is the most important, the long-term aim being to encourage people to assume responsibility for their own health. When the Regional Committee discussed this question in October, it stressed the importance of indicators for monitoring the success of strategies; the general opinion was that the best course was to use few but accurate indicators, including some of a socioeconomic nature.

27. In the Eastern Mediterranean Region, following subregional meetings on health for all, held in Mogadishu (in February), Damascus (March) and Kuwait (April), draft regional strategies were formulated, based on the conclusions reached at the subregional meetings and on individual country strategy statements. Annexed to the draft was a proposal for the adoption by Member countries of an 11-point Charter for Health in the Eastern Mediterranean Region.

28. The Regional Committee for the Western Pacific unanimously adopted a regional strategy for attaining the goal of health for all by the year 2000, confident that this strategy would be strengthened as countries reached towards the goal through new knowledge and the application of existing knowledge. The strategy calls for three basic courses of action: laying the foundation for health (providing adequate food, water and shelter); developing individual and community self-reliance in health; and providing appropriate and affordable health technology for the sick, the disabled, the chronically ill and the socially maladjusted. The strategy focuses on primary health care as one of the principal approaches. The Regional Committee urged Member States to implement, monitor and evaluate their national strategies, reviewing them and updating them as required.

29. Of course, strategies require funding, and since funds originate from many sources and in many ways, it behoves WHO, in its international coordinating capacity, to foster mechanisms for the mobilization and rational channelling of funds. A new body, the Health 2000 Resources Group, since renamed the Health Resources Group for Primary Health Care, met for the first time in May and again in December. It is a mechanism established in accordance with resolution WHA29.32 for "attracting and coordinating an increased volume of bilateral and multilateral aid for health purposes". It is, as originally envisaged, a consultative group with an invited membership from bilateral, multilateral and nongovernmental agencies, with participation by developing countries, to advise the Director-General. The aim of the group is to promote rationalization of the flow of resources required for primary health care activities in developing countries and to stimulate the mobilization of new resources.

30. The African Region also has its Resources Group, already mentioned in paragraph 22. Technical cooperation among developing countries is being evolved in the Region, but funds are required to complement national efforts, particularly as regards countries whose currencies are not convertible. In view of their special needs, technical cooperation is being ensured with the national liberation movements recognized by OAU, particularly in relation to drug policies, and to priority programmes oriented towards 1990. In these endeavours the African Regional Health 2000 Resources Group has been working closely with the Regional Standing Committee on TCDC.

31. The Resources Group held its first meeting in Brazzaville in June. It includes representatives of Member countries, of organizations of the United Nations system, and of intergovernmental, governmental and nongovernmental organizations. Its terms of reference
include advising on how best to secure extrabudgetary support, stimulating the mobilization of resources for health development, and promoting the exchange of information on health needs and resources.

32. The meeting urged contributors to focus their attention and financial support on the regional strategy for primary health care. The priority programmes identified as requiring extrabudgetary support in the African Region were: essential drugs (including the construction of pharmaceutical production plants, bulk purchasing, quality control, research on traditional medicine, training of personnel, and information exchange), malaria control (including the training of supervisory and operational staff, action on supplies and equipment, and technical cooperation between African countries and other developing and developed countries), immunization, and the provision of safe water supplies and sanitation.

33. In February there were meetings between senior officials from PAHO/WHO and from the Inter-American Development Bank, to continue discussions begun in 1979. They agreed that regular meetings should be held to work out ways of increasing collaboration between the two institutions. There was discussion of the implications that the goal of health for all by the year 2000 has for the Organization's programme of technical cooperation and the kinds of loans that the Bank makes to its member countries. The Bank participants agreed that priority attention must be given to primary health care and the extension of health service coverage, and requested the involvement of PAHO/WHO in the early stages of health-related projects.

Political support for health for all strategy

34. On 29 November 1979 the United Nations General Assembly, during an examination of long-term trends in economic development and of the working out of the New International Economic Order, unanimously adopted resolution 34/58 entitled "Health as an integral part of development". In adopting this resolution, the General Assembly recognized the vital role that health and health care play in the development of countries; fully endorsed the Declaration of Alma-Ata, and in particular its emphasis on primary health care; and approved the rerientation of WHO's activities towards the achievement of health for all by the year 2000. In May the World Health Assembly warmly welcomed this resolution.

35. What are the implications of resolution 34/58? It has implications for WHO, which should strengthen its commitment to its current objectives and elaborate appropriate strategies, keeping the General Assembly, through the Economic and Social Council, informed of its efforts in that direction. It has implications for the relevant bodies of the United Nations system, which should coordinate with and support the efforts of WHO. And, not least, it has implications for Member States, which should implement the Declaration of Alma-Ata and give full support to strategies for achieving an acceptable level of health for all.

36. Political support is an essential prerequisite for implementing the strategy for health for all. Such support needs to be actively sought and promoted. One source of political support can be geopolitical groupings of countries. An example is the OAU; WHO is inviting the OAU to include health for all by the year 2000 as an agenda item at one of its forthcoming summit meetings.

37. Another example is ASEAN. The cooperative spirit characteristic of ASEAN has permeated the health sector and reinforced international health cooperation, particularly with WHO. A meeting of ASEAN Health Ministers (from Indonesia, Malaysia, Philippines, Singapore and Thailand) held in Manila in July accepted among the regional priorities WHO's goal of health for all by the year 2000 through primary health care. The Ministers signed a Declaration of Collaboration in Health in which they declared "their agreement to strengthen and coordinate regional collaboration in health among ASEAN countries". They adopted the following guidelines:

- ensure that collaboration contributes directly or indirectly towards regional self-reliance and self-determination;

- emphasize health as an integral part of overall socioeconomic development;
- aim at making health care accessible to the total population, with priority being given to the underserved and depressed areas;

- promote health manpower development consistent with the needs of the ASEAN member countries;

- continue with international collaboration in health while striving to be self-reliant in the delivery of health services;

- emphasize primary health care in the overall development strategy.

38. The Ministers also declared that the programme areas of technical collaboration among their countries should include: primary health care; disease control; health planning, management and information systems; nutrition; health manpower development; environmental and occupational health; pharmaceuticals, biologicals and traditional medicine; and mental health. They agreed to develop a formal mechanism within the ASEAN structure to facilitate effective collaboration in these areas.

39. A third example is the movement of non-aligned countries. In May, the fourth meeting of Ministers of Health of the Non-Aligned Countries and Other Developing Countries discussed several aspects of WHO's goal of health for all by the year 2000. The meeting adopted a resolution supporting the goal and calling on all countries in the movement to develop an appropriate programme of action. The Ministers agreed to use the mechanisms of WHO to:

- engage in bilateral and multilateral exchanges of the experience obtained in this direction;

- exchange information;

- request or send consultants and advisers, in line with each country's possibilities;

- coordinate research projects in biomedical and health matters; and

- request or offer material, technical, human and financial support for implementing the priorities of the programme of action adopted at the Sixth Summit Conference of Non-Aligned Countries in line with possibilities and needs.

40. The adoption of regional charters for health development is a welcome phenomenon, indicative of widespread political support for WHO's policies and acceptance of the concept of technical cooperation. The official signing by certain countries of the Charter for the Health Development of the African Region was a milestone of major importance. It marked a decisive step in reaffirming Member States' individual and collective determination to attain a reasonable level of health. The objectives of the Charter include improvement of the levels of health in the agreed priorities of primary health care, manpower development and training, provision of safe water and sanitation, promotion of maternal and child health, and control of communicable diseases. The Charter affirms the commitment of Member States in areas which they jointly consider to be important for health development. By collectively binding governments to common ideals which they already hold individually, the Charter can be an effective instrument for achieving peace, progress and cooperation.

41. During the year Sri Lanka, Thailand, Bangladesh, India (in February), Indonesia (April), Mongolia, Democratic People's Republic of Korea (July), Nepal and Maldives (August) signed the Asian Charter for Health Development. The Charter is a means for the countries of the Region to cooperate in building up individual self-reliance and collective self-sufficiency. It aims to promote intercountry consultation and collaboration and to foster close international cooperation, providing a common basis for formulating health plans, programmes and projects in the best way possible, within the framework of national, regional and global development policies.
WHO's structures in the light of its functions

42. In addition to funding, strategies need smoothly-running mechanisms to put them into operation: the structure of WHO must be appropriate to the work it has to carry out. Having reviewed the Executive Board's study on the subject of WHO's structures in the light of its functions, the World Health Assembly in May decided that WHO should concentrate its activities on support to strategies for attaining health for all, and that it should take action for health in addition to indicating how such action might be carried out. The Assembly felt that the functions of the regional offices and WHO headquarters should be redefined, and organizational structures and staffing adapted, so as to ensure the provision of adequate and consistent support to Member States. The engagement of national staff and of international WHO field staff should be reviewed, to ensure the full involvement of both kinds of staff in collaborative national programmes.

43. The Health Assembly considered that the Executive Board should strengthen its role in giving effect to the decisions and policies of the Health Assembly and in advising the Assembly; become increasingly active in presenting major issues to the Assembly; and correlate its own work with that of the Assembly and the regional committees, monitoring the way in which the regional committees reflect the Assembly's policies in their work.

44. The regional committees, in the view of the Health Assembly, should intensify their efforts in developing regional health policies and programmes in support of health for all, support technical cooperation among all Member States, support the establishment or strengthening of multisectoral national health councils, and increase their monitoring, control and evaluation activities.

45. The Health Assembly did not omit to indicate what the Member States themselves should do. They should review the role of their ministries of health, establish multisectoral national health councils, and mobilize all possible resources that could contribute to health development. In addition, they should improve their coordinating mechanisms in support of their health development strategy and technical cooperation, and co-ordinate their representation within WHO and in the United Nations and its specialized agencies concerned with development.

46. If the instructions of the Health Assembly are faithfully followed - difficult though that may be in many cases - there is no doubt that Member States and their Organization will be in a much better position to cooperate with each in progressing towards the long-term goal that they have set themselves.

47. WHO's moves in this direction include the more widespread use of nationals and collaborating centres. The African Region, for instance, now has 11 WHO programme coordinators who are nationals, i.e., nearly one-third of the total. As expected, they are making a valuable contribution: frequently they are members of national delegations to the Organization's governing bodies, and they have free access to political leaders and participate in national structures. They therefore facilitate technical cooperation.

48. In the South-East Asia Region too, there has been greater involvement of nationals in WHO's work. Since 1976 nationals have been appointed to carry out various project assignments in six countries of the Region, and contractual service agreements have been signed during this period with over 70 individuals, more than 20 of whom were national project managers or project staff recruited to assist specifically with the technical and administrative development of a particular project or national activity. The experience so far with these arrangements, which encourage national self-reliance and make use of national expertise, has been extremely satisfactory and has highlighted the need to pursue the employment of national project staff under suitable agreements that retain as much flexibility in their employment as possible.

49. WHO has increased the number of its regional collaborating centres in the South-East Asia Region. Efforts have been made to identify and designate collaborating centres for undertaking specific activities under the regional research plans in the following subjects:
health services research, nutrition, liver diseases including liver cancer, and mental health. These are in addition to existing WHO collaborating centres. An inventory of national centres of excellence in various fields is being compiled and appropriate institutions are being identified for designation as WHO-recognized centres.

Launching the Water Decade

50. The great potential of inter-agency and international action for promoting change will become evident during the International Drinking Water Supply and Sanitation Decade (1981-1990). On 10 November the Decade was launched at a special meeting of the United Nations General Assembly. It is estimated that about 80% of all disease in developing countries is related to an unsafe water supply and sanitation, and well over 1000 million people lack adequate amenities. To remedy this situation, the organizations within the United Nations system concerned with this field (United Nations, UNICEF, UNDP, ILO, FAO, World Bank, WHO) are pursuing a collaborative approach during the Decade, based on encouraging self-reliance by the developing countries, with the focus on community involvement and participation. The aim is to achieve maximum benefit for the rural and urban poor.

51. The overall strategy has six major objectives:

- to support governments in developing and carrying out their strategies;
- to promote a sense of responsibility and self-reliance at the community level, particularly through educating people about water, health and disease;
- to support the institutional development required in countries;
- to ensure the training of the manpower required at all levels;
- to help develop practical, low-cost technologies supported by exchange of information and expertise;
- to mobilize additional resources and rationalize their international transfer.

52. Although the Decade will require on average an estimated annual investment totalling about US$ 30 000 million, the potential benefits will be many times more than that in terms of social and economic progress. External contributors include the World Bank, several regional development banks, the agencies of OPEC, the cooperating organizations of the United Nations system, and nongovernmental organizations.

53. WHO has global technical responsibility for the Decade and also acts as the secretariat to the United Nations Steering Committee for the Decade, composed of representatives of the seven agencies mentioned above. The strength of WHO's participation in the Decade resides in the Organization's technical cooperation at the country level. For the biennium 1980-1981 some 150 projects of technical cooperation are provided for in 93 countries, and the long-standing involvement of the Organization in this type of work is the basis of WHO's expertise. No other international agency has so much experience in national planning for water supply and sanitation.

Technical cooperation

54. During 1980 the Executive Board and regional committees reviewed the subject of technical cooperation. There was general agreement that WHO's technical cooperation and coordinating functions are mutually reinforcing aspects of the Organization's international health work. This work should not be fragmented; it should be pursued by Member States individually and collectively as envisaged in the Constitution, "for the purpose of cooperation among themselves and with others to promote and protect the health of the people". The days of "technical assistance" are well and truly over. That concept has given way to "technical cooperation", which was described as "joint action of Member States cooperating among themselves or between them and WHO, directed to the attainment of the main goal of the Organization as stated in the Constitution, resolution WHA30.43 and other Health Assembly resolutions, as well as the Declaration of Alma-Ata".
55. The new concept implies equality of the cooperating parties, sovereignty and responsibility of each side for a more rational use of all forms of cooperation, and mutual responsibility for the achievement of goals, exchange of information and experience, and evaluation of results. The "donor" and "recipient" relationships of technical assistance are no longer valid. While it is helpful to classify technical cooperation into four types (between WHO and Member States; among developing countries - i.e., TCDC; among developed countries; and between developed and developing countries), they should be viewed as an organic whole, with WHO exercising a leadership role and a coordinating function.

56. Some examples illustrate both the combination of WHO's coordinating and technical cooperation functions and the mutual support of research and technical cooperation:

- In the campaign to eradicate smallpox (see also para. 68), WHO coordinated the development of policies, principles, and scientific and technical bases, which were applied in the Organization's technical cooperation with individual countries. This technical cooperation in turn stimulated improvements in methods which were universally disseminated through WHO's coordinating information exchange function.

- In the Special Programme of Research, Development and Research Training in Human Reproduction (see also para. 101), the management of research is carried out on a cooperative basis, and the research itself - for instance, research carried out on intrauterine contraceptive devices - is pursued on a collaborative basis, both horizontal (institutions of different countries working together) and vertical (scientists in various countries attacking different aspects of a common problem, in accordance with a defined strategy).

- Malaria research is dealt with jointly by the UNDP/World Bank/WHO Special Programme of Research and Training in Tropical Diseases (see also para. 174) and WHO's Malaria Action Programme (see also para. 133). The research undertaken - for instance, research on the resistance of Plasmodium falciparum to chloroquine and other 4-aminquinolines - is, as in the case of the other illustrations mentioned above, agreed upon and conducted as an international collaborative effort within WHO's coordinating function. The Organization stimulates the scientific community, in both developing and developed countries, to tackle problems identified in the countries themselves, and ensures that the findings are disseminated worldwide so that they can be utilized wherever they are needed. Thus, WHO's research, information and technology transfer, and operational functions are closely interlinked and mutually supportive.

57. The African Region has a Standing Committee on Technical Cooperation among Developing Countries. In the view of the Standing Committee, experience with bilateral and multilateral technical cooperation has highlighted the need for a multisectoral approach. In 1980 it recommended a coordinated system for the group purchasing of drugs and for the development of a pharmaceutical industry and of a traditional pharmacopoeia. The Standing Committee felt that the regional structures for implementing TCDC were satisfactory: subregional working groups, regional expert panels, collaborating centres and intercountry projects. It considered that the development of a regional network of national health development centres should further stimulate technical cooperation among developing countries.

58. This subject was to the fore in the discussions of the Regional Committee for Africa. The Regional Committee invited Member States to ensure that health is given its rightful place in any agreement on technical cooperation, and to strengthen the role of health ministries in all multisectoral mechanisms for promoting technical cooperation, and especially among developing countries. The Regional Committee wished the World Health Assembly to consider proposals for increasing the voluntary contributions to the African Region in order to implement primary health care, support national liberation movements recognized by OAU, deal with the consequences of disasters and natural catastrophes, and promote biomedical and health services research.
Research promotion and development

59. Health services and technology cannot make progress without research, and the research needs to be relevant to overall objectives rather than an end in itself. Research also needs to oversee adequate institutions, facilities, personnel, training arrangements and funding. To oversee its activities in this field, WHO has a global Advisory Committee on Medical Research (ACMR) and six regional ACMRs.

60. The World Health Assembly reaffirmed in May that biomedical health services and health promotion research should contribute in a major way to progress towards health for all by the year 2000. It urged Member States to intensify their cooperation in health research and to give high priority to research training and institution strengthening.

61. The twenty-second session of the global ACMR was held in Geneva in October. The Committee reviewed progress made in current WHO research efforts, including the special programmes on research and training; it also discussed reports of action taken on suggestions and recommendations made by the ACMR at its previous session, especially on the topics of nutrition, control of diarrhoeal diseases, and ethical review procedures for research involving human subjects. The ACMR reviewed the work of its subcommittees: information, health services research, research on mental health and human behaviour in primary health care, research administration, and research career structures. It recommended that the subcommittees on information and on research administration should continue their work; that a subcommittee be established to study the research component of the WHO cancer programme; that the subcommittee on health services research, following its session in November 1980, be transformed into a scientific planning group; and that scientific planning groups be established for the programmes in nutrition and in mental health and human behaviour in primary health care.

62. When reviewing the activities of the regional ACMRs (the important issues that they discussed are listed in Table 3), the global ACMR noted that one of the main constraints preventing effective action by some regional ACMRs was lack of funds, and proposed that all regional offices should earmark a minimum of 5% of their regional budgets for research. There was a wide disparity between the capabilities of the various regions and between countries in the regions, which also prevented some regional ACMRs from achieving their objectives of instituting relevant country-based studies.

63. In the view of the ACMR, the practical implementation of relevant research programmes at country level depended not only on the availability of resources but also on effective communication. It suggested that efforts should be made to achieve better interdigitation between national research priorities and those of WHO at regional and global levels. Certain projects could be funded partly by WHO and partly by Member States, while others could usefully benefit from experience acquired at interregional level.

64. The ACMR also discussed research career structures, including a recommendation that, rather than promote research career structures per se, WHO should support research activities as a basic component of health plans and programmes. In the discussion, it was stressed that the problem of research opportunities and research career structures was essentially a national one and that careers in research could not be viewed separately from careers in other government services and institutions. The general view was that appropriate systems of peer approval and provision of opportunities for young scientists to interact with colleagues were stimuli to research workers.
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<td>Diarrhoeal diseases</td>
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<td>Health services research, with particular reference to social science and operational research</td>
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<td>Ethical review of investigations involving human subjects</td>
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<td>Acute respiratory infections</td>
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<td>Biomedical research methodology</td>
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65. In 1980 a subcommittee of the South-East Asia Regional ACMR was set up to review research priorities and identify research needs in relation to the goal of health for all by the year 2000 with primary health care as the key approach. In November a consultative meeting was held in New Delhi on ways for encouraging health promotion research, and plans were made to develop social services research in relation to health. To further the implementation of the diarrhoeal diseases research programme, a scientific working group was set up in the Regional Office to consider operational research studies. Research methodology courses, both of a general nature and on specific subjects, were conducted in several countries of the Region with a view to developing research capability.

66. Under the auspices of the Eastern Mediterranean Regional ACMR a study was undertaken in Bahrain, Egypt and Yemen - due for completion in 1981 - on the perspectives and requirements for achieving effective health service coverage by the year 2000. The study is concerned with identifying what predicts whether or not a health service delivery system is a good one. In May-July, the Regional Office for the Eastern Mediterranean, in collaboration with the University of Nottingham, United Kingdom, organized a course in Nottingham on community medicine and health services research. In September the Regional Office convened a consultation on research management.

67. In October the Regional Office for the Western Pacific organized a national workshop on health service research at the Korean Health Development Institute, Republic of Korea.

Global eradication of smallpox

68. The story of smallpox eradication provides a shining example of how the countries of the world can work together in research and in action to combat a menace to health. The last case of endemic smallpox occurred in Somalia in October 1977. Continuing surveillance in the Horn of Africa and elsewhere in the world has confirmed that the world has been free from endemic smallpox for the last three years.

69. On 8 May 1980 the World Health Assembly proclaimed the global eradication of smallpox and adopted a resolution expressing its deep gratitude to all nations and individuals who had contributed to the success of this programme, calling the attention of all nations to this unprecedented achievement in the history of public health, which demonstrates how nations working together may change the world for the better, creating a hopeful new impetus towards health for all by the year 2000. The proclamation was based on the report of the Global Commission for the Certification of Smallpox Eradication, an independent body of 21 experts from 19 countries who evaluated the evidence that eradication of smallpox had been attained throughout the world.

70. The Health Assembly adopted the recommendations of the Global Commission concerning future policies and further research designed to ensure permanent freedom from the disease. The Commission concluded that smallpox vaccination is no longer justified except for investigators at special risk and that international certificates of vaccination against smallpox are no longer required. But it stressed that vaccine stocks sufficient to immunize 200 million people should be maintained and regularly tested for potency. Suspected cases of smallpox will continue to be reported and all such reports should be thoroughly investigated. A special surveillance and research programme on human monkeypox and other important orthopoxvirus infections should be continued. Adequate security and control should be maintained in laboratories retaining stocks of variola virus.

71. The Global Commission concluded that monkeypox virus does not constitute a threat to the permanence of smallpox eradication, but recommended that research and surveillance should continue. The collection of material for laboratory investigation, as well as information aimed at determining the natural reservoir of monkeypox, continued throughout 1980. Although monkeypox-specific antibodies have been found in sera of some non-human primates, the natural reservoir of the virus remains unknown, so research is continuing. A workshop to develop a surveillance system for monkeypox and haemorrhagic fevers was conducted in Brazzaville in April-May 1980, in which scientists from 13 African countries participated. Laboratory studies on the genetic structure of orthopox viruses are also continuing.
72. During 1980, 26 rumours of smallpox were investigated either by WHO, by national authorities or by joint WHO/national teams in various parts of the world. The results of the investigations, which showed that none of the reports were due to smallpox, reinforce the credibility of global eradication. At the end of 1980, six laboratories retained stocks of variola virus: one each in China, the Netherlands, South Africa, the United Kingdom, the United States of America and the USSR. All were inspected by WHO teams, and safe measures for storing or working with variola virus were ensured. At the end of the year, a total of 66 million doses of vaccine were being stored in WHO repositories in Geneva and New Delhi, and donations exceeding 35 million doses were outstanding from pledges. There were also at least 102 million doses in national vaccine reserves of 30 individual countries. Smallpox vaccination was no longer obligatory in 78 countries. An international certificate of vaccination against smallpox was still required by Chad and Democratic Kampuchea.

World Health Day

73. Whereas smallpox has been eliminated through international and national action, there are some health problems, such as smoking, that need something in addition, namely action or decisions on the part of individuals. Indeed, the goal of health for all by the year 2000 will never be achieved unless communities and individuals become fully health conscious, that is, become aware of obstacles to health and how those obstacles can be overcome. Individuals need to be encouraged to adopt healthy lifestyles with regard, for instance, to smoking, alcohol consumption, and the excessive use of drugs, for medical or other reasons. Such encouragement in respect of smoking was offered by World Health Day, 1980.

74. The theme of World Health Day (7 April) was "Smoking or health - the choice is yours". WHO's information kits and a documentary film exposed the strategies adopted by the tobacco industry to transfer high-pressure sales techniques to developing countries (there is some parallel with the activities of the drug and infant formula industries in this respect), as sales have levelled off in developed countries. UNCTAD estimates that the industry spends US$ 2000 million per annum on cigarette advertising and promotion.

75. Following WHO's lead, many Member States began aggressive national education campaigns - frequently for the first time, and often supported by nongovernmental organizations and civic groups - and awareness of the man-made smoking epidemic spread worldwide. A number of governments responded to the heightened public awareness of the problem by launching programmes and introducing legal and administrative curbs on smoking. These measures dealt particularly with the production, advertising, promotion and sales of cigarettes. Information reaching WHO from many sources confirmed that the theme of World Health Day 1980 was a decisive spur to action. The Annex to this report gives details of selected measures in various countries, and shows the remarkable extent to which countries responded to the call of World Health Day.

Development of comprehensive health services

76. If the Organization's objectives are to be achieved, every country in the world must now take steps to provide primary health care accessible to all its population, shifting resources and decision-making powers from the centre to the periphery, and devoting less of the health budget to costly, sophisticated, irrelevant technology and more to appropriate technology and preventive and health-promoting behaviour programmes. In 1980, WHO's endeavours in promoting the development of comprehensive health services were largely directed to such ends.

77. Primary health care. During the year the countries of the African Region showed a growing interest in primary health care. In collaboration with WHO, several countries (including Benin, Burundi, Congo, Gambia, United Republic of Tanzania, Upper Volta and Zambia) formulated their national action programmes for primary health care, and several others were in the process of doing so. These programmes take into account the national resources involved and the external contributions required.
78. In the Region of the Americas, much emphasis was placed during 1980 on the promotion of technical cooperation activities in primary health care. Costa Rica, Jamaica, Mexico and Peru were particularly active, developing comprehensive projects in this area. The Andean Region group of countries participated in a major subregional undertaking on the programming, development and maintenance of health care facilities as a component of the extension of health services coverage; this undertaking involves technical cooperation in programme development at the national and subregional levels.

79. In October, the Regional Office for South-East Asia convened an expert group meeting on teamwork and its role in the provision of primary health care. The participants were WHO staff members and national colleagues involved in health teams and teamwork, planning, implementation and evaluation. The meeting examined the main issues likely to promote the development of teamwork in primary health care services, the various existing models and their possible application in the Region. The aim of the meeting was to enable the Regional Office to offer Member States recommendations concerning the elaboration of national policies for the coordination and strengthening of primary health care resources and activities. Further meetings will follow at country level to work out details of training programmes for teamwork and the allocation of tasks to specific members of each health care team.

80. In the Eastern Mediterranean Region, Democratic Yemen, Pakistan and Yemen completed the formulation of comprehensive primary health care programmes and took the initial steps in their implementation. Somalia and Sudan put their primary health care programmes into operation. UNICEF and WHO are fully involved in the programme in Somalia, which includes the training of large numbers of primary health workers recruited in the communities that they will serve. Community acceptance of the ADB- and UNICEF-supported programme in Sudan was demonstrated by local willingness to construct and equip the new primary health care units.

81. In the Western Pacific Region, a national workshop on primary health care was held in the Trust Territory of the Pacific Islands. In the Philippines, the primary health care research project at Tacloban, Leyte, became part of a wider process to improve the health care delivery in one region of the country. WHO collaborated with the Government of the Philippines and with ESCAP in an integrated rural development project in Pangasinan Province. National workshops on the nursing aspect of primary health care took place in Papua New Guinea, the Philippines and the Republic of Korea. Training courses in primary health care started in China; three of these courses were held in 1980 at primary health care centres located in three rural counties being used as pilot areas for such training.

82. A major concern of WHO and UNICEF has been how the principles of primary health care were being put into practice, the constraints and obstacles to the formulation of national policies, strategies and plans, and the means for overcoming them. In 1979-1980 UNICEF and WHO undertook a joint study to elucidate these critical issues. This study, entitled "Country decision-making for the achievement of the objective of primary health care", was of direct use to the participating countries (Burma, Costa Rica, Democratic Yemen, Finland, Mali, Mozambique and Papua New Guinea) individually and as a means of exchanging experiences; in addition, it will be of use to the international community as a whole. In October, a meeting of the principal investigators and others consolidated and synthesized the country experiences. In several of the countries the process of carrying out the study had a useful promotional effect and made an impact on the way in which policy decisions were made.

83. Means used to further national policies, strategies and plans included numerous interregional, regional, intercountry and national workshops and seminars held with the aim of mobilizing staff. Perhaps of greater consequence were the preparatory and post-workshop activities undertaken in the individual countries by teams comprising representatives of the health sector and other sectors such as education, agriculture, public works and information. UNICEF representatives and WHO programme coordinators were active in promoting this multisectoral collaboration, and the staff of the two organizations often participated in the country teams. Technical modules were developed to help country teams address various issues and also to provide them with information that might be useful in activities prior to workshops, during the workshops themselves, and in the follow-up activities in countries.
84. One workshop of this kind was the joint UNICEF/WHO workshop on primary health care that was held in March at Nampula, Mozambique, for English-speaking participants. It was attended by nationals from the health sectors in Botswana, Ethiopia, Gambia, Lesotho, Mozambique, Nigeria, Swaziland, Uganda and the United Republic of Tanzania. The main aim of the workshop was to develop in the countries a common understanding of the concept and activities of primary health care, to study the possible points of entry for introducing primary health care into other development activities, and to promote collaboration at country level among the various sectors and agencies involved in planning for primary health care. One important product of the workshop was a set of recommendations on priorities, strategies and feasibility, multisectoral coordination, indicators and TCDC.

85. In February, a UNICEF/WHO interregional workshop on the community health worker took place in Kingston, Jamaica. The workshop was part of a study: nearly a year previously, a background document containing a set of 15 issues and questions was sent to principal investigators in 13 countries in all the WHO regions. An analysis of the responses, carried out by the participants themselves, served as the basis of the workshop, attended by the principal investigators. The outcome was twofold: a set of recommendations based on agreed principles relating to the selection, training, functioning and support of community health workers; and follow-up activities in connexion with further in-depth study or the gathering of additional information on this important topic.

86. An interregional workshop on primary health care, supported by UNICEF and WHO, was held in Chiang Mai, Thailand, in June. Case studies of important primary health care projects in two countries of each of the two regions concerned (South-East Asia and Western Pacific) were discussed in the workshop as examples for sharing experience in the implementation of primary health care in developing countries.

87. WHO and UNICEF, in collaboration with other agencies in the United Nations system and intergovernmental and nongovernmental organizations, undertook activities relating to the cost and financing of primary health care. With the cooperation of 16 participating countries in all the WHO regions, information was collected on country experience in this field. Following the country studies, an interregional workshop held in Geneva in December considered country reports that gave costings of the major components of primary health care programmes and schemes and described methods or patterns of financing. Quite apart from providing up-to-date information on the present situation and on countries' concern for the future, this activity had a catalytic effect, mobilizing financial and technical support from international and regional agencies and nongovernmental organizations.

88. Over a period of 18 months, information was gathered on national experiences of malaria control as a constituent of primary health care, particularly in China, Costa Rica, Cuba, India, Thailand and Viet Nam. An informal meeting on this topic was held in Washington, D.C. in July, and a paper outlining the experiences of the six countries was presented at the Seventh Asian Malaria Conference in Manila in November. The experiences demonstrate the possibility of integrating malaria control into the health system under a variety of political, economic, epidemiological, social and cultural conditions. It was shown that the effective planning, implementation and evaluation of malaria control activities within the framework of primary health care requires a nucleus of malaria experts with the ability to determine malaria strategies in keeping with local conditions as well as political and economic factors; this nucleus must be linked with the health services system.

89. Interagency action for rural development was undertaken. WHO pursued its collaboration with the ACC Task Force on Rural Development, including participation in a five-country evaluation study. This is a continuing activity aimed at strengthening a collaborative approach to rural development among agencies, particularly at the country level. During 1980 the focus was on the reassessment of joint activities with a proposal for a programme of work based on the reassessment and on an agreed plan of action for agrarian reform and rural development.
90. WHO's policies regarding health care are not only applicable to developing countries: they are equally relevant to conditions in the developed countries. Politicians, health administrators and others in some of the richer countries of the world are now realizing the impossibility of meeting the spiralling costs of health technology and are seeking more rational ways of using resources to provide health care for the people. In the European Region, WHO is maintaining close contact with the Italian health authorities during the implementation of the National Health Service Law, in order to facilitate the exchange of experience between Italy and other countries. The new national health service, based on the national health plan for 1980-1982, came into operation on 1 January 1980.

91. The overall objectives of the Italian plan are to improve the health care provided, to contain costs, and to reduce the differences in health resources and coverage among the regions. The service is financed by a national fund for health, based on the contributions which the population has hitherto made to the various health insurance systems. The Bank of Italy has a role in managing the national fund. The distribution of the financial resources among the different regions is based on the size of the population and local health indicators relating to children, workers, and old people. Equity among the regions will be achieved by stages over six years. The setting of priorities contributes to the attainment of equity by facilitating greater efficiency in the regions, thus liberating resources that can be assigned to less favoured areas and groups. The changes initiated in Italy take into account various themes advocated by WHO: primary health care, community participation, intersectoral cooperation, decentralization and regional equity.

92. During the meeting of the Regional Committee for Europe in October, technical discussions were held on "The problems of medical technology", with particular reference to the development, assessment and utilization of medical technologies; education and training; professional and public attitudes; and future trends in technology in the context of health for all by the year 2000. Various views were put forward on the value of centralized as opposed to regionalized technology assessment procedures. It was stressed that each country would have to choose assessment measures closely adapted to its own health care system. It was also apparent that the question of cost would have to be closely investigated in relation to functions. The conclusions reached at the discussions included the following:

- It is essential to develop national medical technology policies.
- There is a clear need for national or regional centres which would undertake comprehensive assessments of medical technology, including analyses of safety and efficacy, as well as economic, social and ethical issues.
- Cost-effectiveness and cost-benefit analyses of current and developing medical technologies are worthwhile and should be supported, and above all a concept of general cost-consciousness should be developed in all parties concerned.
- The results of assessments should be disseminated to the practising and scientific communities and others concerned.
- Utilization studies should be conducted and adverse effects be reported.
- Adequate graduate, postgraduate and continuing education of all those involved (physicians, scientists, technicians and other health care personnel) should be planned and implemented.
- Balanced information should be provided to the public.
- WHO should coordinate the activities of national assessment networks and, whenever possible, also act as a clearing-house for information on medical technology.

93. Maternal and child health. In the Region of the Americas, under an agreement between PAHO/WHO and the W. K. Kellogg Foundation, the Organization began in 1980 coordinating and
participating in a major maternal and child health programme financed in part by the Foundation (to the extent of US$ 4.1 million). Through the three-year programme (1980-1982) PAHO/WHO is seeking to develop an expanded network of family health projects in Latin America. The aim is to improve and increase the coverage of services, extending them to underserved populations. The PAHO Latin American Center for Perinatology and Human Development, located in Montevideo, will be deeply involved in the programme; it will develop models for maternal and child health care in two states of Uruguay, utilizing advances in appropriate technology developed by the Center. A second part of the programme will deal with the dissemination of scientific information and the production of education materials. A third part will involve the creation of a network of national subprojects combining the provision of services, teaching, and research in maternal and child health. The programme is an enlargement of a joint programme begun with the Foundation in 1974 in Brazil and Colombia.

In the Eastern Mediterranean Region, the maternal, child and family health project jointly sponsored in Somalia by UNFPA and WHO made such good progress in the project area that it was decided to extend it to the whole country. The project area includes the city of Mogadishu, three agricultural and seminomadic districts and a resettlement area with a total population estimated in 1979 to be about 700,000. From January 1979 to August 1980, the number of maternal and child health centres in this area increased from 13 to 20 and the number of public health nurses/midwives from 33 to 52. Five of the seven new centres were started in villages and nomadic areas and five of them were built by the community. The furniture for the rural units was also provided by the community. Home visiting by public health nurses/midwives has been greatly increased, and families are encouraged to approach the centres for treatment in case of sickness. By the end of 1980, about 10,000 families had been registered for integrated care, and some 90% of the children in these families had been immunized. Integration of health services is gaining momentum. All registered pregnant and nursing women and severely and moderately malnourished children are given food supplements provided by WFP. Nurses organize nutrition demonstrations and give talks on health and nutrition at orientation centres. Health education has also become a regular feature of life.

In the Western Pacific Region, a WHO working group met in Manila in March to discuss and recommend programmes for bringing about improvements in the health care of adolescents. Experts from 10 countries (Australia, China, Japan, Malaysia, New Zealand, Papua New Guinea, Philippines, Republic of Korea, Singapore and Viet Nam) also identified the types of research, training and service intervention for meeting these health needs. The importance of adolescents in terms of physical, psychological, economic, social and political factors was stressed. In urbanizing societies, they constitute a specific group with certain identifiable characteristics, needs and problems. Psychologically, adolescence represents the most vulnerable phase of the life cycle. The stress of rapid technological development and social change must be held largely responsible for the alarming increases in accidents, drug and alcohol abuse, sexually transmitted disease and unwanted pregnancies, psychological problems and suicide among young people. It was acknowledged that adolescence represents the last great chance for change, and provides a golden opportunity to set things right, to practise preventive care and thus influence the health and well-being of adults in the future. Less research had been undertaken on this age-group compared with other age-groups and little teaching had been provided in relation to the needs and problems of adolescents. The working group formulated recommendations to WHO and to governments on this subject.

In May the World Health Assembly endorsed in their entirety the statement and recommendations made by the joint WHO/UNICEF Meeting on Infant and Young Child Feeding, held in Geneva in the previous October. These included the encouragement and support of breastfeeding; the promotion and support of appropriate weaning practices; the strengthening of education, training and information; the promotion of the health and social status of women in relation to infant and young child feeding; and the appropriate marketing and distribution of breastmilk substitutes.

During 1980 WHO intensified its activities for promoting the application of these recommendations, and specific global and regional plans were made. For example, a three-year programme was developed in the African Region (already operative in Angola, Ethiopia, Madagascar, Nigeria, Senegal and Sierra Leone) for collaboration in national activities with the aim of improving maternal nutrition, safeguarding breastfeeding, and ensuring the better
use of local foods during the weaning period. A national workshop on the status of women and their role in improving child care, especially breastfeeding, was held in July in Ghana, with the collaboration of the Ministry of Health and the United Nations University. In the Region of the Americas, national and subregional workshops were held on the subject of breastfeeding. In the European Region, WHO continued to collaborate with the Swedish National Board of Welfare, and a task force was established in Sweden to examine the question of guidelines for the export of infant foods, and infant food technology. In the Eastern Mediterranean Region, UNICEF supported studies on infant feeding practices in the Gulf States, and WHO laid stress on the importance of breastfeeding as part of ongoing maternal and child health activities. In the Western Pacific Region, a national workshop held in Hong Kong in June resulted in the setting up of a task force. Other workshops were held on the occasion of international and regional professional conferences. WHO completed the first phase of its collaborative study on the prevalence and duration of breastfeeding.

98. The Organization participated in interagency bodies concerned with the promotion of adequate weaning. Activities related to weaning were developed as part of the action-oriented research, development and training programme in nutrition, focusing on meeting the nutritional needs of the young child through the use of locally available and acceptable foods.

99. One of the recommendations emerging from the joint WHO/UNICEF meeting was that there should be an international code of marketing of infant formula and other products used as breastmilk substitutes. WHO and UNICEF formulated a first draft of such a code and sent it to all Member States in February, with a request for comments and observations. Based on these comments and the outcome of a series of consultations with interested parties - governments, agencies of the United Nations system, nongovernmental organizations, the infant food industry, and experts - a second draft was prepared for the World Health Assembly in May. In compliance with the decisions and comments made in that forum, a third draft was prepared and discussed at two additional consultations, following which what is now known as the draft International Code of Marketing of Breastmilk Substitutes was elaborated for submission to the Executive Board and Health Assembly in 1981. The Code recommends action to govern the production, storage and distribution, as well as advertising, of infant feeding products. It calls for relevant information in infant feeding to be provided by the health care system. Products should meet international standards of quality and presentation, in particular those developed by the Codex Alimentarius Commission, and their labels should clearly inform the public of the superiority of breastfeeding.

100. The activities described above were carried out not in isolation but as part of the larger programme of family health which focuses on maternal and child health and family planning, including improved infant and young child feeding, healthy child growth and development, and the betterment of the health and nutrition of the family as a whole. The overall programme constitutes an essential element of primary health care, and complements the WHO activities of technical cooperation carried out in collaboration with UNICEF, UNFPA, and other agencies within the United Nations system.

101. Special Programme of Research, Development and Research Training in Human Reproduction. This Programme has four main objectives: strengthening of research capabilities in developing countries; research on the safety of current methods of fertility regulation and development of new methods, on service and psychosocial aspects of family planning care, and on infertility; coordination of world efforts in this field; and dissemination of information to policy makers, service providers, scientists and the public.

102. In 1980 the Programme brought together in collaborative research and institution-strengthening the talents, skills and resources of scientists and administrators from 82 countries, 55 of them developing countries. During the year, in response to requests from Member States, there was a considerable increase in collaboration in strengthening national capabilities for research in family planning; this included major collaboration in institution-strengthening and research in China. Based on the results of studies completed in 1980 in the Special Programme’s network of collaborating centres, guidance is now available to health authorities on the relative safety and efficacy of different oral contraceptives, intrauterine devices, procedures for sterilization, and national family planning methods.
103. Arrangements were made for the large-scale manufacture of the vaginal ring, a new contraceptive device developed by the Special Programme. Also in 1980, the chemical synthesis programme begun in 1976 continued, and by the end of the year a total of about 250 new compounds had been prepared in university and government laboratories in Australia, Brazil, Bulgaria, Iran, Israel, Mexico, Nigeria, Poland, Singapore, Spain and Sri Lanka. They were screened in small animals by the United States Center for Population Research. Compounds for testing in primates, for larger-scale synthesis and for preclinical toxicological studies were selected in November. The chemical synthesis programme is funded directly by WHO, indirectly by the United States National Institutes of Health through their support of the biological screening, and also indirectly by the participating laboratories, which cover most of the personnel costs. As yet, no new contraceptive agent has emerged from the chemical synthesis programme. Nevertheless, the programme shows promise and is noteworthy as being the first successful example of a multinational cooperative project in this field being established outside traditional pharmaceutical channels.

104. Health service research showed that nurse/midwives, when properly trained, can provide services concerned with intrauterine devices as well as, or better than, physicians. In March, a three-week training course was held in Geneva on health service research in family planning. The participants were senior administrators, public health physicians, epidemiologists, social scientists and statisticians from eight developing countries. Trainees developed protocols for studies to be implemented in their own countries, based on research issues identified by them with the national authorities prior to the course.

105. The Special Programme is the world's largest research training programme in family planning, with an expenditure of US$ 2 million in 1980, including doubling the number of research training grants awarded in 1979, and the holding of several research training courses. It is largely financed by voluntary contributions; in 1980 the donors included Australia, Cuba, Denmark, Finland, Federal Republic of Germany, India, Nigeria, Norway, Sweden, Thailand, United Kingdom, and UNFPA. To quote one regional example only, in the African Region the Special Programme received 61 contributions (30 for research, 28 for research training, and three for institution-strengthening); the total amounted to US$ 104 000.

106. Nutrition. In the South-East Asia Region, WHO supported the development of national food and nutrition policies, nutrition surveillance and training by means of short-term consultancies and seminars. A regional seminar and subsequent national seminars emphasized the importance of integrating nutrition activities within the context of primary health care. The minimal nutrition component of primary health care was identified and guidelines were developed for training primary health care workers in nutrition. Work began on developing a regional strategy for setting up an action-oriented research, development and training programme in nutrition; the mechanisms used were a regional planning meeting followed by consultancy services and specific activities in countries.

107. Action-oriented nutrition research projects were initiated in almost all the countries of the Region, and detailed protocols were reviewed at a regional meeting of principal investigators in New Delhi in November, which undertook a situation analysis of the nutrition component of primary health care. A regional collaborating centre was developed in Bogor, Indonesia, for research and training in vitamin A and iron deficiency anaemia. A nutrition unit was established in Nepal. To train medical and paramedical personnel, national workshops and training courses on nutrition in primary health care were organized in Bangladesh, Mongolia, Nepal and Thailand. Several countries in the Region expressed interest in undertaking research projects on nutrition surveillance; contractual agreements were finalized and protocols developed.

108. At a WHO interregional workshop for trainers of community health workers in nutrition, held in Manila in February, it was stressed that nutrition was a most important aspect of primary health care. Emphasis was laid on the need for involvement and cooperation of the people, the only way by which primary health care could be carried out. Simple and realistic nutrition activities were recognized as constituting a cornerstone of primary health care, since malnutrition is probably the most glaring public health problem in the developing countries. The participants were reminded that WHO had developed simple, task-oriented
training in nutrition for community health workers. The guidelines have been tested by a large number of trainers and the revised form is available for self-learning. The workshop elaborated methods through which such guidelines could be utilized in the light of national experiences. The participants in the workshop came from Bangladesh, Fiji, Greece, India, Maldives, Philippines, Republic of Korea, Sri Lanka, Thailand and Turkey.

109. Health education. In the African Region, the programme of health education continued to be directed towards training the trainers. Courses were given at the Regional Centre for Health Development, Cotonou; the African Regional Centre for Health Education, Ibadan, Nigeria; the WHO regional training centres at Lomé and Lagos; the Faculty of Medicine, Lusaka; and the Higher National Institute of Health Sciences, Brazzaville. With the support of UNFPA, ILO, FAO, UNESCO, WHO and IPPF, four countries in the Region (Benin, Mali, Upper Volta and Zaire) organized national multidisciplinary conference-workshops on subjects related to health education and information of the public. In July the recently created Association of Health Educators for Africa and Madagascar organized an intercountry seminar, attended by nationals from 14 French-speaking countries in the Region, on primary health care and health education and the role of health education in primary health care.

110. Most communities do not give high priority to health. Economic activities, building roads or school houses or producing food are usually considered more urgent. Health workers therefore may have to work in projects other than health in order to link up with or be considered part of community undertakings. It is important for the health services to initiate the move to establish the link with other development projects. However, it does not necessarily follow that the community will participate or get involved simply because of the first steps taken by the health workers. The community has to prepare itself for such involvement. These are among the issues discussed in the technical presentation made on the subject of "Community involvement in the development of health services" during the session of the Regional Committee for the Western Pacific in September. There was reference to case studies of experience in primary health care activities in four countries: China - the cooperative medical service; New Zealand - the Porirua community health project; the Philippines - the Carigara (Leyte) experiment; and Samoa - women's committees.

111. Health problems were stated to be formidable and complex; by focusing attention on the community and attempting to shift it from its passive role of compliance to one of active partnership, governments are following a logical approach. Only full partnership between the community and health professionals will give the necessary dynamism to health care systems. Ideally, community involvement starts with the individual who learns that he can exercise some control over his own health. This leads to community awareness of health and diagnosis of health or health-related problems. At this stage technical and managerial support can come from outside the community to develop activities that will link up with government programmes. The key to the process is individual awareness and community action. Practical ways for developing community involvement were considered, but it was stressed that each community or society is unique and suitable approaches must be selected in each case in accordance with local conditions.

112. Mental health. The integration of mental health components into general health care is an essential part of the strategy of WHO's mental health programme. To achieve this integration and evaluate its effects, adequate assessment methods are needed. The Organization therefore initiated a project in which seven countries collaborated to develop new and adapt existing methods and techniques of monitoring the mental health needs and resources at community level; these were Bulgaria, Ghana, Kuwait, Panama, Papua New Guinea, Thailand and the United States of America. The objective was to identify all health, social and other services in well-defined communities with which mentally disturbed patients may have contact, to develop means for recognizing and recording characteristics of such patients that are relevant to the planning, monitoring and evaluation of mental health programmes, and to link this information with sociodemographic and socioeconomic data on the general population. The year saw the successful conclusion of the project; the collaborating investigators met to review achievements, exchange ideas on how to establish routine monitoring systems within their own countries, and agree on ways to disseminate information on the project's methodology and encourage other countries to undertake similar work. As a follow-up, a new project was
initiated in 1980 to assess the usefulness of multiaxial recording and reporting of physical, psychological and social components of reasons for primary health care contacts. Centres in countries in all WHO regions agreed to participate in this project.

113. At the same time, another collaborative activity was under way, aiming to develop and test technology for the management of mental health problems at the primary care level.1 The first phase of this study involved an epidemiological assessment of the study areas and the design of training courses for general health personnel. In 1980 the intervention phase took place, and investigators from seven countries (Brazil, Colombia, Egypt, India, Philippines, Senegal, Sudan) met early in the year to map out the final phase. The study is designed to investigate the extent of mental health problems in selected communities, the community reaction to mental disorders, and the possibility of providing basic mental health care for the millions of mentally ill people who today receive no effective treatment.

114. There is worldwide concern about the consequences of the increasing consumption of alcoholic beverages. WHO compiled an international review of the situation, based on a literature survey and contributions from more than 80 countries. The review was used as a background document for the meeting of a WHO Expert Committee2 and also for a WHO project on community response to alcohol-related problems, which involves the collaboration of Mexico, Scotland and Zambia. Reports drafted on the experience in each country, as well as an international report, will be used for discussions of the implications with national authorities. Additional countries will be invited to embark on similar action-oriented projects.

115. In May the World Health Assembly discussed the abuse of narcotic and psychotropic substances and advocated that drug abuse control should be integrated in primary health care programmes. During the year WHO published the results of its study on drug programmes in the sociocultural context.3 In collaboration with investigators from developing and developed countries, case studies were conducted at country level, followed by an analysis of common factors and differences among drug use patterns in the various countries; different approaches to the management of drug dependence were identified and sociocultural considerations were found to be of central importance in selecting the health care approaches likely to achieve the desired results. Case studies were also selected as a method of work in a major study aiming to identify different country approaches to the prevention of drug dependence; here too, preliminary analyses demonstrated that sociocultural factors must play a determinant role in selecting action strategies. In 1980 WHO issued the following publications on research and reporting on the epidemiology of drug dependence, all in the WHO Offset Publication series:

No. 50. R. G. Smał et al. A methodology for student drug-use surveys.
No. 52. Lloyd D. Johnston. Review of general population surveys of drug abuse.
No. 55. I. Rootman & P. H. Hughes. Drug-abuse reporting systems.
No. 56. P. H. Hughes et al. Core data for epidemiological studies of nonmedical drug use.

116. Prophylactic, diagnostic and therapeutic substances. Within the framework of its action programme on essential drugs, WHO cooperates with Member States in formulating drug policies and management programmes that are relevant to the health needs of populations and aimed at ensuring permanent access of the whole population to essential drugs at a cost the country can afford. During 1980 the process begun in 1977 continued and the subject of essential drugs was discussed by regional committees and by working and study groups with the full participation of Member countries, emphasis being placed on national drug policies and technical cooperation, especially among developing countries.

117. A consultant visited several countries in the African Region and worked for six months on a programme of essential drugs, summarizing current views and concrete proposals on this subject. A national list of essential drugs was established in about 30 countries in the Region. On this basis, a provisional regional list was drawn up and circulated to Member States, of which 32 out of 43 approved it. In March the programme was discussed at subregional meetings. In June a delegation from ECA visited the Regional Office to define the spheres of technical cooperation between ECA and WHO. The following activities were identified for drug policy and management: feasibility study of materials available in the Region; feasibility study on various aspects of pharmacy, to facilitate the establishment of pharmaceutical industries; cooperation between ECA, UNIDO and WHO in establishing pharmaceutical factories and inspection laboratories; and cooperation with ECA in the programme of joint purchasing of drugs.

118. In the South-East Asia Region, WHO developed a programme on drug policies and management for cooperation with countries in strengthening their pharmaceutical supply systems for essential drugs. Indonesia and Thailand benefited from cooperation of this kind in regard to their primary health care programmes. In these two countries WHO was also active in the establishment, through the ASEAN mechanism, of a task force for TCDC in the field of drug legislation, evaluation and quality control. Related activities were undertaken in other countries of the Region: Bangladesh (as regards pharmaceutical technology in a recently established unit for the production of essential drugs), Burma (UNDP/FAO/WHO collaboration in strengthening the food and drug control administration and drafting the necessary rules and regulations), India (as regards establishing a national control laboratory in connexion with the testing of oral poliomyelitis vaccine, now prepared by the Haffkine Institute), Mongolia (in the planning of a production unit for biologics), Nepal (in collaboration with UNDP and the Government of the Netherlands, a primary health care project with emphasis on the production, procurement, distribution and utilization of modern and ayurvedic drugs), and Sri Lanka (with regard to setting up a formulation unit for manufacturing essential drugs for primary health care, to strengthening national quality control, and to manpower development).

119. In October an intercountry meeting on drug policy and management, held at the Regional Office, identified problems, constraints and strategies in regard to pharmaceutical supply systems in the countries of the South-East Asia Region and defined WHO's role in promoting national self-sufficiency in this field.

120. In the Western Pacific Region, a revised draft memorandum of agreement for establishing the South Pacific Pharmaceutical Service was drawn up and sent to potential participating countries for comments. A subregional workshop on drug quality control and management was held in Kuala Lumpur in February-March attended by participants from China, Malaysia, Philippines, Republic of Korea, Singapore and Viet Nam. In April a task force conducted a feasibility study on the implementation of seven identified areas for technical cooperation in pharmaceuticals among the ASEAN countries.

121. It is evident that conflicts can arise between the concepts of social justice and the public interest on the one hand, and the commercial interests of the pharmaceutical industry on the other. WHO continued its efforts to minimize these conflicts by meeting with 40 pharmaceutical companies to explore mutually acceptable avenues of cooperation. In addition, WHO participated with the pharmaceutical industry in joint fact-finding missions to assess country needs for essential drugs in support of national health services in Burundi, Rwanda, Somalia and Yemen.
122. During the year WHO participated in the activities of the United Nations interagency task force for the development of the pharmaceutical programme for the non-aligned and other developing countries. A further interagency activity in this field was the informal consultations held with UNICEF with a view to developing a joint UNICEF/WHO programme on the provision of essential drugs for primary health care to the less developed countries.

123. The revision of the International Pharmacopoeia continued, and during the year work was completed on the second volume of the third edition, containing monographs on 120 active substances selected from the list of the most widely used essential drugs, especially those important in primary health care.

124. The Organization pursued its policy of transfer of technology by formulating international requirements for the production and control of vaccines such as those against rabies, hepatitis B and rubella, as well as updating the requirements for the vaccines against pertussis, diphtheria, tetanus and poliomyelitis.

125. WHO cooperated with Algeria, Burma, Nepal, Pakistan and Papua New Guinea in field operational studies on the establishment of peripheral laboratories. In this joint exercise, WHO and the government concerned study all the operational aspects of the establishment of peripheral laboratories, identifying problems and alternative solutions for them. Emphasis is placed not only on the establishment of small peripheral laboratory units to serve primary health care delivery and disease control, but also on the operational strengthening of intermediate and central laboratories essential for the functioning of peripheral units. In 1980 WHO also published a 487-page Manual of basic techniques for a health laboratory.

126. Traditional medicine. Three WHO collaborating centres for traditional medicine were designated in 1980, located in China, India and Mexico. Others were in the process of being established, in Ghana, Mali, Nigeria (2) and the United States of America (2).

127. WHO organized two training courses on acupuncture in China, in September-November, funded by UNDP. The first was a French-language course, held in Shanghai, and attended by 15 participants from the African Region. The second was an English-language course, held in Nanking, and attended by 20 participants from the African, South-East Asia and Western Pacific Regions.

128. Literature on the administrative aspects of traditional medicine in relation to official health services is very scarce. To help bridge this gap, a handbook designed for use by health administrators and health workers was developed. The handbook, intended for issue in 1981, attempts to review the main concepts and systems of traditional medicine in selected countries, reviews current legislation on the subject around the world, and suggests procedures that might assist administrators wishing to extend their health services by making fuller use of traditional healers and indigenous health care systems.

Disease prevention and control

129. During the year WHO's activities in the field of disease prevention and control were reoriented in the context of primary health care. There is a shift away from the traditional containment campaigns directed against single disease entities, towards sharper epidemiological surveillance with problem-oriented approaches within the framework of technical cooperation. Interlinking with WHO's other major programmes is being improved. Also, the Organization is contributing to the planning, implementation and evaluation of communicable disease programmes as an integral part of national health services based on primary health care.

130. Epidemiological surveillance. In the Eastern Mediterranean Region, field work was started on the epidemiological surveillance of communicable disease in Somalia - in Merka, a regional capital, where the last case of smallpox in the world was registered, and cured, in October 1977. This activity will be extended to cover a representative sample from the
population of all regions of Somalia. After implementation of the initial phase, in which WHO consultants will join, a Somali sanitarian will be assigned to each of the 16 regions of the country for follow-up after completion of the phase of operations. The project, financed by WHO and UNDP in the total amount of about US$ 824 000, aims at helping the Government in its efforts to control communicable diseases, one of the national goals of Somalia. This project, through the provision of data on the occurrence of these diseases in various parts of the country, can contribute largely to scientific planning for communicable disease control. Also, through the establishment of continuous surveillance activities, the project will help in the early identification of changes in disease occurrence and hence early intervention for implementation of control measures.

131. A regional workshop on the teaching of epidemiology was held in Manila in October-November. It was supported by the Special Programme for Research and Training in Tropical Diseases and included a promotional effort to integrate population-based studies into the curriculum of postgraduate medical students in particular. The workshop was attended by 22 participants, mainly from departments of epidemiology, community medicine or preventive medicine in the Western Pacific Region. Other topics discussed were the roles and functions of epidemiologists, manpower needs and the development of teaching material.

132. During the year WHO strengthened its epidemiological surveillance team in the South Pacific, stationed in Suva. There are now two epidemiologists, one entomologist and one microbiologist covering the needs of more than 10 countries or areas.

133. Malaria action programme. In the African Region, consultant teams from intercountry projects contributed to the development of antimalaria programmes in nine countries, analysing the general situation, and planning activities, the training and recycling of personnel, and the dispatch of supplies and drugs. Antimalaria training was given to 21 health workers at the training centre at Lagos and to 44 at the regional health development centre in Cotonou.

134. The Organization, in collaboration with the National University of Benin, Cotonou, organized a course for 11 nationals from French-speaking countries on the in vitro testing of *Plasmodium falciparum* sensitivity to 4-aminoquinolines. In collaboration with USAID, a support strategy was developed for antimalaria programmes in Africa (vector control, early treatment of disease, prevention in vulnerable groups). In this connexion two conference-workshops and an information tour were arranged in seven countries (Congo, Kenya, Senegal, Sierra Leone, Togo, United Republic of Tanzania and Zaire).

135. During its thirtieth session the Regional Committee for Africa studied the overall strategy for malaria control, recognized the need to reorient national and regional strategies, and invited Member States to formulate their national strategies accordingly.

136. The Regional Office for South-East Asia issued an up-to-date guide \(^1\) to the diagnosis and management of acute malaria. This publication, which is particularly useful to staff of peripheral health institutions, has been in great demand.

137. In the European Region, the gravity of the malaria situation in Turkey continued to cause concern in 1980. UNDP and WHO set up a special intercountry project in 1978 to meet the challenge of resurgent malaria in south-east Europe, particularly in view of vulnerability and receptivity to the disease in several countries. To establish effective coordination of these antimalaria activities, WHO, in collaboration with UNDP and the Government of Bulgaria, held a meeting in Sofia in March. The participants included representatives from Bulgaria, Greece, Turkey and Yugoslavia (the countries in the project), as well as the Syrian Arab Republic.

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\(^1\) World Health Organization. *The clinical management of acute malaria.* New Delhi, 1980 (WHO Regional Publications, South-East Asia Series, No. 9).
138. In two of the countries (the Syrian Arab Republic and Turkey) malaria outbreaks have been occurring since 1976; while the epidemiological situation seems gradually to have improved, malaria transmission continues in several areas. Major efforts are directed to attack operations in order to reduce the endemicity level in active foci, whereas surveillance activities are performed in areas in the consolidation phase. Malaria eradication was certified in Bulgaria and Yugoslavia in 1965 and 1973 respectively. In Greece, the last indigenous cases occurred in 1975 (two cases) and 1976 (three cases) in villages on the west bank of the river Euros on the Greek-Turkish border. The existence of receptive areas and the increase of imported malaria cases in these three countries, and the persistence of transmission foci in the Turkish border areas close to two of them (Bulgaria and Greece) constitute a serious risk of reintroduction of the disease.

139. The meeting recognized the need for, and feasibility of, closer cooperation and exchange of expertise among the participating countries. It made a series of detailed recommendations concerning vigilance activities, a standard epidemiological information system, the use of immunological screening methods, cooperation with neighbouring Middle Eastern and European countries, training, and logistic matters.

140. WHO cooperated in the assessment of the antimalaria programmes of Democratic Kampuchea, Indonesia, Sri Lanka and the Syrian Arab Republic, and the Plasmodium falciparum containment programme in India. Preparations were made for the development of a malaria training programme in Asia as a cooperative effort of national training centres and WHO; the permanent secretariat established for this purpose will start functioning in Kuala Lumpur early in 1981. A seminar on field applied malaria research and a workshop on quantitative epidemiology held in China, a workshop on the continuous in vitro cultivation of P. falciparum held in the USSR, and courses on the assessment of drug sensitivity in P. falciparum were among the major activities for the strengthening of epidemiological and research capacity. Research remained oriented towards the goal of improving malaria control and yielded significant methodological progress in the testing of drug sensitivity.

141. Information on national experiences in the area of primary health care and malaria control was gathered over 18 months by various means, including the holding of an informal meeting on this subject in the Regional Office for the Americas in July. A paper was prepared outlining the experiences of six countries (China, Costa Rica, Cuba, India, Thailand and Viet Nam). This paper was presented at the Seventh Asian Malaria Conference in Manila in November, and also at other meetings, including those convened for the joint mobilization of WHO and UNICEF staff (see also para. 25).

142. The Malaria Conference provided a forum for exchanging views on technical and other aspects of malaria control. Senior malaria and health workers from 27 countries in the South-East Asia, Eastern Mediterranean and Western Pacific Regions participated in the discussions. The Conference reviewed the current status of malaria in Asia, examined the role of malaria control within the strategy of health for all by the year 2000, considered immediate requirements for orientation and training in malaria control, reviewed recent advances in malaria research, and identified priority areas for research. The Conference recommended that malaria control should be maintained as a priority, in accordance with the strategy advocated by the World Health Assembly.

143. Parasitic diseases programme. Praziquantel is a newly developed antischistosomal compound that is not structurally related to previously used drugs active against human schistosomes. Following preclinical parasitological, pharmacological and toxicological studies and also double-blind studies of tolerance in healthy volunteers, the manufacturers suggested in 1975 that WHO might wish to cooperate in further research and development. This cooperation led to the use of standard clinical trial designs and agreed technical protocols, the parasitological techniques of which varied with the species of infecting

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1 Praziquantel is the international nonproprietary name of EMBAY 8440; Biltricide R; 2-(cyclohexylcarbonyl)-1,2,3,6,7,11b-hexahydro-4H-pyrazino[2,1-a]isoquinolin-4-one. It is a product of joint research by E. Merck, Darmstadt, and Bayer AG, Leverkusen, Federal Republic of Germany.
parasite. Coordinated by WHO and IARC, multicentre investigations of mutagenicity were carried out with respect to various biological systems. Next, double-blind assessments of tolerance and efficacy of three oral dose schedules against Schistosoma haematobium, S. mansoni and S. japonicum were conducted as a multicentre clinical trial in Brazil, Japan, the Philippines and Zambia, with extremely promising results. Many more clinical centres in Africa, South America and Asia then undertook trials of the efficacy of a wider dose range, using quantitative parasitological techniques. In 1980 field trials, also based on a common design, were nearing their final stages. This type of close professional cooperation with the pharmaceutical industry constitutes a useful model for initial clinicopharmacological studies and provides a new approach to research and development.

144. The Blue Nile health project in the Gezira-Managil and Rahad irrigation scheme, Sudan, initiated in July 1979, was further developed in 1980. It covers a population of two million and aims to prevent or control important water-associated diseases (malaria, schistosomiasis and diarrhoeal diseases) by means of a comprehensive multidisciplinary approach. As far as possible, national expertise is being used in the staffing of this project. Chief among the activities undertaken are environmental management, including improvement of the design of the irrigation and drainage system; assistance with operation and maintenance methods; and provision of water supply and latrine systems. The success of the programme will largely depend on the support of villagers — for instance, on their collaboration both in avoiding contact with polluted canal water, and in providing community labour for sanitation and drainage activities. Primary health care is receiving high priority, and the development of surveillance, diagnosis and treatment of water-associated diseases in conjunction with the project will play a key role. In research, the assessment of the impact of health on agricultural productivity is being emphasized. In 1980 both epidemiological investigations and methodologies for the diagnosis and chemotherapy of schistosomiasis were instituted in the project area. Particular attention was given to the irrigation scheme in Rahad, where no transmission of schistosomiasis has yet been found. Guidelines were provided for project staff, and field trials of specific drugs for the treatment of schistosomiasis (oxamnique and praziquantel) were arranged.

145. For financing the project, a donors’ meeting was held in February 1980 in Khartoum. A number of countries, as well as international and bilateral agencies, pledged their financial and technical support. The Blue Nile health project should significantly reduce the prevalence and incidence of schistosomiasis, malaria and diarrhoeal diseases, thus not only improving the health of the population in the areas of the irrigation schemes but also playing a positive role in the agricultural productivity of the area, which is of major economic importance to Sudan.

146. Following the end of the first year of the second phase of the onchocerciasis control programme in the Volta River Basin area, it was established that the extension of spraying in the Ivory Coast had limited reinvasion by the vector. In certain areas, where transmission had been completely interrupted, the infection rate in younger groups — which had ranged from 10% to more than 30% before the programme started in 1975 — came down to zero. These findings indicated that spraying should be further extended in Benin, Ghana, Togo, and to the Senegal River Basin. Epidemiological investigations confirmed that blockage of transmission had persisted. An economic planning course related to this activity was organized at the University of Clermont Ferrand, France, in collaboration with the University of Michigan, United States of America, and was attended by nationals of Benin, Ghana, Ivory Coast, Mali, Niger, Togo and Upper Volta.

147. In recent years WHO, in cooperation with other organizations of the United Nations system (including UNDP, UNEP, FAO and UNESCO) and nongovernmental agencies, has developed a programme on water resources development and health. A major objective proposed at the inception of the programme was the elaboration of a set of guidelines, or a methodology, for the prevention and control of communicable diseases (especially those of a parasitic nature) liable to be introduced or increased in areas where water resources development was planned or was in progress. The original idea was to prepare such a methodology for the prevention and control of parasitic diseases on a global scale, covering situations which could be encountered in all parts of the world. It soon became apparent that this proposal was very ambitious and that a carefully planned regional approach would need to be undertaken.
the components of which could ultimately be integrated to provide for the varied situations encountered in different zoogeographical areas. The requirements of the wide range of users of such guidelines (governments, financing bodies, industry and engineering, public health workers and international organizations) also had to be kept in mind.

148. It was therefore decided to prepare a bibliography on the subject, and at the same time to carry out field surveys in selected areas representative of conditions prevailing in various parts of the world, special emphasis being placed on schistosomiasis, as this disease is typically associated with water projects in developing countries. Two editions of the bibliography have been issued, and at the end of 1980 a completely revised third edition listing 1250 references was nearing completion. Field surveys have been undertaken in Argentina, Brazil, Ghana, Ivory Coast, Paraguay and Venezuela, and in South-East Asia. Future plans include the preparation of guidelines on essential steps in the planning, construction and operation of water development schemes to avoid or minimize the introduction or spread of major communicable diseases, and investigation of the effects of small water impoundments on health, especially in Africa.

149. Leprosy. There are over five million cases of leprosy in the South-East Asia Region. In Bangladesh, WHO provided advisory services relating to training programmes and to evaluation of operational and epidemiological aspects of the control programme. In Burma, the rifampicin trial continued, including the treatment of open cases in the field; WHO cooperated in the BCG cohort study; and a field study was started to assess the prevalence and incidence of dapsone resistance. In India, WHO collaborated in exploring the possibility of opening reconstructive surgery units for treating deformities in leprosy patients, and also funded research and workshops; a SIDA-funded pilot project for multi-drug trials was begun; and the Damien Leprosy Foundation of Belgium supported epidemiological surveillance, the establishment of model leprosy control units, and the supply of drugs through WHO. In Indonesia, the Danish Save the Children Organization, through WHO, supported training projects. In the Maldives, a survey with 97% coverage showed that leprosy is endemic in 143 out of 202 inhabited islands. In Nepal, work on case detection, health education and the setting up of treatment clinics continued, with emphasis on the training of national auxiliary personnel in the basic health services, to ensure successful treatment and case-holding; community participation and the introduction of multi-drug regimens was begun in two districts with support from WHO and the Japan Shipbuilding Industry Foundation. In Thailand, emphasis was given to the training of basic health workers at the peripheral level; and surveys on dapsone resistance and the use of multi-drug regimens were begun with support from the Japan Shipbuilding Industry Foundation, which also funded various other leprosy control activities in the Region.

150. An intercountry consultative meeting held in New Delhi in June reviewed the current status of leprosy control and research in the South-East Asia Region in the light of problems such as dapsone resistance. The meeting formulated criteria for the provision of multidisciplinary regimens, suggested specific regimens for field use, and identified and developed protocols for specific areas of research (chemotherapy, epidemiology, immunology, and operational problems).

151. A WHO meeting in Mogadishu in February reviewed guidelines for leprosy control, training and research activities and identified special problems in the Eastern Mediterranean Region with regard to leprosy control as part of primary health care.

152. Courses in leprosy were held at the Leprosy Training Centre in Suva in February (11 participants from six countries) and September (12 participants from eight countries). Leprosy is an important problem in several countries in the Western Pacific Region, and training is emphasized in their leprosy control programmes.

153. In view of the high priority assigned to leprosy control within the concept of primary health care in a number of countries, and also in view of recent changes in leprosy control procedures, it was agreed at a UNICEF/WHO meeting in June that UNICEF would provide support not only in the form of drug supplies and equipment but also in the wider context of joint formulation of plans of action, with emphasis on the formulation of programmes including the training of multidisciplinary health care staff.
154. In 1980 WHO published *A guide to leprosy control*, which incorporates as far as possible the latest advances in knowledge of the disease, and also guidelines recommended by recent international conferences on leprosy, the WHO Expert Committee, and other groups. The guide is addressed in particular to health programme managers and pays special attention to the process of project formulation.

155. **Tuberculosis control.** The World Health Assembly in May expressed concern about the inadequacy of efforts in tuberculosis control programmes, urged Member States to give earliest attention to the application of tuberculosis control as an integral component of primary health care, and stressed the need to promote programme evaluation, epidemiological surveillance and health services research in this field.

156. The results of a large-scale controlled field trial on the effectiveness of BCG vaccination, carried out in southern India with support from WHO, showed no evidence of a protective effect against bacillary pulmonary tuberculosis after 7-1/2 years of follow-up. An Indian Council of Medical Research/WHO Scientific Group, convened to examine the findings, confirmed the high standard of the scientific investigations carried out, but considered that, in view of several epidemiological and immunological peculiarities in the study area, the results should not be readily extrapolated to other areas.

157. A WHO Study Group examined the current BCG vaccination policies in the light of all the available information. The Group found itself in substantial agreement with current BCG vaccination policies, and recommended the continued use of BCG as an antituberculosis measure. In the view of the Group, the results of the Indian trial serve to highlight the fact that there are situations in which the effectiveness of BCG cannot be predicted with certainty. Every effort should be made to identify the local factors that apparently may modify the outcome of BCG vaccination, but in the meantime it would be wise to go on using BCG, particularly in infants and children. Since the tuberculosis problem differs from country to country, the kind of BCG programme chosen must be based on the local epidemiological situation; in countries with a high prevalence of tuberculosis, for instance, BCG vaccination should be administered as early in life as possible. The Group stressed that BCG vaccination should not be considered in isolation as a means of tuberculosis control, but should form part of a comprehensive control programme that includes case-detection and treatment.

158. **Virus diseases.** In support of its major programmes in acute respiratory infections, diarrhoeal diseases and immunization, the Organization continued to encourage the development of simplified and rapid techniques for the diagnosis of viral infections. Hitherto, most virological techniques have been cumbersome and inapplicable in many countries. Newer techniques which simplify specimen collection and the necessary laboratory structures and equipment are being developed in a WHO collaborative programme with countries. This programme involves the evaluation of new methods, the preparation of guides, the production and distribution of reagents and the organization of training workshops.

159. A Scientific Group was convened in Geneva in September-October to examine the progress made recently in this area and advise on the further research necessary to make these methods of value in the context of primary health care. The Scientific Group reviewed the technical characteristics - advantages and disadvantages - of several rapid techniques recently developed or adapted for the rapid viral diagnosis through the detection of antigen and early antibody, as applied to various types of disease. In addition, the Scientific Group examined the problems of standards and quality control relating to the reagents used in the techniques. It also advised on how WHO might expand its efforts in this field.

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160. **Diarrhoeal diseases control.** In the African Region 21 countries requested WHO collaboration in the control of diarrhoeal diseases. Burundi, Ethiopia, Gambia, Ghana, Kenya and Rwanda formulated plans of action in this field. Feasibility studies on the manufacture of oral rehydration salts were carried out in Ethiopia, Kenya and Zambia. An advisory group met in Brazzaville in July and recommended the primary health care approach, and especially community participation, for this purpose. Cholera epidemics occurred in Congo, Kenya, Mozambique, Rwanda, Uganda, and the United Republic of Tanzania.

161. Two WHO collaborating centres for research and training in the control of diarrhoeal diseases were designated in the South-East Asia Region, in Bangladesh and India: the International Centre for Diarrhoeal Diseases Research, Dacca, and the National Institute of Cholera and Enteric Diseases, Calcutta. A training course for country programme managers in the control of diarrhoeal diseases was organized in Bangkok in October-November. Technical support for the development of diarrhoeal disease research protocols was provided to Member countries in the Region. A working group on diarrhoeal diseases was established to advise on the development and implementation of a services and research programme in this field. An intercountry meeting on this programme was organized in New Delhi in November to review the current national control programmes and develop an outline of major activities for the next three years. During the year services and research in the Region greatly benefited from the availability of extrabudgetary resources.

162. Diarrhoeal diseases are the most common cause of admissions and outpatient attendance in paediatric hospitals in Egypt. They kill 50 000 infants and over 100 000 children under the age of five annually and also retard physical and mental growth and impair the quality of life of those who survive. To help in combating this problem, WHO collaborated with the University of Alexandria in establishing an oral rehydration training and demonstration centre at El Shatby Hospital. The centre is planned to serve the national diarrhoeal disease control programme. A WHO consultant provided practical demonstrations of the effectiveness of oral rehydration in the treatment of diarrhoea. Three members of the staff visited the WHO collaborating centre in Dacca, mentioned above, on WHO fellowships.

163. The Western Pacific Regional ACMR meeting in April established a subcommittee on diarrhoeal diseases to promote and develop research on this subject in the Region. The subcommittee met in April and reviewed current research in the Region, identified priorities for research and suggested mechanisms for the establishment and funding of research. During the year the Region’s diarrhoeal diseases research programme was elaborated, consisting of two main elements: cooperation with Member countries in planning their national programmes, and the promotion and implementation of oral rehydration therapy. A training module on the management and prevention of diarrhoea, intended for training middle-level health personnel (public health nurses and midwives) was developed and field-tested in the Philippines. A seminar-workshop on clinical management of diarrhoeal diseases was held in Manila in October. An inventory was drawn up of national health officials and institutions involved in the control of diarrhoeal diseases and with a potential for conducting operational research.

164. In fact, in all six WHO regions there have been meetings of senior national public health administrators and scientists to discuss how national plans for diarrhoeal disease control might be developed, and to determine how WHO could best cooperate in these programmes. By the end of 1980, these meetings had helped to stimulate the development of plans of operation in over 70 countries for national programmes as an integral part of primary health care. The emphasis was on reducing mortality from diarrhoea - by the early treatment of acute diarrhoea with an oral rehydration solution recommended by WHO and UNICEF - and on reducing morbidity from diarrhoea, by improving relevant maternal and child care practices, by improving environmental health, and through the detection and control of epidemics. Globally, the target is to provide, by the end of 1983, access to treatment by oral rehydration therapy to 25% of cases of diarrhoea occurring in children in developing countries under the age of five.

165. One of the major constraints to the setting up of national programmes was obtaining an adequate supply of prepackaged oral rehydration salts. With the support of UNICEF, WHO cooperated with countries in overcoming this difficulty and in meeting national needs.
Guidelines for local production were made available, and 13 large-scale production centres were in operation.

166. The training aspects of the programme focused on national staff with managerial, supervisory and training responsibilities. Courses, which were modified at regional and national level to meet local needs, provided instruction on the best means of implementing diarrhoeal control activities within primary health care services and on building an evaluation scheme for assessing the impact of the programme. A project was under way with UNDP to establish regional technical training centres in the South-East Asia and Western Pacific Regions. A manual of operations and four technical training manuals were completed.

167. The programme had the support of the United Kingdom, the World Bank, UNDP, UNICEF, SIDA, and other international organizations and bilateral and multilateral agencies. A total of 180 letters of intent (more than 40% from developing countries) were received from scientists desirous of receiving support, and initial steps were taken towards funding research projects.

168. Expanded Programme on Immunization. By the end of 1980, the impetus of the global Expanded Programme on Immunization had stimulated planned activities in more than 100 developing countries to increase protection of their infant populations against diphtheria, whooping-cough, tetanus, measles, poliomyelitis and tuberculosis. The goal of the Programme is to provide immunization protection to all of the world’s children by 1990, and the more immediate target is to increase the present estimated coverage of 20% to 50% by 1983.

169. By the end of September, 28 countries in the African Region were operating an expanded programme on immunization and others were about to do so. Training activities continued. An interregional high-level management course was held in Brazzaville, attended by 24 nationals from the 16 French-speaking countries in the Region, and five from other regions. National courses, organized whenever possible in collaboration with neighbouring countries, were held in eight countries and being prepared in eight others. Nationals were used more and more as course promoters. The courses on immunization were adapted to teaching by training centres in the Region, as a module of primary health care.

170. In the Region of the Americas, the revolving fund for the purchase of vaccines and related equipment was consolidated, with the participation of 22 countries and eight territories. A regional centre was established at Cali, Colombia, for developing and manufacturing cold boxes and carriers for the programme in Latin America. It forms part of a project with the long-term goal of strengthening cold chain systems (i.e., systems of methods and materials for the distribution and storage of vaccines in developing countries) in the Region.

171. The Global Advisory Group of the Expanded Programme on Immunization held its annual meeting in Geneva in October. The Advisory Group consists of 12 members nominated so as to provide geographical and technical balance. It discussed global strategies, programme implementation and research and development. It reviewed global and regional activities and endorsed an outline for WHO’s research on poliomyelitis, polioviruses and poliomyelitis vaccines, prepared by a WHO working group, also in October. Examples of evaluation activities that had been carried out were national programme evaluations in seven countries, cost analyses in three countries, the development of an information system to assess the quality of the vaccines being used, and 25 immunization coverage surveys (during 1979-1980).

172. The year saw considerable evolution in the type and extent of training for the programme. Priority for interregional training of senior-level staff in planning and management shifted to emphasis on national training in three areas: management for middle-level supervisory personnel, logistics and the cold chain, and maintenance and repair of cold chain equipment. Moreover, the training materials were integrated into national health training and broadened to cover other primary health care interventions. An example of the training courses mentioned above was the interregional senior-level planning and management training course held in Manila in August.
173. Systems of vaccine distribution were improved in eight developing countries. Vaccine packaging and shipping procedures were also improved following an analysis of current methods and the preparation of draft guidelines. Equipment for the storage and transport of vaccines was identified in two ways: independent testing of existing equipment by laboratories in developed countries, to establish whether it is suitable for use in tropical countries, and the development of new equipment and the adaptation of existing equipment to meet the requirements of developing countries. The product information system already in operation was expanded. Considerable support was provided by UNICEF and the Consumers’ Association (United Kingdom). Activities in the field of the cold chain provide an excellent example both of the development of appropriate technology and of TCDC.

174. Special Programme for Research and Training in Tropical Diseases. In 1980 this global programme of international technical cooperation, initiated by WHO and co-sponsored by UNDP and the World Bank, made significant progress towards its two objectives: (1) research and development towards new and improved tools to control six tropical diseases (malaria, schistosomiasis, filariasis, trypanosomiasis - both African sleeping sickness and Chagas' disease - leishmaniasis and leprosy); and (2) the strengthening of national institutions, including training, to increase the research capabilities of the tropical countries affected by the diseases. Up to 30 December 1980, the Programme had supported 1088 projects; and over 2000 scientists from 109 Member States participate in the planning, implementation, operation and evaluation of the Programme. More than US$ 52 million has been obligated for direct support to national scientists and institutions. The percentage of the project operations budget going to developing endemic countries has risen from 29% in 1977 to 56% in 1980.

175. Early scientific results include progress in chemotherapy for malaria, schistosomiasis and filariasis; in biological control of vectors; and in simple and accurate diagnostic field tests for malaria, leprosy and African trypanosomiasis. At the same time institution-strengthening and training support, awarded exclusively to institutions and scientists of developing countries where the diseases are endemic, has increased rapidly. Over 210 individual training grants have been awarded and 22 institutions are receiving long-term support. Twenty-three governments (including those of six developing countries where the diseases are endemic), and six other organizations, together with UNDP and WHO, have contributed over US$ 70 million to the Programme. The Joint Coordinating Board approved maximum budgets of US$ 26.51 million for 1980 and US$ 30.09 million for 1981.

176. The fifth meeting of the Research Strengthening Group of the Special Programme was held in Geneva in September, to discuss policy and priorities and to consider requests for funding. It was stressed that initial reports from Group-supported institutions showed that their relationships with the Group were at a very early stage, and that the Group should not allow individual problems to create doubts about the overall plans and policies. The creation of a viable research capability in developing countries was an important long-term aim and could not be expected to produce immediate results.

177. In view of the large number of requests received for funding for various activities, the Group felt that it should review its policies and, in some cases, establish stricter guidelines for the granting of awards. It decided to focus all grants for research training fellowships on the objective of institution-strengthening, irrespective of whether the request came from an institute, an individual, or a scientific working group. Courses, workshops, and seminars would be supported only if they were relevant to the Special Programme, and if they were likely to advance research or make an identifiable contribution to institution-strengthening.

178. The Group reiterated that internal evaluation is a required component of long-term support grants, intended mainly to improve the management of the supported institutions and thus the use and effectiveness of the grants. The Group examined 20 proposals for renewal of long-term funding and approved 18 of them. Of 13 new proposals, funding was recommended for four capital grants, two long-term support grants, and three courses. Three proposals were deferred and three were not accepted.
179. **Vector biology and control.** Taking into account the recommendations of the WHO Expert Committee on Vector Biology and Control,\(^1\) UNEP, FAO and WHO in 1980 strengthened coordination of their activities for better prevention of the waterborne and vectorborne diseases associated with the development of water resources. Interagency cooperation was agreed upon for the closer monitoring of water development schemes so that the necessary prevention measures can be considered at the time of planning such schemes. A memorandum of understanding concerning specifically that cooperative effort was signed. Efforts are being made to broaden its scope to involve other organizations and institutions (see also para. 147). Special emphasis was given in 1980 to WHO-sponsored research on the biological control of vectors as part of the Organization's efforts for developing integrated vector control strategies that could be used at the community level.

180. A biological larvicide, extremely safe for man and the environment, derived from *Bacillus thuringiensis* (serotype H-14), which gave very promising results when evaluated against blackflies and mosquitoes, reached the stage of industrial production for large-scale operational use. In 1980, in one part of the zone covered by the onchocerciasis control programme in the Volta River Basin area, the larvae of one of the local vectors of onchocerciasis developed resistance to temephos, the larvicide used for controlling onchocerciasis vectors in that area for the last six years. It was possible to control temephos-resistant vectors by using chlorphoxim, an alternative larvicide screened earlier for that purpose in anticipation of such an eventuality. Action was also immediately taken to speed up the operational evaluation of other environmentally safe larvicides to minimize problems associated with cross-resistance. A large-scale field trial of the experimental larvicide derived from *Bacillus thuringiensis* was made within that context with promising results. This trial indicated that a wide-scale use of this biological larvicide may be possible after further research on industrial production and formulation.

181. One of the serious constraints in the prevention of vectorborne diseases is the shortage of adequately trained national personnel able to develop vector control tools, methods and strategies more appropriate to the socioeconomic and cultural conditions of the countries where these diseases are endemic. A network of institutions which will train specialists in vector biology and control to the Master of Science level was being strengthened under the aegis of the Special Programme for Research and Training in Tropical Diseases. Medical entomology and vector control courses were sponsored in Bogor (Indonesia), Abidjan, Nairobi, Jos (Nigeria), and Valencia (Venezuela). They will serve a number of countries in the spirit of TCDC. Efforts are being made to develop this network further and expand it to cover additional epidemiological zones.

182. **Noncommunicable disease prevention and control.** A WHO consultation held in Geneva in June advocated an integrated programme in this field, with WHO collaborating in the setting up of integrated programmes in both developed and developing countries. Where such programmes already exist, for instance in the field of cancer and cardiovascular diseases, further development should be encouraged. Use should be made of experience already gained in such centres as Gabrovo (Bulgaria) and North Karelia (Finland). Methods of influencing populations to change to more healthy lifestyles should be further explored.

183. One example is the prevention and control of cardiovascular diseases at the community level, the basis of one WHO programme that embraces the concept of primordial prevention, stressing the need to take appropriate action at an early stage to prevent the development or entrenchment of those social, economic and cultural patterns of life that have been shown to contribute to the incidence of cardiovascular diseases in populations. Plans were prepared in 1980 to launch an approach to primordial prevention in developing countries, to see whether, if the occurrence of risk factors is prevented, cardiovascular disease can be prevented from

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reaching the epidemic proportions experienced in industrialized countries. Initially, community smoking control activities will provide the main thrust to primordial prevention; WHO will collaborate with a limited number of Member States to develop, implement and evaluate methodologies of field surveys of the smoking situation and of community smoking control programmes adapted to local conditions and needs. Attention will also be paid to other cardiovascular disease "risk factors" such as unhealthy dietary habits, hypertension, obesity and lack of exercise.

184. The results of the first five years of the North Karelia project on the comprehensive control of cardiovascular disease in the community became available and are now being published by the Regional Office for Europe. Also in the European Region, the coordination of hypertension research related to health care was welcomed by 25 countries, of which 16 contributed with projects at the national level. A 10-year study on the community control of hypertension was concluded; the results were discussed at a final meeting of the investigators in December in Geneva and the report will be published in 1981.

185. The year saw the widespread acceptance of 3 DMF (an average of three decayed, missing or filled) teeth at the age of 12 years as an indicator of oral health by the year 2000. The International Dental Federation collaborated in developing interrelated indicators for other ages or age-groups and pertaining to other oral diseases and conditions. Emphasis was placed on developing a standard method for situation analysis and coordinated planning in the oral health sector, and a demand for this approach was common to highly industrialized and developing countries. The year marked the beginning of a long-term programme to achieve oral health, an indication of the extent of achievement being the 3 DMF teeth "barrier"; evaluation of progress will have as a base global data bank information for 1980. The trend towards decreased oral disease in highly industrialized countries, associated with a continuing high level of manpower production, has reached a stage at which dental manpower excesses of considerable proportions are likely in a number of these countries. Consideration was therefore given to WHO's role in devising a process for balancing such excesses, when they occur, with worsening manpower deficiencies in developing countries.

186. During 1980 field trials of the basic radiological service project were started in Yemen and were at an advanced preparatory stage in Colombia and Egypt. The basic radiological system is a solution for improving the coverage of the population with diagnostic radiology and includes appropriately designed X-ray machines and training packages for operators and general practitioners. It is aimed at providing technical support for primary health care activities. The development of this system was treated as a priority area since it offers a realistic solution to the problem of adequate radiological coverage of populations in developing countries and rural areas of some developed countries. Technical specifications for the machines involved were finalized and circulated to manufacturers. A manual for machine operators was drawn up and work begun on another for general practitioners involved in interpreting films produced by the equipment. Two consultations of the WHO advisory group on this system took place in June (Amsterdam, Netherlands) and December (Copenhagen) to discuss results and plan the development of the project.

187. In 1980, in the Region of the Americas, a model of technical cooperation was successfully implemented in cancer research among oncology institutions in Latin America and the United States of America entitled "Latin America Cancer Research Information Project" (LACRIP). The project was made possible through the technical assistance and contracts of US$ 2 900 000 from the United States National Cancer Institute and the United States Environmental Protection Agency. It includes specific activities reflecting the transfer and adaptation of appropriate technology, the training of junior personnel focusing on local needs, the strengthening of institutions through direct support, and the promotion of formal cooperation among centres within a given country. It also includes a dynamic information system for dissemination and collection of cancer research information and an annual meeting of participants to review progress and design future plans of action. By the end of the year, LACRIP included the

formal participation of 53 institutions and 95 investigators from seven Latin American countries and the United States of America in clinical trials and epidemiological research, and 3500 scientists throughout the Region were participating in the information exchange activities.

Promotion of environmental health

188. In May the World Health Assembly endorsed the basic policy for WHO's participation in the International Drinking Water Supply and Sanitation Decade, 1981-1990 (see para. 50), with a view to implementing this most essential element of primary health care. WHO provided information on water supply and sanitation in more than 100 countries and disseminated it widely as a means to promote the Decade and attract more resources for it. In 33 countries programmes of technical cooperation were undertaken for the development of national plans. At the regional level, WHO used political and technical avenues to increase awareness and stimulate commitment for the Decade and to provide guidance for planning and implementing national programmes and for supporting them. At the global level, the flow of information between Member States and the donor community was accelerated with a view to increasing external participation in the Decade. WHO continued its close relationship with other agencies, particularly UNDP, UNICEF and the World Bank, but also others, and provided secretariat services for the Decade Steering Committee.

189. Under an agreement between the Federal Polytechnic School, Lausanne, Switzerland, and the Inter-State School for Rural Public Works Engineers, Ouagadougou, October saw the opening of a year of specialization in health engineering. The agreement provides for enhanced cooperation with WHO. In collaboration with DANIDA and the World Bank, workshops for training high-level staff in planning and management techniques relating to the Water Decade were organized in Algeria, Congo, France, Ethiopia, Gabon and Kenya.

190. In March GTZ concluded an agreement with WHO on the subject of planning in Niger, Rwanda and Upper Volta for the Decade. Also in March SIDA signed an agreement with WHO covering similar activities in Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Swaziland, Uganda and Zambia. The GTZ/WHO activities began in July with a mission to Niger; later there was a mission to Rwanda and a workshop in Upper Volta. By the end of the year, the permanent staff for the project were being placed. Also by the end of the year, most of the countries of the African Region had prepared their situation reports as required by resolution 1979/31 of the United Nations Economic and Social Council. The countries responded to an invitation by ECA to a conference organized at Addis Ababa in August on the subject of the Water Decade, at which the situation reports proved to be most useful, and for which WHO prepared all the technical documentation. Ten countries received loans from the World Bank for water supply and sanitation projects, and three other countries were under consideration for the same purpose.

191. In the Region of the Americas, three aspects of human resources development were stressed: planning, training and education, and utilization. A symposium on environmental manpower development was held in Rio de Janeiro in collaboration with the Brazilian National Housing Bank and the Brazilian Association of Sanitary Engineers, with the participation of 40 professionals from 18 countries of the Region, and representatives of funding agencies. The Caribbean Water Basin Management Project, supported by CIDA and the International Reference Centre, aims to upgrade the quality of local water systems, chiefly through the development of a self-sustaining training delivery system for water and sanitation utility personnel. A complementary project at the Pan American Center for Sanitary Engineering and Environmental Sciences, supported by the Inter-American Development Bank and the Government of Peru, is also directed towards improving the operation and maintenance of water and sanitation systems; the emphasis is on the training of trainers, the development of information exchange activities, and the investigation of problems associated with water distribution and disinfection. Another approach to manpower development in Central America was the formation of an association of managers of water supply and basic sanitation agencies; this collaborative network facilitates the exchange of experiences, personnel and equipment, as well as the development of materials and programmes to train trainers - an excellent example of TCDC.

192. The support of lending institutions and bilateral agencies proved invaluable in the Region of the Americas. Activities included strengthening of national capacities for identi-
fying and developing projects, among them projects relating to pollution control. For the first time, the World Bank proposed to make funds available to a governmental agency, which could in turn reimburse industry for control devices to solve specific pollution problems. GTZ cooperated with WHO by funding projects in Bolivia, Haiti and Paraguay for infrastructure development prior to implementing water and sanitation improvement projects.

193. The following are some examples of international cooperation in the development of national plans for the Water Decade in the South-East Asia Region during 1980. There was a UNDP interregional project, with WHO as executing agency, involving Bangladesh (with inputs from the WHO/World Bank cooperative programme under consideration), India (whose plan is expected to be ready early in 1981) and Nepal (whose plan was completed in 1980). The Government of the Federal Republic of Germany cooperated with Burma, Indonesia and Thailand, using WHO as the executing agency. With the active participation of WHO, USAID provided technical and financial resources for Sri Lanka. Donor agencies supported many other high-priority projects for the Water Decade in the countries of the Region.

194. In the Eastern Mediterranean Region, pre-investment studies were begun for a national waste management plan for Lebanon. In January, a regional seminar on the design and operation of waste stabilization ponds was held in Lahore, Pakistan, to develop technology appropriate to the conditions in Member States. WHO collaborated with the Institute of Public Health Engineering and Research, Lahore, in establishing postgraduate training facilities.

195. The Eastern Mediterranean Region's largest UNDP-funded rural water supply project was initiated in Sudan. A first batch of hand-pumps was ordered in 1980, for installation in the south of the country before the next rainy season, as part of the project, executed by WHO, to provide one million people with a safe supply of drinking-water. The project is expected to last for about eight-and-a-half years, carries a budget of US$ 6 million in addition to 1.5 million Sudanese pounds, and is concerned mainly with the provision of hardware: supplying drilling rigs, pipes and pumps, and boring a large number of wells. Institution-strengthening and manpower production have not been forgotten, however: by the end of the project, the local government will be able to take over all functions of the development programme, including water resources control. Similar programmes are going on in other parts of the Region, some of them supported by UNICEF and nongovernmental organizations. WHO has the task of co-ordinating all these programmes.

196. WHO's second major priority in the field of the environment is the recognition, evaluation and prevention of adverse effects on health resulting from chemicals and other environmental hazards in air, water and food. During 1980 an international programme on chemical safety was launched jointly with UNDP and ILO. The World Health Assembly decided that such a programme would be implemented through the delegation of specific tasks to national institutions. The programme's initial priorities include the evaluation of the health effects of priority chemicals, the dissemination of information (to be implemented through UNEP's International Register of Potentially Toxic Chemicals), the development of methodology for risk evaluation and hazard assessment, and the training of manpower. Nine Member States actively joined the programme in 1980 and agreed to assume specific tasks through their scientific institutions.

Health manpower development

197. It has truly been said that, while people can make buildings, buildings cannot make people. Constructing health centres is useless if there are no personnel to staff them. Equally, teaching institutions serve no useful purpose unless they are producing staff with the motivation and training to deal with local conditions. The main problems are the shortage of health workers, their maldistribution (both nationally and internationally), and the fact that their training is related neither to existing services nor to needs. In 1980 the basic principle of WHO's health manpower development programme was collaboration with Member States to satisfy the health needs of their populations through health services made up of teams of health workers functioning at the most peripheral level of the health service as is practicable. The main aim of the programme is to help bring about a change in the health manpower development process so that it will be relevant to the present and foreseeable future health needs of the communities in Member States.
198. The health manpower development programme in the African Region laid particular stress on the training of health personnel in the management process for health development. To this end, the regional health development centre established in Cotonou provided common training for 40 health workers of various kinds from 13 countries. The course consisted of modules dealing with health and development, management, primary health care, and research and development. The training was given in the form of workshops and made use mainly of teaching material produced by WHO.

199. The first regional meeting of education and health administrators, organized in collaboration with UNICEF and the World Federation for Medical Education, took place in Brazzaville in December. Deans of faculties and institutes of health sciences participated. The aim of the meeting was to promote mechanisms for integrated health manpower development at all levels. The meeting approved broad outlines for training in basic medical sciences and stressed the need to introduce clinical disciplines as from the first year of these studies. Curricula should be reinforced, taking into account the objectives of primary health care. In order to improve the quality of teaching, the participants approved in principle the establishment of an African regional network for the production and distribution of textbooks and teaching materials.

200. An interregional project on the training of teachers of community health workers with particular emphasis on family health, already initiated in Sudan and Papua New Guinea, was extended to the United Republic of Cameroon during the year, with the full support of the Ministry of Health. A building for a proposed health centre, located in a village 70 km from the capital, was improved and enlarged with the voluntary assistance of the community. The health centre/training school will develop the training of teachers and supervisors of community health workers in conjunction with a community health care programme. A training workshop for resource staff took place in June, and the first regular course for teachers and supervisors of one province of the United Republic of Cameroon began in October. In relation to the project, a study of job specifications of all workers was being planned as a starting-point for the reformulation of training programmes and for the effective management of health personnel and health services.

201. In the Region of the Americas, the Latin American Center for Educational Technology for Health, Rio de Janeiro, developed in 1980 the first course of specialization in educational technology for health. The objective of the 11-week course is to give professions an opportunity to participate in learning experiences from the fundamental courses, with the topics being developed to a greater depth. It is intermediate between the short courses and the Masters' degree courses also offered by the Center. Fifteen participants attended the course in 1980.

202. In the Eastern Mediterranean Region, WHO provided technical advice and support for the planning of new medical schools in Bahrain, Egypt and Yemen, and to the newly established school in Sudan. Those responsible for the new schools are applying modern approaches in educational planning, taking into account the needs of the health services and the resources available, and defining the tasks to be performed by their future graduates in close collaboration with those who will employ them. WHO collaborated in organizing the first workshop on curriculum planning for the new medical school in Yemen mentioned above. In an effort to promote approaches in training that will prepare physicians capable of playing a socially constructive and relevant role, WHO sponsored a workshop on problem-based learning, alternative instructional approaches, and the role of the medical school in providing area health services; the workshop took place at the University of Maastricht, Netherlands, with 10 participants from education centres in Bahrain, Iraq, Jordan and Sudan.

203. The Health Manpower Institute, Sana'a, which trains many health personnel other than physicians, ran a workshop on task analysis and curriculum design in the training of auxiliaries; the workshop undertook a complete review of the extent to which the present curricula for the several categories of health worker meet the defined needs of the country. A working group on teaching/learning materials for medical assistants prepared a set of books for this category of staff and the same approach will be used in preparing suitable materials for other categories of middle-level health personnel.
204. In cooperation with three nongovernmental organizations (the International College of Surgeons, the International Federation for Hygiene, Preventive Medicine and Social Medicine, and the World Medical Association), WHO developed studies on the role and tasks of team leaders in primary health care. Each of the three organizations selected a few countries in which to conduct the study. There will be an analysis of the existing literature in the country on the role and tasks of leaders of primary health care teams in the prevention of disease, health promotion and the management of primary health care services and personnel. The role and tasks of the leaders of primary health care teams in each country will then be identified, taking into account the composition of the different teams and the role and tasks of their members. The final task, to be completed in 1981, will be the preparation of a report covering these issues and recommending possible modifications of the present role and tasks of team leaders.

205. With a view to promoting the training and utilization of community health workers and the mobilization of traditional practitioners, such as traditional birth attendants, WHO pursued the development of a learning system and strategies for teachers of traditional practitioners. Included are training in maternal and child health care and family planning, as well as teaching techniques used in adult education and in literacy programmes. WHO also carried out research and study directed towards a better definition of how traditional birth attendants can contribute to primary health care, for instance, in the screening of high-risk mothers and children, and how they can work alongside the formal health system.

206. The following are some WHO publications issued in 1980 on subjects relating to health manpower development:


The primary health worker: working guide, guidelines for training, guidelines for adaptation (revised ed.)

P. Hornby et al. Guidelines for health manpower planning

On being in charge: a guide for middle-level management in primary health care

Programme development and support

207. Managerial processes for national health development. In the African Region, an interministerial conference on the planning and management of health services was held in Dakar in April with the participation of the Ministers of Health and of Economic Planning of Benin, Mali, Mauritania and Senegal.

208. The first regional consultation on the development of management training was held in Arusha, United Republic of Tanzania, in July. The objective of the meeting was to promote and strengthen health management training in the African Region through the establishment of national networks of institutions in order to develop national health management capacities for the attainment of health for all by the year 2000. Participants came from health and management training institutions and from ministries of health and social welfare in many countries of the Region. Prior to the meeting, questionnaires were sent out to determine the management procedures at present being taught in some institutions in Africa, so that these procedures could be reviewed at the meeting together with those used by ministries and WHO. The relevance of existing courses to the goal of health for all by the year 2000 was discussed, together with ways in which existing training programmes at all levels could be strengthened. It is hoped, for instance, that health management training opportunities may be established in institutions which have not so far offered them.

209. Among the recommendations of the consultation were that WHO should establish an African network of health management development programmes and prepare an up-to-date inventory of health management programmes in the African Region and make it available to all Member States and institutions in the Region; the working document on national health management processes
should be amended, published and distributed to governments and health management institutions in the Region; and teaching modules on the health management process should be prepared and distributed to all training institutions. Recommendations were also made for action by health management development institutions and ministries of health in the Region.

210. In October-November an intercountry workshop on country health programming was organized in the African Region, attended by 30 participants from English-speaking countries, a similar workshop for French-speaking nationals having been held late in 1979. Training workshops concerned with country health programming were held during the year in Namibia (16 participants), Rwanda (29) and Zanzibar, United Republic of Tanzania (26).

211. PAHO/WHO, in support of the existing network of 49 regular courses in health care administration in the Region of the Americas, initiated the implementation of a new phase of its programme in health administration with the support of the W. K. Kellogg Foundation. The main purpose of this programme is the strengthening of health care administration as a means to improve the health of the people in the Region. Three areas of interest were developed in 1980, through the preparation of literature and workshops, as the strategy to improve the educational process and content of courses: teaching of economics and finance, teaching of organizational behaviour, and teaching of health assessment and planning. The institutions participating in the process were the Regional Library of Medicine and the Health Sciences, the Latin American Center for Educational Technology in Health, the London School of Hygiene and Tropical Medicine, and Case Western Reserve University. Also in the Region of the Americas, two further important activities were initiated in the field of training in health planning, management and administration: an advanced programme in health administration education for the Central American countries, and an international course on planning for the development of health services systems at the School of Public Health, Mexico City.

212. Three countries of the South-East Asia Region - Burma, India and Sri Lanka - participated in a study to develop training programmes aimed at improving manpower management of primary health care personnel. Burma undertook a systems analysis of the management problems of the primary health care programme and, based on this analysis, began developing a training programme for all levels of managers of primary health care services. India and Sri Lanka initiated the development of similar programmes.

213. In Thailand, the National Economic and Social Development Board established a macro-social development subcommittee with three task forces concerned with health, education and culture, and social welfare and security. The subcommittee, involving five ministries, requested guidelines from the Development Board, which formulated long-range targets and strategies and indicated the mechanisms for achieving them through a long-term (20-year) development plan. To cover the first five years (1982-1986) there is a national social development project. The task forces mentioned above will devise medium-term plans for the five years. The objectives, established initially on the basis of an analysis of past development trends, will be refined with experience. Indicators will be selected and specified in terms of targets to be agreed by all the agencies concerned. Progress will be monitored throughout the five-year period and evaluated before the next five-year planning cycle commences. For the achievement of objectives and targets, fundamental strategies and supportive strategies will be identified for the main sectoral areas. Future resources will be estimated and service delivery will be planned accordingly. This broad approach is well in line with WHO's recommendations, and progress in Thailand will be watched with great interest by many Member countries.

214. The first workshop on the strengthening of health management in the Eastern Mediterranean Region was held in Mogadishu in September, with participants from Democratic Yemen (2), Somalia (19), Sudan (2), and Yemen (1). The emphasis was on training in health management needs, and use was made of local case material and other learning materials adapted to the requirements of the participants and countries concerned.

215. Countries of the Western Pacific Region made use of managerial processes in the context of updating policies and strategies to support primary health care and attain health for all.
For instance, the country health programming process was used in Fiji, Papua New Guinea and Samoa, Malaysia, Solomon Islands, Tonga and the Trust Territory of the Pacific Islands developed new five-year health development plans. The Philippines developed an organizational strategy for achieving health for all. WHO provided support for the Department of Health of Samoa in planning and conducting a middle-level management workshop for staff of the Department. Initial preparations were made for establishing a network of national health development centres in the Region. In collaboration with the University of the South Pacific, a short course in hospital administration for middle-level nonmedical administrators, funded by UNDP, was held in Suva. Training in hospital administration was strengthened in the Philippines and in the Republic of Korea.

216. In 1980 WHO completed the formulation of a strategy aimed at supporting Member States in developing and applying an integrated managerial process for national health development. The components of the strategy include: promotion, technical cooperation, training, further development of methodology, and strengthening of WHO's support capacity. Global and regional plans are in preparation to give effect to this strategy.

217. Guiding principles, intended for adaptation by countries, on managerial processes for national health development were finalized in 1980 after several years of preparation. They will be published in 1981 in a new WHO series entitled "Health for all", as follows:

No. 3. Health for all by the year 2000 - global strategy.
No. 4. Development of indicators for monitoring progress towards health for all by the year 2000.
No. 5. Guiding principles for the managerial process for national health development in support of strategies for health for all by the year 2000.

218. Health information. Only a small number of the 800 biomedical journals published in Latin America are included in existing international indexing and retrieval services, so that a considerable amount of valid information never reaches health workers. This situation prevents the necessary exchange of information between developing countries with similar health problems. The new Index Medicus Latino Americano, prepared and published by the PAHO/WHO Regional Medical Library in São Paulo, Brazil, constitutes the first serious attempt to cope with this problem. With the aid of a minicomputer provided by the Government of Brazil, and with the use of a translation of the indexing rules of the original Index Medicus, nearly 200 journal titles are now being published and analysed. This collaborative effort between the United States National Library of Medicine, PAHO/WHO, the Brazilian Government and the health authorities of Latin American countries is a noteworthy example of what can be done within the framework of the concept of TCDC.

219. A serious obstacle to the development of water supply and sanitation programmes in the Caribbean and in Latin America is the lack of services for the transfer of technical information. The need to overcome this obstacle is urgent if all available technologies are to be employed in achieving the goals of the International Drinking Water Supply and Sanitation Decade. In 1980 a master plan for a regional information and documentation network on sanitary engineering and environmental sciences, sponsored by PAHO/WHO through the Pan American Center for Sanitary Engineering and Environmental Sciences, was approved and entered on a phase of pilot operation, testing and evaluation, with the support of the International Development Research Centre in Canada. The focus is on the development and coordination of a network of collaborating national information centres, including the International Reference Centre in The Hague. The network currently consists of five national focal points, When in full operation, with 12-15 such centres, the system will, in keeping

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1 No. 1 and No. 2 in the series were originally issued as nonserial publications in 1978 and 1979 respectively, but have now been incorporated into the series:

No. 2. Formulating strategies for health for all by the year 2000.
with the principles of technical cooperation among developing countries, constitute a national information infrastructure at the service of environmental engineers and scientists, research workers, teachers, designers, managers, technicians, operators and community developers working with water supply and public health agencies throughout the Caribbean and Latin America.

220. Emergency relief operations. Health agencies should assume a responsible role in the relief work after a natural disaster. They should also be involved in the planning, and siting of water supply and sewerage facilities so as to minimize the disruption of services. They should assist responsible agencies in the preparation of contingency plans in case of accidental "spills" of toxic and hazardous substances. These contingency plans should be made known widely. These were among the recommendations of a WHO seminar on emergency assistance in environmental health, held in Manila in January and attended by 20 officials from 17 Western Pacific countries. The meeting concluded that although the health agencies in most WHO Member States conduct environmental health programmes, they are not at present involved in the planning, zoning and siting of facilities in accordance with environmental protection needs. Many countries do not have adequate legislation or regulations for the proper control of toxic and hazardous substances. The increasing use of hazardous chemicals in agriculture, industry and in the home makes it important to plan and control the manufacture, storage, transport and use of such chemicals. There is also an increased potential for accidental release of these substances into the environment which may cause harm to people and property. The meeting recommended short training courses or on-the-job training for personnel in the planning and execution of preventive and protective measures against disasters.

221. During 1980, as in the past, WHO participated fully in the provision of emergency relief by the United Nations system, its work being carried out in close collaboration with agencies and other institutions and nongovernmental organizations active in disaster work. Epidemics in Africa, hurricanes in the Americas, the plight of refugees in South-East Asia, earthquakes in Europe - these and other circumstances and events made particularly heavy demands on WHO's resources. During 1980 the Organization undertook 52 separate new emergency actions and mobilized over US$ 9.5 million from extrabudgetary sources for this purpose.

222. To quote one example from the European Region, the sum of US$ 25 000 was made available to the Algerian Government after the earthquake in El Asnam in October. It was used to provide supplies such as vaccines and spraying and injection equipment for health centres, and to finance visits to the site of the disaster by WHO staff and European experts. WHO sanitary engineers were immediately sent to El Asnam to take part in the rescue operations and to advise on provisional basic sanitation facilities and the repair of the water supply system.

223. Also in collaboration with other organizations of the United Nations system, WHO undertook urgent health measures on behalf of national liberation movements recognized by OAU, which are struggling to maintain acceptable levels of health and social conditions under extremely difficult circumstances.

Conclusion

224. Having started with the strategies for health for all that were designed by Member States during 1980, this report ends as it began - with action in countries. That is where the impact of WHO's activities has to be felt in the final assessment of WHO's usefulness. Based on national experience, regional and global policies and programmes have to be defined, but these have to focus in turn on support to national health endeavours. WHO has shown that it is capable of crystallizing regional and worldwide health policies and of defining strategies for their implementation that have all the potential for leading to radical improvements in the health situation of all its Member States. It is up to these Member States to use their WHO fully to this end, and in so doing to convert it into the WHO they deserve.
A SELECTION OF MEASURES TAKEN IN VARIOUS COUNTRIES RELATED TO THE THEME OF WORLD HEALTH DAY 1980: SMOKING OR HEALTH – THE CHOICE IS YOURS1

**Austria.** In accordance with an informal agreement between the Ministry of Health and the tobacco companies, the nicotine and tar content of cigarettes must be indicated on packages. Tobacco advertising on radio and television has been prohibited by law; and tobacco advertising in other media, particularly those likely to influence young people, has been severely restricted.

**Bahrain.** Tobacco advertising is banned on radio and television, and smoking is prohibited in schools, clubs, and health centres, as well as at meetings held by the Ministry of Health.

**Bangladesh.** A national anti-smoking advisory group has been set up, which will submit a report to the Ministry of Health and Population Control on measures that might be taken to curb the smoking habit.

**Belgium.** Cigarette vending machines have been prohibited, as well as free distribution. Health warnings in French and Flemish must be printed on cigarette packets. Cinema, radio and television advertisements have been banned, as have advertisements in publications for children. It is forbidden for tobacco companies to sponsor sports events and competitions.

**Brazil.** The tax on the sale of cigarettes is now higher than that on any other consumer product, providing 12% of the overall federal tax yield. A national anti-smoking programme has been established, and smoking has been banned in all offices of the health secretariat.

**Bulgaria.** Doctors have been urged to give up smoking to set an example, and smoking has been banned in areas where pregnant women and nursing mothers are present, as well as in airports, railway and bus stations, railway carriages, aircraft where the flight does not exceed two hours, in rest and eating areas in factories, institutions such as schools, youth hostels and youth club, and in restaurants, except for specially designated areas.

**Canada.** Although 57% of Canadians over 15 years of age do not smoke, more teenage girls are smoking. A nationwide "Weedless Wednesday" is staged each year to alert the public to the smoking hazard. The Fifth World Conference on Smoking and Health will be held in Winnipeg in 1983.

**China.** A major anti-smoking campaign has been launched, with the support of the Vice-Minister of Public Health.

**Denmark.** A Ministry of Health circular advised the provision of non-smoking rooms for patients in hospitals, forbade smoking in waiting rooms, and recommended that health personnel in contact with patients should not smoke.

**Egypt.** An anti-smoking publicity campaign has been stepped up, including efforts to persuade cigarette manufacturers to reduce the tar and nicotine content of their products. There is no mass media advertising of tobacco.

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1 This selection is in no way complete, nor does it attempt to give an adequate representation of all regions of the world; it merely reflects some recent trends. Sources of information include statements made by delegates to the World Health Assembly in May and communications from governments and nongovernmental organizations.
Finland. A comprehensive approach has been adopted, involving health education, legislation, and research into the effects of smoking on health. A total ban on tobacco advertising has been imposed, and smoking has been restricted in public places. These measures have led to a continuing decrease in smoking among men and teenagers. There is now a demand for even more restrictions on smoking at workplaces, and initiatives are being developed with the trade unions. The Tobacco Act provides that 0.5% of tobacco tax revenue must be spent on anti-smoking publicity.

France. The Ministry of Health launched a nationwide programme. 7 April (World Health Day) was the day of the "petite fleur", when French people were invited to give up tobacco for 24 hours at least. Nine million special stamps were issued; a vast range of public information activities included twenty 30-second items on the major television networks, and the issue of one million copies of brochures and printed information.

Federal Republic of Germany. A private health education organization, the German Green Cross, distributed millions of brochures and thousands of displays on the theme of World Health Day. The Federal Government's television channel presented a variety of programmes in some of which people were invited to participate in courses to share their personal experiences and give up smoking.

Greece. Smoking has been banned in cinemas, theatres, hospitals and clinics, and public transport. It is a punishable offence to smoke in all indoor public places. The Ministry of Health is organizing a broad educational campaign to further the decline of smoking.

Iraq. Tobacco has been banned in schools and universities and, during working hours, in all medical establishments and at meetings in State ministries. Tobacco can no longer be advertised in the press or on television, and cigarette packets must carry a health warning. Iraqi Airlines is being encouraged not to sell tobacco on its aircraft. Action has been taken to limit, and gradually reduce, the area of land under tobacco cultivation.

Ireland. The campaign against smoking has been stepped up. A cigarette packet called Conquest contains, instead of cigarettes, 30 cards on how to give up the habit; it is distributed free through chemists.

Italy. A National Committee for the Fight Against Smoking has been set up at the Ministry of Health.

Japan. The Japan Scholars' Association on Circulatory Organs proclaimed 1980 the year to give up smoking.

Kenya. To coincide with World Health Day, a sweeping ban was imposed on smoking on public transport and in theatres and hospitals.

Kuwait. The first legislation against tobacco advertising has been passed.

Malaysia. The country is increasingly concerned about smoking, as the annual per capita cigarette consumption for the population over 15 years of age is about 2000, and increasing at the rate of around 7% annually; more money is spent on advertising tobacco than on any other form of advertising (about 9% of total advertising expenditure).

Netherlands. Legislative measures have been taken to protect the atmosphere in public places: smoking has been prohibited in government schools, cinemas, department stores, theatres, trains and buses. Tobacco advertising in the mass media has been banned, and an intensive campaign to discourage smoking is gaining momentum.
New Zealand. World Health Day, designated as a smoke-free day, served as a launching pad for other anti-smoking activities and was fully supported by the media. A voluntary agreement between the Ministry of Health and the tobacco companies was renegotiated, covering the inclusion of a more strongly worded warning notice and the tar range in advertisements, further restrictions on advertising, particularly at the point of sale, and monitoring of the agreement by the news media's Committee on Advertising Practice.

Nigeria. The tobacco industry in Nigeria, although helping farmers by encouraging crop diversification, has launched massive marketing campaigns. The medical profession, however, is beginning extensive educational campaigns.

Papua New Guinea. The World Health Day theme stimulated the Ministry for Health to consider introducing legislation to reduce and control tar and nicotine in cigarettes made and distributed in Papua New Guinea. Cigarette manufacturers agreed to discuss this matter.

Poland. The number of smokers is now roughly twice as high as in 1955, and the smoking habit is spreading, particularly among women and young people. The World Health Day theme encouraged measures to implement the World Health Assembly resolution on smoking and health.

Portugal. An anti-smoking campaign was held in conjunction with World Health Day, and a national interministerial commission has been set up to formulate a national plan to control the rising number of smokers.

Saudi Arabia. Tobacco advertising has been banned in the press, radio and television, and action is being taken to ban smoking in educational establishments. Smoking is prohibited in the Ministry of Health and its hospitals.

Singapore. An all-out campaign against smoking has been mounted, linked to several diseases related to lifestyle (smoking and overeating). Advertising has been banned in all the media. Laws are being drafted to enforce the printing of warnings on cigarette packets.

Sri Lanka. Action has been taken to ban all advertisements for smoking, smoking in public places and transport has been forbidden, and it is now obligatory for cigarette packets to carry a health warning.

Sweden. Cigarette packets must carry one of at least 16 different warnings, to ensure that the smoker does not become accustomed to the same message.

United Arab Emirates. Tobacco advertising is banned on national radio and television and in official newspapers. Smoking is prohibited in cinemas and educational establishments. Anti-smoking information programmes are under way.

United Kingdom. Discussions are continuing between the Department of Health and Social Security and the tobacco industry to modify and update the present voluntary agreement on the advertising and promotion of tobacco. Particularly controversial is the sponsorship of sports activities by the tobacco companies.

United Republic of Cameroon. The theme "Smoking or health - the choice is yours" had a great impact. Prior to the campaign, even many medical staff seemed unaware of the dangers of smoking.

United States of America. There are still an estimated 350,000 deaths a year due to smoking, but significant gains have been made since 1974, when 42% of adults smoked. The current rate is 34%, meaning that 30 million smokers have successfully given up the habit and millions more have not started. However, more girls are smoking each year. Each year the American Cancer Society holds the Great American Smokeout, to help make Americans aware of smoking risks.
Union of Soviet Socialist Republics. Nationwide propaganda campaigns are under way. A striking success is Sochi, a Black Sea resort, which is a non-smoking city: cigarettes are banned from beaches, restaurants, offices, public and private transportation, and schools and hospitals.