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GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000

Report on monitoring progress in implementing strategies for health for all

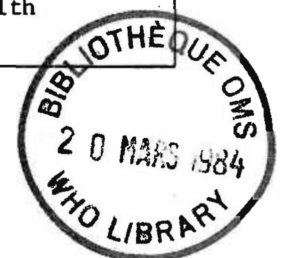
Report of the Executive Board

This report has been prepared in response to resolution WHA35.23, in which the Executive Board is requested to monitor progress in implementing the Global Strategy for Health for All by the Year 2000, and to report to the Health Assembly on progress made and problems encountered.

About three-quarters of the Member States have submitted their progress reports on the implementation of the national strategies for health for all in accordance with the Common Framework and Format, which was prepared to enhance monitoring by countries of the progress made in implementing their national strategies, and to enable them to present the results in a uniform fashion so that they could be used to prepare a regional synthesis. This global report has been prepared from the six regional reports (synthesized on the basis of country reports) and relevant information from the Secretariat, and thus reflects the overall progress achieved in the implementation of the strategies for health for all at national, regional and global level.

In view of the relatively short time that has elapsed since the strategies for health for all were launched, the emphasis at this stage was placed on reviewing the relevance of national health policies to the attainment of the goal of health for all and the progress being made in implementing national strategies with respect to their major thrusts, including the development of appropriate managerial processes which would facilitate their development. The report also examines the relevant regional and global actions in support of the national strategies and summarizes the information received on the 12 global indicators as included in the Global Strategy.

Attention is drawn to the records of the Executive Board's discussion on this matter[1] and to resolution EB73.R6,[2] in which the Board recommends a draft resolution for adoption by the Health Assembly.



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[1] Document EB73/1984/REC/2, summary records of the 5th, 6th, 7th and 11th meetings.

[2] Document EB73/1984/REC/1, p. 4.

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I. INTRODUCTION

1. In 1979, the Thirty-second World Health Assembly launched the Global Strategy for Health for All by the Year 2000, and invited the Member States of WHO to act individually in formulating national policies, strategies and plans of action for attaining this goal, and collectively in formulating regional and global strategies (resolution WHA32.30).

2. The Global Strategy for Health for All by the Year 2000[1] was adopted by the Thirty-fourth World Health Assembly (May 1981). When approving the Global Strategy, the Health Assembly also decided to monitor its progress and evaluate its implementation at regular intervals. It requested the Executive Board to prepare a plan of action for the immediate implementation, monitoring and evaluation of the Strategy. It also invited the Member States to formulate or strengthen, and implement, their strategies for health for all accordingly, and to monitor their progress and evaluate their implementation, using appropriate indicators to this end.

3. In May 1982, the Thirty-fifth World Health Assembly approved the Plan of Action for Implementing the Global Strategy for Health for All[2] (resolution WHA35.23). The resolution called on the Member States, the regional committees and the Director-General to fulfil their responsibilities in carrying out the activities devolving on them for implementing and monitoring the Strategy. It further requested the Executive Board to monitor progress in implementing the plan of action in conformity with resolution WHA34.36 and to report to the Health Assembly on progress made and problems encountered.

4. The Plan of Action[2] calls on the Member States to review, update and formulate as required their national health policies, strategies and plans of action for their implementation, including specific targets as possible; to review and reorient their health systems as necessary; undertake actions which will promote and support the development and implementation of their strategies, including mobilization of resources; and to introduce a process and establish the necessary mechanisms to monitor and evaluate their strategies, including selection of the indicators which would be used for this purpose.

5. It calls on the regional committees to update and adapt the regional strategies as necessary and prepare regional plans of action, considering the possibility of defining regional targets on the basis of national targets; undertake promotional and supportive actions including fostering of intercountry cooperation and mobilization of resources. It also requests the regional committees to decide on indicators to monitor and evaluate the regional strategies, to monitor progress in implementing the regional strategies every two years, and to evaluate the effectiveness of the regional strategies every six years and update them as necessary in relation to the preparation of WHO's General Programme of Work.

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[1] Global Strategy for Health for All by the Year 2000, Geneva, World Health Organization, 1981 ("Health for All" Series, No. 3).

[2] Plan of Action for Implementing the Global Strategy for Health for All, Geneva, World Health Organization, 1982 ("Health for All" Series, No. 7).

6. The plan also assigned specific action to be taken by the Executive Board, the Health Assembly and the Director-General in support of the implementation of the strategies. The Executive Board is called upon to monitor progress in implementing the Strategy every two years following the monitoring of progress by the regional committees; review in intervening years reports on the implementation of the Strategy presented by the Director-General in accordance with resolution WHA34.36; and evaluate the effectiveness of the Strategy every six years in relation to the preparation of WHO's General Programmes of Work, following the evaluation by the regional committees.

7. According to the Plan, the Member States were to submit the first progress report on implementation of their strategies to the regional committees in March 1983, while monitoring of progress in implementing the regional strategies was to be carried out by the regional committees in September 1983. The Executive Board will monitor progress in implementing the Global Strategy in January 1984 and submit a report to the Health Assembly, including recommendations for adjustment of the Global Plan of Action as necessary, in May 1984.

8. This global report has been prepared from the six regional reports[1] (which in turn were prepared on the basis of country progress reports) and relevant information from the Secretariat, and thus reflects the overall progress achieved in the implementation of the strategies for health for all at the national, regional and global levels.

9. In view of the relatively short time that has elapsed since the strategies for health for all were launched, it was considered appropriate that countries should concentrate at this stage and in this first progress report on the monitoring of the <u>relevance</u> of their health policies to the attainment of the goal of health for all and on the <u>progress</u> made in implementing them. In assessing <u>progress</u>, the main emphasis has been placed on finding out to what degree strategies have already been formulated and are actually being carried out and on indicating wherever possible reasons or factors which are facilitating or impeding progress. In addition, an effort has been made to collect information, to the extent possible, on the 12 global <u>indicators</u> agreed upon by the Health Assembly.

10. A Common Framework and Format was prepared for the monitoring of national, regional and global strategies.[2] The document, whose basic aim was to enhance monitoring by the countries of progress made in implementing their national strategies, was also intended to enable them to present the results of monitoring in a uniform fashion so that these results could be used to prepare regional and global syntheses. The Common Framework and Format was reviewed and approved by the regional committees in 1982, and Member States were requested to submit their reports to the corresponding regional director by March 1983 so that they could be consolidated at the regional level. The table below shows that about three-quarters of Member States have sent progress reports to their regional office. The consolidated regional reports were then sent to WHO headquarters for the preparation of the global report. The regional committees reviewed their regional reports in September and October 1983; their comments and recommendations have been incorporated in the global report.

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[1] Documents AFR/RC33/12, AMR/CD29/24, SEA/RC36/14, EUR/RC33/10, EM/RC30(83)/5 and WPR/RC34/7.

[2] Common framework and format for monitoring progress in implementing the strategies for HFA/2000 (document DGO/82.1).

Number of progress reports received from Member States, by WHO region[1]

Region	Number of reports		Coverage (%)
	Expected	Received	
Africa	44*	37	84
Americas	31	19	61
South-East Asia	11	11	100
Europe	35	21	60
Eastern Mediterranean	23	22	96
Western Pacific	17	12	71
All regions	161*	122	76

* Including 1 Associate Member.

II. PROGRESS AT COUNTRY LEVEL, INCLUDING ANALYSIS OF SELECTED GLOBAL INDICATORS

11. As indicated earlier, at this phase of the monitoring process the emphasis is placed on reviewing the relevance of national health policies to the attainment of the goal of health for all and the progress being made in implementing national strategies with respect to their major thrusts, including the development of appropriate managerial processes to facilitate their implementation.[2]

Health policies and political commitment

12. The Strategy for Health for All is based on the following fundamental policies: health is a fundamental human right; an equitable distribution of health resources leading to universal access to primary health care and its supporting services is required; emphasis should be on the right and duty of people to participate in their health care; governments have a responsibility for the health of the people, and therefore high-level political commitment is essential; health should be considered as an integral part of development, and the coordinated efforts of many social and economic sectors will be required to achieve health for all.[3]

13. Countries were asked to examine the relevance of their existing national health policies to the goal of health for all.

14. The responses indicate that a large majority of the countries answering have reviewed their health policies and practically all felt that their policies were geared to the attainment of health for all. In some countries, health policy review was a continuous process for some years even before the Declaration of Alma-Ata, although many others have only recently reviewed and appropriately adjusted their health policies, incorporating the principles of the Alma-Ata Declaration. Several countries have a clause in their constitutions ensuring the right to health for every citizen, and most countries endorse the government's responsibility for the protection of their people's health.

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[1] In mid-1983 WHO had 160 Members and one Associate Member.

[2] Common framework and format for monitoring progress in implementing the strategies for HFA/2000 (document DGO/82.1).

[3] Global Strategy for Health for All by the Year 2000 ("Health for All" Series, No. 3), op. cit.

15. Existing health policies in most countries recognize health as an integral part of development and the importance of coordinated intersectoral action for health. A high level of political support for health in some countries is evident, as reflected in the statements of heads of state, the establishment of high-level interministerial bodies for health, and the incorporation of health policy objectives in socioeconomic development plans. Of the 107 countries which provided information on global indicator 1, 103 answered positively, two stated that a partial endorsement has been received, and only two replied negatively.[1]

16. While in principle the existing national health policies conform to the Alma-Ata Declaration and are oriented to the achievement of health for all, they differ in their contents, the means by which they were formulated, and the level of endorsement they have received in the government. In some countries the policies express the need to give greater attention to special groups (such as the aged, or disabled persons) or special geographical groups that are underserved or unserved. Some countries in the European Region have included in the policy provisions the right of individual access to medical care, control of environmental pollution, continuous improvement in living, housing and working conditions, and increased emphasis on medical scientific research. The right of individuals to education and information on health matters and the participation of people as individuals or groups is emphasized. All countries have stressed the strengthening of primary health care and preventive measures for the protection of health of the people.

17. Very few countries have taken specific steps to adopt appropriate legal provisions to give effect to their policies. Most of the developing countries appear to be concerned with the gross inequity in the distribution of health resources. Some countries, particularly the least developed ones in Africa, have commented that they do not have the means to become self-reliant.

18. It is evident that a high level of political sensitization to the goal of health for all has taken place in the countries. National health policies, however, do not indicate how social equity in health will be achieved except in a few countries where special consideration for unserved or disadvantaged groups has been included in socioeconomic development plans.

19. The establishment of national health policies is a continuing element of the health development process and requires some system for the periodic review of existing health policies, the refinement of policy measures, the shifting of priorities and identification of specific goals and objectives for disadvantaged groups, on the basis of information refinements and the progress being achieved. Very few countries have established mechanisms such as an intersectoral council to review progress periodically and to define and promote action in other sectors to support health. Countries will need to refine their policies further, especially to achieve a more equitable allocation of health and health-related resources. Countries where a high-level political commitment has not yet been made will need to do so in the near future.

Formulation of national strategies and plans of action

20. Countries are called upon to review their national health strategies in the light of their health policies, to update or formulate these strategies as necessary to achieve clearly stated objectives and, wherever possible, specific targets, and to indicate broad lines of action to be taken to achieve them. The implementation of these strategies requires the formulation of a well-defined plan for principal actions which need to be undertaken, such as organization or reorientation of health systems based on primary health care and integration into these health systems of country-wide programmes that deliver appropriate health technology; development of health infrastructure support, including health manpower development; and measures to involve communities. These plans should indicate the time-frame, resource projections and allocations, and responsibilities for the implementation of these actions.[2]

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[1] Global indicator 1 is defined as the number of countries in which health for all has received endorsement as policy at the highest official level.

[2] Global Strategy for Health for All by the Year 2000 ("Health for All" Series, No. 3), op. cit.

21. To assess the level of progress being made in the development of national strategies and plans, governments were requested to report on the status of formulation of their national strategies and plans of action and the extent to which their national health strategies formed an integral part of their national socioeconomic development plan.

22. The majority of countries indicated that they have continuing activities related to the formulation of national strategies. Some have either formulated their national strategies for health for all or are in the process of reviewing and adjusting their national health strategies, incorporating the principles of the Alma-Ata Declaration. A few countries have indicated that their strategies have been within these principles for many years (even before the Alma-Ata Conference) and hence there is no need to adjust them.

23. A few countries have developed long-term plans covering two decades up to the year 2000. Examples of these plans given are: "An outline of health development for the coming two decades" in China, "Strategy and plan of action for achieving health for all Filipinos by the year 2000", "A long-term prospective health plan for the year 2000 as part of the national development strategy in the Republic of Korea", and a "Long-term health development plan" in Indonesia. In most of the countries, however, the plans have been formulated for a medium-term period (five years), generally corresponding to the period of the national socioeconomic development plan. Several countries have also reported that their health plans are an integral part of their socioeconomic development plans. In some countries national plans of action are tentative, awaiting government approval, or are in the process of being formulated. Several have reported that they have not formulated their plans.

24. In most cases, however, the national plans are very general and give overall objectives, emphasize main priority areas such as improvement of community-based services, improvement of the health of specific population groups, or control of certain diseases, and indicate main strategies focusing primarily on the expansion of health systems, with primary health care as the basis. They do not include specific targets, a time-frame or a projection of resources. Specific definitions of the actions and policies proposed and the health implications of alternative strategies are not given adequate consideration.

25. Even where in principle the health plans are an integral part of socioeconomic development plans, the links between national socioeconomic plans and programmes in health and health-related sectors are not clearly defined. Some of the developed countries (European Region) have emphasized plans in other sectors that support health, such as housing, social services, reduction of unemployment, and environmental control. In most countries, however, identification of those aspects of development schemes that can either promote or threaten health has not received adequate attention from economists and health planners.

26. Few countries appear to have adequate planning processes installed as an integral part of management processes for health development. The planning process requires an adequate feedback of information which would permit adjustments, refinement of targets, and allocation of resources. It is evident that in most countries planning processes need to be strengthened and supported by the improvement of health information systems and management training. Suitable methodologies for intersectoral planning are still to be developed and utilized to show the effects of alternative strategies for integrated development programmes.

Progress achieved in the implementation of national strategies

27. The main thrust of the Strategy for Health for All is the development of the health system infrastructure, based on primary health care, for the delivery of country-wide programmes that reach the whole population. The Strategy involves specific measures to be taken by individuals and families in their homes, by communities, by the health services at the peripheral and supporting levels, and by other sectors. A high degree of community involvement is essential. The goal of health for all cannot be achieved by the health sector alone; coordinated action with other sectors, especially health-related sectors, is therefore crucial. While the Strategy calls for self-reliance of the countries in achieving the goal of health for all, many countries may not yet be in a position to become self-reliant and hence they need to cooperate with other countries and establish effective mechanisms for doing so,

including the encouragement of a flow of financial and technical resources from the developed to the developing countries.[1]

28. Only two years have elapsed since the approval of the Global Strategy, and many countries are in the process of formulating or adjusting their national strategies and formulating plans of action for their implementation. However, the processes for the review and strengthening of health systems to provide health services to a greater number of people have been under way for the past several years. It is thus not too early to review the status of development in the countries of some of the key processes considered crucial to the achievement of the goal of health for all.

Health systems development

29. Countries have recognized that concerted efforts will need to be made to develop health systems of which primary health care is the central function and the main focus, in conformity with the Declaration of Alma-Ata and in line with the recommendations and details concerning primary health care contained in the report of the Alma-Ata Conference.[2] The need for wider coverage of services, more inter- and intrasectoral coordination, administrative decentralization, and greater involvement of communities in decision-making and implementation have important implications for the organization of the health systems and their management. National health systems require the capacity to identify problems and recognize groups of action or priority actions which need to be taken to solve these problems. Where appropriate, existing health services delivery systems will require a systematic review in order to define what mix of the health services delivery system is appropriate to achieve the goal of health for all; what the contents of the services to be delivered and the technologies to be used should be at each level; and what resources - physical, material and human - are appropriate to support each level in order to achieve a well-coordinated infrastructure, starting with individual, family and community care, and continuing with intermediate and central support and referral levels.

30. Countries were asked to provide information on the extent to which they have reviewed and adjusted their health systems to reflect the essential characteristics of such systems based on primary health care, including the necessary health programmes and infrastructures.

31. The reports indicate that several countries have initiated efforts to review their health systems and to define the reorientation needed. Some countries have begun to implement some of the changes, such as reorganization of the central levels of ministries of health and definition of the roles and functions of the intermediate administrative levels, with emphasis on increasing decentralization of authority and responsibilities. A few countries have reviewed their existing public health laws and introduced revisions in support of the changes desired.

32. Several countries have taken steps to define more clearly the levels of health care delivery systems, the linkages, and referral mechanisms. The emphasis in all cases is on strengthening the community-based health services and the corresponding health infrastructures. To achieve the latter, many countries have introduced and trained new categories of health workers at the community level or strengthened the role and technical capacity of existing health workers, established informal or formal mechanisms to give more authority to the community and intermediate level health administration, and provided additional physical and financial resources to expand the community-based health services.

33. The need to strengthen managerial capacity in their health systems is recognized by most developing countries and some have initiated efforts in this direction. Examples given are improvement of health information systems to strengthen monitoring and evaluation processes; coordination of research and reorientation towards priority areas; and improvement of coordination mechanisms at different levels, e.g., establishment of health councils or committees. Very few have actually introduced administrative reforms, including legal measures, to decentralize administrative authority.

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[1] Global Strategy for Health for All by the Year 2000 ("Health for All" Series, No. 3), op. cit.

[2] Alma-Ata 1978: Primary health care, Geneva, World Health Organization, 1978 ("Health for All" Series, No. 1).

34. Some countries, particularly the developed countries, have indicated that there is no need to adjust their existing health systems but rather to shift the emphasis to services outside the hospitals and to priority programmes such as the control and prevention of diseases of concern, the reduction of disability-causing conditions, and the establishment of services to reach underserved areas and disadvantaged or special population groups, especially the elderly and the handicapped. A few have even indicated that their health systems are already in line with the principles of the Alma-Ata Declaration and are achieving good coverage of the population.

35. In general, to summarize from the available reports, a large majority of countries have accepted the need for reorienting their health system and strengthening their managerial capacities, with emphasis on the strengthening and expansion of primary health care services. From the types of approaches taken by the countries, it is clear that, in general, countries have recognized what needs to be done to develop and strengthen their health systems.

36. Reorientation of existing and established health systems is a long-term, complex and dynamic process which requires a continuous feedback of information and, in many areas, trials to define clearly what changes are required and which would be effective or feasible. Countries have not given much information on how these changes are being brought about, what constraints and difficulties are being experienced in bringing about these changes, or how effective some of these changes have been. It is evident therefore that national capabilities for the collection, analysis and utilization of information in support of the managerial process for health development require strengthening. In this area, countries can learn much from each other. There is also a clear need for health services research and simple, pragmatic and effective procedures and methodologies which the countries could develop and utilize in bringing about the desired changes in the health system.

37. Issues concerning the appropriate mix of health technologies, especially for the essential components of primary health care, and a balanced approach to the delivery of these technologies through a well-defined health infrastructure which supports primary health care, are still confronting countries in their efforts to develop their health systems.

Community involvement

38. One of the most dynamic factors in the achievement of the goal of health for all is the active involvement of communities in the process of health development and in the promotion and adoption of positive attitudes towards health by the people of the region. Effective community involvement in health is multifaceted. It requires involvement of the communities in identification of needs and in planning and decision-making processes for health development; an understanding by communities of their responsibility in contributing towards health resources and ensuring proper utilization of the resources available; and acquisition and transmission of better information and knowledge about health and disease in order to take responsibility for maintaining health and preventing illness. It also implies delegation of authority and the allocation of resources to the communities. It calls for the training of health staff able and willing to engage in a dialogue with communities.

39. Countries were requested to provide information on progress being achieved in involving communities in planning and carrying out their national health strategies.

40. Most countries recognize the need for community involvement, which is not new in many countries. Of the 97 countries that provided information on global indicator 2, 78 replied affirmatively, two indicated a partial involvement, and 17 stated that there was no participation.[1] Community involvement appears to be lowest in the countries of the Americas (in 26% of the reporting countries) but is reported to be high in the South-East Asia and the European Regions (100% of the reporting countries). Various mechanisms and approaches have been utilized in some countries for many years to bring about effective community involvement in health and development.

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[1] Global indicator 2: The number of countries in which mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning.

41. The principle of community involvement at all levels of health development has been incorporated in many of the national health policies and in some in the overall development policies. Some countries gave examples of the approaches and mechanisms being used and strengthened, particularly to bring about community involvement in decision-making processes. These include the establishment of national health councils which include community members, and health committees or councils at the local level with the active involvement of community leaders. The role of many nongovernmental organizations, professional groups and voluntary groups (women's groups, youth associations, trade unions, pharmaceutical associations, medical associations, consumers' associations, religious and business groups, the Red Cross or Red Crescent, etc.) in health matters is increasing in many countries and is proving supportive. A few countries have actually decentralized power and authority for the management of health resources to the community level through appropriate administrative reforms. Wherever this has occurred, community participation has been reported to be more effective. In some countries, the control of and contributions to health resources at the community level have increased, for example in the share of hospital beds available at the intermediate level, the financing of health centre construction, and the management of community-based pharmacies. In others, communities are contributing resources such as material and labour for health and volunteer health workers have been trained who are supported both by the health system and the communities. The latter play an important part in the selection of these health workers.

42. Some countries have used and/or extended the role of existing mechanisms for community involvement such as village-level development councils and community councils. Very few have actually introduced appropriate legal and/or administrative reforms to make these mechanisms more effective. In a few countries community involvement has also been organized around specific health problems or projects such as water and basic sanitation, environmental improvements, and immunization campaigns. These have generally been intensive but sporadic involvements and have not been sustained.

43. Several countries have reported that they have not initiated any significant measures for increasing community involvement and have no well-defined policy for this. A few are initiating experimental projects to gain experience.

44. In general, the need to involve communities in health is recognized and accepted by most if not all, and countries are trying several approaches to bring about such involvement at various levels of the health system. The reports give relatively little information on what is effective and what is not, and whether the countries have been able to sustain motivation and involvement. Hardly any information was given on efforts made to promote health literacy through information to the communities about health and disease in order to increase their self-reliance and to inculcate a spirit of responsibility for their own health. The reports do not indicate what difficulties are being experienced in this sensitive and complex area and how some of them are being resolved.

45. The experience of some of the countries appears to indicate that real decentralization of responsibility, authority and resources to the community-level health system is essential. Such experiences need to be shared with other countries so that their relative feasibility in other cultural, political and administrative settings can be examined.

46. It is obvious that much more effort needs to be devoted to developing effective education and information strategies to involve individuals, families and communities in taking more responsibility for their health. Countries can learn much from each other through sharing their experience, technologies and materials in this field.

Orientation and training of health workers

47. The health delivery system is labour-intensive in its functions, and health manpower represents its most important asset. The stress on primary health care has placed new emphasis on the need for qualitative and quantitative changes in health manpower, as well as a better geographic distribution of such health manpower. A comprehensive approach to health manpower planning and development efforts based on health systems review and reorientation plans is required. Existing health workers have to be reoriented and trained in order to

expand and improve their technical knowledge and skills so that they can function effectively in their new or expanded roles, especially at the community level, and new categories of health workers are needed to complement those that exist in the health systems. Steps to ensure that future health workers receive training that is more appropriate to their expected functions within the health system are also required.

48. Countries were requested to report on progress made in orienting and training health workers to fulfil their role in planning and carrying out the Strategy.

49. The reports indicate that this area in general is receiving much attention in all countries, although to different degrees. Many countries appear to have recognized and accepted the need for reorientation and training of health workers in line with the primary health care strategy and have initiated specific actions to achieve this.

50. The emphasis in a large number of developing countries is on reorientation and training of health workers in the community health services. Many countries have introduced new categories of health workers at the community level and are implementing training programmes for them. Training or reorientation of existing health workers at the community level, such as traditional birth attendants, midwives and community health workers, has been extensively undertaken by many countries. In some, training of volunteers has also been encouraged and supported.

51. The changing roles of nurses and intermediate-level health workers have been recognized by some countries and training programmes have been initiated to prepare them for their expanded roles. Basic training programmes for these health workers are being reviewed and revised to reflect the principles of primary health care and provide community-based orientation in several countries. Countries have not reported on administrative or legal reforms they have undertaken to formalize the expanded or changing functions and roles of these health workers within the health system.

52. Some countries have recognized the need to change the training of physicians and to reorient the existing medical manpower to community health services. In a few countries, community-based medical schools have been initiated, while others are strengthening or establishing faculties of community medicine in medical schools. Some of the developed countries have particularly emphasized the need to give physicians more training in health education and to shift the emphasis in the training of physicians from the hospital-based to the community- and family-oriented physician.

53. The need for training in management and supervisory skills has been recognized in a few countries and workshops/seminars are being developed to improve these skills, particularly for health workers at the middle-management level.

54. Very few countries mentioned the formulation of health manpower development plans consonant with the needs of their health systems. The role of teaching institutions and the needs for the preparation of teachers have not been adequately considered by the countries in their health manpower development efforts.

55. It may be concluded that the principle of improving and strengthening the capacity of health workers, the principal resources in health systems, has been accepted in most countries. Only a few did not report on any particular initiative in this area. Efforts to date have concentrated much more on the reorientation of existing health workers in community health services or the training and deployment of new categories of health workers at the community level than on the adoption of a more comprehensive approach to manpower development based on a review of health systems and plans for the introduction of the changes required.

56. Development of health systems based on primary health care has important implications for health manpower resources in the health systems. Emphasis on health workers functioning as a health team supporting and complementing each other and on management and supervisory skills increases. Interprofessional conflicts or jealousies can appear if roles are not adequately defined. Countries did not provide information on supporting administrative or legal reforms in this area. Countries also did not provide information on the effect of their training

efforts on the actual practice and attitudes of the health workers. Have they become more community-oriented? Are they accepting their role and providing appropriate information so that individuals and communities increase their self-reliance and responsibility in health, or are they still functioning as providers of health care? Has the motivation of health workers improved and been sustained so that they remain in the community-based health services and in rural areas? How are the attitudes of the higher professional-level health workers being modified and interprofessional conflicts being resolved? Adequate attention should also be paid to the development of effective training approaches and methodologies and appropriate learning materials. The role and involvement of training institutions in support of this process is extremely important and effective dialogue with these institutions, as well as with professional groups, has still to be established in order to gain their support for the implementation of health manpower development plans.

57. It is evident that more intensive and simultaneous action is needed in many areas, including changes in basic curricula of health workers; training of well-prepared teachers; reorientation of existing health workers to expand their skills and knowledge in accordance with their new or altered roles; and preparation of new categories of health workers. Essential to this process is the analysis and redefinition of the role of each category of health worker corresponding to each level of the health care system and in relation to each member of the health team.

Mobilization of material and financial resources

58. Just as the successful implementation of the Strategy will mean mobilizing all possible human resources, it will also depend on mobilizing all possible financial and material resources. This implies that the existing resources within and among countries will be equitably distributed and more efficiently used. At the same time, additional resources for health will have to be generated. This calls for the countries to review the distribution of their national budgets, in particular allocations to health and health-related sectors, and to reallocate existing resources as necessary for the provision of primary health care, especially to underserved population groups. It further calls for countries to estimate their overall financial needs to implement their national strategies up to the year 2000, identify activities for external support, and take appropriate action to generate the necessary support from both national and external sources.

59. Countries were requested to report on progress in mobilization of material and financial resources.

60. Countries in general experienced difficulties in measuring the percentage of their GNP spent on health and it seems that many countries have not yet developed the mechanisms to estimate the financial resources spent on health. Only 63 of the 122 countries were able to provide an estimated percentage of GNP spent on health and of these more than half spent less than 5% on health.[1] Even fewer (50) were able to provide the percentage of their health budget devoted to local health care.[2] Thus many countries find it difficult to analyse health expenditure and define precisely what is being spent for primary health care. This is partly due to the existing budget structures or to the lack of simple procedures for budgetary analysis.

61. A few countries have undertaken or initiated reviews of the distribution of their health budget and have indicated the need to increase the allocation of financial resources to primary health care. Reallocation or changes in distribution of existing health budgets has not been found easy, as in general there has been no or very little real increase in health budgets and the expenditure to support the existing health care structure must continue to be met. Without a serious reorientation of health systems, changes in the budget distribution will not be feasible in most of the developing countries.

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[1] Global indicator 3: The number of countries in which at least 5% of the gross national product is spent on health.

[2] Global indicator 4: The number of countries in which a percentage of the national health expenditure is devoted to local health care.

62. Some countries, however, are making efforts to increase the allocation to primary health care either from existing health budgets or by directing any additional resources that become available to primary health care. Several countries have prepared projects in collaboration with bilateral and multilateral agencies to obtain grants or loans to develop the health infrastructure for primary health care, especially in underserved rural and marginal urban areas. In many of the developed countries, concern is expressed about the constant rise of health expenditure, particularly because of the high-cost technologies being utilized. Hence research on health economics, the assessment of existing technologies, and studies on relative cost-benefits and better distribution of resources are receiving special attention. Efforts are also being made to increase contributions from individuals and communities for their health care. Some countries have initiated or expressed interest in developing alternative approaches to financing to increase the efficiency of the health care delivery system and to studies on the cost-effectiveness of different technologies and models to meet the health needs of their people.

63. Very few countries have carried out health resource utilization studies, and even fewer have prepared an overall master plan for resource requirements taking into consideration available national resources and projections for additional resources, national as well as external.

64. The types of health projects being considered for support by some bilateral and multilateral funding agencies indicate that there is a trend towards channelling additional resources to the underserved population and to strengthen some components of primary health care. If this trend continues it may also help to increase allocations from national budgets to support recurring and maintenance costs. Whether this will bring about a more equitable distribution of resources remains to be seen. Most countries need to achieve a real reorientation of their health care delivery systems, giving more emphasis to the provision of health care outside the hospitals, strengthening their activities in prevention and health promotion, and utilizing technologies that are really needed and that they can afford.

65. Managerial processes in the health systems will also require strengthening, particularly the planning process, which should be based on information feedback so that countries can define their priorities more clearly, develop their health budgets according to programmes and not items of expenditure, and analyse and allocate their resources in accordance with their priorities and objectives. More countries will have to identify their overall needs and prepare a plan for the mobilization of resources, both national and external.

Coordination within the health sector, and with other sectors concerned with health development

66. The strategies for health for all call for increased coordination within the health sector, especially collaboration between the various health services institutions and agencies belonging to government, social security and the private sector, and coordination and effective linkages between the various levels of health care systems. As health is recognized as an integral part of the development process, the adoption of intersectoral development strategies is not only essential for the achievement of health for all but equally necessary for progressive advances in all other sectors and towards social equity. Countries are urged to devise mechanisms and ways for ensuring adequate and effective cooperation between health and other sectors.

67. The review of progress has shown that efforts are being made to varying degrees in these areas. In general, in many countries there appears to be an increased consciousness and awareness of the need to bring about more effective coordination within and outside the health sector and efforts to improve coordination have been initiated. Coordination appears to be relatively easier to achieve in smaller countries.

68. Several approaches have been undertaken by countries, such as the establishment of more appropriate organizational structures for the health system, including definition of functions and relationships of different levels of the health care delivery system; improvement of linkages and referral mechanisms between the community-based health services and hospitals;

and establishment of national health development councils on which a number of institutions, including the private sector, are represented. Some countries are unifying their national health system, incorporating the social security institutions in the structure for delivery of health services where such participation is already extensive or increasing in order to achieve better coordination and avoid duplication of services. The degree to which effective coordination has developed, especially between the different levels of the health care system and among the special health programmes, has not been reported adequately.

69. Many countries are instituting mechanisms for intersectoral action on health, for example, the establishment of intersectoral committees to promote health at the ministerial level or to deal with specific health action programmes in such fields as environmental health, nutrition, population, and rural development. At the intermediate and local levels, village development committees and village health councils or committees which include representatives of various sectors as well as community leaders have been set up. A few countries have established national health development networks, but their effectiveness has not been reported. From the reports it appears that efforts to achieve intersectoral coordination at intermediate and village levels have been more effective where administrative or legal measures have been taken to increase authority for action at those levels.

70. The reports also indicate that there is an increased awareness and recognition of the need to incorporate health components into development projects, especially agricultural and industrial development sectors. Health implications of rapid urbanization and industrial development are being increasingly recognized and some countries have taken measures such as zoning for industrial projects; measures to limit urban migration; and monitoring of people's health where large-scale development projects or construction of irrigation and hydroelectric systems have been undertaken. Projects which may have deleterious effects on health are being monitored more carefully and safety rules are being introduced in industrial projects in the developed countries.

71. Not all countries have reported progress in achieving intersectoral coordination. Some have found it very difficult to involve other sectors in health development or to include a health component in development projects being undertaken in areas where health services are inadequate or nonexistent.

72. While a variety of mechanisms have been introduced and institutionalized by many countries, their degree of effectiveness is not known. Where coordination appears to have been achieved to some degree within the health sector, real decentralization of authority and power has been introduced through administrative and legal measures. Coordination among different levels of the health care delivery system and institutions and between different categories of health workers through better definition of their roles and tasks still needs much attention.

73. Countries are giving increasing attention to health hazards and impacts of development projects, but not enough to introduce the health component when such projects are being developed for hitherto underserved areas. The health sector will have to engage other sectors selectively in a process of joint planning for health. In the prevailing economic conditions in most countries, the ability of the health sector to ensure an adequate allocation of resources for primary health care is limited and the situation demands a more active dialogue and involvement with the often more powerful and affluent sectors of the national economy. Likewise, efforts to mobilize support from the private sector and the nongovernmental organizations will need to be intensified.

Cooperation with other countries

74. The Strategy for Health for All underscores the need for intercountry cooperation, as some developing countries and particularly the least developed ones, in the present state of their health resources and economic development, will not be able to achieve their health objectives alone. Cooperation among countries in sharing resources and the transfer of technical and economic resources from the developed to the developing countries are therefore crucial.

75. Countries were requested to provide information on the cooperation developed with other countries in implementing their national strategies and the amount and types of resources received or offered for health development.

76. All countries that reported expressed the need for more effective cooperation among countries, particularly in the areas of training, research, information exchange and communicable disease control. Some referred to the need to increase the flow of technical and economic resources from the developed to the poorer countries. Specific information on the actual amount and trend of resource flow from the developed to the developing countries is lacking.

77. Existing mechanisms for regional or geopolitical cooperation have been utilized and in some cases strengthened for cooperation in health matters as well as promotion of specific cooperative efforts. Examples given of these mechanisms are the Association of South-East Asian Nations (ASEAN) and the South Pacific Commission in the Western Pacific Region; the Council of Arab Ministers of Health and the Council of Ministers of Health of the Arab Countries of the Gulf Area in the Eastern Mediterranean Region; the Nordic Council, the Council for Mutual Economic Assistance, the Organization for Economic Cooperation and Development and the Council of Europe in the European Region; South Asian Regional Cooperation and ASEAN in the South-East Asia Region; the River Plate Basin Group, the Caribbean Community, the subregional Andean Group of countries, and the Meeting of Ministers of Health of Central America and Panama in the Region of the Americas; and the Economic Commission for Africa in the African Region. In many regions or subregions, these mechanisms are being used to attempt to increase the flow of financial resources from the developed or richer countries to the developing and less fortunate countries, for example in the Eastern Mediterranean and European Regions. The agreement between the Nordic countries has been amended in the spirit of health for all to emphasize preventive health activities and primary health care.

78. In the African Region, technical cooperation among developing countries is playing an increasing part, especially with regard to the manufacture and distribution of essential drugs and vaccines. Lesotho has set up a pharmaceutical manufacturing plant which is supplying Botswana, Malawi, Mozambique, Zambia and other countries with drugs under nonproprietary names. Zimbabwe is similarly involved through the Central African Pharmaceutical Services (CAPS). The Great Lakes Economic Community has brought together Burundi, Rwanda and Zaire for the production and control of essential drugs and vaccines. Laboratories in Ethiopia, Ghana, Kenya, Madagascar, Senegal and Zimbabwe are acting as collaborating centres for vaccine quality control. Training courses using TCDC mechanisms have been organized in Kenya to enable participating countries to share their experience of essential drug distribution in rural areas.

79. Special meetings of ministers of health have been organized in South-East Asia, Africa and the Americas to promote and foster intercountry consensus and cooperation on important health matters among the countries of the region and to promote concerted action for the implementation of strategies for health for all. Regional health charters have been formulated in the South-East Asia, African and Eastern Mediterranean Regions, and regional targets have been established by the countries of the Americas and are being considered by the European Region.

80. Intercountry cooperation in health is a long established tradition, especially in the surveillance and control of communicable diseases and training. This cooperation is now being extended for the promotion of efforts which, it is hoped, will stimulate national health development based on primary health care and promote effective action on priority health problems affecting a large majority of people in the developing countries. Sharing of technical know-how and information is essential for this process and more effective mechanisms must be developed for information flow. Real equity, however, can only be achieved through the transfer of financial resources from the richer countries to the poorer, especially the least developed countries which lack the resources to become self-reliant or even to improve their existing health services. Monitoring of these resources is important to reflect trends as well as to ensure that they are being channelled to priority health problems and to extend primary health care to the hitherto unserved and underprivileged population groups. The emphasis must however be on building up national capacities so that the countries ultimately become self-reliant.

III. REGIONAL AND GLOBAL ACTION IN SUPPORT OF IMPLEMENTATION OF THE STRATEGIES

81. The Global Strategy identifies international action to be taken by WHO to support national action for the implementation of strategies for health for all. It specifically calls for the formulation of the Organization's General Programmes of Work in response to the Strategy, and in relation to the restructuring of the Organization in the light of its functions in support of the Strategy, as decided by the Thirty-third World Health Assembly. The Organization is requested to promote and coordinate action in support of the Strategy within the United Nations system, to mobilize the support of banks, funds and multilateral and bilateral agencies for health, and to promote the Strategy through nongovernmental organizations and the use of mass media.

82. WHO is also requested to facilitate technical cooperation among its Member States, and to promote intersectoral action at international level through the establishment of bilateral and multilateral arrangements with other organizations of the United Nations system. Other areas identified for WHO's action are international mobilization of people and groups who can support the Strategy and coordination of international transfer of resources in support of the strategies of developing countries.

83. In this section WHO's regional and global health policies and programme directions and its functions and structure, with particular emphasis on their relevance to the support of the national strategies, are reviewed. Action taken by the governing bodies of WHO and its Secretariat in support of the Global Strategy as defined in the Plan of Action is also examined.

Regional and global health policies, strategies and programme directions

Relevance

84, The process of formulation, updating and adoption of regional and global strategies has been a very dynamic one and was launched following the Declaration of Alma-Ata and the adoption of resolution WHA32.30 by the Thirty-second World Health Assembly in 1979. In all regions, regional strategies were formulated during 1980 and reviewed during 1981 in the light of the Global Strategy for Health for All, which was approved by the Thirty-fourth World Health Assembly. The process for the formulation of regional strategies, policies and plans of action has varied a little from region to region.

85. The overall objective of the regional strategy for health for all by the year 2000 for the African Region[1] is to provide primary health care to all individuals, families and communities in the Region with their full participation and to strengthen regional solidarity through TCDC. The specific objectives focus on the development of comprehensive health systems based on primary health care, promotion and utilization of appropriate health technologies for the eight essential elements of primary health care, and promotion and support activities. The strategy identifies major political, economic and technical measures to be taken for the achievement of objectives.

86. The regional strategies of the Region of the Americas,[2] as adopted by the Regional Committee in October 1980, serve as a broad guide for the countries of the Americas to attain health for all by the year 2000. The goal of health for all is defined in terms of priorities for human groups, health status and structure, and wellbeing profiles. The principal strategy adopted to achieve those goals is that of primary health care. The strategy includes regional objectives and minimum regional goals, which reflect the reality within the Region. A plan of action for the implementation of regional strategies for health for all by the year 2000[3] has also been adopted, reaffirming the regional objectives and goals.

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[1] Regional strategy to achieve the social target of health for all by the year 2000 (document AFR/RC30/3, July 1980).

[2] Health for all by the year 2000; Strategies. PAHO/WHO, 1980 (Official Document 173).

[3] Health for all by the year 2000: Plan of action for implementation of regional strategies. PAHO/WHO, 1982 (Official Document 179).

87. The health policies in the South-East Asia Region,[1] as reflected in the Charter for Health and the resolutions of the Regional Committee, are also directed towards the attainment of the social goal of health for all by the year 2000. Their aim is to promote harmonious and integrated health development in all countries of the Region so as to reduce the inter- and intra-country disparities in the health field. The regional strategy has also been refined and updated in the light of the Global Strategy, incorporating its main targets; its principal objectives relate to the improvement of health status, health care delivery, and quality of life.

88. The regional strategy in the European Region[2] aims at a fundamental reorientation of health policies in three main areas: promotion of life styles conducive to health; reduction of preventable conditions; and provision of adequate, accessible and acceptable health care, based on the development of primary health care. Regional targets are also being considered, and these together with a revised regional plan of action will be submitted to the thirty-fourth session of the Regional Committee in 1984.

89. The main long-term objectives of the strategy for the Eastern Mediterranean Region[3] are to achieve general coverage of the population by primary health care and to increase life expectancy to a minimum of 65 years. The strategy includes specific objectives relating to the eight essential elements of primary health care and identifies the principal support measures - political, economic and technical. It emphasizes generation and mobilization of resources and intercountry collaboration.

90. In the Western Pacific Region,[4] a regional strategy and a plan of action for the implementation of the regional strategy have been adopted by the Regional Committee. The main thrust of the regional strategy is the development of health systems based on primary health care, with particular emphasis on the improvement of managerial processes, reorientation and training of health and health-related personnel, research on appropriate technologies and health care delivery systems, practical evaluation procedures, development of information systems, exchange of information, and mobilization of external resources.

91. At the global level, following the adoption of the Global Strategy (resolution WHA34.36), a plan of action for implementing the Strategy was approved by the Thirty-fifth World Health Assembly, which called on the Member States, regional committees and the Director-General to carry out specific activities in support of the Strategy[5] (resolution WHA35.23). The Global Strategy is built on the concept of country-wide health systems based on primary health care. The main thrusts are the development of the health infrastructure, starting with primary health care, for the delivery of country-wide programmes that reach the whole population and that utilize appropriate technologies. Crucial to the Strategy is a high degree of community involvement and coordination within the health sector and between health and other sectors.

92. In conclusion, it can be stated that all regions have been engaged in dynamic processes aimed at the formulation and adoption of appropriate regional policies and strategies for the attainment of the goal of health for all. In three regions, regional health charters have been formulated. One region has adopted specific minimum regional goals and another is engaged in developing specific regional targets. These regional strategies conform to the principles of the Alma-Ata Declaration, are highly relevant to the attainment of health for all, and are supportive to the implementation of national strategies for health for all. All regions have also initiated planning processes for the implementation of their strategies, the progress of which is being reviewed periodically. The overall process has linked the Member States, the Secretariat and the governing bodies of the Organization as a whole and provides for a continuing interface in the implementation, monitoring, refining and evaluation of the strategies at all levels.

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[1] Documents SEA/HSD/43 Rev.1 and SEA/RC35/7.

[2] Documents EUR/RC30/8 Rev.2 and EUR/RC32/8.

[3] Documents EM/RC30/9, August 1980, and EM/RC30(81)/7, July 1981.

[4] Documents WPR/RC31/15, 9 July 1980, and WPR/RC31/15, Annex 2, Rev.1.

[5] Plan of action for implementing the global strategy for health for all, Geneva, WHO, 1982 ("Health for All" Series, No. 7).

Programme directions

93. The Sixth General Programme of Work for the period 1978-1983 was implemented during a transitional period marked by great policy changes in the light of resolution WHA30.43, which defined the goal of "Health for all by the year 2000", and resolution WHA34.36, by which the Global Strategy for Health for All by the Year 2000 was adopted. The Programme was thus reviewed at all levels and to some extent modified for the periods 1980-1981 and 1982-1983 to give greater emphasis to areas which supported the building up of national and WHO capacities for the development and implementation of their strategies for health for all.

94. In the light of these policy developments, the Executive Board at its sixty-fifth session, in January 1980, decided that the focus of the proposed Seventh General Programme of Work should be on the long-term goal of health for all and on WHO's response to the Global Strategy for attaining that goal.

95. The Seventh General Programme of Work,[1] which was approved by the Thirty-fifth World Health Assembly,[2] is the first of the three general programmes of work of WHO needed to cover the period until the target date of the year 2000. The targets for the Seventh General Programme of Work are therefore intermediate targets for the period 1984-1989 in relation to the long-term targets for the year 2000. The Programme constitutes WHO's support to the national and regional strategies for attaining health for all by the year 2000, and to the Global Strategy that is the synthesis of these national and regional strategies.

96. The Programme was prepared following extensive consultations at national and regional levels of the Organization and hence represents the Organization's response to the individual and collective needs of its Member States in connection with the implementation of the strategies for health for all. The principal objective is to promote, coordinate and support the efforts of Member States individually and collectively in implementing the Global Strategy. The Programme consists of priority issues for WHO action in the health sector and in other sectors concerned and is aimed at supporting the development of comprehensive health systems, based on primary health care, for the delivery of health programmes that make use of appropriate health technology and that have a high degree of community involvement. The Programme includes objectives and targets in support of the development of health system infrastructure and health science and technology and identifies broad approaches for WHO's action in specific components.

97. The main principles guiding the programme budget for 1982-1983[3] were the application of interlinked efforts to give effect to the Strategy for Health for All through the individual and collective action of the Member States; to provide valid information to this end; to improve the capacity of Member States to absorb and apply this information in the light of their specific circumstances; and to mobilize national and international resources in support of the endeavours of developing countries in these fields.

98. The extent to which the above principles were being put into practice was reviewed and a number of important lessons were learned which were applied to the preparation of the programme budget for 1984-1985,[4] which has the following general objectives:

- to build up national capacities to work out and carry out a national strategy for health for all by the year 2000 and to strengthen the health infrastructure to this end;

- to strengthen national capacities to identify and absorb scientific, technical, social and behavioural knowledge that is relevant to the country's health and socioeconomic

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[1] Seventh General Programme of Work covering the period 1984-1989. Geneva, WHO, 1982 ("Health for All" Series, No. 8).

[2] Resolution WHA35.25.

[3] Proposed programme budget for the financial period 1982-1983 (document PB/82-83).

[4] Proposed programme budget for the financial period 1984-1985 (document PB/84-85).

situation, and to develop appropriate technology for the national strategy on the basis of this knowledge;

- to promote research aimed at developing new knowledge and new tools required for the Strategy for Health for All;

- to ensure the most effective and efficient use of all available resources throughout the world for the Strategy for Health for All - national, multinational, international, nongovernmental and voluntary.

99. It may be concluded that the programme directions of the Organization are highly relevant to the implementation of national, regional and global strategies. Active participation of the Member States in this process at the national, regional and global levels has been crucial to achieving this. The achievement of the objectives set forth will be determined to a large extent by the way the Member governments use WHO's resources and also by the monitoring and evaluation processes applied for the implementation of national, regional and global strategies.

Relevance of WHO's functions and structures in relation to implementation of the Strategy

100. The Global Strategy for Health for All called for continuing restructuring of the Organization at national, regional and global levels to permit the regional committees, the Executive Board, the World Health Assembly and the Secretariat to carry out the responsibilities devolving on them in accordance with resolution WHA33.17 on the study of WHO's structures in the light of its functions.[1]

101. The recommendations contained in the report[1] stressed the need to correlate better the work of the Organization at various levels; to strengthen the mechanisms for continuing dialogue between each Member State and the Organization; and to intensify the work of the regional committees, especially in their monitoring and control functions with respect to the implementation of the regional policies and strategies for health for all. The recommendations also included the strengthening of the role of the Executive Board and the Health Assembly in the work of WHO and improvement of the correlation of the work of the governing bodies of the Organization.

102. A review of the regional reports on monitoring of progress in the implementation of health for all strategies indicates that significant efforts have been made towards the implementation of the Health Assembly's decisions contained in resolution WHA33.17. The managerial processes for WHO's programme development have been streamlined and strengthened, with emphasis on improving the coordination and management of WHO's work at country, regional and global levels.

103. The regions have adopted various mechanisms to implement the recommendations. Organizational studies or reviews of existing structures have been carried out in all the regions. Changes have been introduced aimed at realignment of responsibilities, improvement of coordination, promotion of the multidisciplinary approach in programme development, and improvement of monitoring of WHO's collaborative activities. Measures to strengthen the role of the WHO programme coordinator and representative (WPC) at country level through greater delegation of authority and responsibility have been introduced in order to improve the management and monitoring of WHO's activities at this level, and the regions have initiated joint reviews of the policies and programmes with some Member countries through the visits of multidisciplinary teams.

104. Participation of the Member States in the review of intercountry programmes is being intensified in all regions through the establishment of coordinating/consultative committees which include senior representatives from health and other relevant sectors. Mechanisms for coordination of research, mobilization and generation of financial resources, and cooperation among countries in health matters are also being strengthened. The use of national expertise and national and regional institutions in collaborative activities has also increased.

[1] Study of WHO's structures in the light of its functions (document A33/2).

105. At the global level several mechanisms have been strengthened or introduced to improve coordination and participation of different levels of the Organization and its governing bodies in programme development evaluation. Particular attention is being given to the coordination of activities in support of the implementation of national strategies and to improve linkages between the programmes dealing with the building up of the health system infrastructure and those dealing with health science and technology, as well as their effective monitoring and evaluation. Procedures have been adopted to improve the correlation of the work of the regional committees, the Executive Board and the Health Assembly. A number of working groups and committees set up by the Board have facilitated active discussions and in-depth reviews of various programme matters. The Assembly has also begun to give more attention to the implementation of its main resolutions related to the health for all strategies by the Member States, the regional committees, the Executive Board and the Secretariat.

106. The Organization has continued to strengthen coordination with other organizations of the United Nations system, especially UNICEF, UNFPA and UNDP, for support to the health for all strategies. Coordinating mechanisms with several bilateral agencies and nongovernmental organizations to obtain support for the implementation of national strategies are also being developed.

107. A number of measures have been implemented to ensure that WHO's support to the implementation, monitoring and evaluation of strategies for health for all at all levels is coordinated and meaningful, although much still remains to be done. The main objective of the changes introduced in the structures and mechanisms is to provide maximum and meaningful support to the Member States in the implementation of their national strategies. The essential ingredient in this process is the active participation of Member States in guiding, coordinating, monitoring and evaluating WHO's collaborative activities at all levels. The Member States will also have to improve further the coordinating mechanisms within their own countries so that they are able to ensure the mutual relevance and support of their own health development strategy and of their technical cooperation with WHO and with other Member States of WHO.

Support provided by WHO's governing bodies

108. The regional committees, the Executive Board and the Health Assembly have provided important support for the formulation of regional and global strategies and the plan of action and in the follow-up of their implementation since the adoption of the goal of health for all by the Thirtieth World Health Assembly in 1977 and the launching of the Global Strategy in 1979.

109. Regional strategies for health for all have been adopted by all regional committees (except in the Eastern Mediterranean Region, where the Regional Committee did not meet between 1979 and 1983). Plans of action for the implementation of regional strategies have been approved by the regional committees in the African, American and Western Pacific Regions. Charters for health development have been formulated in the African, the South-East Asia and the Eastern Mediterranean Regions. The Regional Committee for Europe has also reviewed draft regional targets. Regional contributions to the Seventh General Programme of Work (1984-1989) were considered and approved by the regional committees, which subsequently also reviewed and approved the 1984-1985 programme budget to give effect to the implementation of WHO's collaborative action in support of national and regional strategies.

110. Some of the regional committees have also carried out special activities in support of regional strategies. The Regional Committee for Africa considered and approved special programmes of cooperation with Angola and Chad, in the light of local situations in those countries. Concerning apartheid, the Regional Committee adopted the Brazzaville Declaration following an International Conference on Apartheid and Health in 1981 and considered appropriate measures to implement the plan of action formulated at the Conference. The Regional Committee for the Americas adopted a five-year plan for women in health and development which was integrated into the regional plan of action. It also promoted increased cooperation between the health and agricultural sectors through a series of resolutions it adopted on the programme for animal health.

111. The regional committees have also provided support in the monitoring of the strategies, reviewed the first progress report on the implementation of national strategies, and approved resolutions urging Member States to strengthen their national mechanisms for the monitoring and evaluation of their strategies.

112. At the global level the action taken by the Executive Board and Health Assembly in support of the strategies is coordinated and linked with that taken at regional level. The Executive Board at its sixty-ninth session, in 1982, finalized the plan of action for the implementation of the Strategy, prepared the Seventh General Programme of Work, and considered the global targets. It also reviewed the report on the international flow of resources and financial needs of the Strategy.[1] The Thirty-fifth World Health Assembly reviewed and approved the plan of action for implementing the Strategy and the Board's recommendations concerning global targets. In resolution WHA35.25, the Assembly also approved the Seventh General Programme of Work covering the period 1984-1989. In reviewing the international flow of resources for the Strategy, it called for sustained support from the more affluent countries with well-defined strategies for health for all. In 1983 the Board at its seventy-first session and the Thirty-sixth World Health Assembly reviewed and approved the programme budget proposals for 1984-1985 and reviewed the Director-General's report on the implementation of the Strategy in accordance with resolution WHA34.36.

113. The governing bodies of WHO will need to continue this leadership role in the monitoring and evaluation of the Strategy and in promoting the necessary action at national, regional and global level to support Member States' efforts to achieve the goal of health for all. Crucial to this endeavour are the mobilization of internal and external resources for health and cooperation among countries.

Support provided by the WHO Secretariat

114. All the work of the Organization is being increasingly geared to support Member States in their endeavours to prepare and implement their strategies for health for all. This is a gradual process; as implementation proceeds, the areas requiring major support become more clearly identified and hence will receive even greater thrust in the programmes of WHO. As mentioned in paragraph 93, the Organization's programme at all levels was reviewed and to some extent modified for the periods 1980-1981 and 1982-1983 to give greater emphasis to areas which supported the building up of national and WHO capacities for the development and implementation of their strategies for health for all. The reports of the Director-General on the work of WHO for 1980-1981[2] and 1982[3] describe in detail the activities of the Organization in different programme areas in support of the Strategy for Health for All at all levels.

115. The plan of action includes a number of specific actions to be taken by the Secretariat in support of the formulation, implementation, monitoring and evaluation of the Global Strategy. Among the major areas for such actions are promotion and information dissemination; development and monitoring of national strategies; support to national action for developing health systems, including strengthening of the managerial processes; promotion and coordination of technology and research in support of the implementation of national strategies; mobilization of external resources for health; and promotion of intercountry cooperation and of intersectoral action at international level. Actions in these directions have been taken at different levels of the Secretariat.

Promotion and information dissemination

116. The Global Strategy, once approved by the World Health Assembly, was widely disseminated to the Member States, other United Nations, intergovernmental and nongovernmental organizations, and many other institutions. A number of publications[4] supporting the Strategy to guide and

[1] Document EB69/1982/REC/1, Annex 1.

[2] The work of WHO 1980-1981: Biennial report of the Director-General. Geneva, WHO, 1982.

[3] Report of the Director-General on the work of WHO in 1982 (document WHA36/1983/REC/1, Annex 8).

[4] WHO "Health for All" Series, Nos. 1-7.

support the development of national strategies have been prepared and widely disseminated to Member States, education and training institutions, individuals and agencies to enlist their support for the strategies.

117. The Global Strategy has been promoted through contacts with governments, national and regional institutions, intergovernmental and nongovernmental organizations, and health professional groups at national and international levels. World Health Day 1983 was dedicated to the goal of health for all, with the theme "Health for all by the year 2000: the countdown has begun".

118. At the regional level, numerous activities have been undertaken to promote the Strategy for Health for All and relevant technical information has been widely distributed to Member countries. In the Region of the Americas, 250 senior national personnel from top policy and administrative levels in the health and other sectors and WHO staff were given orientation in regional seminars in order to promote understanding of the implications of national and regional strategies for health for all. The Regional Office for South-East Asia organized a special meeting of ministers of health of the Region to promote the strategies and to identify priority areas for action. All regions are giving increasing attention to the coordination of production and dissemination of technical information on health. The European Region is giving emphasis to the production of new types of publications relating to critical programmes, such as the protection and promotion of the health of specific population groups. It is also promoting the formulation of programmes and plans of action in innovative areas of the regional strategy, especially inducing healthy behaviour and motivating individuals to reduce self-imposed risks.

Development of national strategies for health for all

119. Very few countries have requested intensive support from WHO for the formulation of their national strategies. Support has been requested for specific components of the national strategies such as formulation of national health plans, preparation of monitoring reports, activities for the reorientation of health manpower, and the preparation of projects for external support.

120. The UNICEF/WHO Joint Committee on Health Policy, in the light of the strategies, has agreed to provide systematic and joint support to countries with a clear and continuing national commitment to implement the primary health care approach. The process of identifying countries, securing official commitments, and initiating the development of the national strategies has been rather slow. Joint UNICEF/WHO consultation missions have visited a few countries to identify lines of action to be taken to support the primary health care approach.

121. To support the implementation of national strategies, WHO has collaborated with countries in the development of important areas such as organization and reorientation of health systems based on primary health care, including the strengthening of the managerial processes; orientation and training of health personnel; promotion of community involvement; and intersectoral action in health.

122. Guiding principles for strengthening the managerial processes in national health systems have been prepared[1] and provided to the countries to support action for the translation of national strategies and policies into well-defined health plans and programmes. Technical cooperation has been provided upon request to countries for the formulation of national health plans, strengthening of the planning structures and processes, estimation of resource requirements, and definition of priority areas for external cooperation. Intercountry and national training activities in health management and health planning are being supported in most of the regions. The Organization has also undertaken several collaborative activities at the global level in support of the reorientation of health systems and strengthening of the managerial processes in health systems. Two publications - "National health systems and

[1] Managerial process for national health development: guiding principles, Geneva, WHO, 1981 ("Health for All" Series, No. 5).

their reorientation towards health for all: guidance for policy-making" and "Health systems support for primary health care" (based on material collected for and resulting from the Technical Discussions at the Thirty-fourth World Health Assembly in 1981 - are being issued in the WHO Public Health Papers series and will be distributed for use at the national and regional levels.

123. A number of collaborative activities have been supported in the area of orientation and training of health workers. The emphasis of these activities has been on support to national and regional institutions for education and training of health workers; promotion and support to the development of learning materials, especially for primary health care workers; development and implementation of continuing education programmes; and review and reorientation of curricula. Technical Discussions on "The role of universities in the strategies for health for all" will be held at the Thirty-seventh World Health Assembly in 1984. On request, countries have also received support in the health manpower planning process.

124. As reported earlier, countries are trying out several mechanisms and approaches to facilitate effective involvement of the community in the planning and implementation of health services, and in taking more responsive and responsible action for its own health. A document, based on experience from countries around the world, has been prepared to clarify the main trends and issues of community involvement in health development.[1] This will be used as a basis for the preparation of approaches and plans for encouraging community involvement in health. Further technical consultations on the subject are planned at regional and global levels in 1983 and 1984.

125. To support the development of intersectoral action in health, WHO is reviewing concepts and experiences related to the contribution of other sectors to health. A fact-finding inquiry on the contribution of other sectors to health was followed by a consultation (Kerala, India, 1982) organized to identify the crucial social and economic development factors which influence health; to understand the role of intersectoral collaborative action for the involvement of health; to support mechanisms and appropriate strategies to promote, plan and implement intersectoral actions at various levels; and to identify needs for action-oriented research. In order to strengthen the health component of integrated rural development projects, assessments of this component have been carried out in a number of countries (Bangladesh, Nepal, Sri Lanka) in collaboration with FAO and the Centre for Integrated Rural Development for Asia and the Pacific. Similar activities are now being undertaken by the Regional Office for Africa and the Centre for Integrated Rural Development for Africa.

126. The Secretariat has continued its many collaborative activities in countries in support of the strengthening and development of the priority components of primary health care. Approaches for integrated delivery of these programmes through health systems based on primary health care are still to be developed. Guiding principles are needed to assist countries in the organization and delivery of priority health components in an integrated manner at all levels of the health care delivery system. Educational activities to support further the involvement of individuals, families and communities in their own care and in preventing health problems and reducing self-imposed risks need stronger emphasis in the Secretariat's work.

Research and technology development

127. Among the areas identified for WHO support for the implementation of the Global Strategy for Health for All are: the international coordination of research to identify and generate appropriate health technology for the essential elements of primary health care; promotion and development of health systems research, including support to such research in countries; strengthening of national research institutions; promotion of intercountry collaboration; and research and development on specific issues of major concern on health.

128. Many countries, especially in the developing world, have not developed an effective national organization for the management of health research or even for articulating health

[1] Community involvement in health systems for primary health care (document SHS/83.1).

research policy. At the national and international levels growing concern has been expressed over the disparities between developed and developing countries in research and development investment and the lack of coordinated global research efforts that are relevant to worldwide health problems. WHO's efforts at the regional and global levels are being directed at improving the coordination of research efforts and identification of priority research needs for health systems based on primary health care. At the regional level, the mechanisms for coordination of research have been reviewed and are being further strengthened through the regional advisory committees on medical research. Among the areas receiving greater emphasis are: the identification of national and regional institutions to develop regional networks for undertaking operational research on relevant issues; promotion and formulation of national health policies on research; and establishment of more effective linkages between the research institutions and the ministries of health. At the global level, the global Advisory Committee on Medical Research and the Organization's special research programmes (the Special Programme for Research and Training in Tropical Diseases, the Special Programme of Research, Development and Research Training in Human Reproduction, and the Diarrhoeal Diseases Control Programme) are being challenged to give greater consideration to operational research and health systems research issues and to support the development of this type of research.

129. Information on appropriate technologies in primary health care is being compiled and disseminated by the regional offices and at the global level. Emphasis is being given to the review and development of appropriate and relevant diagnostic technologies for primary health care. Support has also been provided for the development of appropriate rehabilitative technology for the community level and adaptation of technical aids for the disabled. Links are being established with the universities and nongovernmental organizations in the development and improvement of technologies, with particular reference to the primary care level. The European Region is emphasizing the assessment and relevance of high-cost technologies used in the Region with a view to reorienting and rationalizing the use of technology in health care. This effort will be useful for developing countries that are concerned with the introduction of such technologies in their health care systems.

Mobilization of external resources for health

130. Several actions related to the mobilization of financial resources at the international level are proposed in the Global Strategy. Among these are an estimation of the order of magnitude of financial and material needs for the Strategy, promotion of resource transfers from developed countries to developing countries that are ready to devote substantial additional resources to health, and review of the nature and size of such transfers with the aim of satisfying the needs of the Strategy. The Strategy further calls for the strengthening of the capacities of developing countries to prepare proposals for possible funding by their governments and from external resources. The establishment of regional and global mechanisms to identify needs and facilitate the rational transfer of resources for health are also crucial for the coordination of resource mobilization.

131. In May 1981, the Thirty-fourth World Health Assembly adopted resolution WHA34.37 on "Resources for strategies for health for all by the year 2000", in which it urged Member States that are in a position to do so, and the relevant agencies, programmes and funds of the United Nations system, as well as other bodies concerned, to provide financial and other support to developing countries for the implementation of national strategies to achieve health for all by the year 2000. It also requested the Director-General to take appropriate measures for identifying external resource requirements in support of well-defined strategies for health for all and to support developing countries as required in preparing proposals for external funding for health.

132. A review of the health expenditures, financial needs of the Strategy for Health for All and the international flow of resources for the Strategy was made in 1981.[1] Notwithstanding the many difficulties in arriving at these estimates, the review indicated a large gap between what is available now (US$ 2 to US$ 3 per head) and what seems necessary to fulfil the aspirations of all countries of the world in line with the resolutions on health for all. This applies especially to the poorer developing countries where the needs are greatest. The review also provided estimates for the required resource transfer from the developed to the developing countries.

[1] See document EB69/1982/REC/1, Annex 1.

133. A Health Resources Group for Primary Health (HRG) was established by the Director-General in 1981 with the aim of promoting the rationalization of the international flow of resources for the Strategy and increasing the flow if necessary. It was also recognized that the main operational action for implementing the Strategy for Health for All must take place at country level, with the support, as necessary, of other Member States, other partners in health work, and WHO at regional and global levels. Countries were invited to carry out "country resource utilization reviews" as a possible approach to initiate action and attract external collaboration in health. After such reviews were tried out in a few countries in 1981 (Benin, Ecuador, Gambia, Sri Lanka and Sudan), general guidelines were evolved which were subsequently utilized in other countries.

134. A "country resource utilization review" (CRU) is a study carried out by a developing country, involving the ministry of health, the planning authorities and departments in other sectors, to analyse resource flows and to identify total requirements, resources available or committed, and opportunities for reallocation of internal resources and mobilization of external resources in relation to health for all in general and primary health care in particular. To date CRUs have been carried out in Gambia (1980), Sri Lanka, Benin, Ecuador and Sudan (1981), Nepal and Malawi (1982), Bangladesh, Papua New Guinea, Democratic Yemen, Yemen and Bhutan (1983). CRUs in Guinea-Bissau and Lesotho are planned before the end of 1983 and in 10 other countries in 1984. CRUs have generally been financed by external funds (bilateral agencies); they include proposals or "ideas" for external resource requirements and can be used by the countries in negotiations for resources for health from both national and external sources. The real value is thus dependent on the use the countries make of them, especially to attract funds where they are most needed. Benin and Gambia, for example, used their CRU documents for their health sector presentations to the round-table meeting with interested funding agencies and has attracted some support.

135. The regional offices have continued to provide support to countries in the development of specific project proposals for external cooperation in priority areas of primary health care such as maternal and child health and family planning; diarrhoeal disease control; expanded programme of immunization; water and sanitation; and improvement of the physical infrastructure for primary health care. Financial support for these projects has been provided by UNFPA, the World Bank, the Inter-American Development Bank, the Arab Fund for Economic and Social Development, and bilateral donors.

136. In spite of the increasingly unfavourable world economic situation, the existing level of resource flow from the many bilateral and multilateral agencies was maintained during 1981 and 1982 for the support of health programmes and projects aimed at achieving the goal of health for all by the year 2000. Australia, Denmark, the Federal Republic of Germany, Italy, Japan, the Netherlands, Norway, Saudi Arabia, Sweden, the United Kingdom of Great Britain and Northern Ireland and the United States of America have been among the largest contributors, together with UNFPA, UNICEF, UNDP, the Arab Gulf Programme for the United Nations Development Organizations (AGFUND), and the Japan Shipbuilding Industry Foundation.

137. While in general the Organization's efforts for the mobilization of external resources in support of the Health for All Strategy have been intensified, much more remains to be done in the rationalization and more efficient use of national resources for health. An increased flow of external resources for health implies an even greater financial commitment by the countries to absorb the recurrent costs generated by additional investments in health infrastructure and to continue the level of operations when the external funding declines or is terminated. Without a serious effort at the national level to allocate resources to primary health care, consider alternative ways of financing the health system, promote increased collaboration of other sectors for health, especially through incorporation of the health component into development projects, and strengthen the management of health systems to improve efficiency and effectiveness, it will be very difficult for the countries to achieve any degree of self-reliance.

Promotion of intercountry and international cooperation in health

138. Intercountry cooperation and coordination with other organizations of the United Nations system and with intergovernmental and nongovernmental organizations have been promoted and

fostered extensively in the development and implementation of the Strategy. Such efforts have been made at the country, regional and global levels and the levels and types of cooperation reported by the countries are described earlier in this report.

139. At the regional level, cooperation with the regional offices of the United Nations system, regional economic cooperation agencies, and geopolitical groups has been promoted in support of the regional strategies. With the Economic Commission for Africa, a five-year plan is being developed on priority areas for collaboration, which include essential drugs, nutrition, promotion of the role of women in development, drinking-water supply and sanitation, and management training. In the Americas, areas for collaborative action are being defined with the Economic Commission for Latin America, the Inter-American Development Bank and the regional offices of UNICEF. In the South-East Asia Region, support for the Strategy is being promoted through ASEAN and other groups, one of which has established a study group on health and population activities. Close links with the Economic Commission for Europe on environmental matters, traffic accidents, and statistics already exist and contacts with several geopolitical groups for promotion of intercountry collaboration are being strengthened. The Economic and Social Commission for Asia and the Pacific, along with UNICEF and WHO, sponsored an intergovernmental meeting on health and development in the Western Pacific Region.

140. At the global level contacts with the organizations of the United Nations system, the geopolitical groupings of countries that transcend regional boundaries and with the nongovernmental organizations have been strengthened and promoted. Coordination within the United Nations system continued to be an important concern, particularly in view of resolution 34/58 adopted by the United Nations General Assembly in 1979 entitled "Health as an integral part of development".

141. The Director-General presented the Global Strategy to the Economic and Social Council in 1981, and a progress report on the implementation of General Assembly resolution 34/58 to the Council in 1981 and to the General Assembly in 1982. A further progress report will be presented to the Council in 1984.

142. WHO has maintained its full participation in the work of the Administrative Committee on Coordination (ACC) and its subsidiary bodies. It was agreed in the Consultative Committee on Substantive Questions (Programme Matters) to identify a few areas for joint planning. A baseline survey of the existing activities of other organizations in support of primary health care was made and this information was circulated to all the organizations, requesting them to identify activities which could be further strengthened or developed. A good response has been received and this effort is generating a further exchange of information and collaboration in programmes. Close coordination has been maintained with UNICEF through the UNICEF/WHO Joint Committee on Health Policy for the development of action in support of primary health care. Contacts have been maintained and/or strengthened with several geopolitical groupings of countries that transcend regional boundaries, in support of the Strategy. At the global level formal contacts have been established with the Group of 77, the Non-Aligned Countries, the Commonwealth Secretariat, the European Economic Community, the Council for Mutual Economic Assistance, the Organization of the Islamic Conference, and the Council of Ministers of Health of the Arab Gulf States. Support for the Strategy is being promoted through these contacts, both political as well as financial.

143. The attainment of the goal of health for all by the year 2000 is intimately related to socioeconomic development and a commitment to world peace. In response to the request of the Thirty-fourth World Health Assembly,[1] with a view to intensifying WHO's contribution to the socioeconomic development of countries and the preservation and promotion of peace, the Director-General set up an authoritative multidisciplinary international committee to study

[1] Resolution WHA34.38 on "The role of physicians and other health workers in the preservation and promotion of peace as the most significant factor for the attainment of health for all".

comprehensively the threat that thermonuclear war constitutes for the life and health of peoples of the world. The conclusion in the Committee's report,[1] which was endorsed by the Thirty-sixth World Health Assembly, was that it is impossible to prepare health services to deal in any systematic way with a catastrophe resulting from nuclear warfare, and that nuclear weapons constitute the greatest immediate threat to the health and welfare of mankind.[2] The Health Assembly recommended that the Organization, in cooperation with other United Nations agencies, continue the work of collecting, analysing and regularly publishing accounts of activities and further studies on the affects of nuclear war on health and health services, keeping the Health Assembly informed. The Assembly also endorsed another report of the Committee[3] which emphasized the need to ensure that economic growth actually benefits people and that health aspects are taken into consideration in social and economic development planning.

144. The nongovernmental organizations were recently reviewed to identify those whose programmes focus more directly on primary health care. The thrust of WHO's effort is to strengthen the collaboration of these organizations at the national level in support of national strategies for health for all. Several steps have been identified in this process in interested countries. WHO has assisted in the compilation of information on the nongovernmental organizations involved in health and health-related activities. It has then supported consultations between the government and the organizations' representatives at the national level, to foster mutual understanding and collaborative activities in support of national strategies. Several countries have taken such initiatives (Bolivia, India, the Netherlands, Nigeria, Sri Lanka, Sudan and Thailand). WHO's support will be further extended in this area to promote the exchange of information and experience between governments and nongovernmental organizations, and among the organizations themselves, and an integrated approach to health development at the national level.

IV. CONCLUSIONS AND FUTURE OUTLOOK

145. The strategies and plans of action have received national, regional and global attention, and the Member States and Secretariat have been active in their formulation and implementation. Intensified follow-up of the implementation process is now required. It is noted that about a quarter of the Member States have not submitted their progress reports and many of the reports submitted were not as complete or accurate as they should have been. At the regional and global levels, synthesis and consolidation of the available information lends itself only to a very general overall assessment of the progress being achieved. The report also suffers from a lack of detailed and precise information on many of the important aspects which are crucial to the national strategies. The report, furthermore, indicates that implementation of the Strategy and its monitoring have not proceeded as rapidly as desirable.

146. The Common Framework and Format has played a generally positive role in facilitating reporting. However, in view of the difficulties experienced by some of the countries in its application as well as in providing information on the 12 global indicators adopted by the Thirty-fourth World Health Assembly, it is necessary to refine and improve the monitoring tools. An analysis of what problems exist at national level in the interpretation of the indicators and in the collection and analysis of the relevant data should be carried out with a view to improving the monitoring of the implementation of the strategies. Clear explanatory notes also need to be given to facilitate the utilization of the global indicators by countries.

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[1] Document A36/12 (Effects of nuclear war on health and health services: report of the International Committee of Experts in Medical Sciences and Public Health to implement resolution WHA34.38) (1984, in press).

[2] See resolution WHA36.28 (document WHA36/1983/REC/1, p. 25).

[3] Document A36/13 (The contribution of health to socioeconomic development: report of the International Committee of Experts in Medical Sciences and Public Health to implement resolution WHA34.38).

147. The principle of full national participation on a cross-sectoral basis is the keystone to the implementation of the Strategy for Health for All. The report indicates that a high level of political sensitization appears to have taken place and many countries have initiated the processes of formulating their national policies, strategies and plans for the achievement of the goal of health for all by the year 2000. While health policies appear to be oriented to achieve greater coverage of the population through primary health care, it is not clear whether this is adequately reflected in national sociopolitical and economic development policies. Health is only one aspect of development and social equity can be achieved only through simultaneous action in many sectors. Available information does not indicate that health is yet receiving a high priority in the allocation of national resources in spite of the adoption of national policies for health for all by the year 2000 at the highest political level. Member States are again urged to assume their full responsibility for the implementation of their strategies in order to achieve the universally accepted goal of health for all by the year 2000, and take the necessary action to mobilize full support from all relevant sectors.

148. Many countries still have to formulate detailed plans of action with specific objectives, targets and a projection of resources for the achievement of these objectives. Ideally these plans should be for a long-term period (up to the year 2000) with short-term and medium-term targets. Implicit in this is a review of existing resources, an analysis of overall needs, and plans for mobilization of these resources from national and external sources. Very few countries appear to have accomplished this and most find it difficult to estimate the resources now going to their health sector. An in-depth review is needed to identify what constraints exist and what specific actions should be taken to improve the utilization and distribution of existing resources and to generate additional resources, especially from other sectors, in support of health.

149. Several countries appear to be making efforts to review and reorient their health systems and to train health manpower to extend primary health care services. Available information is inadequate to assess how effective these efforts have been in achieving improved coverage of the population, and what constraints or difficulties are being experienced in bringing about any changes. Several crucial issues still remain largely unresolved. Among these are: the establishment of effective linkages among the different levels of health care delivery systems so that they are really supportive to primary health care; effective coordination of technical programmes, especially the essential elements of primary health care which are to be delivered through health systems; planning and training of health manpower consonant with the needs of the health system; and achievement of real changes in the attitudes and value of health workers in support of the goal of social equity. National capabilities for carrying out a suitable managerial process for health development, including the collection, analysis and utilization of information in support of the process, require further strengthening. This is an area where WHO should intensify its technical cooperation, particularly with those Member States that are fully committed to achieving the goal of health for all.

150. National experience in stimulating a greater degree of community involvement and participation of other sectors in health appears to point to the need for real decentralization and delegation of authority to the intermediate and local levels of health administration and the communities. Some countries have made no or very little effort to involve the communities or have found it difficult to involve other sectors effectively. What policy constraints exist in these areas which need to be resolved? Little information has been provided by the countries on their efforts to improve the health literacy of their populations. Without adequate understanding and sustained motivation on the part of individuals, families and communities in dealing with their own health matters, the goal of health for all is not likely to be achieved. It is obvious that much more effort is needed in these areas, and countries can also gain from sharing their experience, technologies and resources with others.

151. The reports indicate a trend towards increased cooperation among countries, particularly in the promotion of efforts which will stimulate national health development action to support primary health care and tackle priority health problems affecting a large number of people in the countries. While sharing of information and technical know-how are important, transfer

of financial resources from the richer to the poorer countries, and especially the least developed ones, is even more critical if the latter are to make significant progress towards achieving the goal of health for all. Available information does not permit an assessment of trends in this area. Monitoring of these resources will be important to reflect trends as well as to ensure that they are being channelled to priority health problems and to extend primary health care to hitherto underserved and underprivileged population groups.

152. Information provided on action at national, regional and global levels in support of the national strategies shows that the Organization has largely met its responsibilities to date with respect to providing guiding principles to facilitate the process of implementing the strategies. Serious efforts are now required to implement these principles in a practical manner in the countries. The Organization should intensify its support to the countries in applying them and further improve and modify them as necessary on the basis of the experience gained in the course of their implementation. The need for guidance for research aimed at health development in line with the strategies for health for all is also evident. It is noted that the efforts of Member States, WHO's governing bodies and the Secretariat in the development, implementation and monitoring of the strategies for health for all are being coordinated. The participation of the governing bodies in reviewing and reorienting WHO's programme and functions has also been active. They need to devote continuing and serious efforts to the monitoring and evaluation processes, as indicated by a review of this progress report and the discussions and observations of the regional committees. WHO should also further strengthen its role as coordinator of international health work with respect to organizations of the United Nations system so as to facilitate wherever applicable combined technical cooperation activities, primarily at the country level but also at regional and global levels, in support of the implementation of national strategies for health for all.

153. It is felt that, in spite of its limitations, the process has yielded useful information on the efforts of governments to implement their national strategies for health for all by the year 2000. What is even more important at this stage is that a process for monitoring progress at national, regional and global levels has been set in motion. Through concerted efforts to improve information systems at the national level, this process could in the future yield more valuable data and support the development of managerial processes at the national level and within WHO. Improved data will also help in analysing factors which are facilitating or impeding the development of national strategies and suggest areas for supportive or developmental action which would enhance and facilitate national health development processes. Hence the importance of careful monitoring of progress at the national level and the need for Member States to assume full responsibility for and to give high priority to the monitoring and evaluation processes in support of their national strategies for health for all cannot be overemphasized.

ANNEX

ANALYSIS OF THE TWELVE GLOBAL INDICATORS

1. The Common Framework and Format used by national health managers for the monitoring of their national strategies contained a list of 12 global indicators adopted at the Thirty-fourth World Health Assembly together with the Global Strategy for Health for All,[1] with relevant definitions and elements to be considered in generating and presenting these indicators. Global indicators were selected from a long list prepared by WHO in response to a request by the Executive Board.[2] In addition to the 12 global indicators, countries and WHO regions were encouraged to select and adopt national and regional indicators relevant to their specific situation.

2. National progress reports prepared in accordance with the Common Framework and Format were forwarded by 122 Member States to their respective regional offices, that is, about three-quarters of those that were expected. This part of the report will present mainly the information reported by Member States using the Common Framework and Format.

GLOBAL INDICATOR 1

3. Global indicator 1 has been defined as the number of countries in which: "Health for all has received endorsement as policy at the highest official level".

4. One hundred and seven countries answered this question, i.e., 88% of those which sent a progress report; 103 answered positively, 2 stated that a partial endorsement had been received, and 2 answered negatively.

GLOBAL INDICATOR 2

5. Global indicator 2 has been defined as the number of countries in which: "Mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning".

6. Ninety-seven countries provided information on this indicator; 78 answered yes, 2 indicated a partial involvement, and 17 mentioned that no participation was taking place.

[1] Global Strategy for Health for All by the Year 2000, Geneva, World Health Organization, 1981 ("Health for All" Series, No. 3), section VII, paragraph 6.

[2] Development of indicators for monitoring progress towards health for all by the year 2000, Geneva, World Health Organization, 1981 ("Health for All" Series, No. 4).

Annex

7. The following table shows the results obtained by WHO regions:

Percentage of countries where people are involved in strategy implementation

WHO region	Number of countries		%
	With available information	With involvement of people	
Africa	25	23	92.0
Americas	15	4	26.7
South-East Asia	10	10	100.0
Europe	17	17	100.0
Eastern Mediterranean	20	15	75.0
Western Pacific	10	9	90.0
Total	97	78	80.4

Global indicators on financial resources

8. Three global indicators were adopted to evaluate resource allocation and distribution:

- gross national product per head;
- the percentage of the gross national product (GNP) spent on health;
- the percentage of the national health expenditure devoted to local health care.

GLOBAL INDICATOR 12

9. Global indicator 12 is defined as the number of countries in which: "The gross national product per head exceeds US$ 500."

10. One hundred and one countries provided quantitative information. Some countries provided the gross domestic product (GDP) per capita instead of GNP per capita. It is important to note that out of 122 countries that sent a progress report, 21 were not in a position to indicate a value for this indicator.

11. The following table shows the distribution of GNP (GDP) per capita by WHO region.

Distribution of gross national product per head[a]

GNP per head	Number of countries						Total
	AFR	AMR	SEAR	EUR	EMR	WPR	
Less than $ 100	-	-	-	-	-	-	-
$ 100- 199	3	-	4	-	-	-	7
$ 200- 299	9	1	1	-	2	1	14
$ 300- 399	5	-	1	-	3	-	9
$ 400- 499	7	-	-	-	2	1	10
$ 500- 999	9	4	2	-	1	3	19
$ 1000-1999	2	8	-	1	4	1	16
$ 2000-2999	1	-	-	2	1	-	4
$ 3000-3999	-	-	-	1	-	-	1
$ 4000-4999	-	1	-	2	2	-	5
$ 5000-5999	-	-	-	1	-	-	1
$ 6000-6999	-	-	-	-	-	-	-
$ 7000-7999	-	-	-	1	-	-	1
$ 8000-8999	-	-	-	-	-	1	1
$ 9000-9999	-	-	-	2	-	1	3
$ 10 000 or more	-	2	-	4	4	-	10
Subtotal	36	16	8	14	19	8	101
Without data or data disqualified	1	3	3	7	3	4	21
No progress reports	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

[a] If GNP was not available, countries used GDP and GDP at factor cost.

12. When the US$ 500 threshold is applied, it is found that 61 countries have a GNP per capita exceeding the limit, i.e., some 60% of those answering the question. From the above table some regional variations can be noted. The figures should be seen and interpreted with care. Other international organizations are currently publishing similar information with a higher coverage. It seems appropriate to recommend a greater exchange of information between national health authorities and the economic and financial sector.

GLOBAL INDICATOR 3

13. Global indicator 3 is closely related to the previous one and is defined as "the number of countries in which: "At least 5% of the gross national product is spent on health".

14. Some countries experienced difficulties in measuring the percentage of their GNP spent on health. GNP itself is not always available for recent years, as mentioned above. It seems that many countries have not yet developed an appropriate mechanism for estimating financial resources spent on health. Some countries took into account only government expenditures and omitted the private sector, if any, or ignored the contributions made by the community or local authorities. However, 63 countries provided an estimated percentage. The following table shows the distribution of Member States by region according to the percentage of GNP spent on health.

Annex

Percentage of the gross national product spent on health

Percentage of GNP spent on health	Number of countries						Total
	AFR	AMR	SEAR	EUR	EMR	WPR[b]	
Less than 1.0%	-	1	-	-	-	-	1
1.0-1.9%	1	1	2	-	4[a]	-	8
2.0-2.9%	2	-	1	-	2[a]	1	6
3.0-3.9%	3	3	-	-	3	2	11
4.0-4.9%	4	2	1	1[a]	2	1	11
5.0-5.9%	2	1	-	7	1	1	12
6.0-6.9%	1	-	-	1	-	-	2
7.0-7.9%	1	-	-	2	1	1	5
8.0-8.9%	-	1	-	1	-	1	3
9.0-9.9%	-	-	-	1	-	-	1
10.0% or more	-	1	-	2	-	-	3
Subtotal	14	10	4	15	13	7	63
Without data or data disqualified	23	9	7	6	9	5	59
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

[a] Government expenditure on health only.

[b] Including resources received by the developing countries from more affluent countries.

15. The indicator specifies a reference value of 5%. The following table shows by WHO regions the percentage of countries spending at least 5% of their GNP on health.

Percentage of countries with at least 5% of their GNP spent on health

WHO region	Number of countries		%
	With available information	With at least 5% of GNP spent on health	
Africa	14	4	28.6
Americas	10	3	30.0
South-East Asia	4	-	-
Europe	15	14	93.3
Eastern Mediterranean	13	2	15.4
Western Pacific	7	3	42.9
Total	63	26	41.3

16. Information is available for 63 countries. Of those countries only 26 spent more than 5% of their GNP on health. Regional variations are shown above. Because of the low percentage of answers received and the difficulty experienced by countries in estimating health expenditure, it is not possible at this stage to formulate any general conclusions.

GLOBAL INDICATOR 4

17. Global indicator 4 is defined as the number of countries in which: "A reasonable percentage of the national health expenditure is devoted to local health care".

18. The formulation of the indicator implies the knowledge in each country of the percentage of the health expenditure spent at local level. At this stage no clear definition of reasonable percentage can be provided as a reference value, and hence this report will take into consideration only the distribution of the percentage indicated in the national analysis. Information on this indicator was provided by 50 countries, as shown below.

Number of countries reporting on global indicator 4

WHO region	Number of countries		%
	With progress report	Reporting indicator	
Africa	37	14	37.8
Americas	19	2	10.5
South-East Asia	11	6	54.5
Europe	21	9	42.9
Eastern Mediterranean	22	11	50.0
Western Pacific	12	8	66.7
Total	122	50	41.0

19. The distribution of the percentages of health budget devoted to local health care is shown in the following table. Comments made earlier on the difficulties faced by the countries in collecting and integrating information on health expenditure are also valid for this indicator.

Percentage of the national health expenditure devoted to local health care

Percentage of national health expenditure	Number of countries						Total
	AFR	AMR	SEAR	EUR	EMR	WPR	
Less than 10.0%	3	-	-	-	1	-	4
10.0-19.9%	3	-	-	2	1	-	6
20.0-29.9%	3	-	3	1	4	3	14
30.0-39.9%	2	-	-	2	3	1	8
40.0-49.9%	2	1	1	2	1	2	9
50.0-59.9%	1	-	-	-	-	2	3
60.0-69.9%	-	1	1	1	-	-	3
70.0% or more	-	-	1	1	1	-	3
Subtotal	14	2	6	9	11	8	50
Without data or data disqualified	23	17	5	12	11	4	72
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

20. Because of the lack of precise national definition of the meaning of "reasonable percentage", it is not possible to calculate the global indicator as was anticipated. The above table shows that nearly half of the countries that answered spend more than 30% of their national health expenditure on local care.

GLOBAL INDICATOR 5

21. Global indicator 5 is defined as the number of countries in which: "Resources are equitably distributed".

22. The material provided by countries is rather heterogeneous. Some countries answered by a yes/no statement, others formulated quantitative replies indicating the number of inhabitants for selected health professions or various types of institutions. Without precise criteria for measuring the equity of the distribution of resources, it is not possible to interpret globally the information provided. Research should be undertaken in the near future on that aspect of the Strategy and some guidelines should be available before the next evaluation reporting in 1985 and 1986.

GLOBAL INDICATOR 6

23. Global indicator 6 in the Global Strategy is defined as: "The number of developing countries with well-defined strategies for health for all, accompanied by explicit resource allocations, whose needs for external resources are receiving sustained support from more affluent countries".

24. Out of the 161 Member States and Associate Members (in mid-1983), 124 are considered as developing countries. The remaining 37, considered as developed countries, are located in three WHO regions, 2 in the Americas, 3 in the Western Pacific, and 32 in Europe. Only a few of the 124 expected contributions reached the regional offices. As already mentioned, countries are still in the process of formulating their national strategies and the related resource allocations have not yet been fully worked out. Thirty-three countries answered positively, but at this stage it is not possible to measure with any precision how the needs for external support are being met. In practice all developing countries are receiving some support from other countries; how far this support is in line with the national strategy remains to be assessed.

GLOBAL INDICATOR 7

25. Global indicator 7 is defined as the number of countries in which: "Primary health care is available to the whole population, with at least the following:

- safe water in the home or within 15 minutes' walking distance, and adequate sanitary facilities in the home or immediate vicinity;

- immunization against diphtheria, tetanus, whooping-cough, measles, poliomyelitis, and tuberculosis;

- local health care, including availability of at least 20 essential drugs, within one hour's walk or travel;

- trained personnel for attending pregnancy and childbirth, and caring for children up to at least 1 year of age."

26. Global indicator 7 thus comprises sub-indicators related to each of the above elements and will be reported below accordingly.

Sub-indicators on environmental hygiene

27. Two sub-indicators, to assess the availability of safe water and adequate sanitary facilities, were reported by countries.

(a) Percentage of the population with safe water available in the home or within 15 minutes' walking distance.

28. Sixty-two countries provided information on the availability of safe water. Some did this separately for urban and rural areas, but this breakdown has not been included in the present analysis. In future the possibility of such a breakdown will be envisaged. The following table shows the distribution of coverage of safe water by WHO region as reported by Member States according to the Common Framework and Format.

Safe water in the home or within 15 minutes' walking distance

Proportion of population for whom safe water is available	Number of countries						Total
	AFR	AMR	SEAR	EUR	EMR	WPR	
Less than 10.0%	1	-	-	-	-	-	1
10.0-19.9%	2	1	-	-	1	-	4
20.0-29.9%	2	1	-	-	-	1	4
30.0-39.9%	1	-	-	-	4	-	5
40.0-49.9%	1	1	-	-	-	-	2
50.0-59.9%	-	5	-	-	1	-	6
60.0-69.9%	3	2	-	-	-	-	5
70.0-79.9%	1	4	-	-	2	-	7
80.0-89.9%	-	2	-	-	1	-	3
90.0% or more	2	2	2	9	7	3	25
Subtotal	13	18	2	9	16	4	62
Without data or data disqualified	24	1	9	12	6	8	60
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

(b) Percentage of population with adequate sanitary facilities available in the home or immediate vicinity.

29. Only 52 countries provided values at national level for this indicator. The same remarks made on availability of safe water apply, namely, the need to envisage a breakdown by urban and rural areas for the future. Out of these 52 countries, 15 countries (29%) indicated a coverage of 90% or more of the total population with adequate sanitary facilities. The following table shows the distribution of countries by region according to the coverage.

Annex

Adequate sanitary facilities in the home or immediate vicinity

Proportion of population for whom adequate sanitary facilities are available	Number of countries						Total
	AFR	AMR	SEAR	EUR	EMR	WPR	
Less than 10.0%	2	1	-	-	1	-	4
10.0-19.9%	3	3	-	-	2	-	8
20.0-29.9%	2	3	-	-	1	1	7
30.0-39.9%	-	3	-	-	1	1	5
40.0-49.9%	2	3	-	-	1	-	6
50.0-59.9%	-	-	-	-	-	-	-
60.0-69.9%	-	1	1	-	2	-	4
70.0-79.9%	-	-	-	-	2	-	2
80.0-89.9%	-	-	-	-	-	1	1
90.0% or more	-	-	1	8	5	1	15
Subtotal	9	14	2	8	15	4	52
Without data or data disqualified	28	5	9	13	7	8	70
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

30. The number of countries reporting information for the above two sub-indicators is low. It is not possible at this stage to explain the reasons for this poor coverage; it is hoped that measures can be taken at country level to improve collection of the data.

Sub-indicators on selected immunizations

31. Concerning immunization against diphtheria, tetanus, whooping-cough, measles, poliomyelitis and tuberculosis, the Common Framework and Format defined four sub-indicators:

Proportion of infants under 1 year of age who have been fully immunized against:

- diphtheria, tetanus, and whooping-cough (3 doses)

- measles (1 dose)

- poliomyelitis (3 doses)

- tuberculosis (1 dose)

32. The information provided by countries that forwarded progress reports was rather heterogeneous. Information was not reported or available in accordance with the specifications of the indicator. The following global figures were obtained.

Number of countries reporting on immunization

Immunization against	Number of countries		%
	With progress report	Reporting immunization coverage	
Diphtheria, tetanus and whooping-cough	122	52	42.6
Measles	122	43	35.2
Poliomyelitis	122	50	41.0
Tuberculosis	122	29	23.8

33. The following tables show the distribution of countries which provided progress reports, according to the immunization coverage for each of the four groups of diseases.

Immunization against diphtheria, tetanus and whooping-cough

Proportion of infants under 1 year immunized	Number of countries						Total
	AFR	AMR	SEAR	EUR	EMR	WPR	
Less than 10.0%	2	1	-	-	-	-	3
10.0-19.9%	-	2	-	-	-	-	2
20.0-29.9%	3	2	-	-	1	-	6
30.0-39.9%	1	1	-	-	-	-	2
40.0-49.9%	3	3	1	-	1	-	8
50.0-59.9%	1	2	-	-	1	1	5
60.0-69.9%	-	1	-	-	-	-	1
70.0-79.9%	-	-	-	-	1	-	1
80.0-89.9%	1	2	-	3	4	-	10
90.0% or more	-	3	2	4	2	3	14
Subtotal	11	17	3	7	10	4	52
Without data or data disqualified	26	2	8	14	12	8	70
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

Annex

Immunization against measles

Proportion of infants under 1 year immunized	Number of countries						Total
	AFR	AMR	SEAR	EUR	EMR	WPR	
Less than 10.0%	-	1	-	-	-	-	1
10.0-19.9%	2	1	-	-	-	-	3
20.0-29.9%	1	3	-	-	-	-	4
30.0-39.9%	2	1	-	-	-	1	4
40.0-49.9%	1	1	-	-	1	-	3
50.0-59.9%	1	3	-	1	3	1	9
60.0-69.9%	1	1	-	-	3	-	5
70.0-79.9%	-	1	-	-	1	1	3
80.0-89.9%	1	2	-	2	1	-	6
90.0% or more	-	-	2	3	-	-	5
Subtotal	9	14	2	6	9	3	43
Without data or data disqualified	28	5	9	15	13	9	79
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

Immunization against poliomyelitis

Proportion of infants under 1 year immunized	Number of countries						Total
	AFR	AMR	SEAR	EUR	EMR	WPR	
Less than 10.0%	2	1	-	-	-	-	3
10.0-19.9%	-	1	-	-	-	-	1
20.0-29.9%	4	2	-	-	1	-	7
30.0-39.9%	1	2	-	-	-	-	3
40.0-49.9%	2	2	1	-	-	1	6
50.0-59.9%	-	-	-	-	1	-	1
60.0-69.9%	-	1	-	-	1	-	2
70.0-79.9%	-	-	-	1	2	-	3
80.0-89.9%	1	5	-	2	3	1	12
90.0% or more	-	2	2	4	2	2	12
Subtotal	10	16	3	7	10	4	50
Without data or data disqualified	27	3	8	14	12	8	72
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

Immunization against tuberculosis

Proportion of infants under 1 year immunized	Number of countries						Total
	AFR	AMR[a]	SEAR	EUR	EMR	WPR	
Less than 10.0%	-	N.A.	-	-	2	-	2
10.0-19.9%	2		-	-	1	-	3
20.0-29.9%	-		-	-	-	-	-
30.0-39.9%	2		-	-	-	1	3
40.0-49.9%	1		1	-	-	-	2
50.0-59.9%	1		-	-	2	-	3
60.0-69.9%	2		-	-	-	-	2
70.0-79.9%	1		-	-	2	-	3
80.0-89.9%	2		-	4	-	1	7
90.0% or more	1		2	-	-	1	4
Subtotal	12	N.A.	3	4	7	3	29
Without data or data disqualified	25	19	8	17	15	9	93
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

[a] The information provided does not permit this indicator to be tabulated.

Sub-indicators on local health care

34. The proportion of the population having access to local health care, including availability of at least 20 essential drugs, within one hour's walk or travel, was to be reported. Forty-five countries (provisional, since no information is available from the Americas) have provided usable information. The following table shows the actual results obtained.

Annex

Availability of local health care

Proportion of population for whom local health care is available	Number of countries						Total
	AFR	AMR[a]	SEAR	EUR	EMR	WPR	
Less than 10.0%	-	N.A.	-	-	-	-	-
10.0-19.9%	-		-	-	3	-	3
20.0-29.9%	2		-	-	-	-	2
30.0-39.9%	1		-	-	-	-	1
40.0-49.9%	2		-	-	-	-	2
50.0-59.9%	-		-	-	1	-	1
60.0-69.9%	1		-	-	-	-	1
70.0-79.9%	3		-	-	1	2	6
80.0-89.9%	1		-	-	1	2	4
90.0% or more	4		3	10	8	-	25
Subtotal	14	N.A.	3	10	14	4	45
Without data or data disqualified	23	19	8	11	8	8	77
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

[a] The information provided does not permit this indicator to be tabulated.

35. From the above table it may be noted that 25 countries indicated that 90% or more of the population have access to local care with at least 20 essential drugs. Of those countries, 10 are located in the European Region.

Sub-indicators on availability of trained personnel

36. Two sub-indicators have been defined:

- Proportion of women attended during pregnancy and childbirth by trained personnel.

- Proportion of children aged under 1 year cared for by trained personnel.

37. Provisional information is shown in the following tables. Apart from the Region of the Americas, 37 countries provided information for the attendance of pregnant women and 22 countries for the care of infants under 1 year of age. At this stage of the data analysis, it would be premature to elaborate any conclusion on the coverages. Reasons for non-response should be investigated and possible remedies suggested.

Availability of trained personnel for attending pregnancy and childbirth

Proportion of women attended during pregnancy and childbirth	Number of countries						Total
	AFR	AMR[a]	SEAR	EUR	EMR	WPR	
Less than 10.0%	1	N.A.	-	-	2	-	3
10.0-19.9%	-		-	-	-	-	-
20.0-29.9%	2		-	-	-	-	2
30.0-39.9%	2		-	-	-	-	2
40.0-49.9%	-		-	-	1	-	1
50.0-59.9%	-		-	-	1	-	1
60.0-69.9%	-		-	-	2	-	2
70.0-79.9%	1		-	-	-	-	1
80.0-89.9%	2		1	-	1	1	5
90.0% or more	4		2	10	4	-	20
Subtotal	12	N.A.	3	10	11	1	37
Without data or data disqualified	25	19	8	11	11	11	85
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

[a] The information provided does not permit this indicator to be tabulated.

Availability of trained personnel to care for children up to at least 1 year of age

Proportion of children aged under 1 year cared for	Number of countries						Total
	AFR[a]	AMR[a]	SEAR	EUR	EMR	WPR	
Less than 10.0%	N.A.	N.A.	-	-	2	-	2
10.0-19.9%			-	-	-	-	-
20.0-29.9%			-	-	1	-	1
30.0-39.9%			-	-	-	-	-
40.0-49.9%			-	-	-	1	1
50.0-59.9%			-	-	1	-	1
60.0-69.9%			-	-	-	-	-
70.0-79.9%			-	-	-	-	-
80.0-89.9%			1	-	-	-	1
90.0% or more			2	10	3	1	16
Subtotal	N.A.	N.A.	3	10	7	2	22
Without data or data disqualified	37	19	8	11	15	10	100
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

[a] The information provided does not permit this indicator to be tabulated.

Annex

GLOBAL INDICATOR 8

38. Global indicator 8 is defined as the number of countries in which: "The nutritional status of children is adequate, in that:

- at least 90% of newborn infants have a birth weight of at least 2500 g;

- at least 90% of children have a weight for age that corresponds to the reference values given in Annex 1 to Development of indicators for monitoring progress towards health for all by the year 2000".

39. The two sub-indicators are dealt with separately below. Fifty-two countries provided information about birth weight and 14 only on weight for age of children under 5 years. The following table presents the distribution of countries for each of the two sub-indicators. The poor response rate does not allow for valid conclusions.

Birth weight of at least 2500 g

% of newborn infants with birth weight of at least 2500 g	Number of countries						Total
	AFR	AMR	SEAR	EUR	EMR	WPR	
Less than 10.0%	-	-	-	-	-	-	-
10.0-19.9%	-	-	-	-	-	-	-
20.0-29.9%	-	-	-	-	-	-	-
30.0-39.9%	-	-	-	-	-	-	-
40.0-49.9%	-	-	-	-	-	-	-
50.0-59.9%	-	-	1	-	1	-	2
60.0-69.9%	-	-	1	-	-	-	1
70.0-79.9%	1	-	3	-	-	-	4
80.0-89.9%	9	-	1	-	3	-	13
90.0% or more	1	1	1	17	7	5	32
Subtotal	11	1	7	17	11	5	52
Without data or data disqualified	26	18	4	4	11	7	70
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

Weight for age of children under 5 years

% of children under 5 years corresponding to the reference values	Number of countries						Total
	AFR	AMR[a]	SEAR	EUR	EMR	WPR	
Less than 10.0%	-		-	-	-	-	-
10.0-19.9%	-		-	-	-	-	-
20.0-29.9%	-		-	-	-	-	-
30.0-39.9%	-		-	-	-	-	-
40.0-49.9%	-		-	-	1	-	1
50.0-59.9%	-	N.A.	-	-	-	-	-
60.0-69.9%	1		-	-	-	-	1
70.0-79.9%	1		-	-	1	-	2
80.0-89.9%	1		-	1	-	1	3
90.0% or more	1		-	4	1	1	7
Subtotal	4	N.A.	-	5	3	2	14
Without data or data disqualified	33	19	11	16	19	10	108
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

[a] The information provided does not permit this indicator to be tabulated.

GLOBAL INDICATOR 9

40. Global indicator 9 is defined as the number of countries in which: "The infant mortality rate for all identifiable subgroups is below 50 per 1000 live-births".

41. Infant mortality rate is the number of deaths of infants under the age of one year per 1000 live-births in a given year. This is known to be a sensitive indicator of impacts of health programmes and of the status of health care. Member States were requested, in monitoring the implementation of their national strategies, to provide the latest information available at national level and also for identified subgroups of population.

42. Out of 122 national reports received, 112 countries provided information on infant mortality at national level. The distribution by WHO region is shown in the following table. In general no indication was provided in the national progress reports as to whether the infant mortality rate was calculated or estimated. For some countries the reference period was old, which may reflect the difficulty experienced by many developing countries in estimating this indicator. Disaggregation for identified groups of population was not reported by most countries. It is not therefore possible in the present analysis to provide ranges and to highlight discrepancies within a country.

Annex

Infant mortality

Infant mortality (deaths under 1 year per 1000 liveborn)	Number of countries						Total
	AFR	AMR	SEAR	EUR	EMR	WPR	
Less than 10.0	-	-	-	6	-	-	6
10.0-19.9	1	4	2	8	3	2	20
20.0-29.9	-	3	-	2	3	2	10
30.0-39.9	1	2	1	1	1	3	9
40.0-49.9	1	1	-	-	-	2	4
50.0-59.9	-	2	-	-	1	-	3
60.0-69.9	-	1	-	-	1	1	3
70.0-79.9	1	-	-	-	-	1	2
80.0-89.9	1	4	-	-	3	-	8
90.0-99.9	2	1	2	-	1	-	6
100.0-149.9	20	1	3	-	3	-	27
150.0-199.9	7	-	-	-	4	-	11
200.0 or more	3	-	-	-	-	-	3
Subtotal	37	19	8	17	20	11	112
Without data or data disqualified	-	-	3	4	2	1	10
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

43. With reference to the threshold mentioned for this indicator in the Global Strategy (50 infant deaths for 1000 live-births), 49 Member States out of 112 (43.8%) have a level of infant mortality below 50 deaths per 1000 live-births. There is a great variation between WHO regions. The following table shows the percentage of countries with an infant mortality rate (IMR) lower than 50 deaths per 1000 live-births. In the African Region, 81.1% of the reporting countries have an IMR higher than 100 infant deaths per 1000 liveborn.

Percentage of countries with an infant mortality rate below 50 per 1000

WHO region	Number of countries		%
	Reporting IMR	With IMR below 50 per 1000	
Africa	37	3	8.1
Americas	19	10	52.6
South-East Asia	8	3	37.5
Europe	17	17	100.0
Eastern Mediterranean	20	7	35.0
Western Pacific	11	9	81.8
Total	112	49	43.8

44. As mentioned in some national and regional reports, efforts should be made in collaboration with national civil registration offices to improve the national capability and/or to apply alternative methodologies to generate data required in the construction of this indicator.

GLOBAL INDICATOR 10

45. Global indicator 10 is defined as the number of countries in which: "Life expectancy at birth is over 60 years".

46. One hundred and ten countries out of 120 provided this information. No indication was given how life expectancy was calculated. For some countries national values may also be rather obsolete. The following table shows the distribution of countries, by WHO region.

Life expectancy at birth

Life expectancy at birth (in years)	Number of countries						Total
	AFR	AMR	SEAR	EUR	EMR	WPR	
Less than 40.0	2	-	-	-	-	-	2
40.0-49.9	24	-	2	-	5	-	31
50.0-59.9	8	4	4	-	6	3	25
60.0-69.9	1	10	3	2	5	5	26
70.0 or more	1	4	1	15	3	3	27
Subtotal	36	18	10	17	19	11	111
Without data or data disqualified	1	1	1	4	3	1	11
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

47. With reference to the threshold fixed at 60 years, the following table shows the results obtained in each WHO region.

Percentage of countries with life expectancy (e^o) of over 60 years

WHO region	Number of countries		%
	With available information	With e^o over 60 years	
Africa	36	2	5.6
Americas	18	14	77.8
South-East Asia	10	4	40.0
Europe	17	17	100.0
Eastern Mediterranean	19	8	42.1
Western Pacific	11	8	72.7
Total	111	53	47.7

48. Out of 111 countries, 53 have a life expectancy of over 60 years. Only two countries in Africa have reached that level (5.6% of responding countries).

GLOBAL INDICATOR 11

49. Global indicator 11 is defined as the number of countries in which: "The adult literacy rate for both men and women exceeds 70%".

50. Progress towards health for all is likely to be strongly influenced by education. The adult literacy rate was included in the list of global indicators as an indicator of the contribution of education to health. This rate was defined as the percentage of the population aged 15 and over able to read and write in any language.

51. Out of 122 countries that sent in progress reports, 84 provided quantitative information on adult literacy. Thus, 31% of the countries sending progress reports did not provide this information. Moreover, most countries did not separate the rates for males and females as required. The following table shows the distribution of countries according to the adult literacy rate by WHO region.

Adult literacy rate

Adult literacy rate	Number of countries						Total
	AFR	AMR	SEAR	EUR	EMR	WPR	
Less than 10.0%	3	-	-	-	1	-	4
10.0-19.9%	3	-	-	-	3	-	6
20.0-29.9%	3	-	-	-	2	-	5
30.0-39.9%	3	-	2	-	-	-	5
40.0-49.9%	2	3	-	-	1	-	6
50.0-59.9%	2	2	-	-	-	-	4
60.0-69.9%	1	-	-	-	5	-	6
70.0-79.9%	4	3	2	-	-	2	11
80.0-89.9%	-	4	3	-	2	3	12
90.0% or more	-	6	2	14	1	2	25
Subtotal	21	18	9	14	15	7	84
Without data or data disqualified	16	1	2	7	7	5	38
No progress report	7	12	-	14	1	5	39
Total	44	31	11	35	23	17	161

52. The Global Strategy suggested a threshold of 70% for this rate. The following table shows the number of countries by WHO region having reached that level.

Percentage of countries with a literacy rate higher than 70%

WHO region	Number of countries		%
	With available information	With literacy over 70%	
Africa	21	4	19.0
Americas	18	13	72.2
South-East Asia	9	7	77.8
Europe	14	14	100.0
Eastern Mediterranean	15	3	20.0
Western Pacific	7	7	100.0
Total	84	48	57.1

53. Intersectoral collaboration in data generation and exchange with education and social services should be promoted by countries which are not yet in a position to obtain and use this type of information. On the international side, the provision of the necessary technical cooperation from UNESCO may be called for.

Discussion on the findings

54. One Member State out of four did not send its national report on monitoring progress on time. Furthermore, some of the reports received did not contain the requested national values for the global indicators adopted by the World Health Assembly. It is therefore apparent that for certain essential indicators Member States were not in a position to provide the information.

55. During the discussions of the subject at the regional committee sessions in September/October 1983, Member States adopted resolutions proposing that they collectively develop and further improve their monitoring and evaluation systems and reorient and strengthen their national information support.

56. Among the recommendations made at those sessions, WHO was requested to increase its support to Member States in order to develop national mechanisms for generating essential information. Training of national and WHO staff was also requested, especially in management and information support.

57. The relevance of global indicators was reviewed during the regional committees' discussions. In the light of these discussions the mechanisms for the collection, analysis and interpretation of the global indicators may be improved for the evaluation reports due in 1985 at national and regional levels.

58. In order to measure differences within a country, it will be necessary for health authorities to establish mechanisms to collect information at regional, provincial, or district levels for quantified indicators. The same principles could also apply to different socio-economic groups in the population.

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