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EXECUTIVE BOARD

Eighty-third Session

PROVISIONAL SUMMARY RECORD OF THE EIGHTH MEETING

WHO Headquarters, Geneva
Thursday, 12 January 1989, at 14h30

CHAIRMAN: Dr M. QUIJANO NAREZO

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EIGHTH MEETING

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The meeting was held in private from 14h30 to 14h55 and resumed in public session at 15h00.

1. APPOINTMENT OF THE REGIONAL DIRECTOR FOR THE WESTERN PACIFIC: Item 10 of the Agenda (Document EB83/25)

At the invitation of the CHAIRMAN, Dr MOHITH (Rapporteur) read out the following resolution adopted by the Board in private session:[1]

> The Executive Board,
> Considering the provisions of Article 52 of the WHO Constitution and Staff Regulation 4.5; and
> Considering the nomination and recommendation made by the Regional Committee for the Western Pacific at its thirty-ninth session,
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> 1. APPOINTS Dr Sang Tae Han as Regional Director for the Western Pacific as from 1 February 1989; and
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> 2. AUTHORIZES the Director-General to issue to Dr Sang Tae Han a contract for a period of five years from 1 February 1989, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN, congratulated Dr Han on his appointment and conveyed to him the Board's best wishes for success in all his endeavours in the Western Pacific Region.

Dr HAN (Regional Director designate for the Western Pacific) said that a great honour had been bestowed on himself, his family, his country - the Republic of Korea, and the entire staff of the Western Pacific Region. In all humility, he shared the moment with friends, colleagues and fellow workers for health in the Western Pacific who had helped him along the way.

Two decades ago, he had started his career with WHO as a foot soldier - a staff member working in the field. The fact that he now stood before the Board to accept responsibility for an entire region demonstrated the faith that Member States had in the staff of the Organization. WHO owed its strength, stability and flexibility to the professionalism, technical integrity and devotion of those who worked for it. Those qualities which had sustained WHO in the past were all the more necessary for the present and the future. The days to come would be full of new and complex challenges and there would be many important tasks demanding the best from everyone.

He expressed his indebtedness to the three Regional Directors who had preceded him. They had set records that might be difficult to surpass. He would be guided by the standards they had set, inspired by their dreams and motivated by their dedicated service to WHO. He would draw strength from their wisdom.

In conclusion, he thanked members of the Board for their endorsement of his nomination as Regional Director by the Regional Committee for the Western Pacific. He would seek to be worthy of the trust they had placed in him and assured them that he would endeavour to fulfil his responsibilities to the utmost of his ability.

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[1] Resolution EB83.R1.

Following warm expressions of congratulation and sincere wishes for every success during his coming five years in office on the part of members of the Board and at the invitation of the CHAIRMAN, Dr HAN (Regional Director designate for the Western Pacific) took the oath of office contained in Staff Regulation 1.10 (Basic Documents, 37th Edition, 1988, page 90).

2. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1990-1991: Item 6 of the Agenda (Documents PB/90-91 and EB83/5) (continued)

REPORTS OF THE REGIONAL DIRECTORS ON SIGNIFICANT REGIONAL DEVELOPMENTS, INCLUDING REGIONAL COMMITTEE MATTERS: Item 7 of the Agenda (continued)

PROGRAMME REVIEW: Item 6.2 of the Agenda (Documents EB83/3, EB83/4, EB83/6, EB83/7, EB83/8, EB83/9, EB83/10, EB83/11, EB83/12, EB83/13, EB83/14, EB83/INF.DOC./2, EB83/INF.DOC./3, and EB83/INF.DOC./6) (continued)

HEALTH SYSTEM INFRASTRUCTURE (Appropriation Section 2) (continued)

Organization of health systems based on primary health care (programme 4; Documents PB/90-91, pages 117-123, and EB83/12) (continued)

The CHAIRMAN, recalling that the programme review should be completed as early as possible in order to allow time for preparation and approval by the Board of the Board's report on the subject to the Health Assembly, urged Board members to keep their statements as brief as possible.

Professor COLOMBINI commended the Director-General and his staff on the programme statement. However, he would call attention to one point - of relevance to countries as well as to the Organization - the relationship between the different levels of the health system. From proceedings of the Alma-Ata Conference it was clear that primary health care was conceived of as the first link in a continuous chain of health care delivery based on referral. In other words, the higher levels of the health system should not be the first level of contact. In pre-Alma-Ata times the hospital had been the central focus of health service administration and financing; the intent at Alma-Ata had been to correct that and to shift the emphasis to the first point of contact with the health system. That aim seemed at present to have lost some of its force; in some countries, such as his own, former trends to emphasize the base rather than the hospital level were tending to be reversed. The different relationships between the various levels of the health care system should therefore be highlighted to encourage changes that would ensure that primary health care received support.

Mr ABI-SALEH, expressing his appreciation of the quality and usefulness of the programme budget document though regretting that its bulk had not been divided into three volumes, deplored somewhat the atmosphere of gloom that pervaded the introductory literature, reflecting the background of economic crisis, social deterioration and other deficiencies and disasters. The programme statement under review was no exception. While he did not contest the reality of the economic constraints of recent years, which had held programmes back and permitted the resurgence of certain diseases, it should be remembered that primary health care had from the beginning been conceived to cope with such situations, which had existed long before the Alma-Ata Conference. Given the necessary willpower and determination to implement it, primary health care remained the only means for health care to surmount the crisis. An essential aspect of primary health care was that it received a collective input from a number of sources: local communities, organizations and bodies of the United Nations system, nongovernmental organizations, national administrations, health workers and health care consumers; that multiple partnership should aid in removing, or at least reducing, the impact of economic and financial difficulties. What was required was to motivate all the partners in the enterprise and provide them not only with funds but with moral support. The

responsibility of the community needed to be highlighted; it should no longer be relegated to a background role. Was not reliance on the support of the grass-roots community the best way to cope with the crisis and any failure on the part of the other partners?

Dr TALL said that the developing countries, especially in the African Region, had looked to WHO for assistance in implementing the objectives of primary health care. However, he wondered why, in the budget summary at the end of the programme statement, the regular country budget allocation for health care systems based on primary health care had diminished in the case of the African Region while increasing for the other regions. Africa, and certain of its regions in particular, was at present in the grip of an extremely serious economic crisis, which had compelled some States to make major structural adjustments that had, in the health care field, meant that health care workers on whose training large sums had been expended could not be used in the implementation of primary health care. Help was therefore needed to avoid such double wastage of resources and the consequent under-utilization of the health and other personnel urgently needed to service the various components of primary health care in African countries.

Dr TAPA noted that the very important programme in the proposed programme budget had a 1990-1991 regular budget allocation of US$ 51 781 300, a 10.54% increase over its 1988-1989 allocation. It ranked sixth out of the fifteen programmes with the highest dollar allocations in the budget document. That rank was acceptable at present, but it remained to be seen whether the programme might not deserve a higher ranking in the future. The programme statement and the regular budget allocation proposed was quite acceptable.

He commended the Director General on the excellent report on the strengthening of primary health care contained in document EB83/12. He shared the concern expressed by other speakers about the situation of the least developed and developing countries and their peoples, and associated himself with the plea for priority action to be taken by WHO and the international community in accordance with the report. The views he had expressed on the subject during consideration of the Global Strategy for Health for All by the Year 2000 were also relevant to the present debate and should be taken into account. He fully endorsed the contents of the report and its annexes and joined previous speakers in urging WHO to take the necessary action on strengthening the organization and management of primary health care, strengthening human resources, technology development and assessment, financing and economic strategies for primary health care and increasing capacity for primary health care research and development, as outlined in sections 3.3-3.7 of the report, as well as to give the exceptional support to the least developed countries described in its sections 4.1-4.4. He was personally convinced that the emphasis in WHO's action should be on the future, since the vision of health for all by the year 2000 was about the future. The future was more important than the present, which had already become the past.

Mr SRINIVASAN said that the information under programme 4, read in conjunction with the Director-General's report on strengthening primary health care (document EB83/12), were central to the entire WHO programme, and taken together went to the heart of the matter. He drew particular attention to paragraphs 37, 38 and 39 of the programme statement, which were an affirmation of WHO's conviction that, in seeking to achieve primary health care in developing countries at affordable costs, it was essential to go on experimenting and supporting a very flexible approach. The question to be faced in accomplishing the enormous task of primary health care to which Mr Abi-Saleh had referred was how to do so in the light of the high cost involved. Governments had an enormous responsibility in developing programmes, which they could only fulfil through practical partnerships at the grass-roots level that would differ from country to country. The Organization should use its vast influence to back up and support the efforts made throughout the world to find innovative and flexible approaches and should also endeavour to ensure that the quality of service at the primary health care level continued to improve constantly. In his country and others where experiments had been carried out with inadequate commitment of resources for primary health care, a dualistic phenomenon had been seen in which services had been improved in one sector while primary health care was regarded as second or third best. The provision of marginal resources by external agencies, including WHO, could be extremely useful.

It was also necessary to ensure that the infrastructure being established for primary health care was set up with due regard not only to the trained medical professional but to a large number of suitably trained paramedical staff, a large investment being made in planning and devising training modules for paramedical professionals who could perhaps support the bulk of the primary health care system under the leadership of the professional.

The priority placed by the poor in most of the areas where primary health care was suffering was not on health as such but on the rapid curing of illness, and a situation arose in which the doctor was tempted to become a proponent of more and better curative services to the detriment of primary health care. The answer was to seek ways and means of motivating the doctor and restoring his leadership in public health issues. In his country's experience, that would need more imaginative support from organizations outside the country. Support must also be given to activities outside the health system which could have a great impact on primary health care: one possibility was to empower the professionals and the district health system to work under local councils, for which special emphasis by WHO on making the system work under those councils could be a great contribution.

He shared the concern expressed by several members at the disturbing information given in Annex 2 to the Director-General's report with respect to international support for the least developed countries, bearing in mind the special emphasis that WHO was required to place on the needs of those countries. One disturbing point, mentioned in paragraph B2(2), was the WHO practice of including the cost of the WHO representative's office and staff as part of project costs in the least developed countries. It should also be considered whether adequate funds had been marshalled for assistance to those countries, for which special account had been taken fourteen years earlier. Far greater attention might need to be focused on the procedures and mechanisms for providing such assistance.

While information was essential for optimal use of resources, a proper balance must be struck between data and analytical rigour on the one hand and empathy and sound judgement on the other. Many of the least developed countries would be better assisted if an overall position could be taken on the approach they should adopt.

Dr LIEBESWAR said that although much emphasis was placed in the budget on the organization of health systems based on primary health care, a real increase for the programme as a whole would have been desirable. He realized, however, that the existing financial situation did not allow of more funds being provided from the regular budget. He hoped the Director-General would do everything possible to mobilize further funds from other sources, particularly for the development of district health systems, which were indispensable for providing an efficient infrastructure in all areas of the world.

Professor HASSAN observed that WHO was the legislative and leading authority in the international sphere for promoting research aimed at education and training in health and connected careers. The Executive Board was the body responsible for planning programmes and monitoring the implementation of action decided upon by the World Health Assembly, by reviewing the programmes in the proposed programme budget. He had observed at an earlier meeting that although WHO had adopted many important health programmes aimed at achieving health for all by the year 2000, it would be extremely difficult to implement them without the help of other sectors. Training courses should be organized, in cooperation with ministries of health, for personnel from other sectors, such as the media, agriculture, planning and energy, as the best means of securing their participation in the implementation of WHO programmes. The funds for such activities should be provided from the Organization's budget.

Steps should also be taken to secure the cooperation of individuals and of small communities at the grass-roots level - thereby relieving the financial burden on the Organization in the future and helping to achieve the common goal - and to overcome the obstacles encountered in primary health care. He had received no response to his earlier comments on the subject but hoped they would be taken into consideration.

Professor FIGUEIRA SANTOS said that the importance the Board rightly attached to the organization of health system, as shown in the discussion on the Global Strategy as well as the current debate, reflected the interest shown in it throughout the world. He

welcomed the fact that its importance was also recognized in the programme budget, as that would facilitate the mobilization of further financial resources for the pursuit of what was in general a clearly positive experience.

The work carried out by the Organization over a number of years had produced tangible results in showing how to improve the health of large numbers of people throughout the world, but it was clear from statements made by many Board members that implementation problems had been encountered in a number of instances. Most of those problems, which were currently being analysed, were linked to local and national traditions and problems that had to be overcome before the goals of health for all and primary health care could be satisfactorily implemented. It was difficult for the Executive Board to go into details of what could be done in individual countries to overcome the obstacles.

Meetings had been held in the various regions to discuss the question, since countries within a particular region had more problems in common with one another than with those outside, but there were still some obstacles that could be investigated in greater depth at global level, and possibly by the Executive Board. One such difficult problem for many countries, particularly the least developed countries, was that of referrals from the primary health care level to the secondary and tertiary levels. Formal referral in a way that would ensure best results was not, as was well known, part of the tradition of many countries. However, an informal system had always existed, although it was not well delineated geographically and the links were perhaps not well established in terms of reciprocal responsibilities, partly because transport and communications were less effective than in the more developed countries. If, however, the district approach could be introduced as one of the main instruments for achieving health for all, that approach in itself would make the referrals easier. It might be possible to discuss at global level how that approach could be more extensively used to produce better results with referrals.

A further problem was to determine whether there was a real lack of resources or inadequate use leading to wastage. Impressive figures had been given for the Americas in that connection. The question might be more intensively examined. While solutions would have to be applied at the individual national level, a comparison of the experience in the various regions might reveal some common features and help to identify those solutions.

In that connection, there was certainly a need to strengthen programme 3.3 (Health systems research and development). There were problems specific to countries that had to be solved at the local level, but the mobilization by the Organization of the necessary human and financial resources to expand that programme would be highly beneficial for all countries throughout the world.

Sir Donald ACHESON said that financing was a crucial aspect of strengthening primary health care and agreed with Mr Srinivasan that the area under discussion was the main focus for the Board's work. The Board should consider recommending that, whenever extrabudgetary resources were discussed with donor agencies, the need to establish a sound and sustainable primary health infrastructure should be emphasized, since the long-term success of most of the ad hoc vertical programmes would depend on that.

Dr BLACKMAN said that the strengthening of health systems based on primary health care was quite rightly an ongoing process and WHO would be called upon to continue its support. WHO had responded to the need for exceptional support for the least developed countries; however, such support would require careful and frequent monitoring and evaluation if it was to be effective. Because of the limited capacity of the health-care systems in some developing countries, any deterioration produced a significant impact on mortality and morbidity. In developing countries with severely depressed economies, health-care staff were adversely affected psychologically and tended to set their own priorities. The managerial and technical skills of WHO would be needed in such countries to ensure that certain basic services and structures were properly and adequately maintained.

Another area of concern was the information provided in section B, paragraph 3 of Annex 2 of document EB83/12 on the Special Account for Assistance to the Least Developed among Developing Countries, established in 1974 in response to resolution WHA27.34. That Account had been established because, in conditions of global economic instability, it

was the least developed among developing countries which suffered the most. He was not impressed by the slow rate of development of the Account, since over 13 years only US$ 11.3 million had been received; in addition, there had been no systematic approach to its use. The Account was needed more than ever at the present time and he therefore urged the Director-General to make a major drive for funds and to find innovative ways and means of organizing and developing the Account properly, so that it could serve the purpose for which it was intended.

Dr MONEKOSSO (Regional Director for Africa), in reply to a question concerning the reduction in the regular budget allocation of US$ 60 400 for activities in the African Region, said that, as indicated in the text (paragraph 41, page 122), the Member States of the Region had, on the basis of a Regional Committee resolution, decided to transfer a portion of the budget (US$ 60 400) from programme 4 to programme 2.3 (General programme development) for specific use in strengthening district focus implementation of primary health care. The funds had not been lost but had been more specifically targeted, to district focus primary health care, and it was hoped that that would attract extrabudgetary resources. It should also be noted that the allocation for programme activities at the country level in the African Region showed an increase of US$ 3 798 000, the emphasis being on channeling as much as possible to the country level.

A number of speakers had raised the question of resources for primary health care in the least developed among developing countries. Of the 40 countries so designated, 24 were in the African Region. It was true that the donor community had not responded as much as might have been hoped for in support of primary health care. Some of the support was for staff from their agencies to observe and evaluate how the poorer countries were implementing primary health care. He was pleased that the Director-General was setting up a task force to study the impact of the economic situation on health in the least-developed countries. There were defined and documented instances of economic stringencies leading to epidemics, clearly indicating the impact on health of a deteriorating economy.

Since 1985 the Regional Committee for Africa had taken up the challenge of implementation of primary health care as a community health matter. Support was needed from all levels of the hierarchy in the form of a partnership between consumers and providers of health care - between the people and their governments. In that context, a number of declarations and resolutions had been adopted in the Region. In Lusaka, a health development framework had been defined for the African Region which all countries were now following. He had encouraged WHO staff to work within that framework. In Addis Ababa, the Heads of State of the Organization of African Unity had recognized in a Declaration that unless action was taken to improve the economic situation the health situation was unlikely to improve and vice versa. In order to achieve health for all it was necessary to encourage the commitment of all for health. Consultations to that end had been held at all levels throughout the Region, including health-for-all conferences, in which social mobilization, health education and public information had played a key role.

The weaknesses in the managerial capabilities of the Member States and WHO's own institutions had been the subject of criticism, and strengthening of management at all levels, particularly at the district level where primary health care strategies were applied, was now a priority. The approach in the African Region was not to look for pilot or selected districts or communities but to throw open the challenge to all. WHO would have to be ready to respond to those who requested support. WHO would need to help countries to determine which national institutions could help in the delivery of primary health care at all levels, beginning at the district level. Ideally, some institutions should have a multisectoral character, e.g., district development committees, national health councils; others would be community-based institutions at all levels, e.g., district health committees, provincial health committees, national health development units, etc. In addition, there would be institutions such as health teams in health offices which could determine the technologies to be used and deliver the programmes chosen. It was a question of dividing the work in a logical way once institutions had been identified, and that process was currently under way throughout the Region. The district focus implementation of primary health care had been adopted by all countries and by September 1988 some 54% of districts had been activated, meaning that they had taken up the challenge and were beginning to implement activities. The role of WHO had been to support national institutions at all levels. The country teams of WHO

representatives included a health information and documentation officer responsible for recording what was happening in the country. The intercountry teams included a programme operations officer, responsible for monitoring district health management, and in the Regional Office there was a health-for-all strategy coordinator, responsible for monitoring progress towards health for all, which included collecting a wide range of information and reacting to it.

Resources were a key issue in the Region, particularly with the further aggravation of the situation resulting from the advent of AIDS. For a country with only US$ 10 per head per year to spend on health, the need to find resources to cope with AIDS was an economic tragedy - even AIDS testing could consume that meagre sum. The health ministers of the Region had concluded that it was not enough to find international funds but that real efforts were needed to generate endogenous resources. They had therefore decided to launch a health fund for the Region, beginning with community health funds at the district level. It was hoped that the international community would be able to assist with matching or converting funds where they were not in convertible currencies, within countries where possible and at the international level. The search for resources to support primary health care was the basis of the Bamako Initiative, a subject to which he would return later in the discussions. He was pleased to note that, in the reorganization being undertaken by the Director-General, the search for international resources was a high priority, which was in line with the wishes of the Ministers of Health of the African Region.

Part of the problem in looking at the allocations in support of primary health care was that programmes 3 (Health system development), 4 (Organization of health systems based on primary health care), 5 (Development of human resources for health), and 6 (Public information and education for health) were all essentially designed to support health system infrastructure based on primary health care, just as programmes 7 to 13 provided a background of support for health promotion, environmental health and disease prevention and control programmes. Nevertheless, there was still a resource gap and he reiterated that so far few institutions or organizations had really supported primary health care in the way being discussed under programme 4. He hoped that with the good will of all a breakthrough would be made.

Dr BART (adviser to Dr Wallace) agreed with Dr Monekosso that it was not easy, from the table of contents of the proposed programme budget, to identify where the allocations for primary health care occurred among all the programmes included under appropriation section 2, Health system infrastructure, as well as some of the programmes under appropriation section 3, Health science and technology - health promotion and care, in particular programme 7 (Research promotion and development, including research on health-promoting behaviour). It was therefore difficult to judge whether the budget proposed for primary health care was adequate, and whether the emphasis was appropriate. From the table of regular budget estimated obligations and the analysis of increases and decreases by programme for programmes 3-7 (page 50), in particular in column (b), there appeared to be more decreases than increases in the allocations relevant to primary health care. He was aware that the Programme Committee had fully recognized that the budget was a transitional one that, together with the classification of programmes, had been inherited by the Secretariat and that, as the Director-General had said, modifications, which depended largely on human resources, would take time. Nevertheless, there appeared to be a net decrease of US$ 1.3 million globally in allocations for primary health care programmes, or of US$ 2.6 million if elements of programme 7 were included. The allocations to be found in the proposed programme budget were therefore not in line with the considerable verbal support expressed by Board members for primary health care programmes.

Furthermore, the allocations for programme 3.3 (Health systems research and development) had been decreased by 46% at the regional and intercountry level, 18% at the global and interregional level and 23% for the programme as a whole. Questions remained as to why primary health care had not been firmly adopted and implemented, so that it was important to retain an operational research component for primary health care.

Referring to programme 7 (Research promotion and development, including research on health-promoting behaviour), he said that research within WHO was guided by a global advisory committee which analysed policy and helped the governing bodies of WHO to translate policy guidance into strategies and plans for programmes. It might be timely

to consider the establishment of a comparable advisory body for primary health care to assist the Secretariat in developing plans and strategies for primary health care programmes in accordance with the priorities set by the governing bodies.

Professor FIGUEIRA SANTOS said that, of the programmes considered by Dr Bart as relevant to primary health care, programme 5 (Development of human resources for health) had suffered the largest decrease in allocation. The decreases for the other programmes were much smaller. The Board should take that into account during its discussion of programme 5.

Dr GOON (Assistant Director General), replying first to Mr Rahman's question about the allocation for intersectoral cooperation, said that it had not decreased but had actually gone up slightly. Concerning the questions by Professor Rakotomanga and other members of the Board on the definition of primary health care, he said that the concept must be seen as relating to the total health system and its eight crucial components, in which a system of referral was included. Yet primary health care was also used to mean the first stage of contact with a patient: in developed countries that often meant contact with a physician, while in developing countries, it might be with a nurse/practitioner or community health worker. All forms of first contact were equally valid: it was not appropriate to describe the care as better or worse in a given situation, it was simply country-specific.

In response to Professor Rakotomanga's question on how allocations for primary health care activities were calculated, he said it depended on how the country in question defined primary health care, and that the most important indicator was not how much money was spent on that item in a given year, but what trends were emerging in the allocations over a number of years. WHO's definition of primary health care expenditure was funds allocated for the eight components, up to the first referral level: in other words, the district level.

Answering Dr Rodrigues Cabral's question on WHO's interaction with the World Bank, he said that the relationship was a good one and many joint activities were carried out, including training. The situation described by the same speaker - namely that nationals already overloaded with their regular duties in certain countries were swamped with additional work on WHO's pilot projects and research papers - was regrettable, and the problem should be looked into. It might be attributable to a breakdown in coordination within the Organization. He would also point out, however, that the designation of areas for research or pilot projects was the exclusive privilege of the Member country itself, and it could only be hoped that the workload of staff would be taken into account when such decisions were made.

Finding qualified staff to send into the field was of the greatest importance: WHO made every effort to deploy staff of the highest possible calibre. In the early years, WHO staff had operated in the field for longer periods of time, but recent trends had been to hand over more responsibility to nationals as a way of promoting national manpower development. Accordingly, consultants were recruited on a short-term basis to provide advisory services. A consultant who had established a good rapport with his counterparts in a country could, of course, be sent repeatedly on advisory missions, while allowing national staff to carry out predetermined activities during the intervening periods.

In reply to Dr Rodrigues Cabral's question on whether the restructuring of the Organization had had any budgetary implications, he felt that the Director-General would apply the same principle as in paragraph 46 of the programme statement for programme 4, which indicated that there had been no real budgetary increase for the programme as a whole but that there had been a considerable increase in the proportion for activities related to the development of district health systems. Regarding the comment about availability of extrabudgetary resources for different activities, he said it was true that many donors were not enthusiastic about providing support for infrastructure development, and that more attention should be paid to that problem.

It was unfortunate that the wording of document EB83/12, Annex 1, paragraph 2, had had an effect different from the one intended: in the final sentence, the "diseases frequently associated with certain life-styles" were meant to refer to noncommunicable diseases such as those of the respiratory system and the cardiovascular system, which were often found, for example, in smokers.

The desirable target of 80% coverage was not a figure that had been taken out of thin air: it was a best guess based on a number of sources of information, including the experience of field staff and reports from countries. Since the second report on monitoring progress in implementing strategies for health for all (document EB83/2) indicated that the coverage was roughly 60% at present, it was not unreasonable to set a target of 80% coverage for 1995.

In response to Professor Kallings' question on the resolution concerning intersectoral cooperation, he said that it had been put on the agenda for discussion at the Forty-first World Health Assembly in 1988 but time had not permitted its consideration: it could certainly be taken up at a future session.

Dr Fernando had asked for information on activities relating to the impact of development on health: in December 1988, a brainstorming meeting with representatives of the World Bank had been held on precisely that subject, and a final report on the meeting would be available soon.

Professor Medina Sandino, in her comment on coordination, had specifically referred to one aspect of primary health care activities, namely the health impact of recent changes in the financing of health services. In a study carried out in Ghana, the results of which would soon be published, the existence of a direct relationship between the use of health services and changes in financing, especially when they involved increased user spending, had been revealed.

Mr Song Yunfu had raised the question of retention of staff working under difficult conditions: it was a crucial problem in primary health care and, indeed, in all health care. WHO had begun collecting information on the numerous factors underlying the complex issue, including living and working conditions and opportunities for professional contact. Finally, however, the solution lay with countries themselves, although it was certain that any choices they made would be affected by the availability or lack of resources. Some countries had found that giving some form of recognition to workers who had served for a certain number of years was a useful incentive. The issue raised by Dr Tall, namely the utilization of health personnel, was also a complex one, whose solution ultimately rested with the government concerned: factors such as relevance of training, working conditions and rewards all came into play.

Finally, in response to the suggestion made by Dr Bart for the establishment of an advisory body for primary health care, he noted that a consultative group on primary health care would be meeting in New Delhi in March 1989.

Mr FURTH (Assistant Director-General) said that a number of speakers had queried the utilization of the money in the Special Account for Assistance to the Least Developed among Developing Countries. Nearly all of the US$ 14.7 million that had been spent had gone to a handful of countries in the Eastern Mediterranean, particularly the Yemen Arab Republic and the Sudan, and only about US$ 1 million was left over for other countries. The reasons for that situation were that the account was used by a number of donor countries from the Eastern Mediterranean Region for voluntary contributions to the least developed among the developing countries located in that Region. Some confusion might have been created by the wording of document EB83/12, Annex 2, section B, paragraph 3, which gave the impression that the funds in the Special Account were the sum total of WHO's assistance to the least developed countries: in fact, its operation had to be seen within the context of the total Voluntary Fund for Health Promotion. Donors tended to bypass the Special Account in favour of those devoted to the specific programmes of interest to them, for example, on malaria, leprosy or the Expanded Programme on Immunization. No breakdown had been made of the amount of resources in all categories of expenditure that went to the least developed countries, but he could assure members of the Board that it was vastly superior to the sum quoted in Annex 2 of document EB83/12.

Dr RODRIGUES CABRAL said that he had not been satisfied by the Secretariat's response to his comment on WHO's advisory services. Many least developed countries did not have the necessary capabilities in crucial areas such as health economics, health planning and the monitoring of the social effects of economic readjustment programmes, and those deficiencies gave WHO an opportunity to resume its role as an operational agency in the international health field, and to mount large-scale initiatives. He did

not believe that short-term consultancy services would suffice in a number of areas, and where there was a need for technical advisers to remain for longer periods, that option should be left open.

The DIRECTOR-GENERAL said that, after ten years of advocacy on the part of WHO, developing countries had adopted the concept of primary health care as the only way to develop the health system, but the time had now come for them to solve their technical problems. WHO could best serve them by assisting in the transfer of appropriate technology and in identifying the areas in which they could solve their own problems, and by providing them with the methodology whereby appropriate technology could be transferred. He considered the proposal for the establishment of an independent advisory committee on primary health care to be an extremely good one, and would be acting on it in the near future.

The meeting rose at 17h40.

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