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STRENGTHENING PRIMARY HEALTH CARE

Report by the Director-General

The Forty-first World Health Assembly strongly affirmed, in resolution WHA41.34, its determination to strengthen the implementation of primary health care in all countries. In the monitoring of their national health-for-all strategies most countries have expressed a real concern for strengthening their operational capacity and the management of their health systems.

In order to respond to their pressing requests WHO will consider redirecting its resources - human, technical and financial - to more coherent and coordinated cooperation with Member States in overcoming the obstacles that have hitherto resisted solution. It will intensify and harmonize its technical cooperation to accelerate the implementation of primary health care. Intensification of WHO's support to Member States, with emphasis on district health systems, will be based on five strategies: strengthening organization and management of primary health care; strengthening human resources; development and assessment of technology; financial and economic strategies for primary health care; and increasing capacity for research and development for primary health care.

Because of the continuing distress of people in the least developed countries, WHO, as also requested in resolution WHA41.34, is committed to priority action, including reallocation of its human and financial resources and orientation of its programmes on behalf of the tragedy-stricken countries urgently requesting its support. WHO will promote and initiate a plan of action that encompasses both strongly-focused technical cooperation and the mobilization of financial resources. In order to do so, it will elaborate adequate mechanisms for coordination and cooperation to support the least developed, country by country. At each level WHO will mobilize all potential partners to cooperate with governments for the implementation of practical national programmes at a pace that is consistent with their capabilities and in a way that is most likely to strengthen their self-reliance in the long run.

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1. INTRODUCTION

1.1 Having endorsed the statement "Alma-Ata reaffirmed at Riga"[1] which called for health for all to be made a permanent goal by all countries, the Forty-first World Health Assembly in May 1988 strongly affirmed its determination to strengthen the implementation of primary health care in resolution WHA41.34, requesting the Director-General:

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> (3) to intensify the programme of activities of research and development in primary health care, including health services, within the existing organizational framework ...
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> (5) to ensure that the activities of the programme and those of all other related programmes give particular emphasis to supporting the least developed countries;

1.2 The second report on the monitoring of the global strategy for health for all (1985-1988),[2] based on country and regional reports, describes the progress made thus far and the major issues and the challenges that must be faced if progress is to be accelerated. The challenges are: sustained commitment to resolving the operational issues besetting health care delivery at all administrative levels; informed decision-making to sharpen the focus on priorities and targets; diligent selection and use of technology and optimum use and management of all resources available. But perhaps the most crucial challenge is the status of the poorest countries with persistently high mortality rates among infants, children under five years of age and mothers. Rapid population growth, increasing urbanization and low literacy rates, particularly among women, make the planning and implementation of health programmes particularly difficult.

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[1] Document WHA41/1988/REC/1, Annex 7.

[2] Document EB83/2.

1.3 In accordance with the conclusion of the monitoring report and in response to the spirit of resolution WHA41.34, the Director-General proposes certain initiatives for cooperation with Member States in overcoming the obstacles that have hitherto resisted solution for effective implementation of primary health care. The proposal emphasizes key strategies for improving the effectiveness of primary health care approaches to health development, especially through strengthening of the district health systems within the national context. Because the least developed countries seem destined to endure prolonged suffering unless new measures can be adopted, this report proposes that a special plan of action be initiated and promoted.

1.4 After a brief review of major obstacles to the implementation of primary health care, this report identifies areas for improvements and selected strategies to be promoted, and then describes ways to achieve these. Chapter 4 deals with the exceptional support that is required to support the least developed countries. Finally, some implications for WHO are presented which may necessitate new structural and organizational arrangements as outlined in chapter 5.

2. MAJOR OBSTACLES TO THE IMPLEMENTATION OF PRIMARY HEALTH CARE

2.1 Ten years after the International Conference on Primary Health Care held in Alma-Ata (USSR), the world health picture is both encouraging and disquieting. Progress in the health status of populations is evident in most countries as reflected in infant, child and maternal mortality and life expectancy. And yet progress has not occurred everywhere in the world - not even everywhere in any single country. The absolute number of those living in poverty has grown, and their poor health and nutrition status is glaringly obvious and tragic.

2.2 Facing a growing demand for health services in a time of increasing financial constraints, most countries are giving greater attention to strengthening their operational capacity and the management of their health systems, and they are translating their concern into action. These efforts must be sustained, in particular in countries where the capacity to fight for improvement in the quality of life has been reduced by the economic recession, often compounded by natural disasters, conflicts and socio-political instability. People in Africa have undoubtedly suffered the most.[1]

2.3 As a means of protecting and promoting the health status of people facing these situations the basic tenets of primary health care are more valid than ever before. Much has already been done under WHO's initiative and with its support to assess the needs and monitor effectiveness of interventions, to promote health manpower development for health for all, to design effective low-cost programmes and strategies, and to promote infrastructure at each level, starting with the communities. A variety of technological resources are now available with a great potential for successful implementation of primary health care.

2.4 However, the application of existing health technology has in many cases not led to the expected results. Although substantial progress has been made in programmes for individual elements of primary health care, overall managerial deficiencies in the health system remain. These deficiencies are generally well known, as is the action required to overcome them. Information bases for management and decision-making, and regular self-assessment to measure improvements in coverage and quality of care, are often

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[1] Annex 1 provides a very brief description of the dramatic situation of the least developed countries. Significant information is also given in Annex 2 of the second report on the global monitoring of the strategy for health for all, 1985-1988 (document EB83/2).

lacking. Establishment of priorities - through the identification of important health problems and high-risk population groups on which existing low-cost effective technology should focus - is often not carried out.

2.5 Also, many interventions are still not integrated; they are often directed and funded from different sources and tend to be at cross-purposes; even when there is an attempt at coordination, unreasonable demands are frequently made on the same limited government resources at national, district or community levels in ways that prevent the interventions from succeeding. Thus a crucial issue in the implementation of primary health care is the development of coordinated approaches, especially at the district level, that are appropriate from a financial and managerial point of view.

2.6 The question of "coordinated approaches" is closely linked to the development of new partnerships. New partnerships will be essential for strengthening primary health care, and many countries are now considering the responsibilities of individuals, communities, nongovernmental organizations and the private sector. New partnerships are needed at all levels, to ensure that health becomes the responsibility of all sectors. For example, crop diversification and food storage (for food safety) should be seen as crucial factors in combating malnutrition. Health should be taught as a subject in all primary schools to instil in children the habits of positive health behaviour. At the same time, the schools should be examples of a healthy environment for children and have services for eye tests, growth monitoring, immunization, etc.

2.7 There is no doubt that in some countries little or no improvement in the health situation can be expected unless more resources are found. In most countries there is a need to make the best use of all available resources, reallocating them as needed to reach this goal. Local resources also have greater impact when used for improving efficiency and reducing waste. Many countries are experimenting with financing schemes as alternatives to the provision of free health care. But the cost of medical care has reached such proportions that even the richest countries have difficulty, while poor people cannot afford some cost-recovery schemes. Research and development are most needed in this area; results would benefit the many countries of the world struggling to find ways to provide health care to the entire population.

2.8 Many official agencies for development assistance are concerned with the outcome of external aid as a whole and measures that will improve countries' capacity to absorb it and make it last, strengthen national capacities for situation assessment and management, and provide a stimulus for policy reform. The agencies will welcome strategies that meet this concern and offer new possibilities for effective use of resources from the international community, especially in the countries where they are most needed.

3. WHO APPROACHES FOR THE ACCELERATION OF PRIMARY HEALTH CARE

3.1 WHO can have the most forceful impact on current critical issues by concentrating on a series of interrelated approaches (see sections 3.3 to 3.7 below) for intensifying primary health care within the context of each country's health-for-all strategy, first in those developing countries most in need, particularly the least developed, and in accordance with the country's own priorities.

3.2 WHO, in both its Seventh and Eighth General Programmes of Work, has placed emphasis on the development of health system infrastructure and science and technology. The role of individuals, communities and health professionals has been considered essential and their involvement in primary health care development has been continuously promoted at all administrative and operational levels. Within district health systems, where primary health care policies and strategies are translated into action, there is no distinction between health infrastructure development and the application of science and technology: without the health system infrastructure there is no sustainable framework for the application of science and technology, and without the ability to apply appropriate technology the health infrastructure has no justifiable purpose. It is therefore within the district health system that health facilities, community groups, providers of private

health care, political and administrative systems, health technology, and the products of health training and research institutions must be coordinated and managed, guided by national primary health care policies and strategies, towards health-for-all goals.

WHO will support the following strategies aiming at strengthening the capacity of the health system infrastructure to provide primary health care of good quality with emphasis on district health systems.

3.3 Strengthening the organization and management of primary health care. WHO, at all levels, has been increasingly concerned to use existing knowledge and technology for the solution of serious problems in the implementation of primary health care. Research in selected districts of some countries is under way to generate specific problem-solving methods that can be adapted to the lessons learned and introduced into the national health system. Such an approach offers great potential for improving primary health care. With a view to strengthening the organization and management of primary health care, WHO will support the following activities through the district health systems, with district personnel playing key roles:

- development of an information base for local decision-making which emphasizes community-based, preventive and promotive rather than curative activities;

- organization of health care schedules according to community requirements;

- development of coordinated programmes to cope with local health problems using available manpower (government or not) so as to encourage more relevant action and teamwork;

- establishment of appropriate supervision, logistics and referral systems to ensure the most effective health care "mix" taking into account constraints in local resources;

- better use of local human and financial resources and mobilization of additional resources;

- strengthening of continuing education.

The Organization will also support the exchange of country experiences from "learning-by-doing" in districts as a means of promoting and disseminating important lessons and useful ideas.

3.4 Strengthening human resources. The full involvement of health personnel in the health development of their countries is critical. In this regard WHO has strongly supported basic and continuing education through community-oriented, problem-based and multidisciplinary training, producing a wide variety of technical and managerial training materials as well as giving technical support for national in-service training and teacher-training courses. Increased WHO support will be given to:

- promoting better management practices and personnel support systems, seeking the introduction of incentives for primary health care practice, especially where it involves hardship and less attractive public health activities;

- revising job descriptions to cover local health problems and available manpower, and strengthening the performance of community health workers and their supervisors;

- formulating new curricula with a strong emphasis on "learning-by-doing" and tailored to community needs;

- providing continuing education programmes for both governmental and nongovernmental staff with a focus on skills required for the organization and management of primary health care, including budgeting and financial management;

- improving at all levels management of support services, including supervision, with a view to ensuring human, technical and financial support required for service staff, especially those working in isolation.

WHO's technical cooperation will include country and district case studies and operational research, creation of networks of institutions, and dissemination of documentation for training and research institutions, district personnel and their supervisors.

3.5 Technology development and assessment. WHO has already helped to promote effective primary health care technology and its proper application, such as oral rehydration, simple laboratory diagnostic tests, the cold-chain and essential drugs. But new technology is emerging very fast that can contribute considerably to the quality of primary health care, so that there is an urgent need to review the measures already being applied in certain countries and assessing them with a view to their transfer and wider application. Among the criteria to be observed in such assessments the following are particularly important: relevance to priority health problems, accessibility for high-risk groups, quality, cost and facility of operational maintenance. WHO will provide support for:

- capacity-building in research on technology, whether clinical, managerial or to facilitate communication, and promotion of much greater awareness of the range of technological choices to be considered;

- the development of tools for assessment and support to countries in conducting technology assessment, including operational research under the proposed network of research and development institutions (see section 3.5);

- research on transfer of technology in various socioeconomic conditions, with emphasis on its strategic use, ways of ensuring its sustained availability, and maintenance;

- the review and dissemination of information from country research in the testing of technology and experiences in its use, as part of a process of strengthening national capabilities in the choice, application, and evaluation of technology.

3.6 Financing and economic strategies for primary health care. Member States are making increasingly frequent requests to WHO for technical support in the better use and mobilization of resources. They want financial information systems to give a clear picture of how much is being spent on what; they want to reduce waste of resources, especially where they are scarce, increase operating budgets for recurrent costs other than salaries, and develop new financing schemes. Response from WHO has been very limited so far; there is an urgent need for WHO, at all levels, especially in regions, to strengthen its capacity in financial management and economic analysis. With a view to providing adequate technical support in health economics and financing for national health-for-all strategies, WHO will cooperate in:

- the building-up of capacity in countries for the analysis of current health policies - including all public policies affecting health - the review of options and decisions for resource allocation, as well as the search for new mechanisms for mobilization of resources and new economic partnerships;

- joint training in health economics and health programme cost analysis for managers and policy-makers from ministries of health, finance and planning;

- development of adequate accounting and budgeting systems as well as resource management information systems, especially for district personnel;

- increasing countries' capacity to prepare high-quality programme and project proposals of reasonable cost that can be sustained in a spirit of self-reliance and, in the poorest countries, increasing the local managerial capacity to absorb funds provided from external donor agencies.

3.7 Increasing capacity for primary health care research and development. Section 3.5 described one type of research and development needed to accelerate the development of primary health care. Countries must also look to their national institutions to develop adequate research on their overall health systems as a tool for improved decision-making on policy and management in order to confront new health problems. WHO has started to support some countries in providing the skills necessary for this area of research, promoting adequate research and using the results in national decision-making. For the immediate future there is a need to bring all these skilled individuals and national institutions together in national networks which support efforts to make their health systems function. Such a network should comprise three essential components:

- a "research and development district" with relative administrative autonomy and including all the major elements of the health system (its health and development authorities with ultimate responsibility for decision-making on local research and development can balance the involvement of health services and of communities);

- a research and training institution such as a school of medicine and/or public health or an institute of management, development or social research (specific arrangements should be made for the continuing participation of social scientists, economists and management specialists); the benefits are that the faculty, students and researchers become aware of the common practical problems of their subject area, and that the quality of services in the district improves; the relationship should evolve into an association equivalent to that of a medical school and a teaching hospital;

- provincial and national decision-makers should be involved in all stages of the research and development process to ensure rapid and wide implementation of results. The "research and development district" will be used as a base for training, and its personnel will assist neighbouring districts in adapting relevant and tested interventions to meet their own needs.

WHO will increase support for the creation and functioning of such networks. This will involve, inter alia, a review of the existing national and international networks that include research and development in primary health care among their activities. It is apparent that these are numerous, and WHO support will seek to help to rationalize their use.

4. EXCEPTIONAL SUPPORT TO THE LEAST DEVELOPED COUNTRIES

4.1 Resolution WHA41.34 called on the international community "to take unprecedented measures to support the least developed countries committed to improving the health of their people in line with the policy of health for all". Important action is being pursued by international agencies including organizations of the United Nations system to stimulate growth and development and include the social dimension in structural adjustment and development programmes. Many agencies for development assistance are already contributing and are prepared to increase their support for the most affected countries (see Annex 2). But the momentum has not yet been created to mobilize all partners to support committed governments in the development of national health programmes as a dynamic force for development. Because of the complexity of development issues and the poor capacity of existing infrastructures for their implementation new measures must be initiated in a pragmatic, realistic and flexible way. Obviously, these measures would include the strategies mentioned in chapter 3 above.

WHO is committed to priority action, including reallocation of its human and financial resources and orientation of its programmes, on behalf of the tragedy-stricken countries which are urgently requesting its support.

4.2 This means that all WHO staff will give priority in their work for those countries receiving WHO support and will include broad and comprehensive activities for entire health systems; where infrastructures are too weak, WHO will be ready for direct and concrete involvement.

4.3 On a country basis, support should be given first to increasing governments' abilities accurately to determine plans of action consistent with sound health objectives. The "product" would probably consist of activities in various sectors which, collectively, determine health status. External funding would then be sought for the various components as they have to be implemented within the overall plan at a pace that is consistent with the country's capabilities and in the way that is most likely to strengthen them in the long run. Special emphasis would be given to strengthening managerial skills. The country programme would be regularly revised and readjusted, and not treated as a "package" the delivery of which could be started and stopped according to a set calendar but as a guide for organizing the use of available resources to improve health status according to the determined priorities.

4.4 On the basis of the findings of countries monitoring their health-for-all strategy, the Organization will often engage in a dialogue with the governments and give them support with human, technological and financial resources in:

- preparing plans of action that are clear expressions of requirements for development;

- launching large-scale imaginative public relations campaigns to create worldwide interest and enthusiasm for the initiative;

- presenting these plans in a convincing way to external donor/partners for technical cooperation;

- enhancing countries' capacities in management and strategic planning; and,

- where national human and technical resources are still inadequate for the planning and managerial tasks, providing interim operational support to priority health services as needed and requested.

5. IMPLICATIONS FOR WHO IN THE ACCELERATION OF PRIMARY HEALTH CARE

5.1 Many WHO and country programmes are already concerned in one way or another with developing and implementing the strategies and activities outlined above. Practically all WHO programmes have activities dealing with one or several components of primary health care and with research and development. Its main challenge is therefore to intensify, harmonize and accelerate the effort. The primary health care strategy with its emphasis on district health systems offers a framework for all programmes, including those of science and technology, to develop the local infrastructures that are essential for sustaining and accelerating action.

5.2 WHO will make arrangements at all levels to ensure the promotion, development and evaluation of the proposed strategies (see sections 3.3 to 3.7) and the full use of findings. Adequate financial support will be given to initiate the necessary work. The role of the WHO representatives and relations between regions and headquarters will be strengthened, and mechanisms for regional and global coordination will be reviewed and made more effective in order to provide the coherent support needed.

5.3 In addition to such efforts for coordination to maximize the success of programmes, programme accounting procedures must be improved to facilitate the control of expenditure and to focus human and financial resources on priority objectives and the most effective measures. To ensure that WHO's programmes are fully consistent with priority objectives, the management of external and internal resources will be more closely coordinated.

5.4 The implications for WHO of exceptional support for the least developed countries are extremely important and so far have not been seriously taken into consideration. Existing mechanisms for coordination in WHO are not designed for all the above activities on a large scale. It will be necessary to consider the administrative, financial, technical and managerial requirements, to span national, regional and global levels, to facilitate integrated action, and to ensure speedy communications and smooth relationships between the governments concerned and potential as well as actual external partners. Such an approach will clearly have to be implemented by phases as the capacity of WHO grows to meet the needs.

5.5 Adequate mechanisms for coordination at all WHO levels will be needed to:
(1) sustain the partnership between infrastructure support programmes and the programmes for coordination and resource mobilization at regional offices and headquarters;
(2) mobilize other technical programmes and staff for support for the initiative;
(3) provide support to strengthen the planning and managerial capacities of ministries of health. WHO field staff and consultants made available to ministries of health in the least developed countries will have to work as a team to strengthen national capacities, to generate the kind of programmes that will strengthen the national and district health systems, reinforce the health infrastructure, enhance absorptive capacities and sustainability, address the manpower requirements, allocate national resources in line with priority needs, and, where external financing is required, ensure that the country's demands are formulated clearly for the donor.

5.6 Institution-building may be required in national centres in the least developed countries to ensure that national staff are able to assume control. This will call for special emphasis on training of national staff in planning, management and health economics. Working relations with good external institutions will contribute to the success of the effort.

ANNEX 1

DESCRIPTION OF THE SITUATION OF THE LEAST DEVELOPED COUNTRIES

1. The repeated economic crises of the last decade have resulted in reduced income and social expenditure in the developing countries, with a consequent diminution of services for the poor.

2. The situation of the poorest or least developed countries as revealed by health indicators is characterized by: high maternal and infant mortality and morbidity, high incidences of undernutrition, and high birth rates. The infant and maternal mortality rates are often used to illustrate the overall health situation, as they reflect daily tragedies and many other aspects of underdevelopment. Deaths of infants and small children are due mostly to diarrhoeal diseases, acute respiratory infections and diseases preventable by immunization, generally complicated by and contributing to malnutrition. These conditions are most prevalent where there is poverty, illiteracy (particularly of women), too large families, contaminated environments and inadequate community-based health services. Diseases frequently associated with certain lifestyles affect the same population groups and are beginning to become important and account for increasing morbidity and mortality.

3. Financial policies and the domestic price structure have led to severe national and external imbalances as reflected in large fiscal and trade deficits, increased unemployment, often accompanied by inflation and low rates of growth. In one country, for instance, between 1970 and 1982, real export earnings fell by more than half, import volume by one third, the rate of domestic investment by 10 percentage points, and real per capita gross domestic product by 30%. The effects of these adverse developments have, in many cases, been aggravated by disastrous weather conditions or civil disturbances.

4. The consequences for health are dire. Evidence from a large number of countries shows that with higher food prices and the sale of subsistence crops, there is a decline in the nutritional status of households and particularly children. A study in one country shows that protein malnutrition as a cause of mortality has risen progressively from under 15% of hospital deaths in 1976 to 37% in 1987. In another country it was found that 87% of mothers gave their children during the weaning period only one or two meals a day, not because of lack of knowledge of what to feed them and how often, but because of insufficient food during eight months of the year.

5. There has also been an important impact on health care. Total and per capita spending in the health sector has actually decreased, in many cases affecting the functioning of existing infrastructures and the development of new services. In Bolivia health expenditure as a percentage of total government expenditure fell from 6.2% in 1972 to 1.5% in 1985, in Sri Lanka from 6.4% to 3.6%, in the United Republic of Tanzania from 7.2% to 4.9%, and in Burkina Faso from 8.2% to 5.5%.

6. The health sector, with its already limited means further curtailed, has been unable to cope, and the repercussions affect the whole structure: health centres are understaffed and have no drugs because of the health budget reductions and the lack of foreign exchange to purchase essential supplies; centres and posts cannot be maintained and many rural health posts do not have water - let alone potable water - an essential requirement in safe care. Patients have little hope of being evacuated to larger centres where supplies might be available, as the few vehicles lie unused for lack of spare parts or fuel.

Annex 1

7. The poorest of the poor, mainly landless rural workers and urban squatters (constituting between 63% and 98% of the total poor in some countries), bear the brunt of this tragic situation. They have far higher levels of malnutrition, lower levels of education and lower life expectancy than the rest of society.

8. Women are among the groups whose health is the first to suffer. The world's poorest women are not merely poor, they live on the edge of subsistence. They are economically dependent and vulnerable, politically and legally powerless; in the poorest countries 24% more women than men are illiterate, only one in three school-age girls is in school, and only 14% of the paid workforce is female. In one recent study which ranked 99 countries in terms of women's status (as measured by indicators of their health, marital and childbearing status, education, employment and social position) 70% of countries scored "poor" and "very poor" as against just 21.6% "good" and "very good".

9. As wives and mothers, women are caught in a cycle that begins with early marriage and too often ends with death in childbirth. Some 25 million women suffer serious complications in childbirth, and yet the technology and medical know-how exist to prevent most deaths from these causes.

10. Infants and children are another particularly vulnerable group, despite advances in health care that have provided the means to stamp out most immunizable childhood diseases and drastically reduce morbidity and mortality from such causes as diarrhoea and respiratory infections.

ANNEX 2

INFORMATION ON INTERNATIONAL SUPPORT TO THE LEAST DEVELOPED COUNTRIES

A. Action undertaken by the United Nations system

1. Substantial New Programme of Action: Some eight years ago, the United Nations launched its Substantial New Programme of Action for the Least Developed Countries for the 1980s. To support these countries in mobilizing new resources and coordinating the contributions of external partners, UNDP assumed responsibility for a regular cycle of round-table meetings, and the World Bank supported a similar process for other countries through its consultative group process. These aid coordination mechanisms have led to better donor coordination and use of resources, although the mobilization of new resources has been disappointing.

2. United Nations Programme of Action for African Economic Recovery and Development: The situation in the affected countries of Africa was reviewed in 1986, by a special session of the United Nations General Assembly, on Africa, and a new programme called the United Nations Programme of Action for African Economic Recovery and Development was initiated. An inter-agency task force has been set up to guide the work of this programme. The roles of participating agencies in this programme are still at an early stage of development.

3. Assessment of the social dimension of structural adjustment: In October 1987, the World Bank, UNDP and the African Development Bank established a regional project facility "aimed at strengthening the capacity of Governments in Sub-Saharan Africa to integrate the social dimensions in the design of their structural adjustment and development programs". Initial funding for the regional facility by these three agencies amounted to US$ 10 million over four years, and other donors have agreed to contribute. Further contributions are being solicited from bilateral and multilateral institutions, both for the facility itself and for bilateral support to country projects which are designed to mitigate the impact of adjustment on the poor and deprived segments of the population and on the social services which the country seeks to provide.

B. The record of action by WHO in favour of least developed countries

1. WHO maintains a country programme in each of its developing Member States, including the least developed countries, that incorporates support to the "managerial process for national health development", and, in most countries, technical support in such areas as primary health care system development, sanitation, endemic disease control, and health manpower training. The magnitude of such support is somewhat difficult to document, as is its relative importance compared to WHO's support to other developing countries.

2. There are a number of features of WHO's work with the least developed countries which, however, do emerge during an examination of the support currently being offered:

   (1) The average WHO country programme in those in the African Region is considerably smaller than in those in, for example, South-East Asia and the Eastern Mediterranean. This suggests the need for a special effort for those on the African continent.

   (2) The WHO country budget per capita for each country varies widely, but there are many factors which may be responsible for this: the smallest countries tend to have the largest per capita budgets, and one reason is that

the WHO representative's office - including the representative and immediate support staff - is noted in the country programme as a project element, usually designated "managerial process for national health development". This is not the practice among most other organizations of the United Nations system, which generally list their representatives under secretariat budgets. This results in a certain distortion in interpreting the actual country programme of technical cooperation.

3. In 1974, at the request of the Health Assembly (in resolution WHA27.34), WHO established the "Special Account for Assistance to the Least Developed among Developing Countries" within the Voluntary Fund for Health Promotion. By the end of 1987, after 13 years, this account had received some US$ 11.3 million in contributions, and some US$ 10 million had been spent on activities in least developed countries. It must be noted that there has not been a systematic approach to the use of the Account, and it has not been possible to raise funds for it in a major way.

4. WHO Health Resources Group: In 1980, WHO set up a global Health Resources Group with a view to rationalizing existing resources for health and mobilizing new resources. This mechanism helped to focus more sharply planning by ministries of health, identify projects for support and facilitate donor coordination in the health sector, but did not succeed in mobilizing very substantial additional resources. It soon became clear that only general coordination could take place at the global level, although the Group did help to launch a method for studying the use of health resources, particularly in the least developed countries - the "country resource utilization reviews" (CRUs). By late 1988 some 26 countries had opted to use this method for reviewing their uses of, and projected needs for domestic and external resources; of these, 21 are among the least developed countries. It has proven a useful means for expressing the demand in the health sector, and CRU documents were used for negotiation with external partners and donors. Eight national health authorities in countries supported by WHO requested that the CRUs should be brought up to date.

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