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REPORT OF THE DIRECTOR-GENERAL ON THE WORK OF WHO IN 1984

and

PROGRESS REPORT ON THE GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000

This short report of the Director-General, which he presents in odd-numbered years to the Health Assembly and which covers significant matters and developments in WHO's programmes during the preceding year (resolution WHA28.29), has been combined with his annual report to the Executive Board on progress made and problems encountered in the implementation of the Global Strategy for Health for All by the Year 2000.

Thus the present report, while including a selection of the work of the first year of the current biennium, attempts for the first time to put the activities of WHO and its Member States in the perspective of national and regional strategies and the Global Strategy for Health for All. The full biennial report of the Director-General to the Health Assembly and to the United Nations on the work of WHO in 1984-1985 will be presented in 1986.

This report was reviewed by the Executive Board at its seventy-fifth session in January 1985.

CONTENTS

I. INTRODUCTION

1. This report by the Director-General is a combination of his report to the Executive Board on the implementation of the Global Strategy for Health for All by the Year 2000 (resolution WHA34.36) and his short report to the World Health Assembly on significant developments in WHO's programmes during even-numbered years (resolution WHA28.29). The process of combining the two reports necessitates a significant shift in emphasis and perspective: rather than being an "interim" communication from the Director-General, the new type of report indicates progress in the implementation of the Strategy for Health for All. Furthermore, it not only refers to the activities of the WHO Secretariat, but primarily attempts to reflect the progress in the implementation of the Strategy within Member States. Seen in this wider context, the activities of the Organization are no more than means and tools whose utility and effectiveness should be measured against the progress of Member States towards their collective goal.

2. It is clear that this method of reporting to the Board and the Health Assembly presupposes a more selective approach to information collation, coupled with an evaluative style of thinking which should be present at all levels. The report does not attempt to cover all the activities of WHO, some of which will be the subject of more detailed reporting in the Director-General's biennial report on the work of WHO in 1984-1985.

II. POLICIES, STRATEGIES AND PLANS OF ACTION

3. The Thirty-seventh World Health Assembly in May 1984 reviewed the first progress report on the implementation of strategies for health for all by the year 2000. 122 Member States submitted their national monitoring reports, which were reviewed at regional and global levels. The report[1] indicated that the political will to achieve the goal of health for all existed in a large majority of countries, and many had initiated the process of formulating their health policies, strategies and plans for its achievement.

4. But the Health Assembly, noting the magnitude of the overall task and the relatively short period left to achieve the goal, also urged Member States to accelerate the reorientation and the modifications of health systems towards primary health care and further strengthen the managerial capacity of their health system, including the generation, analysis and utilization of the information needed; and to use WHO's resources optimally, directing them to the mainstream of activities required to implement, monitor and evaluate the national strategy. It requested the Director-General to ensure the provision of intensive, appropriate and targeted support to Member States for the implementation, monitoring and evaluation of the Strategy, especially in countries where the needs are greatest and which are ready for it (resolution WHA37.17).

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[1] Document WHA37/1984/REC/1, Annex 3, part 1.

5. The critical socioeconomic situation, political strife, and the effects of drought slowed up the development of health-for-all strategies in Africa. The Regional Office for Africa contributed to the preparation of the report by the Secretary-General of the United Nations on the "Critical social and economic situation in Africa" which was submitted to the 1984 regular session of the Economic and Social Council in Geneva in July. The 24 countries most seriously affected by the crisis are Angola, Benin, Botswana, Burkina Faso, Cape Verde, Chad, Central African Republic, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Lesotho, Mali, Mauritania, Mozambique, Sao Tome and Principe, Senegal, Somalia, Swaziland, Togo, United Republic of Tanzania, Zambia and Zimbabwe. The crises further underlined the need to pursue the goal of health for all with greater tenacity, and the Regional Office redoubled its efforts to support the Member States in the formulation of national and regional strategies.

6. A consultation on the regional plan of action for health-for-all strategies held at the Regional Office for South-East Asia in July 1984 reviewed the status of regional and national plans of action and suggested measures for improvement. It also considered the mechanisms for monitoring and evaluation of strategies, policies and plans of action at national and regional levels and the information support needed for this purpose.

7. In September 1984 the Regional Committee for Europe discussed and endorsed the regional targets in support of the regional strategy and plan of action. It also reviewed the list of proposed indicators for monitoring and evaluation of the strategy. The Regional Office is collaborating with several Member States in developing national strategies, in particular Malta, Norway, Portugal and Spain. Collaborative medium-term programmes have been drawn up and signed for the German Democratic Republic, Portugal and Spain, and negotiations are under way for such programmes in Albania, Greece, Hungary, Malta, Morocco and Turkey. The development of national plans is being supported by means of "scenarios" for health for all. Finland, the Netherlands and Sweden are seeking alternative ways of achieving health for all and analysing the possible consequences of various strategies for ultimate incorporation in such "scenarios" to be submitted to public debate and used in developing national health policies.

8. Several Member States in the Eastern Mediterranean Region have reviewed their health policies and have formulated national health-for-all strategies. In March 1984 the newly established Regional Consultative Committee reviewed progress in the implementation of national strategies and identified a number of constraints which may affect future development, such as the uneasy political situation in countries of the Region, slowing down of economic development, and inadequate national managerial capabilities, including lack of information support.

9. In the Western Pacific Region, health-for-all indicators for monitoring were reviewed and revised. The first monitoring exercise has accelerated the development by Member States of procedures and mechanisms for the updating and continuous monitoring of their national strategies. WHO collaborated with three countries in policy analysis, studies and reviews in order to facilitate the formulation of national health policy, while in four countries support was provided for the review and updating of national strategies.

10. According to the Plan of Action for implementing the Global Strategy for Health for All,[1] Member States are expected to undertake the first evaluation of their national strategies by March 1985. To facilitate this process, the Secretariat prepared a "Common framework and format"[2] for monitoring progress in implementing the strategies for health for all by the year 2000, in consultation with the regional offices. A number of preparatory activities were undertaken at country, regional and global levels to facilitate the systematic implementation of the evaluation process. Four workshops were held in the African Region for senior national staff, WHO programme coordinators and intercountry staff from 42 Member States. The common framework and format was tested in 12 countries of Africa and the results were reported to the Regional Committee in September 1984. In the Region of the

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[1] WHO "Health for All" Series, No. 7, 1982.

[2] Evaluating the strategies for health for all by the year 2000: Common framework and format (document DGO/84.1).

Americas it was tested in Brazil, the Dominican Republic, Jamaica and Venezuela, and the results were submitted to the Regional Committee at its session in September 1984. In the South-East Asia Region it was reviewed and endorsed by the Consultative Committee for Programme Development and Management. All regional office staff and WHO programme coodinators were especially briefed on the support required by Members in the evaluation of the strategy. The common framework and format was also tested in two countries and support was provided to other Member States.

11. The Regional Committee for Europe approved the proposed regional indicators for incorporation in the common framework and format. In the Eastern Mediterranean Region it was tested in Kuwait and Yemen, and a meeting of the national focal points to facilitate its use for evaluation of the national strategies was held in Cyprus in August 1984. The common framework was also reviewed by the Regional Committee for the Western Pacific, and regional indicators for monitoring were incorporated in it. Support was provided to the Member States in evaluating their strategies. At WHO headquarters, consultations on the evaluation process were held with senior staff to ensure the orientation of the Organization as a whole to support Member States in this important task.

12. WHO participated in the International Conference on Population held in Mexico City from 6 to 13 August 1984. The Conference re-endorsed some of the basic elements of the Strategy for Health For All. For example, the Mexico City Declaration on Population and Development, and the Conference's 88 recommendations, acknowledged the health risks of "unwanted high fertility"; urged that "special attention ... be given to maternal and child health services within a primary health care system"; mentioned specifically "breast-feeding, adequate sanitation, clean water, immunization programmes, oral rehydration therapy and birth spacing" as essential aspects of these services; stressed the importance of the status and role of women, and the right of couples and individuals to "decide freely, responsibly and without coercion, the number and spacing of their children"; and reiterated the need for continued research and full community participation in health development and population programmes (see United Nations document E/CONF.76/19). The Global Strategy for Health for All provides the necessary framework for the implementation of the health-related recommendations of the World Population Plan of Action. It is essential, however, that each of these recommendations be analysed in the light of the Strategy, so that the implications for the international community, and in particular WHO, can be understood and applied in support of national action.

13. During 1984, WHO made a thorough review of the support it has provided towards the achievement of the goals set for the United Nations Decade for Women (1976-1985) and analysed the progress achieved and obstacles encountered. All regional committees at their 1984 sessions reviewed the status and role of women in health and development and identified areas where greater efforts were required. Resolutions adopted in five regions urged Member States and Regional Directors to continue their efforts to improve both the health status of women and their capacity to contribute to the health of others. Strategies for the advancement of women's health and their role in health and development were formulated for incorporation into the global strategies which will be reviewed at the World Conference on the Decade for Women in Nairobi in July 1985.

III. DEVELOPMENT OF HEALTH SYSTEMS

Organization of health systems based on primary health care

14. In their efforts to accelerate the strengthening or reorientation of health systems based on primary health care (PHC), several countries began systematically to identify weaknesses and difficulties in introducing the necessary changes in their health systems and to take corrective action. In the African Region PHC reviews were undertaken with WHO support in 12 countries, utilizing a set of guidelines and prototype questionnaires adapted to each country's interests and priorities. These reviews are seen as strategic management tools to identify systematically the key administrative weaknesses and to implement the necessary corrective measures.

15. In their search for new approaches to accelerate the implementation of PHC, several Member States in the South-East Asia Region initiated important action. Efforts by governments focused on strengthening the health system at the intermediate and lower levels and building health infrastructure to meet the growing demands of PHC at the community

level. Noteworthy examples include: the strengthening of the district-level (upazilla) health infrastructure in Bangladesh; development of an integrated family welfare "package" based on the restructuring of health services in Indonesia; implementation of a PHC model approach in Huvsgul Province (Aimak) in Mongolia aimed at maximum self-reliance at the community level; development of a PHC approach in Thailand at the community level with emphasis on the intersectoral approach, self-reliance and decentralized management; and the use of a decentralized section-doctor approach in the Democratic People's Republic of Korea. An intercountry seminar on PHC was held in Ulan Bator in August to review these approaches and to exchange experiences.

16. A number of countries in the European Region, including Greece, Spain and Turkey, increased their efforts in reorganizing their health systems for PHC. Among the major activities to support national efforts during 1984 were: a consultation in Madrid on criteria and guidelines for comprehensive regional health planning in the light of the 1984 Spanish law on basic health structures; a national workshop on health centre development in Athens; a teachers' training course in PHC, at the University of Tampere in Finland; the fourth international course on the organization and evaluation of PHC for developing countries in Brussels; the first international training course in quality assurance in Barcelona, Spain; and a consultation in Copenhagen on technology planning in health care centres.

17. In the Western Pacific Region, WHO collaborated with five countries in the review of their health systems and in the development of a plan of action for PHC orientation of key national staff at intermediate and peripheral levels, strengthening of management capability in the health administration at intermediate level, and planning to meet the needs of the secondary and tertiary referral hospitals. WHO also provided support for urban PHC development in Manila and Seoul.

18. WHO and UNICEF collaborated with selected countries in accelerating the development of PHC, identifying critical issues and constraints in PHC implementation and supporting the prospective implementation of corrective measures. The UNICEF/WHO Joint Committee on Health Policy (JCHP) had selected Burma, Democratic Yemen, Ethiopia, Jamaica, Nepal, Nicaragua and Papua New Guinea for such support. During 1984, Indonesia and Peru also expressed interest in participating in this process. A consultation held with representatives of these countries, WHO and UNICEF in Montego Bay, Jamaica, in July 1984 evaluated joint efforts and identified key issues confronting the countries in PHC implementation and areas where WHO/UNICEF support could be most useful. A number of specific recommendations emerged which will be presented to JCHP's next session in January 1985.

19. To promote interest in and action for the strengthening and reorientation of urban health systems based on PHC, WHO and UNICEF carried out reviews in a number of cities, describing urban differentials in the health situation and outlining measures for improvement of services. An interregional consultation with the countries involved was held in Guayaquil, Ecuador, in October 1984, providing an opportunity for exchange of experience with different models of care in urban areas and with methods of extending care to the urban poor. Eleven reports from nine countries (Brazil, Colombia, Ecuador, Ethiopia, Guatemala, India, Peru, Philippines and Republic of Korea) were discussed. The participants examined the issues of resources, community participation, and the provision of full PHC coverage for the urban poor and made a number of suggestions for further orientation of UNICEF and WHO support. The report will be examined by JCHP in January 1985.

20. An interregional seminar jointly sponsored by UNDP, UNICEF, WHO and the Government of Sri Lanka was held in Colombo to explore aspects of that country's experience in PHC and related social programmes contributing to health with community participation; special emphasis was given to the role of women, literacy, food and nutrition including food subsidies, the PHC needs of mothers and children, manpower development, and mechanisms for the management of national health systems. The seminar was attended by senior health and other officials of 16 countries. Following discussion of the recommendations, the Sri Lankan authorities took action on a number of them.

21. An increasing awareness in countries of the need to make the best use of available health resources and to move towards the provision of integrated health care programmes found expression in various ways, including an interregional consultation in New Delhi in June 1984 to examine the opportunities and difficulties at the operational level of health care delivery systems for the integration of health programmes. The participants from nine countries (Brazil, Ethiopia, Finland, India, Indonesia, Kenya, Malaysia, Philippines and

Saudi Arabia) explored ways of expanding and strengthening the coverage, range and effectiveness of health systems. They concluded that greater priority should be given to the development of infrastructural elements of the health system and that the experience with more fully integrated systems based on PHC needed to be further expanded and disseminated to stimulate further progress in countries.

Managerial process, including information support

22. The first report on monitoring progress in implementing national strategies for health for all indicated that national managerial capacities, including the collection, analysis and use of information in support of the process, require further strengthening. The Thirty-seventh World Health Assembly requested the Director-General to intensify technical cooperation with Member States in these areas (resolution WHA37.17).

23. In the African Region, Comoros, Malawi, Senegal, Seychelles and Zimbabwe initiated steps to strengthen the managerial process. WHO support was provided for developing the relevant teaching materials and training in management for Gabon, Namibia and Togo. Technical cooperation was provided to Guinea-Bissau for the formulation of a plan for the strengthening of information support for management of health programmes, especially in maternal and child health. A regional collaborating centre for health situation and trend assessment was established in Mauritius. The centre will provide an intercountry mechanism for sharing and strengthening the information support for the health managerial process in the countries of the Indian Ocean. National workshops to train health personnel in information collection and analysis for health programme evaluation were held in Congo and Lesotho. A plan of action for the introduction of the new managerial mechanisms was elaborated and pilot studies to introduce some of these mechanisms were initiated in seven countries.

24. Workshops on the planning, administration and evaluation of health systems were held in 1984 in the Region of the Americas for decision-makers and regional and country staff. Grants were awarded to schools of public health for courses in health systems development for health personnel, and for exchanges of teaching staff. Brazil, Colombia, Costa Rica and Mexico introduced measures for the regionalization, consolidation and integration of national health systems, and Costa Rica, Mexico and Nicaragua received grants in support of activities for decentralization and intersectoral coordination. A regional consultation was held in Mexico City on the decentralization of health services. Technical cooperation in the area of health legislation was extended to 28 countries in the Region. A review of coordination between ministries of health and social security institutions was carried out in 16 countries. The results of the review were presented to the Meeting of Ministers of Health and Directors of Social Security of Central America and Panama in July.

25. Technical cooperation was provided to several countries of the South-East Asia Region in the planning process. Maldives formulated its health plan and carried out a resource utilization review; Burma formulated the third people's health plan; and Bhutan completed the formulation of its sixth plan. Concern is growing about national capacities to generate the required resources to implement health-for-all strategies and plans. An intercountry consultation on the subject in 1983 has led to national research and planning in health economics and financing in some countries. Indonesia formulated a long-term health development plan and designed and tested a national health insurance scheme, Thailand carried out an economic evaluation of its malaria control programme, and India and Nepal undertook studies on costs of health care. Studies on health organization development were made in Indonesia, Maldives and Sri Lanka. Several countries investigated methods to streamline and improve support systems in order to facilitate the efficient functioning of health services at the periphery. Monitoring and personnel administration systems are being studied in Burma, Indonesia and Thailand. New approaches to the training of health staff in management included field analysis and problem-solving models. Countries gave increased attention to evaluating progress in the implementation of health plans and programmes. A scientific working group on the evaluation of PHC developed guidelines for use at the country level, and a regional mechanism was established for the collection, collation, storage and annual publication of health information.

26. The Third International Congress on System Science in Health Care, held in Munich in July 1984, was co-sponsored by the Regional Office for Europe. It brought together research workers from a wide range of disciplines to discuss improvements in and the evolution of health systems. The European Conference on Planning and Management for Health, held in the Hague, Netherlands, in August 1984, discussed health planning and the management process in a

variety of political, social and administrative settings and health systems. The Conference provided a number of recommendations to countries and WHO on the strengthening of the managerial process and the search for alternative mechanisms. Training in the managerial process for national health development is being carried out with the assistance of collaborating centres, in all the official working languages of the Region. Training in planning for the elderly, evaluation of health services, and prevention and control of noncommunicable diseases received special attention. The Regional Office is developing a computer-based information system to support countries in the monitoring of health indicators.

27. In the Eastern Mediterranean Region, WHO widely disseminated the guiding principles and related learning materials for the managerial process in the languages of the Region. A second intercountry workshop on the process was held in Riyadh in 1984 with participants from seven countries. It was followed by national workshops in several countries. WHO also cooperated with a number of countries in the establishment of an intermediate-level supervisory system and in the improvement of health information support for the managerial process. An intercountry meeting on information and education for health policies and approaches in PHC was held in Riyadh, with participants from 12 countries. In response to a resolution adopted by the Council of Ministers of Health of the Arab Countries of the Gulf Area in January 1984, plans are well advanced to carry out in those countries a series of surveys on infant and early childhood mortality and morbidity in collaboration with UNICEF. A pilot study in Tunisia, general morbidity surveys in Somalia and the Syrian Arab Republic, and hospital morbidity surveys in the Libyan Arab Jamahiriya and Pakistan have been completed.

28. WHO support to countries in the Western Pacific Region in strengthening their health information systems has been considerably increased. The regional data bank incorporated the global and regional indicators. Two countries initiated assessment of their information systems on maternal and child health. A framework for the establishment of a user-oriented health management information system was formulated in the Lao People's Democratic Republic, and training and development activities were initiated. The strengthening of epidemiological surveillance systems received high priority in the South Pacific, where national and regional workshops were held. An analysis of morbidity and mortality data for disease trend evaluation was finalized in Fiji and Tonga and is progressing in Samoa and Solomon Islands. Countries in the South Pacific identified deficiencies in management support programmes and initiated with WHO and UNDP the development of procedures and training packages relating to supplies and logistics, maintenance of equipment and facilities, personnel management and supervision, and financial management. A review of current managerial processes and practices was undertaken in a number of countries with a view to strengthening them as necessary. Countries identified training in various aspects of management as one of their most urgent needs, and the Regional Office collaborated in national training programmes.

29. Deficiency in information support for the managerial process, including monitoring and evaluation of strategies for health for all, was noted during the first monitoring exercise. A number of countries started to assess their existing epidemiological and health statistical services with the objective of reorienting and strengthening information support for the management of national health systems and for the monitoring and evaluation of national strategies. To support these initiatives, collaboration with Member States and international agencies is being intensified.

Human resources development

30. Recognizing the need for more intensive mobilization and utilization of human resources for implementing national strategies, Member States have begun to pay increased attention to the planning and evaluation of health manpower development programmes consonant with the needs of their health systems in accordance with the provisions of resolution WHA37.17, paragraph 1(5). An interregional consultation on health manpower policies and plans was held in Indonesia in October 1984. Three major problems were identified: lack of involvement of those affected by policies and plans in their formulation, lack of managerial capacity, and low motivation. Some of the approaches suggested by the group to solve these problems included an analysis of the role of different parties affected by the plans; the involvement of health personnel at all levels of the health system in identifying goals and strategies to achieve them; assessment of the way plans are carried out; and improved communication between the different levels of the health services.

31. In the South-East Asia Region, Bangladesh, Burma, Indonesia, Nepal, Sri Lanka and Thailand took significant steps to relate health manpower planning to the changing needs of their health systems and to improve consultation and coordination between the training

institutions - the producers - and the ministries of health - the users. In order to collaborate with countries in reorienting to primary care, the Regional Office for Europe undertook a review of legislation governing nursing practice in selected countries. Further guidelines to assist countries in preparing standards of practice are being developed by representatives from five countries. In the Eastern Mediterranean Region, health manpower development activities concentrated on revision of curricula and training of health personnel. An intercountry meeting on community-based, task-oriented curricula was held at the Gezira Medical School in Sudan; and evaluation studies on nursing services in Somalia and the Syrian Arab Republic gave impetus to an intercountry meeting in Pakistan to prepare recommendations for improvement of such services. About two-thirds of the countries of the Region also reported that they were taking steps to reorient their training programmes so that the health workers can perform functions that are relevant to priority health problems and needs. Training of traditional birth attendants and teacher-training in PHC received particular emphasis during the year in several countries.

32. In the Western Pacific Region, an intercountry workshop on training programmes in management for national health development was organized at the WHO Regional Teacher Training Centre, Sydney, Australia. Health manpower research as an important component of health services research was discussed at the ninth session of the Western Pacific Advisory Committee on Medical Research in April 1984. WHO support was provided to China, the Lao People's Democratic Republic and the Philippines in several specific aspects of manpower planning and training.

33. Fifteen case studies on leadership for PHC were analysed and are being published as a complement to The primary health worker[1] and On being in charge.[2] A background paper and a guiding framework for health service managers have been prepared to assist in the presentation of case studies on supervision of health personnel with particular reference to PHC. In order to mobilize nurses for leadership in PHC the International Council of Nurses, with WHO's cooperation, held five regional workshops with participants from 63 countries. WHO also collaborated with the International Nursing Foundation of Japan in gearing the latter's cooperative nursing activities in countries of South-East Asia and the Western Pacific towards the development of leadership strategies and guidance materials for nurses in support of PHC. The implementation of changes in nursing evaluation and practice is being monitored in seven countries to ensure reorientation towards PHC.

34. Under the UNDP-assisted interregional health learning materials programme, detailed plans were developed during 1984 for five-year national projects in Benin, Kenya, Morocco, Mozambique, Nepal, Rwanda, Sudan and United Republic of Tanzania aimed at achievement of national self-reliance in the development and production of relevant teaching and learning materials. Preparatory phases under way in all these countries involved training of key staff, the setting up of infrastructure and premises, and ordering and installation of equipment and supplies.

35. The Technical Discussions at the Thirty-seventh World Health Assembly on "The role of universities in the strategies for health for all" focused the attention of governments and academic circles on the challenge of harnessing the potential of universities to play a major role in health and human development. The report of the Discussions,[3] incorporating recommendations to the governments, universities and WHO, was issued for wide circulation in order to promote much-needed dialogue and further action.

Community involvement

36. While many countries are increasing measures for community involvement in health development, there seems to be very little progress in the decentralization and delegation of authority to the intermediate and local levels of health administration and to the communities. Some countries are trying innovative approaches. For example, in Bangladesh the decentralized administration went to the extent of involving people's representatives in

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[1] World Health Organization. The primary health worker: working guide, guidelines for training, guidelines for adaptation, revised edition. Geneva, 1980.

[2] McMahon, R. et al. On being in charge: A guide for middle-level management in primary health care. Geneva, World Health Organization, 1980.

[3] The role of universities in the strategies for health for all: A contribution to human development and social justice, September 1984 (WHO document).

decision-making in development activities; and in Thailand self-reliance and management of community-based services were encouraged through measures for direct participation. A meeting on the role of religious institutions in health development in Alexandria, Egypt, explored ways to promote healthy life-styles and community self-reliance. Sixteen case studies on community participation in health and development were carried out in eight Latin American and Caribbean countries, to define and refine concepts and information on community participation in health.

37. In eight countries of the Western Pacific Region, WHO cooperated in activities to intensify community involvement and intersectoral coordination through a series of seminars, workshops or meetings on PHC. While these workshops, whether national (as in Tokelau and Vanuatu) or provincial (as in Papua New Guinea), were aimed at promoting the concept of PHC, those at the district and community levels were action-oriented and resulted in the organization of groups working in the community to generate collective action for health development. Activities among the village health committees in Fiji and the village development committees in the pilot area of Papua New Guinea were particularly encouraging, while similar village organizations started to emerge in Kiribati, Solomon Islands and Vanuatu. In one country, village PHC councils were developed from existing village development councils in more than 90% of villages.

38. Two trends relating to community involvement must be monitored closely. One is the tendency to look to community involvement as the panacea for problems of scarce resources. The other is to limit community involvement to time-limited actions oriented to single problems. While such actions could be useful entry-points, they are not sufficient to promote self-sufficiency and self-reliance. Experience from innovative efforts in some countries has shown that adequate coverage and use of preventive and curative health services at the village level have been achieved when the population takes the major responsibility for primary health care in collaboration with the health services. Such participation usually guarantees the community's motivation to accept and use the services, and provides information on its felt needs and aspirations for the decision-makers. The Caribbean strategy on community participation and community health education, arising from a Caribbean workshop held in Antigua in June 1984, stressed that decentralization of the planning process is fundamental in promoting the involvement of members of the community, field workers from health and related sectors, and voluntary and nongovernmental organizations. Decentralization as a vehicle for achieving community participation should take due account of the needs, problems and resources of the community, its socioeconomic and political climate, cultural factors, the literacy level of the people, the health infrastructure and the degree of commitment at various levels.

Intersectoral coordination

39. Notwithstanding the recognition at national, regional and global levels of the need for the involvement of other key sectors in health development as one of the fundamental components of PHC, intersectoral coordination and cooperation still remains a complex area, and many countries are trying to tackle this difficult issue.

40. In the Region of the Americas, a working group on intersectoral action for health has been formed and has made concrete proposals for stepping up action at the country level. A follow-up to the working group on intersectoral action for health was a working paper submitted to the Regional Committee on "The economic crisis in Latin America and the Caribbean and its repercussions on the health sector". A study, "Health and social development in Costa Rica: Intersectoral action", was completed, and provided a comprehensive analysis of the effects of experience and action in other sectors on the patterns of health, the health consequences of economic adjustments to the current economic crisis, and the mechanisms for intersectoral coordination that have been unusually effective.

41. In Thailand a project has been implemented in Korat Province that provides for intersectoral cooperation involving the Ministries of Public Health, Education, Agriculture and Cooperatives, and the Interior at national, provincial, district, subdistrict and village levels, with public involvement in the development process at the village level and the use of social indicators as a planning tool in identifying projects and allocating resources. As a follow-up to the study undertaken by the Marga Institute in Sri Lanka, research has been initiated in an agricultural settlement and plantation area. The parts played by the health sector and other sectors in the prevailing health situation and its causes are being studied.

42. Work with other organizations of the United Nations system has been actively pursued. A major attempt has been made to move away from meetings in capital cities to the promotion and implementation of concrete action in communities. The Task Force on Rural Development of the United Nations Administrative Committee on Co-ordination (ACC) is becoming an increasingly useful vehicle for intersectoral action for health. Its panel on people's participation conducted a workshop in Arusha, United Republic of Tanzania, in October in which case studies on participation in rural development, including health, agriculture and labour and involving women's organizations, were discussed. Case studies from Botswana, Burkina Faso, Congo, Ghana, Kenya, Malawi, Senegal, United Republic of Tanzania and Zambia were presented. The workshop, and the fourth meeting of the panel which followed it, agreed on a joint programme of action involving UNICEF, UNDP, ILO, FAO, WHO and the International Fund for Agricultural Development (IFAD). Nigeria, Senegal, Uganda and Zimbabwe, all countries where WHO collaboration involving women's organizations in health development is functioning successfully, were selected for initial activities in this interagency, multisectoral programme.

43. Sub-Committee A of the 1984 session of the Regional Committee for the Eastern Mediterranean (13-16 October) held Technical Discussions on "Intersectoral collaboration in health development". Among the suggestions arising from the discussions were: the need to develop clear procedures and mechanisms for collaboration between different levels of the health services; and improved and constant communication and contact between the health sector and other sectors which have health-related or health-affecting activities. The Sub-Committee also concluded that while legislation affecting methods of and procedures for collaboration was important, intersectoral collaboration can be enhanced by the availability and sharing of valid and reliable information about health and health-related issues. It was considered that such channels of communication need to be created and used. Intersectoral collaboration is essentially a national concern and the need for deeper analysis of the constraints and the sharing of information on successful approaches among Member States is clearly evident.

IV. ESSENTIAL ELEMENTS OF PRIMARY HEALTH CARE[1]

Education for health

44. Efforts by Member States to inform and educate people in order to promote healthy life-styles and practices encouraging self-reliance were supported by WHO at country, regional and global levels through exchange of experiences, technical cooperation, training, research and dissemination of information. An intercountry workshop in the South-East Asia Region on integration of public information and education for health examined existing strategies and mechanisms and prepared plans to strengthen them. A Caribbean workshop on community participation and community health education discussed and adopted the first Caribbean strategy and plan of action for community participation. The first symposium on smoking and health in southern Europe, held in Barcelona, Spain, led to the creation of the Mediterranean Committee on Health Promotion and Smoking Control. An intercountry meeting on information and education for health held in Riyadh formulated guidelines for countries on the integration of health education within PHC and on collaboration between the ministries of health and education, and identified research needs.

45. Several countries in all regions undertook steps to strengthen their health education services, including development of educational policies, training of health personnel and development of appropriate information and educational materials, and initiated related research in the behavioural sciences. Increased technical and financial support was given to

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[1] See Global strategy for health for all by the year 2000. Geneva, World Health Organization, 1981 ("Health for All" Series, No. 3), p. 32, and Alma-Ata 1978. Primary health care. Geneva, World Health Organization, 1978, reprinted 1981 ("Health for All" Series, No. 1), p. 4. The Declaration of Alma-Ata states in section VII(3) that primary health includes at least: "... education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs".

countries in the Region of the Americas to develop programmes for the promotion of the health of schoolchildren. An intercountry course on methods to evaluate the impact of health education and mass media activities on PHC services in Mexico enabled participants to identify and apply steps for planning and implementing community health education activities and evaluating them in measurable terms.

46. The World Health Day theme, "Children's health - tomorrow's wealth", was used in many countries to promote related health education and information activities. Other supportive activities of WHO during the year included seminars for media personnel and the development and dissemination of press kits and relevant information materials to Member States, institutions and media. In the European Region, a system linking government departments, universities, research and training centres and experts in a network for the exchange of education technology and information was established. Similar networks are being considered in the Region of the Americas and the Western Pacific Region. A draft manual on health education in primary health care for use by health workers was circulated to Member States, collaborating institutions and technical experts for review and field-testing.

Food and nutrition

47. 1984 marked the beginning of full-scale implementation of food and nutrition projects in Burma, Dominica, Ethiopia, Haiti, Mali, Saint Vincent and the Grenadines, Sudan and the United Republic of Tanzania, with support from the WHO/UNICEF Joint Nutrition Support Programme and funding from the Government of Italy. Another joint programme with UNICEF, UNDP and IFAD, and with financial assistance from the Belgian Third World Survival Fund, was implemented in Kenya and Uganda. Nutrition education was the object of collaboration in the Central African Republic, Congo, Gabon and Zaire. Health systems research on nutrition was the subject of WHO-assisted projects in seven African countries, and research on breast-feeding was supported in five others.

48. Food subsidies and food donation programmes for low-income and other vulnerable groups, including mothers and children, were evaluated in selected countries of the Americas. The Central American Health Plan identified food and nutrition as a priority area; and the Regional Office in collaboration with the Institute of Nutrition of Central America and Panama (INCAP) provided technical support in the formulation of country project proposals for submission to donors. Several countries in the Western Pacific Region (China, Malaysia, Papua New Guinea, the Republic of Korea, Viet Nam and countries of the South Pacific) carried out or initiated infant and young child nutrition studies and national nutrition surveys.

49. A global review of related education materials was made to identify those suitable for "packaged" distribution and use in training programmes. An evaluation of the work of the FAO/WHO/OAU Regional Food and Nutrition Commission was also carried out to increase the efficiency of food aid in Africa. Standard terms of reference for its programming missions were agreed.

50. A report on selected global and regional nutrition status and related indicators was reviewed by the Thirty-seventh World Health Assembly, which recommended the development of measures against vitamin A deficiency and xerophthalmia. Follow-up activities in this area included a situation analysis, the development of a long-term interagency plan of action, and the organization of a meeting of international and bilateral agencies to decide on an effective strategy for preventing and controlling vitamin A deficiency and xerophthalmia, including the mobilization of financial resources.

Safe water and basic sanitation

51. The status of provision of safe water and basic sanitation and of implementation of the objectives of the International Drinking Water Supply and Sanitation Decade was reviewed at an interregional consultation. More than 80 Member States and territories reported, representing about three-quarters of the population of the developing world.

52. While some progress has been made, the review further underlined the need for improved information support, more realistic planning, improved intersectoral cooperation and increased community participation. In close coordination with UNDP, the World Bank and other agencies, WHO reviewed the mobilization of external resources for support to water supply and sanitation in the Decade. It also cooperated with the Ministry for Economic Cooperation of the Federal Republic of Germany in the organization of a meeting of European donor agencies

for exchange of information and to discuss policies and strategies for support to water supply and sanitation in developing countries, based on the experience of the first three years of the Decade.

53. Technical support was provided to several countries in the formulation of national plans, the development of adequate information support for monitoring of water supply and sanitation programmes, manpower development and institutional development. An agreement for a project aimed at strengthening the institutional capability for human resources development in Central America, Panama and the Dominican Republic was concluded with the Inter-American Development Bank and the Agency for Technical Cooperation (GTZ) of the Federal Republic of Germany. The Pan American Centre for Sanitary Engineering and Environmental Sciences (CEPIS) organized an international seminar in Brasilia on unaccounted-for losses in water systems. The 50 participants from 10 countries in the Region of the Americas developed strategies for prevention of wastage and drew up an agreement on intercountry cooperation through a network of centres. An international course was held in August, also in Brazil, on the operation and maintenance of small water-supply systems. In the Eastern Mediterranean, it was decided to establish a WHO regional centre for environmental health activities in Amman to develop human resources and disseminate technical information on appropriate technology. The Arab Gulf Programme for United Nations Development Organizations (AGFUND) approved funding of US$ 1 million to meet the cost of fellowships, equipment and personnel for the Centre.

54. To further promote the development of human resources, a human resources development handbook and a guide on planning for community participation in water-supply and sanitation projects were produced and widely distributed; and for reporting on human resources development and to facilitate the sharing of experiences, a case study format was developed. The first part of the new WHO guidelines for drinking-water quality was published,[1] and regional and national workshops were held on the subject. Other major activities included the promotion and development of low-cost sanitation technology and case studies to identify reasons for success and failure in areas related to human resources development and community education and participation in water-supply and sanitation projects.

55. Principles for evaluating health risks to progeny associated with exposure to chemicals during pregnancy were published.[2] Prepared by a group of 40 experts from 13 countries, the publication provides a description of the use of laboratory data in defining the potential embryotoxic hazards of chemicals and outlines methods of assessing the risks.

Maternal and child health, including family planning

56. A large majority of countries throughout the world are engaged in improving their health care services for mothers and children. WHO provided technical and managerial support to some 90 countries. To strengthen national managerial capabilities, WHO and the United Nations Fund for Population Activities (UNFPA) jointly initiated a series of workshops for national programme managers and WHO and UNFPA country staff to improve programme formulation, problem-solving and evaluation skills. Two such workshops were held in 1984 for English-speaking countries of Africa, and one for countries from the European and Eastern Mediterranean Regions. Technical collaboration with Member States was further aimed at improving the coverage and effectiveness of maternal and child health care, strengthening health manpower capabilities, developing health indicators and information support, and supporting health systems research, including the application of the risk approach as a managerial tool to identify the priority health needs of mothers and children.

57. Several countries initiated studies on perinatal, infant, early childhood and maternal mortality and morbidity with a view to identifying priority areas for action and developing the most appropriate preventive approaches. A regional meeting in the Americas on infant mortality and PHC strategies, held in Mexico in May, highlighted the important advances made in reducing infant and child mortality and the relation between these advances and the implementation of PHC strategies.

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[1] World Health Organization. Guidelines for drinking-water quality. Vol. 1. Recommendations. Geneva, 1984.

[2] World Health Organization. Principles for evaluating health risks to progeny associated with exposure to chemicals during pregnancy. Geneva, 1984. (Environmental Health Criteria, No. 30).

58. As part of its support to countries wishing to develop and strengthen their health information systems, WHO organized a technical consultation in Yerevan, USSR, in September, at which national experiences in the development and use of indicators relating to the health of mothers and children were discussed by participants from all regions. Guidelines were drawn up for the development of indicators and information support for effective management of national programmes for maternal and child health, including family planning.

59. An international task force worked closely with WHO collaborating centres, research institutes in developing countries, and interested nongovernmental organizations. Specific research activities in 1984 included evaluation of equipment and methods for home deliveries; development of birth-weight surrogates; evaluation and quality control of supplies and equipment intended for use in programmes for maternal and child health, including family planning, in health systems based on PHC; appraisal of various means of temperature control in relation to the newborn; and evaluation of environments in which deliveries and care of the newborn take place. During the year WHO also supported two major research projects concerning the nature and extent of child labour and its health and social dimensions in India and Kenya, thus marking the culmination of its activities in this area. The study in India provided the stimulus for a national meeting of leading specialists in a variety of disciplines, including child health, welfare and law, and national policy-makers, who discussed the health implications for young people and a reorientation of national policies.

60. Focus on the health of children and adolescents included promotion of intersectoral awareness of the health aspects of child labour and participation in preparations for International Youth Year (1985). WHO convened a study group on young people and health for all by the year 2000 in June 1984 in order to review adolescent and youth health and health-related issues, and to analyse established health systems on the basis of their relevance, resources, and service gaps in respect of the specific needs of this age group. The study group emphasized the impact of the formative years on the development of healthy life-styles and the later health effects of attitudes formed at this time in relation, for example, to smoking, drinking, drugs, and reproductive behaviour. It recommended the adoption of national programme strategies designed not only to meet more fully the health needs of this age group but also to tap its idealism and creative energy as a means of reinforcing their impact on the achievement of national health goals. Health literacy, particularly among young women, was considered a key to guaranteeing child health in future generations.

61. Parallel studies started in China, India and Thailand to identify "milestones" of optimal physical and psychosocial development of the child. An inventory of items for assessing the quality of day care for children was developed and tested in Greece, Nigeria and the Philippines. The revised inventory will be used in research and for the improvement of such care.

62. Following an informal meeting in May 1983 of African delegates to the Health Assembly with the Nongovernmental Organization Subcommittee on the Status of Women and the Working Group on Female Circumcision established under the auspices of the United Nations Commission on Human Rights, the Government of Senegal was host to a seminar in February 1984 on traditional practices affecting the health of women and children in Africa. WHO provided technical, administrative and financial support for this seminar and assisted in the preparation of the final report. The seminar represented an important event in a series of efforts which WHO has made since 1976, especially through its Regional Offices for Africa and the Eastern Mediterranean, to determine the extent, the antecedents, and the significance for health of certain traditional practices, and to provide opportunities for informed and objective discussion of these practices by responsible authorities of the countries concerned.

Immunization against the major infectious diseases

63. During 1984 several countries in all regions began to report improvements in immunization services as a part of PHC, and an increase in coverage. Reductions in the incidence of target diseases covered by the Expanded Programme on Immunization (EPI) were also reported in some countries. In the Region of the Americas all countries have set specific national coverage targets for immunization against diphtheria, pertussis, tetanus, poliomyelitis, measles and tuberculosis; if these targets are reached by 1985, all countries and territories in the Region will have coverage ranging from 70% to 100%. The health for

all strategy for the European Region specifies that by the year 2000 there should be no indigenous measles, poliomyelitis, neonatal tetanus, congenital rubella or diphtheria in the Region.

64. WHO supported the development of immunization services in Member States through the implementation of its five-point action programme for immunization, focused on the promotion of EPI within PHC; the development of human resources; the mobilization and investment of financial resources; continuous monitoring and evaluation to increase the programme's effectiveness; and appropriate research. Training of health workers in immunization continued to be a priority, the emphasis in 1984 shifting from courses for managers using materials developed at global level to training of middle and peripheral level health workers using materials adapted for national use, often in a national language. Programme reviews and evaluation were done in several countries, often including other PHC components, with the active involvement of national health managers. Through these reviews operational and managerial problems in the implementation of EPI were identified and action plans developed to solve them. Community participation needed to be strengthened in many countries, especially to reduce the large drop-out rate between the first and the last dose of multidose vaccines. Lack of trained staff and of management skills still represented severe constraints in several countries.

65. Notable in the area of "cold chain" development and logistics in 1984 was the further development of the cold-chain monitor and of solar refrigeration, as well as the evaluation of sterilizable plastic syringes and pressure-cooker sterilizers for use in rural health centres. On the whole the vaccine availability and cold-chain situation in the countries continued to improve.

66. The Bellagio Conference in March 1984 gave a further impetus to the mobilization of financial resources for EPI. The Conference, co-sponsored by UNICEF, WHO, the World Bank and UNDP, with support from the Rockefeller Foundation, created a task force for child survival. The task force's objective is to promote the reduction of childhood morbidity and mortality through the acceleration of key PHC activities. During the first year, support is concentrated on three countries - Colombia, India and Senegal - in which activities have started. The task force will continue its efforts to mobilize financial resources.

Prevention and control of locally endemic diseases

67. A considerable number of locally endemic diseases continue to affect vast populations of many developing countries, where diarrhoeal diseases, acute respiratory infections and EPI target diseases constitute the major causes of death and illness among young children. Malaria, tuberculosis and parasitic and tropical diseases such as schistosomiasis, leprosy and filariasis affect the health of people of all ages in many developing countries. With some recent advances in technologies for diagnosis and treatment, hopes and efforts for the control and prevention of these diseases have increased, and Member States are taking steps to strengthen this element of PHC.

68. Notable progress was made in diarrhoeal disease control activities. WHO technical cooperation continued to be provided to Member States for the development of national plans, training of managerial and supervisory personnel and programme evaluation, with a view to improving operational management. At the end of 1984, 88 developing countries had well-formulated plans of operation for the control of diarrhoeal diseases; 62 of these countries had begun implementing their plans. During 1984, approximately 1000 national staff participated in WHO-supported training courses on management and supervision. Fourteen countries carried out mortality and morbidity reviews and eight countries made formal reviews of their diarrhoeal disease control programmes with WHO collaboration. One country, Indonesia, field-tested new guidelines on the cost-effectiveness of oral rehydration therapy. Appropriate training and educational materials were developed and widely disseminated. In collaboration with UNICEF, support was provided to countries in ensuring local production and availability of oral rehydration salts. Progress in research included diagnostic microbiology, epidemiology and ecology, immunology and vaccine development, and clinical management.

69. Health systems research and clinical studies on acute respiratory infections were being carried out in over 20 countries in all WHO regions, seven of them started in 1984 (in India, Indonesia, Malaysia, Nepal, Pakistan, Sri Lanka and Tunisia), mainly to test the feasibility

of a standard plan for case management at the PHC level. A working group on case management in developing countries evaluated methods of diagnosis and treatment in children, identifying those most suitable for rural areas and formulating recommendations for training material.

70. The intake of countries participating in the programme on the evaluation of the effectiveness of BCG vaccination in infants and young children was completed with the admission in 1984 of Brazil and the Republic of Korea. The first national prevalence survey in the Philippines was completed in April. A global survey of mycobacterial resistance to antituberculosis drugs was started with the WHO collaborating centres in bacteriology of tuberculosis in order to determine regional and global levels of initial and acquired drug resistance. A regional seminar on chemotherapy of tuberculosis was organized in Bucharest in October with the collaboration of the Romanian Tuberculosis Institute and the participation of 11 countries. Information on the applicability of new knowledge on the treatment of tuberculosis was reviewed, and guidelines relevant to the situation of tuberculosis control in Europe were formulated. A manual was prepared on tuberculosis control within the framework of PHC.

71. Leprosy remained an important public health problem in many developing countries. The activities of WHO were concentrated largely on research and development, including clinical trials with multidrug therapy, training and promoting community involvement, and integration of leprosy control services in PHC. Efforts to mobilize financial resources in support of the leprosy programme from several multilateral and bilateral agencies continued. A videotape, "The leprosy network", was produced for training and promotion purposes.

72. A small working group was convened to prepare a field manual on the application of control measures for sexually transmitted diseases at the PHC level. In the Eastern Mediterranean Region, Djibouti and Somalia prepared national programmes for control of these diseases and for laboratory diagnostic support. A regional training course was held in Tunisia on their epidemiology, clinical aspects and case management.

73. In April, a fourth international symposium on yaws and other treponematoses brought together medical experts and public health officials from over 25 countries to consider the improved control and potential eradication of these diseases. A WHO collaborating centre on acquired immune deficiency syndrome (AIDS) was designated in Paris to collect and analyse the data reported by countries, to ensure the rapid exchange of information between them and to stimulate collaborative studies in Europe.

74. The world malaria situation has changed little from that described in the biennial report of the Director-General for 1982-1983;[1] new information on numbers of cases in the last 10 years was published together with a map of the distribution of chloroquine-resistant Plasmodium falciparum in the World Health Statistics Quarterly.[2] Member States continued to search for more effective ways to implement malaria control strategies within PHC and for new, effective and simple technologies. WHO provided technical support in programme planning and evaluation, training and research and promoted intercountry cooperation. The report of the Study Group on Malaria Control as part of Primary Health Care was published.[3] Antimalarial drug requirements for planning of action by countries within PHC systems were updated and communicated to countries. Basic principles for malaria control and general guidelines for UNICEF/WHO support were issued in a joint statement by the two organizations advocating in particular: implementation of the programme as a part of PHC to prevent mortality; an increase in related information and health education; the supply of antimalarials; improvement of measures for vector control; avoidance of drug resistance in the parasite; and training of workers at the community level in diagnosis and monitoring.

75. The third international course in the English language on malaria and the planning of malaria control took place in Italy and Turkey from 7 March to 29 June 1984, and the first in the French language is being held from 1 October 1984 to 25 January 1985 in Burkina Faso and France. Research and development activities focused on improvements in diagnostic and prevention technologies, antimalarial drugs, and vaccines (see section V).

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[1] World Health Organization. The work of WHO, 1982-1983: Biennial report of the Director-General. Geneva, 1984, paragraph 13.43 et seq.

[2] World Health Statistics Quarterly, 37(2): 130-161 (1984).

[3] WHO Technical Report Series, No. 712, 1984.

76. Measures related to health-for-all strategies in the control of other parasitic diseases included the widespread introduction of antischistosomal drugs and inexpensive techniques for diagnosis of schistosomiasis and African trypanosomiasis, and the formulation of strategies for the prevention and control of these diseases through PHC. Diethylcarbamazine treatment of lymphatic filariasis was implemented as part of PHC in India, and a drug administration campaign was also started in Samoa. Monofilament nylon sieves were developed and used for filtration of water in dracontiasis control (for further details on technology and research development, see section V).

77. Progress in vector biology and control included the development of impregnated bed-nets for malaria mosquito control in the African and Western Pacific Regions and simple tsetse-fly traps in West Africa, elimination of larval habitats of filariasis vectors in southern India, and a large-scale trial of control of Aedes aegypti vectors of dengue and dengue haemorrhagic fever, employing students and schoolteachers with other volunteers, in Thailand. Field trials of new insecticides against Anopheles vectors of malaria were carried out in Indonesia, and against Simulium vectors under the Onchocerciasis Control Programme in West Africa. A symposium on environmental management for vector control was organized in Tokyo and Toyama in collaboration with the Japanese Association of Tropical Medicine.

78. In measures against the zoonoses, progress was made in some countries in integrating the prevention and control of zoonoses and related foodborne diseases in national strategies. Plans were developed for a managerial process to formulate canine rabies control activities in eight countries in the South-East Asia Region, and projects were started in five countries in other regions.

79. A WHO expert committee on viral haemorrhagic fevers met in Geneva from 19 to 23 March 1984. The epidemiology, clinical pathophysiology and laboratory diagnosis of this group of diseases were reviewed. Special attention was given to patient management and prevention and control of viral haemorrhagic fevers in man and animals.

80. In response to general concern in Member States for the integration of diseases control programmes with primary health care, a protocol was prepared to promote and support research and development in countries. This will be further pursued during 1985.

Appropriate treatment and prevention of common diseases and injuries

81. In a number of countries the health care delivery infrastructure requires considerable strengthening, especially at the community level, so as to incorporate appropriate treatment of common diseases and injuries. Referral systems are not functioning adequately in many countries to provide continuity of care at the appropriate level. In collaboration with WHO, Member States continued to search for simple technologies and practical approaches to the prevention and control of common noncommunicable diseases and the promotion of oral health, mental health, and health of workers and of the elderly.

82. Recognizing the need to strengthen material resources and the training of health workers, especially at PHC levels, for the management of these health problems, and to promote the active involvement of people in self-care and preventive measures, WHO supported information exchange among countries, training, transfer of technology, research, especially on appropriate technology, and dissemination of information. In order to strengthen the technical capability of health workers at community and first referral levels, essential medical and surgical procedures were discussed with a view to preparing suitable technical guides and materials. A guide on managing services for the disabled in the community was prepared in order to increase the competence of health and community workers in this field. WHO supported training activities in rehabilitation at national and intercountry levels. Financial resources were provided by the Norwegian Red Cross, NORAD and SIDA for intercountry and global activities. Member States, particularly in the South-East Asia and Western Pacific Regions, took steps to strengthen eye care services within PHC. WHO support was provided in training, programme planning and provision of education materials. Collaboration with nongovernmental organizations was further strengthened through joint reviews and the setting up of a nongovernmental organization consultative group on the prevention of blindness.

83. Noncommunicable diseases, particularly cancer and cardiovascular diseases, are assuming increasing importance in the health of the adult population in both developed and developing countries, and many countries have accelerated health promotion activities aimed at

prevention through change in life-styles and behaviour, early detection and treatment, and promotion of self-care. WHO further supported research, training and exchange of experience in technology.

84. An estimate of the overall burden of 12 major cancers on the five continents was published in the Bulletin of the World Health Organization.[1] "Guiding principles for formulation of national cancer programmes in developing countries" were prepared (WHO document CAN/84.1) and are being used to identify priorities in a number of countries, including Sri Lanka and India. Model cancer care programmes and guidelines for programme planning were developed by the Regional Office for Europe. A meeting on the control of cervical cancer was held in Mexico City in January 1984 to determine the extent of the problem in the Region of the Americas and to review strategies for decreasing mortality. A manual of norms and procedures for cervical cancer control was prepared.

85. A WHO expert committee on prevention and control of cardiovascular disease in the community was convened in December 1984 to review the state of knowledge and to make practical recommendations for public health authorities that can be applied within the context of existing health systems in both developing and industrialized countries, concentrating on hypertension (including cerebrovascular stroke), coronary heart disease, and rheumatic fever/rheumatic heart disease.

86. The combined control of a number of risk factors associated with some major noncommunicable diseases has been adopted by the Regional Committee as part of the regional policy for noncommunicable diseases prevention and control in Europe. Agreements of understanding have been concluded between WHO and eight European Member States for long-term collaboration in community-based integrated programmes for the prevention and control of noncommunicable diseases. A meeting of principal investigators held in Brioni, Yugoslavia, from 4 to 7 September 1984 reviewed the progress made at the national level in respect of this programme activity, and a two-step group consultation on programme monitoring and evaluation methodology was held from 3 to 4 December 1984 in Copenhagen and from 6 to 7 December 1984 in Moscow.

87. At the global level, a consultation on risk modelling for noncommunicable diseases, held in Geneva from 26 to 30 March 1984, reviewed and summarized statistical methodology to assess such risks in the community and provided advice on how the existing statistical models might be used for risk classification for the community, for the prediction of effects of intervention, and to provide information on cost-effectiveness.

88. A guide to non-invasive diagnosis of pulmonary hypertension in chronic lung disease, prepared by a working group at the Regional Office for Europe, was issued in 1984 and distributed at the Ninth European Congress of Cardiology in Düsseldorf, Federal Republic of Germany, in July. A conference on primary prevention of ischaemic heart disease was held in Anacapri, Italy, from 15 to 19 October to discuss the practical application of the recommendations of a WHO expert committee[2] on this subject.

89. The worldwide situation regarding fetal diagnosis of hereditary disease was reviewed by a meeting in Geneva in May 1984 which evaluated the current experience and use of genetic services and identified the need for an international collaborative study to evaluate the obstetric risk of early fetal diagnosis. The design of this collaborative research and standardized protocols were worked out by a WHO consultation held in Rapallo, Italy, in October. To assist in initiating the collaborative study, an international registry for such diagnosis of hereditary diseases was established in the United States of America to collect and disseminate information on the safety and efficiency of early fetal diagnosis.

Essential drugs

90. A large number of countries have accelerated actions towards the development of drug legislation, policies and implementation plans along the lines of the Action Programme on Essential Drugs and Vaccines. A review of the progress in countries of five regions showed

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[1] Bulletin of the World Health Organization, 62: 163-182 (1984).

[2] WHO Technical Report Series, No. 678, 1982 (Prevention of coronary heart disease: report of a WHO Expert Committee).

that about 90 had already established a list of essential drugs, while 36 countries were in various stages of establishment or implementation of measures in accordance with the Action Programme. Another 27 Member States were developing national policies. Most countries already implementing essential drug programmes were making good progress with or without international collaboration. During 1984 a number of countries accelerated activities in this area, including Bhutan, Burkina Faso, Burundi, Democratic Yemen, Djibouti, Equatorial Guinea, Ethiopia, Kenya, Mali, Nicaragua, Oman, Sierra Leone, Yemen, Zambia and Zimbabwe. WHO collaborated with Member States in: the formulation of national plans and programmes; drug legislation; training; exchange of experience and dissemination of information; procurement and production of essential drugs; and quality control. Intercountry cooperation and coordination at the international level was particularly promoted.

91. Training materials have been developed to support national efforts. Examples of topics dealt with are: national drug policies; drug legislation and regulations; management of drug supplies; training and retraining of manpower; and guidelines related to pharmaceutical technology and quality assurance. These materials are freely available on request to countries and interested agencies.

92. A four-day international conference on essential drugs in PHC sponsored by UNICEF, USAID, WHO and member companies in the International Federation of Pharmaceutical Manufacturers Associations, held at the Harvard School of Public Health, Boston, USA, attracted more than 160 participants, including 60 from developing countries. The purpose of the conference was to develop problem-oriented teaching and training material for use in schools of public health. Several schools of medicine, public health and pharmacy were approached to promote interest in a collaborative scheme to teach essential drug principles. The London School of Tropical Medicine and Hygiene began such teaching, and the School of Public Health in Rennes, France, began a test project with support from the French Government for the training of multidisciplinary groups from developing countries.

93. Opportunities for promoting consolidated procurement within individual countries, as well as among groups of countries through pool procurement schemes, were explored in the African Region, the Region of the Americas and the Western Pacific Region. In Central America and Panama, high priority was placed on the promotion and development of national and subregional programmes, and a revolving fund for the joint procurement of essential drugs, based on studies undertaken by PAHO and the Central American Bank, is in the process of establishment. WHO cooperated in the formulation of country projects in this subregion. In the Western Pacific Region, a scheme to modify the South Pacific pharmaceutical service was agreed and implemented in April 1984; a WHO pharmaceuticals officer based in Apia, Samoa, is now assigned to organize the joint purchasing of pharmaceuticals and medical supplies.

94. In May, the Thirty-seventh World Health Assembly reviewed a progress report on the Action Programme[1] and urged the Member States to intensify their action, particularly in the implementation of drug policies and training of personnel, and to strengthen cooperation among themselves. The Health Assembly also requested the Director-General to arrange a meeting in 1985 of experts of concerned parties, including governments, pharmaceutical industries, and patients' and consumers' organizations, to discuss the means and methods of ensuring the rational use of drugs, in particular through improved knowledge and flow of information, and to discuss the role of marketing practices in this respect, especially in developing countries. Consultations and preparations for this meeting were initiated.

95. Efforts to mobilize financial and technical support for the programme were intensified. Discussions with the pharmaceutical industry have been stepped up with a view to facilitating drug procurement by developing countries under favourable conditions. WHO and UNICEF continued to collaborate in support of the procurement of essential drugs by developing countries. An outline of proposed international measures to improve drug procurement was presented to the April-May 1984 session of the Executive Board of UNICEF, and explained to the Thirty-seventh World Health Assembly. Extrabudgetary contributions were received from or promised by Canada, Denmark, Finland and Sweden. Negotiations are under way with other bilateral agencies for increased collaboration.

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[1] Document EB73/1984/REC/1, Annex 7.

Other elements

96. Support was provided to several Member States in the development of health policies for the care of the elderly as an integral part of PHC. The role of nongovernmental (NGO) and voluntary organizations in this area was promoted. A NGO/WHO collaborating group on aging supported these developments, for example, through the provision of simple manuals for community workers on self-care and health promotion, suitably adapted to particular regional and cultural groups. Two important reports were published in 1984: (1) The uses of epidemiology in the study of the elderly (WHO Technical Report Series, No. 706), which should serve to alert decision-makers and professionals to the need for measurement and assessment among populations for the design of cost-effective programmes; it provides practical guidance to Member States that have little or no information on their own elderly population; and (2) The wellbeing of the elderly: approaches to multidimensional assessment, by G. G. Fillenbaum (WHO Offset Publication No. 84), which will assist in selecting appropriate methods for any survey on the subject. Such surveys are under way in countries in four regions.

97. Field trials of various models of PHC delivery to underserved working people in agriculture and small industries were made in a number of countries, including Burkina Faso, Chile, China, Egypt, Nigeria, Republic of Korea, Sudan, Thailand, United Republic of Tanzania, and Zimbabwe. Countries exchanged experiences through regional workshops in the Americas and the South-East Asia Region.

98. In the field of mental health, a major multi-centre study on the epidemiology of schizophrenia and related disorders was completed in 13 geographically defined areas in Colombia, Czechoslovakia, Denmark, India, Ireland, Japan, Nigeria, United Kingdom, USA and USSR. This was the first investigation of the incidence of this group of disorders in which uniform instruments and research techniques were employed, allowing direct comparisons of areas in different countries. The findings provide a basis for long-term forecasts of treatment needs and for the planning of appropriate services, as well as clues to etiologically oriented research.

99. Neuroepidemiological studies coordinated by WHO in China, Ecuador and Nigeria were completed, providing information for programmes for the prevention and control of neurological disorders, and for application after suitable adaptation in Chile, India, Italy, Peru, Senegal, Tunisia and Venezuela. A related training programme included seminars co-sponsored by WHO in Quito and in Bombay, India.

100. Investigators from six countries met in Umea, Sweden, to agree on a research protocol for comparative assessment of services provided for the mentally ill. An informal consultation on alcohol and health in Geneva brought together workers in the public information media and health professionals to develop approaches for the media related to WHO's advocacy role concerning alcohol-related health problems. A review and analysis of legislation on the treatment of alcohol and drug dependence was finalized, and a manual including guidelines for teaching on drug and alcohol dependence in medical and health institutions was prepared.

101. In response to resolution WHA37.23, in which concern was expressed about the dramatic global increase in abuse of drugs, particularly cocaine, WHO launched a project to study the adverse health consequences of cocaine and coca-paste smoking. In this context an advisory group met in Bogotá to review the methodology of problem assessment, treatment approaches and research priorities, and to develop proposals for a worldwide plan of action.

V. APPROPRIATE TECHNOLOGY AND RESEARCH DEVELOPMENT

102. Research and development activities form part of most of WHO's programmes and salient examples are given below. These activities have focused largely on finding more effective technologies for the control of major communicable diseases affecting a large number of people in the developing countries; on the development or identification of more appropriate diagnostic and rehabilitative technology for use at the PHC level; on identifying more effective and appropriate contraceptive technology taking into account psychosocial aspects; on health systems research aimed at the application or delivery of the available technology through the health care delivery system; and on the dissemination of relevant information.

103. Encouraging progress has been made in the Special Programme for Research and Training in Tropical Diseases over the past 12 months. Mefloquine, a potent antimalarial which is effective against strains of Plasmodium resistant to chloroquine and other drugs and is well tolerated, is now ready for use. It is being initially registered for use in adult males and will soon be made available for use in women and children. Simple kits for testing the sensitivity of malaria parasites to drugs in common use have been developed and widely tested under the Special Programme; they are now being widely used in malaria control programmes. Research on malaria vaccines is advancing rapidly. A new technique has been developed for detecting sporozoites in infected mosquitos - an important advance over dissection and microscopy. A promising compound, ivermectin, for the control of filariasis is now undergoing chemical trials and preliminary results are very encouraging. New technologies have recently become available for the control of African trypanosomiasis and others are at an advanced stage of development. These include simple diagnostic tests and new methods of vector control including the use of traps. The Scientific Working Group on the Chemotherapy of Leprosy has conducted surveys on the distribution of dapsone resistance in leprosy and has supported research to define the best multidrug treatment regimens. Evaluation of a leprosy vaccine has begun and remarkable progress has been made in the development of diagnostic tests for leprosy.

104. A biosafety collaborating centre was established at Fairfield Hospital in Victoria, Australia. The United States and the United Kingdom published new national guidelines and regulations for handling of infectious micro-organisms. A programme for vaccine development was started to promote the use of new technology for the production of vaccines for diseases not covered by other WHO programmes; the targets include acute respiratory viruses, dengue, encapsulated bacteria, hepatitis A and tuberculosis. The programme is guided by a scientific advisory group of experts, while the work of each component is the responsibility of a steering committee. So far, funds have been provided for 47 research projects.

105. A WHO working group on research on development of poliomyelitis vaccine using modern biotechnologies met in Geneva from 17 to 19 April. The group recommended that work on infectious poliovirus, DNA and genetically engineered polioviruses should be encouraged with the aim of accelerating progress towards the development of improved vaccines against poliomyelitis, and that WHO should continue collaborative studies on the evaluation of monoclonal antibodies for poliovirus strain characterization.

106. To further support laboratory diagnostic capability at the peripheral levels of health care systems, evaluation of a small, rugged, low-cost field microscope has been completed and has shown that the instrument is well accepted for laboratory work; further technical improvement to achieve greater sensitivity is required. The basic radiological system (BRS) training package consisting of three manuals was finalized. The BRS Manual of radiographic interpretation for general practitioners has been prepared for publication.[1] Field trials of BRS machines were carried out in Burma, Colombia, Cyprus, Denmark, Egypt, Iceland, Indonesia, Nepal, Sweden and Yemen, and have been started in Albania, Jordan, Morocco, Nicaragua, Pakistan, Sudan and the United Kingdom. A scientific group on the future use of new imaging technologies in developing countries met in September-October to analyse data gathered by a WHO inquiry and made recommendations on such use.

107. An interregional consultation of senior staff of national training institutions and programmes from Cameroon, Colombia, Ethiopia, Lebanon, Malaysia, Mexico, Nigeria, Republic of Korea, Sri Lanka, Sudan, Thailand, Yugoslavia and Zambia was held in Cameroon in July 1984 to review and exchange experience on the training in health systems research available in different countries and regions. A training package including a guide for planning training programmes, a course manual, and a guide for administrators and trainers was discussed with participants and improved on the basis of their suggestions. The consultation also made recommendations with a view to generating political and managerial support for health systems research and related training; encouraging administrative activities to promote such research and training; ensuring that adequate materials for training are provided; and ensuring follow-up.

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[1] Palmer, P. E. S. et al. Manual of radiographic interpretation for general practitioners. Geneva, World Health Organization, 1985.

108. At its twenty-fifth session, in 1983, the global Advisory Committee on Medical Research (ACMR) decided that it should concentrate on broad issues related to health research policy rather than confine itself to the review of specific technical programmes. To this effect, three subcommittees were established: on health research strategy for health for all, on health manpower research, and on enhancement of transfer of technology to developing countries with special reference to health. The first results of their activities were presented to the twenty-sixth session, in October 1984, and received priority attention. They had addressed challenging issues, which stimulated fruitful discussions within ACMR itself in the light of which the work is continuing. In addition to presenting their progress reports on regional research activities, the chairmen of the regional ACMRs made valuable contributions to the debate on the crucial issues discussed, particularly on the health research strategy for health for all. It was decided that this debate would continue at all levels of the Organization, and in particular all regional ACMRs would consider this item at their next session in order to build up a common health research policy framework designed to meet the varying needs and aspirations of Member States. In this connection, the need was expressed to further strengthen coordination within the ACMR system at global, regional and national levels (medical research councils). It was decided that a working group would consider the structural and functional implications for an integrated ACMR system.

VI. MOBILIZATION OF HUMAN, MATERIAL AND FINANCIAL RESOURCES, INCLUDING EXTERNAL RESOURCES

109. Collaboration with bilateral agencies, funding agencies within the United Nations system, the World Bank, regional banks and other regional organizations and nongovernmental organizations to mobilize resources for health for all continued during 1984. There were increased consultations and contacts with donors such as Denmark, the Federal Republic of Germany, Finland, Norway, Japan, the Netherlands, Sweden, AGFUND and the Japan Shipbuilding Industry Foundation. Greater coordination between USAID and WHO to assist countries in the implementation of their national health-for-all strategies was the purpose of a three-day meeting held in July with 11 senior USAID health advisers and representatives of four WHO regional offices.

110. The Committee of the Health Resources Group for Primary Health Care met for the fourth time in November. It considered the efforts being made for the global coordination and rationalization of resource mobilization in support of the Strategy for Health for All as crucial in the light of the severe economic constraints facing so many developing countries, especially the least developed countries (LDCs), and the limitations affecting the evolution of technical and financial cooperation with those countries. The Committee made a special effort to explore ways and means of assessing the impact of the country health resource utilization (CRU) reviews carried out with WHO support during the past three years. In 1984, Botswana, Guinea, Maldives, Sierra Leone, Togo and Zambia carried out CRUs, bringing the total to 20 countries (of which 16 are LDCs). Australia, the Federal Republic of Germany, the Netherlands and the World Bank provided both financial and technical support for several of the CRUs. Follow-up began in a number of countries by means of discussions with donor agencies, and the CRU documents for Benin and Gambia served as the basis for presenting health sector needs at UNDP "round-table" meetings.

111. With a view to promoting greater understanding at the regional and country level of the approaches involved in the mobilization of extrabudgetary resources for health, a workshop on health resources mobilization was organized in Geneva in November in which regional office and headquarters staff and WHO programme coordinators participated. The workshop examined lines of approach to donors, stressing the importance of adequate country proposals, collaboration with nongovernmental organizations, and appropriate consolidations of information to permit WHO to use its powers of persuasion to rationalize the use of, and mobilize additional, resources for the health-for-all strategies of developing countries from the international community.

112. Despite the efforts made by Member States of WHO in committing themselves to the goal of health for all and the PHC approach, some resources were still used for low-priority health sector expansion in developing countries, such as large hospital construction, which impeded sound national health development and effective use of resources.

113. Examples of measures to mobilize resources for health included the support given or pledged by AGFUND in 1984, with US$ 1 million for EPI activities in the Eastern Mediterranean Region, another US$ 1 million towards the establishment of a WHO centre for environmental

health activities in Amman, and cooperation in various training programmes in the Region. Environmental health work, particularly that for water supply and sanitation in the context of the International Drinking Water Supply and Sanitation Decade, was also the object of collaboration drawing on the resources of UNDP, while maternal and child health and nutrition activities were supported by UNICEF, a partner with WHO in the Joint Nutrition Support Programme being funded by the Government of Italy. UNICEF and WHO also collaborated with IFAD and the Belgian Government's Third World Survival Fund in further nutrition support activities, including health education. Collaboration with UNFPA continued in maternal and child health and family planning, especially at the country level. An impetus to the mobilization of financial resources for EPI was given by the Bellagio Conference (see paragraph 64).

114. "Guidelines on external financial resource mobilization for health in the Region of the Americas" were prepared by PAHO in 1984 and circulated to Member States. Consultations with prospective donors were initiated to mobilize financial support for the "Basic plan on priority health needs of Central America and Panama" (see paragraph 113). In the Eastern Mediterranean Region, close contacts were maintained with the Council of Arab Ministers of Health and the Council of Ministers of Health of Arab Countries of the Gulf Area.

VII. INTERCOUNTRY COOPERATION

115. WHO participated actively in the inter-organization programme analysis of activities of the United Nations system related to economic and technical cooperation among developing countries. A number of meetings were held to identify further scope for TCDC, and global and regional programmes were reinforced for the identification, promotion and implementation of TCDC activities.

116. In May 1984 the Thirty-seventh World Health Assembly adopted resolution WHA37.14, in which it expressed its full support for the initiative taken by the countries of Central America (Belize, Costa Rica, El Salvador, Guatemala, Honduras and Nicaragua) and Panama embodied in their joint "Basic plan on priority health needs" for the subregion. As a first step in response to this resolution, the Organization initiated consultations with major donors in Europe and North America and also with UNDP, UNICEF and the World Bank. A "round-table" donor meeting is planned from 16 to 19 March 1985 on the island of Contadora to mobilize bilateral support.

117. One of the objectives of the medium-term programme on technical cooperation among developing countries (TCDC) for health for all (1984-1989) adopted by the non-aligned and other developing countries is to accelerate the development of national capabilities for health systems development. The first of a series of leadership development colloquies planned for the period 1984-1986 was held in Brioni, Yugoslavia, in October and was attended by 30 senior health officials from Cuba, India, Thailand, the United Republic of Tanzania and Yugoslavia.

118. Ministers of health of countries of the South-East Asia Region took the initiative for development of a technical cooperation programme to mobilize resources through national efforts. High-level bilateral discussions on aspects of cooperation were held between government representatives of Nepal and of Bangladesh, Sri Lanka and Thailand. An ad hoc committee of senior national officials of countries of the Region met in Yogyakarta, Indonesia, in April to discuss modalities of intercountry cooperation. An interregional seminar on health for all was held from 26 August to 7 September, and health ministers of countries of South-East Asia discussed progress in the implementation of strategies at their fourth meeting, held in New Delhi from 25 to 27 September.

119. Collaboration was pursued in the European Region with the Council of Europe, particularly regarding the European pharmacopoeia, prevention of hospital infections, and postbasic nursing training. Health policy and training were discussed with the Commission of the European Communities. The role and contribution of the medical profession in the achievement of regional targets was discussed with representatives of national medical associations on 7 and 8 December.

120. Countries of the Western Pacific Region continued to cooperate in the South Pacific pharmaceutical supply service and many countries took part in missions to China for exchange of experience in the PHC approach for health-for-all strategies.

VIII. COORDINATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERNATIONAL ORGANIZATIONS

121. In addition to the cooperative programmes and other joint activities reported in earlier sections, coordination with organizations of the United Nations system covered WHO's representation at interagency meetings and other measures to communicate its policies and programmes and ensure awareness of the decisions and planned activities. WHO participated in the first overall review and appraisal of the implementation of the International Development Strategy for the Third United Nations Development Decade. The Director-General submitted the Organization's contribution on the basis of the "Report on monitoring progress in implementing strategies for health for all" submitted by the Executive Board to the Thirty-seventh World Health Assembly (see paragraphs 3-4). In addition, the Director-General reported to the second regular session of the Economic and Social Council on the progress made by Member States of WHO in the attainment of health for all by the year 2000.

122. Following the appeal by the Secretary-General of the United Nations for urgent action on the critical economic and social situation in Africa, the Director-General, in collaboration with the Regional Director for Africa, took the necessary measures to ensure a concerted response to this initiative. An emergency standing committee on the African crisis was established at the WHO Regional Office in Brazzaville, and support was given to several countries to set up national emergency committees in order to define plans of action to combat the effects of drought, including epidemics. WHO and other organizations of the United Nations system are cooperating with the World Bank, which initiated a joint programme of action for sustained development in sub-Saharan Africa in response to the African crisis. Cooperation with the World Food Programme (WFP) on the health and health-related aspects of food aid projects led to the initiation of a sectoral evaluation of the impact of food aid projects on PHC, emphasizing the role they can play in the Strategy. Special cooperative activities with UNICEF included the review of PHC development in selected countries and the Joint Nutrition Support Programme (see sections III and IV). In March, the WHO/UNICEF inter-secretariat committee examined various collaborative activities between the two organizations and made recommendations to strengthen them further.

123. Collaboration with the 131 nongovernmental organizations (NGOs) in official relations with WHO was strengthened in various programme areas. Information on health and health-related NGOs was collected and their role and potential in support of national health-for-all strategies in collaborative programmes with governments were analysed. Consultations for this purpose were further pursued at national level in Bolivia, India, Nepal, Malaysia, the Philippines, Sri Lanka and Thailand. Preparatory activities were initiated for the Technical Discussions on collaboration with NGOs in implementing the Global Strategy for Health for All to be held during the Thirty-eighth World Health Assembly in May 1985. Relations with NGOs were the subject of special studies in the Philippines and Thailand.

IX. CONCLUSION

124. Although the accomplishments evident in 1984 were important, the magnitude of the challenge to Member States in implementing their strategies for health for all in the years ahead is enormous. The worsening socioeconomic situation and threatened environment in Africa, the uncertain sociopolitical and economic climate in Latin America and the Eastern Mediterranean, and the continuing struggle to maintain infrastructure in the face of difficulties in obtaining adequate financial resources for social sectors in many of the developing countries have continued to tax the capacity of the Member States to reorient their health systems to the PHC approach upon which they have collectively agreed. From the limited and selected information presented in this report, evidence of the continuing commitment of Member States and encouraging signs of progress towards the goal of health for all can be discerned.

125. Special mention should be made of two areas in which, although there has been recognition of the need for action, progress remained very slow during 1984: community involvement in health and intersectoral coordination and cooperation. Member States would therefore do well to examine these aspects of their strategies critically and search for innovative and courageous ways to harness the support of other sectors, and even more important, of their people. With worsening economic prospects, the public health sector as a separate entity is unlikely to meet the challenge of health for all. All relevant resources therefore have to be mobilized, and the inherent capacities of people and communities

enlisted. To this end governments will no doubt find it necessary to create appropriate mechanisms and to exploit all available opportunities. WHO stands ready to support Member States in these crucial areas to the best of its capacity.

123. During 1984 and 1985, Member States will carry out the first evaluation of their health-for-all strategies. They will have an opportunity for thorough review of the relevance and adequacy of their policies and measures taken thus far, the real progress in implementing their strategies, the efficiency with which they are doing so, and the effectiveness of these strategies. They will be able to identify the main constraints and obstacles to the implementation of their strategies and develop corrective measures and approaches. For some, evaluation may appear to have come too early, especially if their national strategies and plans have not been clearly formulated. They can still use the evaluation as an opportunity to convert their political will into action.

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