What is health for all?

by Dr Halfdan Mahler
Director-General of the World Health Organization

It is only four years since the idea of health for all by the year 2000 was first put forward at a number of WHO’s Regional Committees. Since then it has fired the imagination of people throughout the world. It has also given rise to severe scepticism. “How do you define health? What do you mean by all? Will no more babies be born with inborn diseases?”

When the Thirtieth World Health Assembly in 1977 decided to adopt health for all as the main social health target of governments and WHO for the coming decades, it referred to it as a level of health that will permit people to live a socially and economically productive life. Such a life is also not easy to define precisely. Yet it is those who live such a life who tend to be the sceptics and who demand explicit definitions, whereas those who live an inferior life, or represent people who do, have become inspired by a new hope and a new determination to work towards better health.

If health for all meant medical repairs by doctors and nurses for everybody in the world for all their existing ailments, much in the same way as mechanics repair faulty motor-cars, it would certainly not be a realistic proposition. But in the past, in trying to do so, people who do, have become inspired by a new hope and a new determination to work towards better health.

It is for these people first and foremost that the concept of health for all is so important. However, it is not for them exclusively. No people can be entirely satisfied with their social and economic productivity. As they move forwards along the road of social and economic progress they strive to improve their lot; they would not be human beings if they did not. But in the past, in trying to do so, they have committed gross errors in their relationships with their environment. In this way they have brought on themselves retributions in the form of slowly developing but insistent ill-health, such as lung cancer and cardiovascular disease as a result of over-smoking, high accident rates, mental illness to the extent that vast numbers live on tranquillizers, and high suicide rates in those countries that consider themselves among the most socially advanced.

In short, health for all aims at all people whatever their present level of social and economic development, but social justice demands that greatest attention be paid to the underprivileged, so that they become able to extricate themselves from the poverty equilibrium in which they are

The provision of safe drinking water—one of the fundamental elements in primary health care.

(Photograph: WHO/M. Jacot)
Top: Youngsters all over the world are knocking at the gates. Will they gain access to the better life they seek?
(Photo WHO/R. Rouleau)

Above: A health visitor brings advice on family planning to the home—rather than waiting for overburdened mothers to visit the clinic.
(Photo WHO/J. Mohr)

Upper right: Life holds no joy for the malnourished. If resources are to be more evenly distributed, this means giving top priority to the socially under-privileged. (Photo WHO)

Lower right: “Health begins at home, in fields, in factories. It is there, where people live and work, that health is made or broken.”
(Photo WHO/P. Almasy)
trapped. As they do so, they will be wise to progress in a way that does not lead them into another trap—that of excessive medical consumption as part of a consumer society. Health for all is thus a moving target. As a certain health status is reached, people will try to reach a higher level, and so on.

The approach that is being adopted to attain health for all is based on the fundamental understanding that health begins at home, in schools, in the fields and in the factories. It is there, where people live and work, that health is made or broken. People must therefore understand what health is all about, and it is the duty of those who know to help others to understand. People must grasp that ill-health is not something that is inevitable, and that to bring about better health proper account has to be taken of a number of factors of a political, economic, social, cultural, environmental, and biological nature. Strengthened by this understanding, people will be in a better position to exploit those factors that are favourable to health and to combat those that are detrimental. But to gain progressively such an understanding a minimum level of health is essential. So health and social awareness must go hand in hand, the one leading to the other and each progressively reinforcing the other. The process I have just briefly described is known as community involvement, or as somebody has expressed it, "health as if people mattered".

Such community involvement can have a broader influence than the local organization of health care. It can be instrumental in bringing about the commitment of community leaders to support the health reforms required, and through them can stimulate the political commitment of their government to introduce and sustain these reforms. For, in the final analysis, governments do have responsibility for the health and socio-economic development of all their people, and not only of the elite in the main cities. This implies distributing resources for health more evenly, and to do so means giving top priority to the socially under-privileged. This applies within countries, but it also applies internationally, since the more fortunate countries have a double responsibility—to their own people and to those in countries in less fortunate circumstances.

Government decision and popular insistence are also necessary to ensure that many sectors in addition to the health sector take the necessary action to promote health. For example, the education of the masses on health matters, the provision of safe drinking-water and adequate sanitation, adequate supply of the right kind of food, and housing that shelters against excessive sun and rain and wind, and gives protection against insects and rodents, usually depend on actions in other sectors as well as in the health sector. The involvement of people in ensuring this action is just as important as their involvement in action within the health sector. The latter has to ensure maternal and child health care, including family planning. It has to deal with the provision of immunizations against the major infectious diseases and to take other measures necessary to prevent and control important local diseases. At the same time, it has to deal with the treatment of common diseases and injuries as well as with the rehabilitation of those left with disability.

Rehabilitation also requires action in sectors other than the health sector. So does the provision of essential drugs. This calls for industrial and commercial action in addition to the careful selection and quality control of those drugs that are really essential. For most purposes these could be reduced to far less than 200 in most countries.

How much will it cost?

The above describes the minimum requirements for moving forward in the direction of health for all by the year 2000. Are the costs exorbitant? Recent small-scale studies have shown that considerable improvements in people's health can take place for as little as 0.5 to 2 per cent of the yearly gross national product per person—or what amounts to a few dollars a year. This is by any standard a reasonable cost, around a hundredth of what is spent on health by people in many rich countries. So cost factors should not hinder governments when they consider if, and to what extent, they should commit themselves to the target of health for all by the year 2000.

So this, in a nutshell, is what is meant by health for all through primary health care. If countries strive towards health for all in this way, and avoid creating the kind of medical consumer society that exists in the developed countries, they will be able to make progressive improvements in their provisions for health at a cost they can afford. This must include support for primary health care from the more central tiers of the health system. In too many countries today, resources are first allocated to central medical institutions that provide sophisticated and costly medical care to the privileged few, only a small fraction trickling down to people where they most need them—in their homes and in their communities. The education of health workers too is concentrated in these central medical institutions, producing health workers who are quite divorced from most health problems of most people. The correct approach to attaining health for all therefore includes training health workers to be socially attuned to the needs of the people they are to serve, and technically equipped to help these people understand what health is all about and to provide them with the care they need, where they need it and when they need it.

The developed countries too will require enlightened community involvement as well as government commitment to introduce the health reforms required to reshape their health systems. These reforms will have to include adequate measures to combat over-smoking, over-eating, over-drinking, over-driving, over-using and abusing drugs, over-pollution of the environment, and over-stressing and over-alienation of people in gigantic urban agglomerations. At the same time they will also have to include giving up the attempt to provide everybody with every type of medical technology currently in vogue, which even the richest countries cannot afford, and which would not be of real benefit to the people even if they could afford it.

In September 1978 the International Conference on Primary Health Care that was held in Alma-Ata in the USSR issued a Declaration calling for urgent national and international action to attain an acceptable level of health for all. No time has been lost by WHO in setting this action in motion. The Member States of who are about to embark on the development of strategies for attaining health for all, individually as far as their own countries are concerned, and collectively for regional and global strategies in support of national strategies.

The involvement of the world community and the commitment of the world's political bodies are crucial for ensuring the success of these endeavours. For we must succeed. The children of today, and those who have not yet been born but who will comprise more than one-third of the people living in the year 2000, will never forgive us if we do not.
An attainable target?

by Dr Amin El Gamal

Under-Secretary of Health, Egypt

To many people, including some political leaders, health services are synonymous with medical services, and good health is the outcome of good medicine. They cannot be more mistaken. Health, as stated in the WHO Constitution, is the "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The International Conference on Primary Health Care, held last year in Alma-Ata, stressed this fact in clear terms in its Declaration when it stated that "Health... is a fundamental human right... whose realization requires the action of many other social and economic sectors in addition to the health sector".

This definition of health and how to attain it is of vital importance if we are to understand and fulfill the goal of Health for All by the Year 2000.

In its quest for this goal, humanity faces many unpredictable and yet controllable factors.

First among these is the present state of health of the community—the presence and extent of endemic diseases, for example. The community’s state of mind is a more subtle, though no less important, consideration. It can not only affect the mental and social well-being of individuals, but can also reflect on the physical condition of the population in the form of high blood pressure, heart attacks, peptic ulcers, and a high rate of conscious and subconscious suicide attempts.

The environment in which the community lives is another factor that requires study and analysis. The quality of air is an important element at a time when industrialization and means of transport are polluting the atmosphere in an ever more dangerous way. Sources of drinking water too are subject to pollution by domestic and industrial waste water which is not effectively treated before discharge, while noise, excessive heat, cold or radiation impose a further burden on the human environment.

The population increase is another factor for consideration. Apart from determining the size of the health services required, the rate of increase gives an indication of the age pattern of the society, which in its turn is an indicator of the health and social problems.

Finally, the type and distribution of the health services available, together with the access the entire population has to them, will obviously have a significant bearing on the present state of health of a community and its future improvement.

If we review these factors and analyse them, we can determine some of the activities that are needed to attain our goal by the year 2000.

First and foremost among these activities is the universal supply of safe drinking water and sewage disposal systems. The United Nations arranged an international conference on Mar del Plata, Argentina, in 1977 specifically to discuss it. The conference came up with resolutions which were subsequently adopted by the UN General Assembly. These resolutions included the attainment of safe drinking water supply and sanitation services by the world’s population by the year 1990. To achieve this, the period from 1978 to 1980 was to be devoted to studies and pilot projects. This was to be followed by the International Decade for Drinking Water and Sanitation 1981-90, during which every effort will be made to make safe potable water and efficient sewage disposal available to all as a human right. To attain such a goal, governmental, intergovernmental, and international efforts are being coordinated and funds will be raised and made available for projects according to the priorities laid down once their feasibility has been studied.

Another important activity that has to be considered is the provision of special nutrition services for mothers and children. The period of pregnancy and lactation is a very critical one, with far-reaching effects on the health, mentality and life expectancy of the infant. For the growing child, nutrition means not only the quantity of food but also its quality, and the inclusion of essential vitamins and minerals besides animal and vegetable proteins.

Immunization against such diseases as smallpox, diphtheria, tetanus, poliomyelitis, tuberculosis and measles has strikingly reduced the incidence of many diseases and has considerably lowered the mortality rate, particularly among children. The list of diseases is fortunately increasing, and the effectiveness and safety of the vaccines is improving. In recognition of this, WHO has launched its Expanded Programme on Immunization.

In the light of increased communications between countries, it is clearly imperative to plan a universal approach to vaccination if we are to follow up the example of smallpox, which is on the point of being declared eradicated from our planet.
Stress, pollution, overcrowding, noise: the conditions of daily life in Cairo, as in other great cities of the world, bear directly on the state of health of the community—and on the community's state of mind.

(Photograph by WHO/M. Jacot)

The waters of the Nile are the life-blood of Egypt. But without careful control they can harbour dangers, such as the water snail that carries schistosomiasis.

(Photograph by WHO/D. Henrioud)

Learning to read. The degree of literacy in any country relates directly to that country's health status.

(Photograph by WHO/M. Jacot)
An attainable target?

Left:
Waiting at the family planning clinic. The better controlled the population's rate of increase is, the greater the chance of securing Health for All.

(Photos WHO/M. Jacot)

Right:
Victory will be won, not in lavish consulting rooms but in settings like this, with the health worker visiting homes and spreading his equipment in the village street.

(Photos WHO/D. Deriaz)

Besides these activities with an obvious relation to health, there are other fields of action where the effect on health may not seem so apparent. Among these is the urgent need for universal literacy. The degree of literacy in any country can be shown to relate directly to that country's health status. This has been proved by many surveys and is a fundamental prerequisite for ensuring that the public has access to health education.

If we review the services mentioned above, we find that they can be grouped under the heading "improved standards of living". This is attainable provided we have the resources and the know-how to use them. Economic development is therefore another essential factor in our endeavour to attain the accepted standard of health.

The better controlled the population's rate of increase is, the more chances we have of securing Health for All. This makes family planning a key-stone in health strategy. Besides improving the health of mothers and children, it helps to ensure that a country's health and social services are not overburdened.

The world situation would have been easier to understand and more predict-
able had it not been for certain uncontrollable and to a large extent unpredictable characteristics of human society. These factors have the effect of impeding many of our initiatives in the right direction, while putting an increased strain on national finances.

Economic crises are becoming a standard feature of modern societies. Even in developed and well industrialized countries, the alternation of depressions with periods of prosperity and the continued increase in prices of vital commodities—apart from their effect on inflation—cause rising unemployment and make it harder for new generations to find suitable jobs. They may also contribute towards swelling the ranks of the underprivileged migrant workers. Such crises impede all efforts to improve the health situation and, even where good intentions and feasible plans are available, may provoke the deterioration of an already unacceptable situation.

Political upheavals too can hamper the implementation of good health plans. The very countries that most need political stability are the ones that are plagued by drastic and frequent changes of their political systems. Unfortunately it is a common experience that every regime brought to power by a coup d'état tends to try to change the policies and plans adopted by the previous regime. It is obvious that plans for development need to be followed through and evaluated over the years if they are to fulfill their targets; it is also obvious that frequent changes in the political system are inimical to such an orderly pattern.

Political change does not always stem from internal unrest but may be brought about by external military hostilities, which in turn result in devastation, famine, epidemics and other forms of human suffering. The loser from all this is clearly the physical and mental health of large communities and nations. The occurrence of cases of smallpox in Somalia and Ethiopia after this disease was wiped out from all other countries may have been due in part to the hostilities that broke out between those two countries.

A further factor which is not man-made but which can cause desperate situations is the natural disaster. Droughts, floods and earthquakes can have a far-reaching effect on the health of the people and on any plans to improve it.

Uncontrollable and unpredictable though some of these factors may be, yet humanity is able to do something to offset the calamities they bring in their train. The Universal Declaration of Human Rights, the Geneva Conventions, and international public opinion itself can and do help to diminish the human suffering resulting from military hostilities, oppressive political regimes and natural catastrophes.

It is in this respect that the international organizations are today more than ever required to play a leading role. Bringing about peace for all peoples, improving the lot of refugees and solving disputes between countries by negotiation will spare humanity a great deal of suffering and in the long term will help to improve the living conditions of mankind.

Is the goal of Health for All an attainable target? From the foregoing it is clear that attaining this goal will not be merely the prerogative of the health services, but will depend rather on a willing collaboration between a great many sectors of human activity. Given such willing collaboration, Health for All by the Year 2000 can certainly be achieved.
The Health Revolution

by Dr Madiou Touré
Director of Hygiene and Health Protection,
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The literature of the Year 2000 is already very much with us; what is surprising is that it has not yet attracted the attention of those who award the big literary prizes—or even the Nobel Prize for Literature.

For it offers a rewarding prospect. The planners dream of a harmonious and integrated unfolding of events that will bring about by the end of this century a world that is more just, more humane, more imbued with brotherly love, who itself has launched an optimistic call for a world that is more just, more humane, that is more imbued with brotherly love. voici

We have never before been so close to the apocalypse through the pathological condition of human beings is directly linked with the social group in which they live and is determined by the structure of their social systems and cultures. Once again everything comes back to culture.

And yet, neither has humanity ever been so close to the apocalypse through the pathological condition of human beings is directly linked with the social group in which they live and is determined by the structure of their social systems and cultures. Once again everything comes back to culture.

The new bourgeois industrial society with all its internal contradictions—on the one hand invididualism and personal success and on the other hand the democratic ideal which demands the same basic living standards for every individual—has shaken the entire social structure and its values to the core by admitting the mass of the people into that society, with all the force of law.

Health, like well-being, has become a right and everyone can aspire to reach the highest possible level. The nations of the world admitted this when, on 10 December 1948, at the seat of the United Nations, they signed the Universal Declaration of Human Rights.

Thirty years have passed and the situation has not changed for the better. It proves therefore all the more essential and urgent to revise the present health system and to adopt an entirely new approach. It will involve integrating the system within the general framework of development, defining operational strategies, and ensuring dynamic technical cooperation between countries as well as community participation in the public health effort—all of this underpinned by a resolute political will. What this amounts to is a veritable health revolution that we are living through, a revolution that strikes the dominant note of medicine today.

Village health workers, on the lines of China’s barefoot doctors, are in effect a response to the arguments of Illich. Traditional practitioners and healers were aware, long before our modern doctors, that the pathological condition of human beings is directly linked with the social group in which they live and is determined by the structure of their social systems and cultures. Once again everything comes back to culture.

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How far can it carry us towards WHO's social goal of Health for All by the Year 2000? Some of the new development strategies already launched in Senegal already go a long way towards it.

African realities

Immediately after Senegal gained its independence, in 1960, the authorities set the country's general economy on a new road; this new direction was based on an original form of socialism that cared for the individual, was democratic and decentralized, and took account of African realities. One of its main innovations has been to implant a unit charged with responsibility for development at the heart of each territorial administration, backed up by machinery for consultation and participation.

The principles of our health policy are based on the idea that health action and the right to health of every citizen are indivisible. At the operational level, this calls on the one hand for the integration of medical action with social action, and on the other hand for the broadening of health coverage.

What is really needed is to bring about preventive, curative, educative and social medicine; to develop efficient services in the rural communities; to organize a rational system of primary health care based on effective community participation; to devise means of educating people in universal health care; to steer a course resolutely towards social advancement; to define a population policy, including family planning, which will have both medical and humanitarian objectives and services, and will be integrated within the maternal and child health services; and to lay stress on medical and paramedical training.

The government intends to devote nine per cent of the national budget to the health sector in the near future, that is, over the next three years.

However, the needs are so pressing that the participation of the population is essential, as well as a perfect understanding of the organizational techniques and methodology required to make the services operational. This is why a training course in administration is being offered to heads of health posts so as to spread around all the available resources.

Ever since the first years of our independence, there has been some sporadic involvement of initiatives by the local community in support of state action in the health field, for instance in building dispensaries and rural maternity clinics or setting up village pharmacies. But it was the administrative reform of the 1970s that enabled an effective system of community participation to be started.

Two basic projects have proved particularly encouraging and deserve special attention in the context of WHO's great goal for the Year 2000. The primary health care experiment in the Sine Saloum area is certainly the most successful of all those that have been developed in regions subject to administrative reform.

... We have never been so close to realizing that ancient dream of "the whole man", in this age of wonderful scientific discoveries ... (Photo WHO/M. Jacot)
The blueprint for the test-zone of Sine Saloum, drawn up on 30 November 1977, envisaged the village pharmacy as a practical expression of the local villagers' desire for health care to be as accessible as possible; the pharmacy was to be run by a member of the community, trained quickly by the health service and equipped with a box of basic medications. The following prior conditions were laid down:

— The community itself should undertake to build a "health house" from locally available materials; this would then be dependent on the local health post.

— The person in charge, designated by the community, would be trained at the departmental health centre, then at the health post, before assuming the running of the community health house under the supervision of the health post chief.

— Financing of the health house is the responsibility of the rural community, which must set aside part of its budget to this end; and the villagers must agree to contribute towards the running costs by paying a small sum for each consultation. The funds thus collected should be handled by a communally-appointed management committee.

— An initial contribution should be provided by UNICEF, WHO and US AID funds.

In this way Sine Saloum found itself well on the way to putting primary health care into action, and always within the framework of the action programme of the nation's Fifth Plan for economic and social development.

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( Photo WHO/D. Henrioud)

The second example is the basic health service scheme at Pikine, with Belgian and Senegalese backing. It relies on a network of urban or suburban health posts, ensuring a satisfactory coverage of the population and an even distribution of services throughout the whole prefecture.

The aim, again, is to develop a curative, preventive, educational and social approach using means that are at the same time simple, inexpensive and effective. They should be easily accessible, in the geographic, economic and cultural sense, and should rely from start to finish on local resources of materials and manpower.

To attain these objectives, it was necessary to win people's confidence at once by creating an official health association, self-managed and self-financed, which was given effective powers to train health personnel, both professionals and volunteers, so as to ensure the broadest possible in-depth coverage.

We are well aware that not everybody thinks as highly as we do of our system and our activities. But what matters is that the guidelines are being laid down that will enable us to keep pace with current trends in developmental theory.

Thanks to administrative reform, the development of basic health services and community participation, Senegal today seems well set to win its pledge for the Year 2000—"Health for all in a socialist society".

We have already said, and it is worth repeating, that the entry of the mass of the people into the new industrial society, with all the force of law, has fundamentally stirred the social structure and toppled its values. The medicine of tomorrow cannot escape from this phenomenon; it will be shaped by the people for the people, because the people themselves will determine their own condition, their own destiny.

That health which conditions the status of the individual, the family and the community clearly constitutes an important element in the well-being of a nation. The global approach to health problems must therefore be placed within the framework of integrated development, and the final goal is the advancement of mankind as a whole.

In tackling this approach, one hears much talk about human structures and societies. But the problems will not be solved under the present system. That will require a systematic new cultural and economic order, an international administration on a planet-wide scale, standing above all petty prejudice. It will need a new science whose symbols have yet to be formulated. Within such a frame the medicine of the Year 2000 will be a symbiosis of all the health sciences, rooted deeply in the positive values of every culture and assimilating every fertile invention of the modern age in its quest for universality.

Once this new order is attained, thanks to the present efforts of the developing countries, the new medical science—stripped of human foibles and failings—will be able to devote itself in all conscience to the quest for the perfect being, that is to say, the integrally balanced individual, redolent with all the values of all the world's civilizations, capable of facing the future with confidence.

To do this, the health revolution will have to set its course towards finding the common ground between widely differing health service structures, between the widely differing abilities of health personnel. Between the hospital and the "health house", between the physician and the village health worker, the rational approach will recognize the need for a single unified system.

Health for All by the Year 2000—a dream or a reality? It could go either way, we will at least ask the state of our planet. All will depend on the conscience of mankind. If we are truly to attain this social objective, it will only be by engaging that human conscience in all our endeavours.
... We have to define a population policy, which will be integrated within the maternal and child health services ...

(Photo WHO/UNICEF/J. Ling)
Helping people to help themselves

by Professor Prakorb Tuchinda

Under-Secretary of State for Public Health, Thailand and President of the Thirty-second World Health Assembly

Health is a fundamental human right. All human beings have a right to the necessities for the enjoyment of good health. For over 30 years, WHO has tried to promote and support health—in the sense of complete physical, mental and social well-being—within all its Member States.

However, there is still a gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries. The gap is widening between the health “haves” in the affluent countries and the health “have-nots” in the developing world; and this gap is also evident within individual countries, whatever their level of development.

Despite phenomenal advances in scientific disciplines in general and medical science in particular, three-quarters of the world’s population still has no access to any permanent form of health care. Basic necessities which may be considered as measures of a reasonable quality of life, such as proper housing, safe drinking water, education and a proper food intake, are denied to the vast majority of rural communities and to the urban poor. Infectious diseases—many of which are preventable—continue to take a heavy toll of human life in most developing countries. Infant mortality remains at an unacceptably high level, with millions of children not living to see their first birthday. Many more millions are handicapped for the rest of their lives following the ravages of malnutrition and associated conditions.

Being fully aware of this world health situation, the World Health Assembly in 1977 resolved to make Health for All by the Year 2000 the main social target of WHO in the coming decades. In turn, the historic Declaration of Alma-Ata, in September 1978, called upon all governments to have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures. Affirming that the primary health care approach is essential to achieving an acceptable level of health throughout the world, the Alma-Ata Conference also urged each
nation to make a strong and continuing commitment to primary health care at all levels of government and society, and to ensure that primary health care is an integral part of community and national development and does not develop as an isolated peripheral action. The Conference emphasized the importance of full and organized community participation and ultimate self-reliance, with individuals, families, and communities assuming more responsibility for their own health.

The services provided by primary health care will vary according to the country and the community, but will include at least: promotion of proper nutrition; an adequate supply of safe water; basic sanitation; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them; appropriate treatment of common diseases and injuries; and provision of essential drugs.

In Thailand, the traditional medical practitioner is recognized as a potential resource for primary health care and is given his due place in community welfare work.

(Photograph WHO/A.S. Kocher)

In my country, Thailand, for some decades in the past, the health service has unfolded mostly in the form of hospitals and clinics for treating diseases. This kind of health system, using action to launch and sustain primary health care as part of a comprehensive national health system and in co-ordination with other sectors. Collectively these policies will be a basis for formulating regional and global strategies. The World Health Assembly also appealed to all agencies and organizations within the United Nations system, and in particular the United Nations Children's Fund (UNICEF) and the United Nations Development Programme (UNDP), as well as to all bilateral agencies and non-governmental organizations concerned, to give full support to formulating and implementing national, regional and global strategies for achieving an acceptable level of health for all.

In my country, Thailand, for some decades in the past, the health service has unfolded mostly in the form of hospitals and clinics for treating diseases.
conventional medical care, has benefited only a small group of privileged individuals in the main cities.

Later on, under our Fourth Five-Year Economic and Social Development Plan, the National Health Development Plan was drawn up on a more scientific basis through country health programming and project formulation. WHO and other UN agencies as well as bilateral agencies were closely associated in the preparation. The main emphasis was laid on improving the health status of the rural population, especially at the village level.

In 1977, the Ministry of Public Health launched the Primary Health Care Programme, with five general objectives:

- to expand the coverage of health services, particularly among the underserved rural population, as quickly as possible, and to help the people to help themselves;
- to utilize community resources and encourage community participation so as to solve individual health problems and eventually to establish self-help programmes at the village level;
- to promote the dissemination of health information to local people, as well as collecting all the data reflecting the needs and health problems of communities;
- to make basic health services available, accessible and acceptable to the people;
- to decrease malpractice, especially in medical care.

Involving local residents

For health manpower development there has been a re-orientation of the training concept towards primary health care workers. The emphasis of primary health care in Thailand is reflected in a variety of efforts aimed at involving local residents in restoring and maintaining their own health status within the framework of rural development. The Ministry of Public Health has realized that there are untapped manpower resources existing in the villages—people who can serve local communities as Village Health Communicators (VHC) and Village Health Volunteers (VHV). Appropriate projects were formulated under the program and the guidelines were laid down for training VHCs and VHVs. Those who are interested in health activities in the villages will help their neighbours and communities after they have been properly trained in simple medical care, disease prevention and health promotion. They can serve their communities and relieve the shortage of government health personnel in rural areas.

VHCs and VHVs are volunteers who are willing to help their communities without any remuneration. They only expect a gain in recognition and respect from the villagers. This programme will help the people by promoting community health services with community participation and the use of community resources.
Helping people to help themselves

Left:
A traditional midwife examines a mother-to-be. Given training to ensure that she does not perpetuate any unsafe practices, the traditional midwife too can help to meet the basic needs of her community.

Right:
The old-style hospital-centred health service used to benefit only the privileged few in the main cities. Today immunization against the major infectious diseases is safeguarding children's lives even in the remotest rural areas.

(Photos Thailand Ministry of Public Health)

The Government of Thailand, through the Ministry of Public Health and other health-related ministries and agencies, has already begun a series of steps to develop national commitment, strategies and action plans in order to reach the goal of Health for All. Following Thailand's participation in the International Conference on Primary Health Care held at Alma-Ata, and based on its recommendations, the Ministry of Public Health made an analysis of the present situation of primary health care schemes and of the obstacles to their success in the country. Recommendations and a policy statement were then made and submitted to the Cabinet for consideration.

In March 1979, the Cabinet approved the principle of primary health care as a National Health Development Policy and supported the allocation of resources and administrative mechanisms to ensure the achievement of the programme objectives. As a consequence of this national commitment, the Ministry of Public Health is currently preparing to set up a new Primary Health Care administrative unit within the office of the Under-Secretary of State for Public Health. This unit will be responsible for co-ordinating, organizing and supporting activities relating to primary health care, and will also serve as the focal point for a national inter-sectoral co-ordinating mechanism.

Initial steps have been taken to formulate strategies and plans of action for achieving Health for All. A series of national inter-sectoral workshops are planned to analyse the issues relating to long-term planning. Joint ventures in regional, provincial and local development planning are being conducted under the auspices of the National Economic and Social Development Board and the Ministry of Interior, in which the Ministry of Public Health is closely collaborating. A national seminar on "Appropriate Technology for Health in Support of Primary Health Care" was also held in April 1979 in co-operation with WHO, UNICEF and other international agencies.

In the area of technical collaboration, Thailand is participating in inter-regional consultations sponsored by WHO with a view to drawing up national case studies in country health programming. Member countries will exchange information, share experiences, and prepare for collaboration in formulating regional and global strategies for Health for All. While we are making every effort to mobilize all available national resources for overall health development, technical and financial assistance from international sources will continue to be quite essential.

Finally, I want to end on a note of hope and sincere optimism. Although the path to Health for All by the Year 2000 will be steep and difficult, with enormous obstacles which we must surmount, provided all of us have the will and commitment, the goal of Health for All should be reached by the end of this century—or even before.
The UN answers the challenge

by Mr K. S. Dadzie

United Nations Director-General for Development and International Economic Cooperation

The United Nations General Assembly decided in January this year that a new international development strategy for the Third Development Decade should be launched during 1980 for the purpose of promoting the accelerated development of the developing countries. It established a Preparatory Committee, open to all Member States, to draw up such a strategy and invited all the organizations of the United Nations system to make contributions to the preparatory process. In doing so it affirmed that the new strategy should be formulated within the framework of the New International Economic Order and be directed towards its objectives.

This affirmation has great significance, for it denoted that the new strategy, unlike the current one, would not be built around a centre-piece consisting simply of quantified growth and aid approaches. It meant, rather, that these approaches would be only one element in a wide range of policy measures aimed at far-reaching structural changes in the system of international economic relations—changes which would make the system operate in more equitable fashion and be more supportive of the development process.

Development is increasingly seen as a process that should be geared to the human factor both as the agent and the beneficiary of development; should be endogenous, involving the autonomous definition by each society of its own values and goals; should rely primarily on the strength and resources of each country; should encompass the transformation of obstructive structures, both national and international; should be in harmony with the environment and respect ecological constraints. In short, the final aim of development must be the constant increase of the well-being of the entire population on the basis of its full participation in the process of development and a fair distribution of the benefits therefrom.

Taking past experience into account, the task of translating these perceptions at the national level and also of reflecting them at the international level in terms of specific and operationally meaningful policy measures will be far from easy. But the Member States of who, individually and collectively as an Organization, can play a unique role in ensuring that health and health-related issues of social development are given due consideration and a proper place in the preparation and implementation of the new international development strategy.

We have over the years witnessed within the international community the declaration of solemn intentions and lofty goals which failed in their implementation largely because they did not command the required political commitment and popular support. It is, therefore, gratifying to observe that, in defining its social target, who intends fully to explore and take into consideration all the political, social, economic and technical aspects of the strategies required to reach Health for All by the Year 2000.

In the Declaration and the recommendations of the Alma-Ata Conference, strong emphasis is given to community participation in the planning, programming and implementation of the health care systems destined to serve the people themselves. Closely linked to community participation, and indeed inseparable from it, is the principle of self-reliance, both at the community and at the national level. As was forcefully stressed at the Conference, the principle of self-reliance implies, in addition to the notion of primary reliance on a country's own human and natural resources, the absence of imposition from the outside of alien concepts and approaches; communities and countries are thus free to decide themselves how to tackle their problems in a manner that is best suited to local conditions.

In emphasizing the contribution of the health sector to the formulation of a new international development strategy, perhaps I have not laid enough stress on the benefits that will accrue to the health sector from accelerated development of the developing countries. So let me conclude by associating the United Nations with the central who tenet, most recently articulated at Alma-Ata, that "economic and social development based on a new international economic order is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace".
Life is full of fun and games today. What will it be like for them—and for their children—in the Year 2000?

(Photo WHO/J. Mohr)
Life in the Americas

From the frozen tundra of Alaska and Northern Canada to the windswept Tierra del Fuego in Argentina, the vast land masses and countless islands that make up the Americas comprise a confusing variety of life-styles. The message of Health for All is going out to every country, whether rich and industrialized or poor and struggling. Each country faces the challenge in a different way, but already the initiatives that have put primary health care on the world map are beginning to have an impact on some of the most far-flung communities of the continent.

1. Farm lads in Ecuador proudly follow their yoked oxen over the difficult ground which will produce good food for their families. (Photo WHO/P.N. Acha)

2. Further north, in Colombia, farmers are learning to grow maize and beans together so that the two crops complement each other in the local diet. (Photo P. Harrison ©)

3. A voluntary health auxiliary brings primary health care to a family in the Lake Titicaca area of Peru. Even where levels of education are low, a new awareness of health and how to improve it is gaining ground. (Photo WHO/D. Henrioud)

4. A nutritious drink helps to build up growing schoolchildren in Guatemala. (Photo WHO/T. Webb)

5. A hurricane—like that which devastated whole areas of the Caribbean in August—boils viciously out of the Atlantic.

6. Oil tanks ablaze in an Alaskan town in the wake of a devastating earthquake. (Photos Len Strman ©)
Health for All by the Year 2000

by Professor John J. A. Reid

Chief Medical Officer, Scottish Home and Health Department
United Kingdom, and former Chairman of WHO’s Executive Board

In 1977, the Thirtieth World Health Assembly in Geneva drew attention to the vast health problems which still exist throughout the world and to the inequitable distribution of resources to deal with this continuing human tragedy. As a result of its discussions the Assembly adopted a resolution which, among other things, decided that the main social target of governments and of WHO in the next two decades should be the attainment by all the citizens of the world, by the year 2000, of a level of health which will permit them to lead a socially and economically productive life. By this decision, who embarked upon the most ambitious task with which it has ever been faced.

The Organization's objective is commonly shortened to the words used in the title of this article; but it is important to bear in mind what was actually decided by the World Health Assembly, since expectations must be realistic. No country will ever achieve a state in which all people enjoy perfect health, but every nation has scope for striving to ensure that its citizens achieve the highest practicable level of well-being.

The magnitude and nature of the problems facing different countries vary enormously; in all too many, health facilities are still totally inadequate, whilst in others they are unfairly distributed in the sense, for example, that particular sections of the populace or geographical areas have inadequate access to health facilities. Some nations are faced with gross problems of malnutrition, inadequate or impure water supplies, poor or non-existent sanitary facilities, and substantial prevalence of communicable or parasitic diseases. Elsewhere the problems lie at the other end of the spectrum, in the form of the growing occurrence of diseases attributable directly or indirectly to affluence. This diversity of problems clearly points to the conclusion that the strategies for achieving the desired objective must primarily be generated within individual countries, and that regional and then global strategies should subsequently be built up from these.

A basic necessity is that there should be clear political commitment at the national level; and governments must appreciate that the attainment of an adequate level of health by their people is not dependent solely on health services. The economic state of the country, its educational system, and its agricultural potential and policies are just a few examples of other parts of the social fabric which are highly relevant. It is equally important that there should be clear public understanding about health matters and that individual citizens should be actively involved in the promotion of their own health. These are vital tasks, which are as necessary in the more developed countries, where illness is all too commonly self-induced, as they are in developing nations, where public participation in attaining and maintaining a satisfactory standard of health is essential over a very wide range of activities.

As a result of the 1977 Assembly resolution, a large amount of preparatory work has been carried out by who towards formulating possible strategies for achieving the desired goal. An opportune and important initiative took place in 1978 in the form of the International Conference on Primary Health Care, held at Alma-Ata in the Soviet Union, and sponsored jointly by who and UNICEF. This was preceded by a range of national, regional and international meetings on primary health care, and the Conference itself was attended by delegations from no less than 134 governments as well as by representatives of 67 United Nations specialized agencies and of non-governmental organizations in official relations with who and UNICEF.

The full scope and importance of primary health care was spelt out, and the Conference called upon all governments to launch and sustain this approach as part of their comprehensive national health systems. It also stressed the importance of international action and, in the historic Declaration of Alma-Ata, affirming that primary health care is the key to attaining the desired level of health throughout the world. The initial emphasis is therefore on community involvement and community services rather than on the more specialized and expensive aspects of health care which are of less relevance to the immediate health problems of much of the world.

Following Alma-Ata, the Secretariat and Executive Board of who prepared a paper on the principles and major issues involved in formulating strategies for health for all by the year 2000. The
Water for washing the clothes, water for drinking—and perhaps it is the village sewer too. Health for All will only be achieved when governments, communities and individuals make a concerted effort to solve the problems of inadequate or impure water supplies.

(Photo WHO/UNICEF/B. Wolff)
The fundamental principle on which the proposed strategies are based is that each country should develop its own health policies in the light of its particular health problems, its social and economic structures, and its political and administrative mechanisms. Experience has shown that, in addition to political commitment and community participation, administrative reform and legislation may well be required in relation both to health and to other related matters. There will also be substantial financial implications, although it is worth noting that a growing number of countries have made impressive progress, particularly in the development of primary health care, at a remarkably low economic cost.

The Executive Board's report discusses the evolution of national plans of action in the health field. It goes on to describe how these, in turn, should lead to well-defined country health programmes and organized health systems to deliver them, based on primary health care but including an appropriate referral process for people requiring more specialized services. The targets of various kinds will have to be defined and periodically updated in the light of the circumstances of individual countries. These might, for example, involve the reduction of deaths from particular causes, the extension of effective health care to certain vulnerable groups of the population, or the achievement of a better geographical distribution of health and related services. Targets will not be approached by the same methods, at similar speeds or in identical order in different countries; but it will be important to try to ensure that the early steps in the development of services are consonant with what it is hoped ultimately to achieve over a period of two decades.

A process of evaluation should be an integral part of the evolving system, supported by appropriate means of gathering health information. Here again, the type of information to be collected will vary from country to country; it must be remembered that, in many cases, elementary statistical information on births and deaths are either lacking or quite inadequate. It may often be more sensible to begin with an unsophisticated system that provides basic data, of a kind that primary care workers themselves can collect, than to evolve elaborate machinery which works better in theory than in practice.

Moving on from the national level, regional strategies should be arrived at through a collective decision of the countries in each of the six WHO regions, their main objective being to ensure the promotion and support of national strategies, and to facilitate technical cooperation amongst countries within the regions in preparing and implementing them. The final stage in the process involves working out a global strategy which, in turn, would support the national and regional strategies. An important aspect will be to strengthen the mechanisms for attracting support funds from the international community, and for ensuring that these funds are channelled into activities considered to have a high priority in recipient countries.

All this will call for the expenditure of much time and effort, since a period of little more than two decades is not long in order to achieve what is required. The 1979 World Health Assembly agreed a timetable which will lead, through a cyclical planning process, to the evolution of the initial global strategy in time for the Thirty-fourth Assembly to consider it in May 1981.

This article is no more than a brief outline of a wide subject, and I will conclude with a few general remarks. First of all, it should be recognized that this is a matter for every Member State of WHO, irrespective of its stage of development or of any other factor. We can all learn from each other and, whilst developing countries may benefit from seeing the successes (and failures) in health service matters of their more developed fellow-states, the reverse process is equally true. Developed countries not uncommonly find that their systems of health care have been inhibited in their evolution as a result of inbuilt and irrelevant attitudes and prejudices, whereas certain developing countries have demonstrated what can be achieved by having to start the process of building up their health services virtually from scratch.

Secondly, it is important that there should be no misunderstanding about what we all hope to achieve by the year 2000. There is no question of a state of affairs in which disease has been abolished, but several things are clearly desirable. Preventable illness should be prevented; there should be early diagnosis, treatment and, where necessary, rehabilitation for those conditions which are treatable; there should be continuing care for patients with maladies which are not treatable; and increasing regard should be paid not merely to the length but also to the quality of life.

Next, it is desirable that there should be a diversity of approach in the evolution of health care systems not merely between countries but, where appropriate, within countries themselves. Such diversity, if accompanied by suitable monitoring, may be of greater value than a totally unified national approach; although this will clearly depend on the size, political constitution and other aspects of particular countries. There will be a need to exchange information about national case-studies in primary health care and its relation to a comprehensive health service, and also about how best to secure co-ordination between the health and other sectors at national and at local levels.

WHO and its Member States have embarked upon a great and challenging adventure. It will involve international organizations and governments; but if it is to succeed it must also involve the participation of individual human beings throughout all countries of the world. Nothing on this scale has ever previously been contemplated, but health is a human right and something which directly affects all of us. We must therefore strive to ensure that, by the year 2000, the overwhelming majority of citizens of the world will be able to look back over the comparatively short period of two decades with a keen appreciation of what has been achieved by their World Health Organization, partly by their own efforts.
"... And increasing regard should be paid not merely to the length but also to the quality of life ..."

Left: Compare this picture with the one on the previous page. No doubt this woman would gladly trade her dried up water-hole for the abundant lake water—however polluted.  (Photo WHO/UN)

Top: It was famine, rather than drought, that set this little family on the move. Such migrant communities pose special problems for the health planners.  (Photo WHO/UN)

Below: At the other end of the spectrum, diseases like obesity and high blood pressure may be directly attributable to "the affluent society".  (Photo WHO/M. Jacot)

Bottom: Disease will not be abolished by 2000 AD. But preventable diseases should be prevented, and there should be early diagnosis and treatment for those conditions that are treatable.  (Photo WHO/E. Schwab)
Vital links
in the health chain

by Professor Boris Petrovskij

Minister of Health of the USSR, and
Member of the Soviet Academy of Medical Sciences

Every country tackles the problem of health care in its own way, as its economic resources and social values dictate.

From its very earliest days the Soviet State recognized health as one of man's basic and inalienable rights and undertook to respect it. Everyone, no matter where he (or she) lives or to what social class he belongs, should have access to whatever medical care he requires, whether it be an injection to protect him from infectious disease or surgery to correct a heart defect.

In setting up our state health services, we chose to use what has been called the district principle of medical care, in accordance with which the country was divided up into administrative areas called rayons, and these in turn into medical districts (uchastoks) of approximately equal population. Each medical district is assigned a doctor and a middle-grade medical worker, or feldsher.

Of course, the way in which this principle is applied in practice depends on the circumstances. In rural areas the medical district generally covers a number of population centres. As a result the first link in the chain of curative and preventive care is the outpatient clinic which has a few beds for inpatients and is run by a physician. Remote villages that are difficult of access are provided with feldsher-midwife posts. These are staffed by feldshers, who work under the supervision of the physician of the rural medical district in which the post is located. In towns, the initial link is formed by adults' and children's polyclinics, women's advisory centres and dispensers—centres for prevention, case detection, treatment and follow-up of specific disorders or groups of disorders.

The district principle brings medical attention very close to the local population; no one is overlooked, everyone is under the watchful eye of the district physician, who is a real family doctor, knows his patients' backgrounds and is able to understand how their illnesses are linked to biological and social factors. This is especially necessary where people are exposed at work to any risk, however slight, of occupational disease. In such cases a dual system of health surveillance has been set up conducted by the district physician and by the workshop physician attached to a health post in the enterprise concerned.

Health care in the USSR forms an integral part of a single state system. As economic resources have grown, so the amount spent on health has increased and extends to environmental protection, to making working and living conditions healthier, to providing for rational nutrition and recreation, and to maintaining the health services themselves, which are in a state of continuous evolution.

At present the district physician has on average 2,000 adults in his care and the

"In other words, the country dweller in the Soviet Union has the same access as the town dweller to the very best in medical care."

A feldsher-midwife and a nurse admire a newborn baby in a Tashkent health post, and a health worker visits a factory in Leningrad to give routine vaccinations to the work staff.

(Photos WHO/Novosti)
district paediatrician not more than 1,000 children. Polyclinics have become large diagnosis and treatment centres, where the treatment of approximately four-fifths of all patients is begun and completed, since it is found in practice that only 20 per cent of the sick require treatment on an inpatient basis. The number of works' health posts has increased and they have expanded into medical departments staffed by hygienists and occupational physicians.

I should like to draw attention to the fact that in the USSR there are close links and a continuity of action between all curative and preventive establishments. This is particularly clearly illustrated in the system of medical services provided for the rural population. These operate in three stages, starting with the initial care given at the feldshersh-midwife post, the outpatient clinic staffed by a physician, or the rural hospital staffed by specialists in various branches of medicine, such as general practitioners, paediatricians, surgeons, stomatologists or obstetrician-gynaecologists. Patients can next be referred for treatment at a central rayon hospital, or finally—when care in a specific “narrow” branch of medicine is required—to a clinic at regional (oblast) or higher administrative level.

The cornerstone of rural medicine today is the central rayon hospital with its attached polyclinics. This has specialists in all branches of medicine on its staff and includes an emergency health care department, with medical aircraft at its disposal so that in emergencies a medical team can be brought by helicopter or aeroplane to a patient living in some inaccessibly remote place. There are now over 3,000 such hospitals in the country, and they have every facility for providing treatment up to the highest modern standards. In other words, the country dwel-
ler has the same access as the town dweller to the very best in medical care.

At the same time the initial link in the rural medical service has been changing. We have been reorganizing small rural inpatient units located near central rayon hospitals into outpatient clinics or rehabilitation units. Rural medical staff working in such clinics and at feldsher-midwife posts thus get an opportunity to devote more attention to preventive care for healthy people.

Regular medical checks are made on pregnant women, children, the war disabled, industrial workers exposed to health risks and persons with chronic diseases. There are now more than 40 million people on the dispanser registers—almost every sixth or seventh person in the country. Nearly 160 million people a year undergo a preventive examination, expenses being paid by the state.

Although the problem of providing the population with qualified medical care has in principle been solved, this does not mean that there is nothing left to do. In order to ensure that the Soviet citizen's constitutional right to health care is met as effectively as possible, further massive capital investment, social measures and scientific research are needed. The scope of medical achievement is increasing and science is finding new and more effective methods for the treatment, prevention and early detection of diseases and of conditions likely to lead to disease. These new techniques have to be mastered quickly, brought widely into practice and made accessible to each of the nearly 900,000 Soviet physicians.

New problems keep arising in an era of scientific and technological revolution, and develop as a result of changes in working practices and the exposure of the human body to environmental factors it has not encountered before in the course of its evolution. In other words, life calls for a flexible approach from the medical service.

One way of improving this approach in the Soviet Union has been to strengthen the initial links in the medical district
service, the “family doctor institution”, on which the effectiveness of preventive care primarily depends. Another has been to develop specialized types of medical care, by setting up large treatment and advisory centres providing both curative and preventive care for the population of a specific area.

These centres and the large comprehensive hospitals at regional and higher levels have instituted polyclinics and outpatient clinics “on wheels”, using special cross-country vehicles. They carry specialist medical teams into remote rural areas to carry out comprehensive preventive examinations of the local population. There are now about 2,000 such mobile units and their numbers are steadily increasing.

As the health care system has developed, so new forms of medical care have grown up and establishments of a new type have been introduced, such as specialized kindergartens and boarding schools where children with chronic diseases receive both treatment and schooling.

Six decades of Soviet rule have eliminated the sharply contrasting levels of health formerly seen in persons belonging to different social strata. The mortality rate has fallen by a factor of three and the infant mortality rate by a factor of almost ten. Life expectancy at birth has now risen to 70 years. But the organizational bases and the principles of the Soviet health system—such as the provision of health care by the state, the emphasis on prevention, and the close links with medical research—remain unchanged, for they have stood the test of time.
Starting from scratch

by Dr E. M. Samba

Director of Medical Services, Ministry of Health, Labour and Social Welfare, Gambia
The world is crying out for social justice. There is a universal state of flux—conflicts between black and white, between the haves and the have-nots, between North and South. Even within any one country there is a great divide between the lucky few and the underprivileged masses. Health for All by the Year 2000—the most momentous decision ever taken by the World Health Assembly—is a noble attempt at bridging this gap. It is universally acceptable; the general mass of humanity is hungry for it; above all, unlike many dreams, it is achievable. The question is therefore how? How can we clearly define, plan, programme and successfully bring into function this noble social objective?

Alma-Ata gave us the instrument with which to achieve it. Primary health care (PHC) when properly applied will, more than anything else, help us towards this goal. The principles of primary health care are universal, but the details have to be tailored to suit the individual country and indeed individual tribes or communities within the same country. The customs and traditions of different social groupings have to be taken into account, while the political colouring of the government must, of necessity, influence the implementation of such care.

Until now, the medical care system of The Gambia has been available to less than 20 per cent of the population (those living largely in urban and periurban centres), while the emphasis has been on the curative side. With primary health care we focus on over 80 per cent of the country. This is easier said than done. It requires a complete reorientation of the attitudes of medical personnel, administrators and politicians. Many questions have to be answered: how can we obtain and maintain political commitment at the highest levels? How can we reverse the curative/preventive ratio? How can we shift the concentration of facilities in order to give the peripheral section of society its fair share of the cake? How can we start from scratch to initiate and maintain the correct impetus up to the year 2000 and beyond?

In The Gambia we almost take for granted the political commitment. The majority of the voters come from the rural areas and, for all practical purposes, all our Cabinet ministers are from the provinces. Over the years they have been struggling to redress the urban/rural imbalance in all fields of socio-economic development. When we

Teaching schoolchildren to wash their hands regularly—this too is primary health care.

(Photo WHO/D. Henrioud)
starting from scratch

left:
"... The agricultural masses contribute the lion’s share of our total national budget and it is only just that they should have a fair share of the budgetary allocations."

(right)
Taking a blood sample during a survey into the incidence of disease. Health workers like this young man have to be properly trained; the Gambia is intensifying its local training facilities so as to provide one village health worker for every 500 population by the year 2000.

we had long been convinced about the broad principles of primary health care, but what Alma-Ata did was to help us define and crystallize our ideas and focus them on the right channels—channels which will lead to Health for All by the Year 2000. We returned from Alma-Ata with our heads bursting with ideas. The field is vast, the target is daunting, one priority cries out for precedence over another, and the resources are very limited. So where do we start?

the first move was to put down our ideas on paper, detailing the present health service situation, the justification for primary health care, the priority areas—proper nutrition, water supply, sanitation, mother and child health, expanded programme of immunization, family planning, health education, and so forth.

To facilitate this exercise, the Alma-Ata documents were circulated and discussed at a series of meetings in the Department of Health, which included representatives of the staff as well as WHO personnel. We organized joint meetings with the Ministries of Economic Planning, Agriculture, Education, Finance, Works and so on. As we had no time to sit down and write up a document, we invited a WHO short-term consultant who visited various parts of the country to familiarize himself with the existing local conditions. With this exhaustive background he was able to prepare a detailed draft PHC document. Once this had been modified so as to be consonant with the country’s political, social and economic realities, it was sent to all ministries and interested parties for their comments. Further meetings were held before a final draft was presented to the Minister of Health for consideration in Cabinet.

While this exercise was in progress, one of the WHO directors from Geneva was on leave in The Gambia. He was a good PHC salesman. He contributed immensely towards making the top brass in this country aware of Health for All by the Year 2000. We had a meeting with him in the National Planning Committee chaired by the President of the Republic, Mr. Dawda Kairaba Jawara, and attended by all the permanent secretaries and heads of departments in the civil service. The President was highly impressed and gave his blessings and full support to PHC. Subsequent events demonstrated that this support was extremely important.

In conjunction with the Ministry of Economic Planning, which is the coordinating ministry, we invited representatives from the Federal Republic of Ger-
The preparations for this exercise were completed in 1996 to ensure that the PHC concepts of the Ministry could be better understood by the capacity of the health personnel. We also wanted to make sure that the health personnel were readily available to work on the project.

We were able to achieve this by ensuring that the PHC concept was clearly understood by the personnel. The approach taken was to ensure that the personnel were well trained and had a good understanding of the concept before working on the project.

We were also able to achieve this by ensuring that the personnel were well motivated. We did this by providing them with the necessary resources and support, and by ensuring that they were well paid.

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Manpower development is another critical factor. It is becoming increasingly obvious that overseas training is not always relevant, and besides, it is expensive. We are intensifying our local training facilities to provide one village health worker for every 500 population by the year 2000. We are retraining traditional birth attendants and community nurses to support the village health workers.

We are going through a very exciting phase in the history of our national development. The appetites of the underprivileged have been stimulated and must be satisfied. The problems are almost daunting, and yet we cannot afford to fail. We must succeed.
Caribbean countries use audio-visual aid to push breastfeeding: UNICEF support

The Caribbean Food and Nutrition Institute (CFNI) has produced with UNICEF support an audio-visual teaching package, "Breastfeeding your baby," for use as a tool in nutritional education programmes in CFNI's 17 member countries.

Developed in response to the need for audio-visual materials felt by health and nutrition workers in the Caribbean, the slide-sound set has been designed to appeal primarily to pregnant and lactating mothers and for use with community youth groups, family life education classes, and training courses for teachers, nurses, midwives, physicians and other health workers.

The package features a number of key concepts related to breastfeeding, and to a lesser extent, weaning. An understanding of these concepts is expected to motivate mothers to want to breastfeed, and to encourage them to breastfeed up to one year or longer, discontinue the use of expensive breastmilk substitutes, and wean their babies properly.

A collaborative venture between CFNI, UNICEF and the Pan American Health Organization (PAHO), the project is aimed at creating a receptive environment for the introduction of good nutrition practices from birth onwards.

The sound-slide presentation is in three parts, each consisting of more than forty 35 mm colour transparencies linked to a 7-minute sound recording on cassette. Part I focuses on preparation for breastfeeding, Part II on the successful management of breastfeeding, and Part III on the introduction of solid foods during the breastfeeding period.

The entire presentation takes 25 minutes, but each segment can also be shown separately to meet specific audience needs. A teaching guide goes with the set with suggestions for use, an outline of objectives, background information on breastfeeding and discussion questions. Also included are a poster and two postcards, one for evaluating the package and the other for requesting additional material.

To reinforce the learning, members of the audience at the presentation are given some printed material to take home. This includes fact sheets with additional information about nutrition, and a mother's booklet with black-and-white reproductions of the visuals seen in the show, flanked by the words heard on cassette and explanatory teaching notes. In areas without electricity or projection facilities, the booklet alone can serve as a pictorial teaching aid.

The presentation was pre-tested at a number of health centres in Jamaica to determine that the medium chosen was appropriate for the audience and that the content and messages were clear and simple. Another evaluation will be carried out to find out how far the teaching package has contributed to the promotion of breastfeeding and improvement of the knowledge of nutrition in the region.

Developed as an undertaking of the International Year of the Child (IYC), the package was launched last June at a CFNI technical group meeting devoted to "Techniques to Promote Successful Breastfeeding". The CFNI, located in Kingston, Jamaica, has the following membership: Antigua, Bahamas, Barbados, Belize, British Virgin Islands, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, Saint Kitts-Nevis, Anguilla, Saint Lucia, Saint Vincent, Surinam, Trinidad and Tobago, Turks and Caicos Islands.

High sodium levels in drinking-water: blood pressure risk

The presence of excessive amounts of sodium in drinking-water can have an adverse effect on blood pressure, according to a report* recently published by the WHO Regional Office for Europe.

The report, based on the deliberations of a working group convened in The Hague last year, comes to the conclusion that there is a link between sodium intake levels and hypertension, and recommends reduction of sodium salt consumption.

The report also makes the following points:
- Sodium in drinking-water can arise naturally or as the result of human activities. A general tendency for sodium levels in drinking-water to increase has been reported in many countries. This may be caused by increased pollution of sources or by water treatment processes.
- Until recently, little attention was paid to the possible health effects of high levels of sodium in drinking-water. In the WHO European and International Standards dated respectively 1970 and 1971, sodium is not listed as a possible hazard. Interest in sodium increased when its association with hypertension was observed. The Working Group recognized that there is strong evidence of a relationship between sodium and hypertension.
- Since drinking-water is an important ingredient in food, it is essential that sodium levels be maintained as low as practicable and trends towards increasing sodium levels in water supplies be discouraged.
- The intake of sodium chloride (common salt) should be reduced. In the case of an adult in normal health it would be reasonable to aim for a progressive reduction of salt to 6 g per day. A long-term goal of 3 g per day may well be desirable, but further research in the matter is necessary.
- Assuming that the contribution of drinking-water to the total intake of salt in the diet is 10 per cent, the concentration of sodium, on the basis of a consumption of 2 litres per day, would be 120 mg/l to correspond with a total intake of sodium chloride of 6 g per day.
- For patients with hypertension or congestive heart failure there is a need for further restriction in the total dietary intake to a maximum of 500 mg of sodium per day corresponding to 1.3 g of sodium chloride. As it is not practicable to provide food with less than 400 mg of sodium per day, corresponding to 1.2 g of sodium chloride, the contribution from drinking-water should be limited to 40 mg per day. Thus, again assuming a consumption of 2 litres per day, the concentration of sodium should not exceed 20 mg/l. In the case of water supplies where this figure is exceeded, health authorities should be notified.

Schizophrenia linked with cultural styles

A relationship between the course of schizophrenia and the cultural background of the patient has been underlined in a newly published WHO report entitled Schizophrenia, an International Follow-up Study.

The 420-page publication describes the latest findings of the International Pilot Study of Schizophrenia which began in 1966 as a large-scale cross-cultural psychiatric investigation carried out simultaneously in nine countries: China, Colombia, Czechoslovakia, Denmark, India, 

* Sodium, chlorides and conductivity in drinking-water: report of a WHO working group. Copenhagen, WHO Regional Office for Europe, 1979; 63 pages; Sw.Fr. 7. —
India's victory over smallpox chronicled

In April 1976, a WHO International Commission announced to a somewhat sceptical world that smallpox had been eradicated from India. The 16-member Commission, comprising experts in epidemiology and infectious diseases from as many countries, had arrived at that conclusion after carefully reviewing all smallpox data in Government records and visiting a number of states, districts and villages for an on-the-spot assessment of the validity of the data.

That the achievement has been hailed the world over as a public health miracle is understandable when it is recalled that in 1974—only two years prior to the declaration—smallpox in India claimed 188,000 cases with 31,000 deaths. The Indian subcontinent was known to be the world's principal focus of endemic smallpox since earliest history, and since 1900 a major epidemic had been recorded every five to seven years. In 1951, 11 years before the Indian National Smallpox Eradication Programme began, more than 250,000 smallpox cases and 64,000 deaths were recorded, and it is now known that these figures probably reflected less than 10 per cent of the actual toll taken by this disease.

The story of this magnificent success and of the tremendous feat of planning, organization and national and international coordination and collaboration has been set down in detail in a publication issued by WHO's South-East Asia office in New Delhi, entitled 'The Eradication of Smallpox from India'.

International assistance played an important role in this achievement, explains Dr Donald A. Henderson, formerly Chief of WHO's Smallpox Eradication unit, in his preface to the book, and adds: ‘But it must be pointed out that even during the intensive final phase of the programme more than 75 per cent of the costs were borne by the Government of India. International staff numbered less than 250 in a staff of the more than 150,000 workers who participated.’

In his foreword, Dr V.T.H. Gunaratne, WHO Regional Director for South-East Asia, describes the achievement as ‘an event which is truly historic in the annals of medicine and public health’. The book is published in the hope, Dr Gunaratne says, that ‘many of the strategies and tactics used in the Indian programme can be applied for the control of other communicable diseases in any country’.

Priced at Sw. Fr. 30—, the book can be obtained from WHO sales agents, the Regional Office in New Delhi or the Distribution and Sales service, WHO headquarters, Geneva.

In the next issue

The December issue of World Health will look at acupuncture—as a treatment and as an anaesthetic—as used in China and elsewhere, and at aspects of traditional medicine.
Vaccination: a weapon against disease

Infectious diseases are passed from one person to another by simple contact or just by being nearby. They have scourged mankind for centuries, and a single epidemic of cholera, for example, used to kill hundreds of thousands of people in a very short time.

Then it was discovered that it was possible to stimulate a defence system within the human body. A person can only catch measles once in a lifetime because the illness gives rise to tiny antibodies which, the next time round, will attack the virus. All one had to do, therefore, was to provoke a "disease in miniature", that is to say, to make the organism sick enough to create its own natural defence system but not sick enough to show the actual symptoms of the disease.

So, in the eighteenth century, the practice of "variolation" began. A small quantity of the virus of smallpox (variola) introduced into the body was enough to protect it from later attacks of the disease. In the course of the same century, Jenner invented vaccination. He had observed that the vaccinia virus, which attacked cattle, was related to smallpox, and it was from this virus that he created the anti-smallpox vaccine.

Since then, vaccines have been made from viruses and from bacilli for an ever-increasing number of diseases. Today, some of these have to all intents and purposes disappeared from many parts of the world. Smallpox itself is soon to be declared entirely wiped out from the face of the earth.

Why then, when we have such a magnificent instrument for preventing infectious diseases, do so many children in the Third World still die from them? The problem is largely one of means and of organization. This is why WHO has launched its Expanded Programme on Immunization with the aim of encouraging and helping countries to vaccinate all children without exception, between now and 1990, against the six most deadly diseases of childhood: diphtheria, whooping-cough, tetanus, measles, poliomyelitis and tuberculosis.

But how can this be done? Only action by the entire community can reach every child, even in the smallest and most remote village. The whole society has to be fully aware and fully involved. If everybody does their social duty, the day will come when we can say for other illnesses what we say today about smallpox: that this disease is about to cease for ever to menace our lives.

In blue in our diagram: Protecting babies from infection. If the mother-to-be contracts a disease before her pregnancy (1) or during it (2), the immunity—shown as blue signs—which she acquires against this disease—red arrows—will be transmitted to the fetus (3). The newborn baby will then be protected by the antibodies which it has received from the mother (4) but not against new infections which she has not encountered (5). Early vaccinations (6) are therefore essential to ensure that the baby is safeguarded against all the common infections of childhood.

Red diagram: Gamma-globulin protection. Another way of protecting babies, at least for a short period of time, is to extract serum from an adult who has been subjected to repeated vaccinations (7 and 8) and who therefore has a very strong immunity to most infectious diseases. This serum (9) is then processed to extract gamma-globulin (10) with which the baby can safely be vaccinated. The gamma-globulin encourages antibody activity and will protect the child from disease for about three weeks (11).
Uninvited guests

No living thing exists in isolation. All creatures depend on what they find around them, and share their existence with other creatures. Their bodies harbour other species, which sometimes feed on their host—and the human body too may support unwelcome guests. Some of these other species, or parasites, stay on the surface of the body (1, 2, 4 and 13), others infiltrate the tissues (14, 16, 17 and 18), while still others make for the internal organs (5, 6, 8, 9, 10 and 12) or circulate with the blood (7, 11 and 15). The mosquito (3) is not strictly speaking a parasite. It feeds on human blood and through its bite can transmit various diseases; it can inoculate humans with blood parasites, such as plasmodium, the malaria parasite.

Many of these forms of life cause illnesses, of varying severity. In the drawing opposite, you can see the main species that live on mankind; we have listed some of the diseases they cause.

1. Louse (typhus)
2. Bed-bug
3. Mosquito (transmits malaria and yellow fever)
4. Flea (plague and typhus)
5. Lung-fluke
6. Liver-fluke
7. Plasmodium, the malaria agent
8. Hookworm
9. Roundworm
10. Tapeworm
11. Schistosome (schistosomiasis)
12. Threadworm
13. Crab louse
14. Guinea worm (dracunculiasis)
15. Trypanosome (trypanosomiasis or sleeping sickness)
16. Trichina (trichinosis)
17. Itch mite (scabies)
18. Onchocerca (transmitted by the blackfly, these tiny worms cause skin nodules and eventually "river blindness")

The vaccination and parasite diagrams are taken from "Le livre de la Sante", published by Andre Sauret, Monte Carlo 1967. They are reproduced by kind permission of the author, Joseph Handler.
Primary health care in action in Guatemala

(Photo WHO/P. Almasy)