

Seventh General Programme of Work covering the period 1984-1989



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**Seventh General Programme of Work
covering the period
1984-1989**

**Resolution WHA35.25 adopted by the World Health Assembly
in May 1982**

The Thirty-fifth World Health Assembly,

Having reviewed, in accordance with Article 28(g) of the Constitution, the draft of the Seventh General Programme of Work covering a specific period (1984-1989 inclusive), submitted by the Executive Board;

Convinced that the Seventh General Programme of Work, the first of three new general programmes of work of WHO to be implemented by the target date of the year 2000, constitutes a satisfactory response of the Organization to the Global Strategy for Health for All by the Year 2000;

Believing that the Programme provides an appropriate framework for the formulation of the Organization's medium-term programmes and programme budgets, and that its content has been sufficiently specified to permit evaluation;

Recognizing the important contribution of the regional committees to the development of the Programme;

1. APPROVES the Seventh General Programme of Work;
2. CALLS ON Member States to use it when deciding on their cooperative activities with WHO as well as their intercountry health activities;
3. URGES the regional committees to ensure that regional programmes and programme budgets are prepared on the basis of the Seventh General Programme of Work;
4. REQUESTS the Director-General to ensure that the Seventh General Programme of Work is translated by the beginning of the period concerned into medium-term programmes for implementation through biennial programme budgets, and is properly monitored and evaluated;
5. REQUESTS the Executive Board:
 - (1) to monitor the implementation of the Programme on a continuing basis;
 - (2) to review the progress and to evaluate the effectiveness of the Programme in supporting the goals of the Global Strategy for Health for All by the Year 2000;
 - (3) to ensure in its biennial reviews of programme budget proposals that these properly reflect the Programme;
 - (4) to carry out in-depth reviews of particular programmes as necessary to ensure that the work of the Organization is proceeding in conformity with the Seventh General Programme of Work.

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1. Introduction

1. Article 28 (g) of the Constitution of the World Health Organization requires its Executive Board "to submit to the Health Assembly for consideration and approval a general programme of work covering a specific period". The World Health Assembly has thus far approved six general programmes of work, respectively for the periods 1952-1956, 1957-1961, 1962-1966, 1967-1972, 1973-1977 and 1978-1983 inclusive. These programmes were formulated by the Executive Board, approved by the World Health Assembly and subsequently adapted to regional needs by the regional committees. The first four general programmes of work were developed in very broad terms. The Fifth General Programme of Work¹ was somewhat more explicit. It identified four principal programme objectives and outlined how they were to be attained. The Sixth General Programme of Work was even more explicit. For each of its six major areas of concern principal objectives, divided into detailed objectives, targets, whenever possible, related to the objectives, and approaches and activities necessary to reach the objectives were specified. A number of output indicators were also specified to facilitate the measurement of the outcome of activities.

2. However, shortly after the adoption of the Sixth General Programme of Work, two major events took place, namely, the adoption in 1977 of resolution WHA30.43 which defined the goal of "Health for all by the year 2000", and the International Conference on Primary Health Care, held in Alma-Ata in 1978. These events greatly affected the implementation of the Sixth General Programme of Work.

3. They also greatly influenced the Executive Board which, at its sixty-fifth session in January 1980, decided that the focus of the proposed Seventh General Programme of Work would be on the long-term goal of health for all by the year 2000 and on WHO's response to the global strategy for attaining that goal. At the same session, the Board also decided that the Seventh General Programme of Work would extend and build on the Sixth. The intention was to retain all that was valid in the Sixth and to refine,

¹ WHO Official Records, No. 193, 1971, Annex 11, p. 65.

update and add to it as necessary to respond to new developments since it was adopted, as reflected for example by resolution WHA29.48 on technical cooperation, resolution WHA30.43 on "Health for all by the year 2000", the Declaration of Alma-Ata (1978), resolution WHA32.30 on "Formulating strategies for health for all by the year 2000", and resolution WHA33.24 on "Health as an integral part of development". The idea was to maintain continuity but to move forward in accordance with the new policies and strategies for "Health for all".

4. The Seventh General Programme of Work is the first of the three general programmes of work of WHO needed to cover the period until the target date of the year 2000. The targets for the Seventh General Programme of Work are therefore intermediate targets for the period 1984 to 1989 in relation to the long-term targets for the year 2000. The Programme constitutes WHO's support to the national and regional strategies for attaining health for all by the year 2000, and to the global strategy that is the synthesis of these national and regional strategies. It therefore does not stand alone but represents the Organization's response to the individual and collective needs of its Member States in connexion with the implementation of the strategies for health for all. In so doing it emphasizes "health" as defined in WHO's Constitution, rather than the mere control of specific diseases.

5. The Programme thus consists of priority issues for WHO action, and the broad lines for such action, in the health sector, as well as in other sectors concerned as far as WHO can have an influence on them, to promote, coordinate and support efforts by the countries of the world individually and collectively to attain the goal of health for all. It therefore aims at supporting countries individually and collectively to refine and implement their strategies for health for all and to evaluate progress towards the attainment of this goal. To this end objectives and targets have been defined for each of the issues included in the Programme. Particular emphasis is laid on supporting developing countries, but the needs of developed countries have also been taken fully into account.

6. The Declaration of Alma-Ata clearly stated that primary health care, based on appropriate technology,¹ with the full participation of individuals

¹ "Technology" and "appropriate health technology" are used in the sense ascribed to them in the Alma-Ata "Report on Primary Health Care", namely: *Technology*—an association of methods, techniques and equipment together with the people using them; *Appropriate Health Technology*—technology that is scientifically sound, adaptable to local needs, acceptable to those who apply it and to those for whom it is used, and that can be maintained by the people themselves in keeping with the principle of self-reliance with resources the community and the country can afford.

and families in the community, is the key to attaining the target of health for all by the year 2000. The Declaration calls on all governments to launch and sustain primary health care as part of a comprehensive national health system¹ and in coordination with other sectors. The Seventh General Programme of Work is therefore structured in such a way as to support the strengthening of health systems that are based on primary health care, for the delivery of health programmes that make use of appropriate technology and that have a high degree of community involvement. This constitutes an evolution of trends that already appeared in the Sixth General Programme of Work. The Seventh General Programme of Work strengthens these trends by emphasizing the systematic build-up of the operational infrastructures of health systems and the delivery by them of a variety of health programmes in an integrated manner. The Programme will be implemented in a flexible manner, allowing for unpredictable changes in the world health situation in the light of which world health policy may have to evolve. WHO's constitutional role, and in particular the work of the regional committees, the Executive Board and the World Health Assembly, will ensure that health policies do indeed evolve in keeping with the requirements of a changing world.

¹ A health system consists of interrelated components in homes, educational institutions, workplaces, communities, the health sector and other related sectors; action taken within any one component affects the action to be taken within the others. The system includes a health infrastructure which delivers a variety of health programmes and provides health care to individuals, families and communities. Such health care consists of a combination of promotive, preventive, curative and rehabilitative measures. The system is usually organized at various levels, the first of which is the point of contact between individuals and the system, where primary health care is delivered; various intermediate and central levels provide more specialized services and support as they become more central. (*Global Strategy for Health for All by the Year 2000*, "Health for All" Series, No. 3, p. 39.)

2. Progress Review of the Implementation of the Sixth General Programme of Work

7. Before work on the formulation of the Seventh General Programme of Work was started, a global review was made of the way in which the Sixth General Programme of Work was being implemented and of the extent of its implementation. It is important to state at the outset that it is being implemented systematically. Details of its implementation at the country, regional and global levels are to be found in the Regional Directors' reports to the regional committees and the Director-General's reports to the World Health Assembly, which to date are available for 1978-1979 and 1980-1981.

8. The Sixth General Programme of Work consists of a conceptual preamble that defines policy, followed by a description of programme activities to be undertaken in the light of that policy. An analysis of the world health situation pinpoints the health challenges to be expected for the period 1978-1983. A short review of the evolution and evaluation of WHO programmes leads to the definition of the role and functions of WHO during that period. Implications for WHO's programme for the period are also derived from a brief analysis of long-term health trends up to the end of the century. General principles are provided, underlining that the programmes of WHO should be oriented towards defined goals and targets. Criteria for the selection of programmes are also spelled out, the basic criterion of giving priority to the problems of developing countries being emphasized.

9. The general programme framework that follows describes the objectives of the Sixth General Programme of Work, grouped under six sections, corresponding to the six major areas of concern of the Organization for 1978-1983. These are: Development of Comprehensive Health Services; Disease Prevention and Control; Promotion of Environmental Health; Health Manpower Development; Promotion and Development of Biomedical and Health Services Research; and Programme Development and Support. The Programme's objectives come as a logical sequence to its policy basis. These objectives, however, are not set in any order of global priority, since priorities vary by country and by region.

10. For each principal objective the Sixth General Programme of Work describes detailed objectives, targets, approaches and activities and, sometimes, output indicators. The World Health Assembly, in adopting the Programme by resolution WHA29.20 (1976), considered that it provided "an appropriate policy framework for the formulation of medium-term programmes and programme budgets within the period covered". The Programme was therefore translated into more detailed medium-term programmes for implementation through programme budgets.

11. The need to test the methodology for medium-term programming at that time led to the development of the medium-term programmes corresponding to the Sixth General Programme of Work in a progressive manner, the order of their development being determined pragmatically. First to be elaborated in 1977 were the medium-term programmes for Mental Health and Health Manpower Development, followed in 1978 by the medium-term programme for the Promotion of Environmental Health. In 1979 the medium-term programme for Comprehensive Health Services was put together, comprising Health Services Development, Family Health, Mental Health and Prophylactic, Diagnostic and Therapeutic Substances. Finally, in 1980, the medium-term programmes for Disease Prevention and Control, the Promotion and Development of Biomedical and Health Services Research and Programme Development and Support were finalized. Consequently, by the end of 1980, all the major areas of concern of the Programme had been converted into medium-term programmes. In the light of this schedule, it was possible to use only three medium-term programmes, namely, Health Manpower Development, Mental Health, and the Promotion of Environmental Health, as bases for the preparation of the 1980-1981 programme budget, due to the short time that had elapsed between the period of its preparation and the adoption of the Sixth General Programme of Work. Medium-term programmes were however more widely used for the first time for the 1982-1983 programme budget proposals, thus helping to ensure that this programme budget reflected the objectives and targets of the Sixth General Programme of Work, since the activities of the medium-term programmes were defined with a view to attaining these objectives and targets.

12. An analysis of the medium-term programmes shows that the Organization's activities since 1978 have generally reflected both the preambular part and the specific objectives of the Sixth General Programme of Work. In some cases, particularly in the case of medium-term programmes that were elaborated first, substantial revisions to the medium-term programmes were subsequently introduced in the light of the policy changes

brought about by the Alma-Ata Conference on Primary Health Care (1978), and the adoption of resolutions WHA30.43 on the goal of health for all by the year 2000, and WHA32.30 (1979) on formulating strategies to attain this goal. For example, in 1979 the programmes of both Mental Health and Health Manpower Development were updated in view of the new policy developments, in order to lay more emphasis on primary health care and related activities. In another case, the priority objectives of the programme for the Promotion of Environmental Health were narrowed down in view of the emphasis to be put on the International Drinking Water Supply and Sanitation Decade. These examples illustrate the flexible manner in which these medium-term programmes have been developed.

13. Have the criteria for programme selection been used? In general, it can be stated that the most important determining criterion, namely priority to developing countries, has been respected, even if the other criteria have not always been systematically applied. In particular, it appears that the criteria relating to the determination of the organizational level or levels for implementation of programme activities were inadequately taken into consideration when programming.

14. The Sixth General Programme of Work's programme classification gave rise to many difficulties in attempts at integrated programming. The Programme had originally advocated a coordinated approach to the implementation of its six major areas of concern, but these included such heterogeneous objectives that coordination, both between the areas of concern and among the constituent programmes of each of them, proved to be difficult to attain.

15. The second major obstacle encountered was that the approaches described in the Sixth General Programme did not make it sufficiently clear which programmes should deal with infrastructure and which with technical substance, or in other words which programmes should deal with the health delivery system and which with the health system's content. This occurred in particular with respect to the major area of concern Comprehensive Health Services, which comprises programmes relating to the content of a health system, such as family health, nutrition, mental health, workers' health, and the development of standard health technologies, as well as programmes relating to health infrastructure such as the planning and management of comprehensive national health services and the development of primary health care. As a result of all the above, during medium-term programming there was a pronounced influence of programmes dealing with technical substance, some of them proposing their own systems for delivering their programme.

16. The lesson to be learned from this for the Seventh General Programme of Work is that there is a need to distinguish clearly between, on the one hand, activities dealing with the infrastructure for the delivery of health programmes, and on the other hand those dealing with the technical content that is to be delivered. The former would include the planning and organization of health systems based on primary health care, manpower, and the relationships between health and other socioeconomic sectors; the latter would include the content of the health system, i.e., the technology to be used, scientific endeavours to arrive at this technology and behavioural alternatives to it, so that it is really appropriate in the sense of the Declaration of Alma-Ata.

17. The above-mentioned problems were exacerbated to some extent by the staggered timing of the development of medium-term programmes. Although this was necessary in order to test the methodology of medium-term programming, it made coordination between major areas of concern more difficult. The lesson to be learned for the general programmes of work is that there is a need to formulate medium-term programmes simultaneously, and before the preparation of the programme budget for the first two-year financial period. Time constraints, however, will make it necessary to prepare concurrently medium-term programmes for the Seventh General Programme of Work with its first programme budget biennium, namely 1984-1985.

18. With these reservations, it can be said that the Sixth General Programme of Work has proved a useful basis for formulating the Organization's programmes. The involvement of the regional committees, the Executive Board (in particular through its Programme Committee), and the World Health Assembly proved a great asset in guiding and monitoring the implementation of the Programme. Its flexibility proved valuable at all organizational levels, the room left for initiative being ample in relation to the varying needs of countries and regions. An outstanding example of this flexibility was the resilience with which the Organization responded during the period of the Sixth General Programme of Work to resolution WHA29.48 on programme budget policy and strategy, adopted by the World Health Assembly in May 1976. In fulfilment of this resolution, the allocations of WHO's regular programme budget to technical cooperation with Member States rose from 51.2% in 1977 to virtually 60% by 1981. Thus by that year an additional sum of more than US\$ 40 million of WHO's regular budget that was formerly being disbursed at other organizational levels was being devoted to technical cooperation activities. This was achieved by cutting down all avoidable and non-essential expenditure on establishment and

administration, both at headquarters and in the regional offices; streamlining the professional and administrative cadres; phasing out projects which had outlived their utility; and making optimum use of the technical and administrative resources available in the individual developing countries. Moreover, what might appear on the surface to be a mere transfer of funds to countries from other organizational levels of WHO evolved into a programme budget strategy which reinforced the new trends that were gathering impetus throughout the world and that gave rise to momentous health policy changes in WHO and its Member States.

19. The Sixth General Programme of Work is being implemented during a transitional period marked by great policy changes throughout the world with respect to health and development and the role of WHO in promoting these. The implementation of the Programme has consequently often been overtaken by the dramatic launching of new health policies that will greatly influence WHO's activities in the 1980s and 1990s. Some of these policy changes were foreseen in the Sixth Programme, particularly in its preamble. But the extent to which countries have been inspired by the Alma-Ata Conference on Primary Health Care, and in consequence their decision to develop strategies for health for all both individually and collectively, could not have been foreseen. The real success of the Sixth General Programme of Work will have to be judged in the final analysis by the degree to which it has prepared WHO to collaborate better with its Member States in the development and implementation of strategies for health for all by the year 2000.

3. Summary of the Global Strategy for Health for All

20. Since the World Health Organization was founded, profound changes have taken place throughout the world. Many new sovereign States have emerged and on accession to independence have assumed new responsibilities. Important changes have taken place in relationships between countries, strengthening the spirit of cooperation among them. Unprecedented advances have been made in science, and health and education have become the birthright of ever-increasing proportions of the world population. During the same period, the human environment has changed more than ever before mainly due to human interventions, and the effects of these are only gradually becoming apparent. Health has to be attained in this continually evolving setting of political, economic, social, cultural, scientific, technological and psychological factors, superimposed on the geophysical environment. The health of people continues to be affected by each of these factors and, in turn, to affect them and the setting as a whole.

**Evolution of
the world health
situation**

21. Health services themselves continue to evolve in answer to existing and emerging problems. To counter these problems, developing countries have frequently resorted to scientific methods and tools which were inappropriate for them because their young health service infrastructures were not always sufficiently developed, and this caused an unnecessary drain on scarce resources. In a large number of countries the already inadequate health structures must now meet the demands of expanding populations with an increased life expectancy, and if health care has become more easily accessible for increasing numbers of people there is still an uneven distribution of health care in many countries, rural populations being particularly underprivileged. As costs soar in many countries, finite resources are limiting the possible application of technological advances for all who require them; this points to the necessity of seeking out new ways of making health care universally available.

22. It has become increasingly evident that individual national efforts alone are not sufficient to deal adequately with such diverse questions as the preparation and use of biological substances, the development of comprehensive health systems and related health manpower in developing

countries, nutrition or health aspects of population dynamics in relation to the future of human society. Thus national, regional and global health systems are closely interwoven, and the modern world must be viewed in terms of these relationships.

23. It is in this perspective that in the course of the implementation of the Sixth General Programme of Work, in 1977, the World Health Assembly decided that the main health target of governments and of WHO should be the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life, popularly known as "Health for all by the year 2000". In 1978, the International Conference on Primary Health Care, held in Alma-Ata, stated that primary health care is the key to attaining this target.

24. In 1979, the Health Assembly launched the Global Strategy for Health For All¹ when it endorsed the Alma-Ata Report and Declaration² and invited Member States to act individually in formulating national strategies and collectively in formulating regional and global strategies. In the same year, the Executive Board issued guiding principles for formulating strategies for health for all by the year 2000.³ Since then a large number of countries in all of WHO's regions have developed such strategies. A global strategy was prepared on the basis of these, and was approved in the Thirty-fourth World Health Assembly, in May 1981.⁴ The Strategy describes the broad lines of action to be undertaken at policy and operational levels, nationally and internationally, in the health and in other social and economic sectors, to attain health for all by the year 2000. In adopting this Strategy, the Health Assembly considered that its implementation would require the combined efforts of governments, people and WHO, and invited Member States to enlist the involvement of people in all walks of life, including individuals, families, communities, all categories of health workers, nongovernmental organizations and other associations of people concerned.⁵

¹ This will be referred to throughout as "the Strategy".

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

³ *Formulating strategies for health for all by the year 2000*, Geneva, World Health Organization, 1979 ("Health for All" Series, No. 2).

⁴ *Global Strategy for Health for All by the Year 2000*, Geneva, World Health Organization, 1981 ("Health for All" Series, No. 3).

⁵ Resolution WHA34.36 (1981).

World health and related socioeconomic situations and trends

25. Health problems and socioeconomic problems are intimately interlinked. In many countries the health and related socioeconomic situation is unsatisfactory, and future trends are not encouraging. In addition, tremendous disparities exist among countries, and these are growing; disparities also exist within countries.

26. Nearly one thousand million people are trapped in the vicious circle of poverty, malnutrition, disease and despair that saps their energy, reduces their work capacity and limits their ability to plan for the future. For the most part they live in the rural areas and urban slums of the developing countries. The depth of their deprivation can be expressed by a few statistics. Whereas the average life expectancy at birth is about 72 years in the developed countries, it is about 57 in the developing countries; in Africa it is only about 50 and in southern Asia about 54. Whereas only between 10 and 20 out of every 1000 infants born in the developed countries die during their first year, the infant mortality rate in most developing countries ranges from nearly 100 to more than 200. Whereas the death rate for children between one and five is only about one per 1000 in most developed countries, it averages about 20 in many developing countries and more than 30 in Africa south of the Sahara. Maternal mortality rates in many areas of developing countries, though not well documented, are known to be from 100 to 200 times greater than in developed countries.

27. Most deaths in most developing countries result from infectious and parasitic diseases. These are closely related to prevailing social and economic conditions, and impede social and economic development. About a tenth of the life of an average person in a developing country is seriously disrupted by disease. The parasitic diseases in particular are chronic and debilitating, and they are endemic in most poverty-stricken areas. The common infectious diseases of childhood are still rampant in the developing countries whereas they have been reduced to minor nuisances in the developed countries. Although they can be prevented by immunization, in 1981 it was estimated that fewer than 20% of the 80 million children born each year in the developing countries were being immunized against them.

28. Diarrhoeal diseases are most widespread in the developing countries; they are transmitted by human faecal contamination of soil, food and water. Only about a third of the people in the world's least developed countries have dependable access to a safe water supply and adequate sanitary facilities. Diseases transmitted by insects and other vectors are also widespread in developing countries and have a serious adverse socioeconomic influence. Malaria remains the most prevalent disease, in spite of the fact that

in theory it can be prevented by the routine administration of inexpensive drugs or by insecticide spraying to kill the mosquito and its larvae and to reduce the degree of contact between human beings and vectors as well as the lifespan of potential vector mosquitos. Some 350 million people live in areas that still lack active control measures. Schistosomiasis, caused by a snail-borne parasite, is endemic in some 70 countries, where an estimated 200 million people are infected. Onchocerciasis, or "river blindness", causes blindness in more than 20% of the adult population in some hyperendemic regions in Africa. Development projects have increased the incidence of these diseases—schistosomiasis due to drainage and irrigation canals providing a habitat for the snails, and onchocerciasis due to the spillways of dams providing a habitat for the blackfly larvae.

29. In the developed countries, on the other hand, about half of all deaths are due to cardiovascular diseases, a fifth to cancer and a tenth to accidents. These problems are increasing in the developing countries too. Environmental health problems due to industrialization and urbanization are assuming growing importance; these same problems could affect developing countries as they build up their industries. Economic growth alone has not necessarily brought in its wake social improvements including better health; it can also have adverse effects on health, if unaccompanied by appropriate measures for containing these effects and for social development. Chronic disease increases as the population grows older. In recent years there has been a steady increase in mental disorders and in social pathology such as alcohol and drug abuse. These problems reflect the importance of life-styles and behavioural patterns in determining community health situations.

30. In the developing countries undernutrition afflicts hundreds of millions of people, reducing their energy and motivation, undermining their performance in school and at work, and reducing their resistance to disease. In these countries as many as a fourth of the people have a food intake below the critical minimum level. Whereas the average per capita daily calorie supply in the developed countries is about 3400 calories, a figure far in excess of standard requirements, it is about 2600 for most developing countries and only 2200 for the least developed. In addition, there are great inequalities within countries; this is catastrophic for the underprivileged in many developing countries, who are actually subsisting on intakes that are well below those average figures and clearly insufficient to satisfy their requirements.

31. Literacy is of major importance for health; it enables people to understand their health problems and ways of solving them, and facilitates

their active involvement in community health activities. Whereas the adult literacy rate is almost 100% in industrialized countries, it is only 28% in the least developed countries, and only 13% among women in these countries.

32. In general, with some notable exceptions, countries with a high gross national product (GNP) have a low infant mortality rate and a high life expectancy, the opposite being the case for countries with a low GNP. Whereas the GNP per capita ranges from only US\$ 200 to US\$ 1000 in most developing countries, it ranges from US\$ 5000 to US\$ 10 000 in most developed countries. Many of the latter, in grappling with the economic problems of inflation, balance of payments, and unemployment, are faced with a decline in the growth of their GNP and are thus reducing public expenditure. These problems spill over to the developing countries, with the result that their GNPs, already low by world standards, decline still further. The per capita income of people living in the least developed countries is likely to grow by no more than 1% a year—an average of only US \$ 2 or 3 per individual. There will even be a reduction in per capita income for the more than 140 million people in the low income countries of Africa south of the Sahara.

33. To add to these difficulties, health systems are poorly organized in most countries of the world. Tremendous inequalities exist between the developed and developing countries. In the latter, approximately two-thirds of the population have no reasonable access to any permanent form of health care. In most countries, developing and developed alike, an overwhelmingly large proportion of resources for the delivery of health care is concentrated in the large cities. In addition, these resources are devoted to expensive, highly sophisticated technology serving a small minority of the population to the detriment of primary health care for the majority. Even in the most highly developed countries, the exploding costs of health care are making it impossible to provide the complete range of health technology to the whole population. Deficient planning and management, including inadequate cooperation with other social and economic sectors, is another affliction of health care delivery systems in many countries. All too often, multiple delivery systems act in parallel to serve the same population group in an uncoordinated manner. This, as well as inadequate training in health management and the insufficient use of good managerial practices, all leads to inefficiency in the use of resources in these countries.

34. Despite a discernible increase in the number of health personnel and initial success in some programmes for training health personnel in

the light of new health manpower policies, health personnel in many countries are not appropriately trained for the tasks they are expected to perform, nor are they provided with the equipment and supplies they require. Health manpower varies greatly from country to country and includes a wide variety of different categories of people fulfilling different functions in different societies, depending on their social and economic conditions and cultural patterns. For this reason, intercountry comparisons are very difficult to make. Nevertheless, to illustrate the disparities among countries, in the least developed countries one health worker of all categories, including traditional practitioners, has to serve on the average 2400 people; in the other developing countries, 500 people; and in the developed countries, 130 people. As for medical personnel, in the least developed countries there is one doctor for an average of 17 000 people; in the other developing countries one for 2700 people; and in the developed countries one for 520 people. To highlight the extremes—in the rural areas of some least developed countries there is only one doctor to serve more than 200 000 whereas in the metropolitan areas of some developed countries there is one doctor for only 300 people, and in many countries there are ten times as many people for every doctor in rural areas as there are in metropolitan areas.

35. The proportion of the GNP spent on health ranges from far less than 1% in many developing countries to more than 10% in many developed countries. This implies an average of a few dollars per person per year in the developing countries as compared with several hundred dollars in most developed countries. Even if the low income countries were to increase the amounts they spend on health at the rate of 10% per annum, in the year 2000 they would still be spending only about 5% of the amount now being spent in most developed countries.

36. Trends in the growth of population and its geographical distribution make the situation even more serious. More sick people means a greater burden on the world's economy. More healthy people would mean more human energy and therefore greater potential for human development. The total population of the world increased in the 1970s at an annual rate of approximately 1.9%. If this rate of increase continues, the total world population will exceed 6000 million by the year 2000. In 1980 the developing countries accounted for almost 75% of the world population; by the year 2000, this figure is likely to increase to about 80%.

37. Changes in age structure are also foreseen. In the developed countries, 23% of the population are below the age of 15, whereas 11% are aged 65

and over; projections for the year 2000 in these countries show a reduction to less than 22% in the population below 15 and an increase to 13% in the population of 65 and over. As for developing countries, an average of 40% of the population is below the age of 15 and 4% are aged 65 and over. These percentages, however, do not highlight the increase in population in different age groups. For example, between 1980 and the year 2000 the world's elderly are expected to increase from 258 million to 396 million. More than 70% of this increase will be found in developing countries. In 1980 more than half of the world's elderly lived in developed countries; by the year 2000 almost three-fifths will be in developing countries. If the present trend towards urbanization continues, half of the world's population will be urban by the year 2000. This trend will result in a concentration of population in relatively few large metropolitan areas, and it is estimated that, by the year 2000, 12 of the 15 largest metropolitan areas will be in the developing countries.

38. The extent of health problems whose causative factors adversely affect the populations of a number of countries in the same geographical area continues to grow. Many of these problems have their roots in environmental factors such as the pollution of the air and international waterways.

39. Together, the sheer increase in numbers of people, the age and geographical distribution foreseen in different groups of countries, and the migration from rural to urban areas, all have important socioeconomic and health implications. They will influence and place additional burdens on physical and social infrastructures, increasing the dangers of unemployment and underemployment. They will affect the production and distribution of food, and have qualitative and quantitative implications for water, education, housing, sanitation and health care. Moreover, a change in the age structure of the population can also change the disease pattern.

40. Global indicators have been selected by the World Health Assembly to monitor progress towards health for all by the year 2000.¹ Information is not yet readily available on some of them. These are the number of countries in which health for all has received endorsement as policy at the highest official level; in which mechanisms exist for involving people in the implementation of strategies; in which a reasonable percentage of the national health expenditure is devoted to local health care; where resources

¹ For the complete list, see *Global Strategy for Health for All by the Year 2000*, section VII, paragraph 6, Geneva, World Health Organization, 1981 ("Health for All" Series, No. 3).

are equitably distributed for various population groups or geographical areas; as well as the number of developing countries with well-defined strategies for health for all, accompanied by explicit resource allocations, whose needs for external resources are receiving sustained support from more affluent countries. The following are the most recent figures for the other indicators based on the best available information:

- as far as the *percentage of the GNP spent on health* is concerned, information is available mainly with respect to public expenditure. With this proviso, public expenditure amounts to 5% of the GNP in only 12 countries; all of these are developed countries; the percentage for all developed countries ranges from 0.9% to 6.8%. In developing countries the percentage ranges from 0.3% to 4.3%, but the majority spend less than 1.5%, including 33 countries that spend less than 1%.
- the indicators selected to measure the *availability of primary health care* to the whole population relate to: safe water and adequate sanitary facilities; immunization; local health care; and trained personnel for maternal and child care.

Most developed countries have coverage with *safe water supply* at a level close to 100%, with piped water supply covering at least 75% of the population. In contrast, in developing countries the coverage varies widely from 3% to nearly 100% but is mostly below 75%. In particular in the least developed countries, the coverage does not usually attain even the level of 40%. While the coverage of *adequate sanitation* is at least 60% in a majority of developed countries, it is less than 30% in a majority of developing countries. The coverage is particularly low in the least developed countries, in which usually not more than 15% of the population have access to adequate sanitary facilities.

In 1981, in most developing countries *immunization* coverage against the six diseases included in the Expanded Programme on Immunization was below 20%, in contrast to coverage of 80% or better in most of the developed countries. As for the *attendance by trained personnel* at pregnancy and childbirth, there is wide variation ranging from 3% to 100% among developing countries, but in a majority of them the coverage is below 50%. On the contrary in developed countries such coverage exceeds 90%.

- for measuring the *nutritional status* of children, information is available only in regard to birth weight. In 40 countries, a majority of which are developed, more than 90% of newborn infants have a birth weight of at least 2500 g. In 51 countries the proportion is inferior

to 90% and 49 of them are developing countries. The information is not yet available for 66 countries.

- *infant mortality rates and life expectancy at birth* are as follows: in most developing countries the infant mortality rate ranges from around 30 to more than 200 per 1000 live births, but in about half of them it exceeds the level of 100 per 1000. The rates for a majority of the developed countries are under 20 per 1000. Life expectancy is at least 60 years in 75 countries, which include all of the developed countries and about one-third of the developing countries. The figure falls below 50 years in 38 developing countries.
- the following is the information available on *the adult literacy rate*: for developing countries, among males the rate is at least 70% in 50 countries, and lower than 70% in 48 countries. The rate is generally much lower among females; only 36 countries have a female rate of at least 70%, and in about 30 countries the rate does not even reach a level of 30%. In all developed countries the literacy rate exceeds 70% for both males and females.
- the figures for the *gross national product per head*¹ indicate that in all of the least developed countries it is below US\$ 500, with a range from US\$ 90 to US\$ 480. In a majority of the developing countries the rate is below US\$ 1000; in 19 of these countries it does not exceed US\$ 500 per head. However, if the oil-producing countries are included the upper level of the range for developing countries will reach US\$ 17 000, although the lowest level is only US\$ 160. In the developed countries the GNP ranges between US\$ 2000 and US\$ 14 000 per capita, with about a half of them exceeding the level of US\$ 5000.

41. But all is not negative in the world health and related socioeconomic situation and trends. It should not be forgotten that smallpox has been eradicated from the world. The very fact that countries have been willing to provide the world with objective information on their health and related socioeconomic situation should give cause for satisfaction. It is possibly a sign that more and more countries have reached a deeper understanding of their health and related developmental situations and, as illustrated for example by the Declaration of Alma-Ata, are determined to change them for the better. International cooperation in health matters has never been as strong as it is now; the collective decision of countries to

¹ Extracted from *World development report 1981—National and international adjustment. Annex—World development indicators*, Washington, D.C., The World Bank, August 1981.

adopt the goal of health for all by the year 2000 as a main social target of governments and WHO over the next two decades is witness to this. The subsequent development of national and regional strategies and the recent adoption by the Thirty-fourth World Health Assembly of a Global Strategy to reach this goal are certainly encouraging signs that the world health situation can and will improve during the period of the Seventh General Programme of Work.

The main thrusts of the Global Strategy for Health for All

42. Most global plans of action resulting from international conferences have been formulated at the global level in the course of these conferences. In contrast, the Global Strategy for Health for All starts with countries, and is built up through regions to global level where the cycle is completed by focusing on support to countries. It is not a separate "WHO strategy", but rather an expression of individual and collective national responsibility, fully supported by WHO. Moreover the Strategy comprises the health component of the International Development Strategy for the Third Development Decade and thus contributes to the New International Economic Order, in conformity with United Nations General Assembly resolution 34/58 concerning health as an integral part of development, and United Nations General Assembly resolution 36/43 on "Global Strategy for Health for All by the Year 2000".¹

43. The Strategy is based on the concept of countrywide health systems based on primary health care as described in the Alma-Ata Report (1978). It relies on concerted action in the health and related socioeconomic sectors following the principles of the Alma-Ata Report. It has been drafted in accordance with the Executive Board's guiding principles on formulating strategies for health for all by the year 2000,² and is a synthesis of ideas derived from national and regional strategies. The Strategy is equally valid for all countries, developing and developed alike; at the same time, it lays particular emphasis on the needs of developing countries. Its framework is broad enough to encompass the needs of all Member States and of all regions, and flexible enough to permit adaptation of national and regional strategies in such a way that they reflect national and regional variations on worldwide themes. The strength of WHO's Member States lies in this very capacity to work out global themes together and apply them in their own country after appropriate adaptation.

¹ This resolution was adopted unanimously by the United Nations General Assembly on 19 November 1981.

² "Health for All" Series, No. 2, 1979.

44. The main thrusts of the Strategy are the development of the health system infrastructure starting with primary health care for the delivery of countrywide programmes that reach the whole population. These programmes include measures for health promotion, disease prevention, diagnosis, therapy and rehabilitation. The Strategy involves specifying measures to be taken by individuals and families in their homes, by communities, by the health service at the primary and supporting levels, and by other sectors. It also involves selecting technology that is appropriate for the country concerned in that it is scientifically sound, adaptable to various local circumstances, acceptable to those for whom it is used and to those who use it, and maintainable with resources the country can afford. Crucial to the Strategy is making sure of social control of the health infrastructure and technology through a high degree of community involvement. Also spelled out is the international action to be taken to support the above national action through information exchange, promoting research and development, technical support, training, ensuring coordination within the health sector and between the health and other sectors, and fostering and supporting the essential elements of primary health care in countries.

45. An inseparable part of the Strategy is the action required to promote and support it. This includes strengthening the ministry of health, or analogous authority representing the whole health sector, as the focal point for the national strategy. It is necessary to ensure political commitment at the highest level nationally and internationally, as well as the support of economic development planners. Professional groups inside and outside the health sector will have to be enlisted. Appropriate managerial process for national health development will have to be developed and applied, and biomedical, behavioural and health systems research oriented to support the Strategy. Policy, technical and popular information to ensure acceptance of and involvement in the Strategy will have to be widely disseminated.

46. Also inseparable from the Strategy is the action required to generate and mobilize all possible resources. All human resources will have to be mobilized, not only health personnel. All types of health personnel as appropriate to the country will have to be trained, motivated and mobilized. The best use will have to be made of available human and financial resources and investments in health will have to be increased if necessary. The international transfer of resources from developed to developing countries will have to be rationalized and these transfers increased if necessary.

47. Intercountry cooperation is an essential feature of the Strategy because few countries will be able to formulate and implement their strategies independently. Such cooperation involves technical and economic cooperation among countries, and the use of WHO's regional arrangements to facilitate such cooperation. WHO in general will be crucial for developing and implementing the Strategy through the exercise of its constitutional role in regard to international health work. Details of this role during the period of the Seventh General Programme of Work are presented in Chapter 4 below.

4. Roles, Functions, Processes and Structures of WHO

Roles and functions

48. The Organization's role and functions are firmly rooted in its Constitution, which states that WHO has a leadership role to play in international health. It can best maintain this role by consistent stimulation of policies, thought and action in the field of health, by pioneering solutions to difficult health problems and by daring to innovate even in the face of conventional wisdom.

49. Different emphasis has been given at different times to the Organization's role and functions in response to the world health situation.

50. While the directives included in past resolutions of the World Health Assembly will continue to be carried out, such as resolution WHA23.59 (1970) which lists certain important functions of the Organization, the role of WHO during the period 1984–1989 will be largely determined by the Organization's responsibilities concerning the implementation, monitoring and evaluation of the regional and global strategies for health for all. Thus it will be shaped by the recommendations of the World Health Assembly in resolution WHA33.17 concerning the study of WHO's structures in the light of its functions, by resolution WHA34.24 concerning WHO's role in international health work through coordination and technical cooperation and by the United Nations General Assembly resolution 34/58 (1979) concerning health as an integral part of development.

51. WHO will be crucial for developing and implementing the Strategy for Health for All by the Year 2000 through the exercise of its constitutional role in regard to international health work; this comprises in essence the inseparable and mutually supportive functions of coordination and technical cooperation. Particular attention will be paid to the formulation of the Organization's future general programmes of work in response to the Strategy, and to the restructuring of the Organization in the light of its functions in support of the Strategy. WHO will intensify its global programmes for the essential elements of primary health care. It will ensure action at national, regional and global levels. To this end, WHO Secretariat will give top priority to the Strategy. The Director-General will exercise his full

constitutional responsibilities with respect to the implementation of the Strategy. At the same time, ultimate responsibility will lie with Member States.

52. Promotion and coordination will be ensured through the fulfilment by the Health Assembly, regional committees and Executive Board of their constitutional functions, and through the enlistment of other sectors as a follow-up of United Nations General Assembly resolutions 34/58 on health as an integral part of development and 36/43 on the Global Strategy for Health for All by the Year 2000. WHO will use the Strategy to support the International Development Strategy for the Third Development Decade, thus contributing to the New International Economic Order. The Organization will take action to gain the support of banks, funds, and multilateral and bilateral agencies. It will also promote the Strategy through nongovernmental organizations and the use of the mass media. As part of the Strategy it will contribute to the promotion of peace in conformity with resolution WHA34.38. In this resolution the Health Assembly recognized that the preservation and promotion of peace was the most significant factor for the protection of people's life and health, and made a strong appeal to Member States to multiply their efforts to consolidate peace in the world, reinforce détente and achieve disarmament so as to create conditions for the release of resources for the development of public health. It requested the Director-General to expedite and intensify the study of the contribution that WHO could and should make to economic and social development and to facilitate the implementation of the United Nations resolutions on strengthening peace, détente and disarmament and preventing thermo-nuclear conflict.

53. WHO will facilitate technical cooperation among its Member States, both developing (TCDC) and developed, and between developing and developed countries. The Organization will act as an international clearing house for valid technical information. It will promote and support research and development, will act as the focal point to support the establishment and application of managerial processes for national health development and will foster manpower development. It will use its influence to strengthen international coordination within the health sector and will promote inter-sectoral action for health at the international level particularly through the establishment of bilateral and multilateral arrangements with other United Nations agencies and with nongovernmental organizations.

54. One of the most important functions of the Organization during the period of the Seventh General Programme of Work will be its role in

the collective generation of knowledge and in turn in the collective and individual use by Member States of the knowledge generated in WHO. The Organization's role with respect to information transfer also illustrates the inseparability of its coordinating and technical cooperation functions. The coordinating function includes capitalizing on WHO's impartiality to ensure the availability of valid information that will permit Member States to make rational decisions on health technology and on health systems. To ensure that information is valid demands a willingness on the part of Member States to cooperate with one another in its generation and selection, and a readiness to use it however much it may contradict existing beliefs and dogmas.

55. To generate and mobilize the necessary resources WHO will ensure the international mobilization of people and groups who can support the Strategy, and will foster the coordinated international transfer of resources in support of the strategies of developing countries. However, the resources to be used will be first and foremost those of the country concerned, and the choice of solution to the problem concerned will therefore have to be largely determined by existing and potential national resources. WHO's resources are meant to develop national resources, not to supplant them. WHO will therefore be increasingly involved in focusing international attention and resources on priority health problems and in assisting Member States to obtain and use external collaboration that will help them solve these problems.

56. As a consequence of the modification of certain of the functions of, and the roles played by, the Organization, its structures are being progressively modified in response to resolution WHA33.17, emphasizing the role played by its Member States in the democratic control of the Organization. Mechanisms are being established or strengthened for ensuring a continuing dialogue and cooperation between Member States and their Organization, with a particular view to ensuring that national and international health programmes are well coordinated.

Structures

57. The World Health Assembly's constitutional authority, as the supreme organ for determining WHO's policies, will be maintained to the full. Its monitoring and control functions will be increased with respect to the work of the Organization, including the follow-up and review of the implementation of its own resolutions. This will entail further improvement of its methods of work and in particular careful consideration of the practicability of resolutions and other policies before their adoption. Greater initiative of the regional committees in proposing resolutions to the World Health Assembly will be encouraged.

58. The role of the Executive Board will be strengthened in giving effect to the decisions and policies of the Health Assembly and in advising it, particularly with respect to attaining the goal of health for all by the year 2000. Among other things the Board will ensure that the Organization's general programmes of work, medium-term programmes and programme budgets are optimally oriented towards supporting the strategies for health for all of Member States.

59. The regional committees will take a more active part in the work of the Organization and will submit their recommendations and concrete proposals on matters of regional and global interest to the Executive Board. They will intensify their efforts to develop regional health policies and programmes in support of national, regional and global strategies for health for all. They will promote greater interaction between the activities of WHO and those of all other bodies concerned in the region, including bodies of the United Nations system and nongovernmental organizations, in order to stimulate common efforts for attaining health for all by the year 2000.

60. Closer correlation of the work of the World Health Assembly, the Executive Board and the regional committees will reinforce the structural interdependence of all echelons of the Organization.

61. To ensure the provision of timely, adequate and consistent Secretariat support to the Organization's Member States, individually and collectively, the functions of WHO staff in countries and in particular the WHO programme coordinators (WPCs), as well as the functions of the regional offices and of headquarters are in the course of being redefined and the organizational structures and staffing are being adapted accordingly.

Managerial process

62. The Seventh General Programme of Work will lead to the building up of global programmes as national and regional variations on universal themes as was the case with the Sixth. This will mean elaborating inter-country and regional programmes that reflect countries' priority needs, interregional programmes that reflect the collective priority needs of a number of regions, and global promotion and coordination of these regional and interregional programmes. The "top to bottom" and "bottom to top" approaches will be combined. Thus, global policies and principles will promote regional and national programme development. These will give rise to programme activities at national and regional levels, and will in turn influence the global policies and principles.

63. In recent years WHO has greatly modified the processes it applies for the development and management of its programme. It has now established

a unified managerial process. Thus, general programmes of work are formulated on the basis of the Organization's policies and strategies for implementing these policies. These programmes of work are then converted into medium-term programmes, and these in turn form the basis of biennial programme budgets. A process of monitoring and evaluation tracks the course of implementation of programmes and assesses their efficiency and effectiveness with a view to improving them as necessary. Ensuring the availability of relevant information for and from all these components is an integral part of the managerial process.

64. The process of medium-term programming, closely linked with biennial programme budgeting, was applied to the implementation of the Sixth General Programme of Work, and has facilitated the development of coordinated programme activities throughout the Organization. The process of programme budgeting has been progressively refined, and applied accordingly particularly at the regional and global levels. The application of the process of the programme budgeting of WHO's resources in countries is still in its early stage. Instead of, as in the past, the execution by WHO of unrelated projects, the process now aims at the joint development of countrywide programmes and health systems for their delivery that can be maintained by the country after WHO's direct cooperation in them has ceased. The process of evaluation is being tried out, thus facilitating the assessment of progress in carrying out the Sixth General Programme of Work and the learning of lessons for the Seventh. The nature of information support for the managerial process has been clearly defined at all levels of the Organization, and a management information system is operational to ensure the availability of relevant information for the planning, monitoring and evaluation of WHO's activities.

65. Further details on the use of the managerial process for the implementation and evaluation of the Seventh General Programme of Work are provided in Chapters 8 and 9.

5. General Programme Framework

Programme principles

66. Taking into account the world health situation in relation to the world socioeconomic situation as described above, the Seventh General Programme of Work covering a specific period will consist of the support WHO can provide to the strategies for health for all during the period 1984-1989 inclusive. WHO's programmes will be oriented towards defined goals and tasks during this period and will include those major fields of activity which have been identified as fundamental in these strategies. These programmes will be sufficiently flexible to integrate globally determined policies, regional characteristics and individual country needs, and to take into account any shift in priorities during the period considered. They will also take into consideration the need for collaboration in all other national and international efforts in the field of socioeconomic development and health. They will be a blend of country, intercountry, regional, inter-regional and worldwide activities, making use of the unique position and role of WHO in the development of world health, as well as its statutory, financial, and other possibilities.

67. Therefore the various programmes, activities, services and functions developed by the Organization within the Seventh General Programme of Work covering a specific period should comply with the following principles:

(1) they should correspond to the major functions of the Organization as defined by Article 2 of the Constitution and in particular by the Twenty-third World Health Assembly in its resolution WHA23.59 (1970) and by the Thirty-third World Health Assembly in its resolution WHA33.17;

(2) they should be guided by the principles of the Alma-Ata Declaration and by the Report of the International Conference on Primary Health Care held in Alma-Ata in 1978;

(3) they should meet defined criteria:

— in regard to quality of planning and management as expressed in previous decisions of the Executive Board and the World Health Assembly, and as reflected in the growing experience of the Organization; and

- specifically in regard to the rationale for selecting programme areas for WHO's involvement, programme approaches for attaining the objectives of these programme areas, the organizational level or levels for implementation of programme activities, and the type of resource to be deployed;

(4) they should, to the extent possible and wherever applicable, have quantified characteristics and country-oriented targets against which their progress could be assessed by the regional committees, the Executive Board and the Health Assembly. They should concentrate on those problems or fields of activity which have been identified as priorities for the implementation of national, regional and global strategies for health for all by the year 2000.

68. The third of the programme principles enumerated in paragraph 67 above states that the general programme of work should meet defined criteria and specify the types of criteria to be used. The selected criteria that follow are intended for use by countries, regional committees, the Executive Board, the World Health Assembly and the Secretariat. They represent the main types of criteria necessary for arriving rationally at decisions, although it is not intended that all of them should be applicable simultaneously. The basic criterion of giving priority to problems of developing countries is emphasized, greatest support being given to least developed countries and to the needs of the economically and socially underprivileged wherever they may be. Those criteria that have a direct bearing on WHO's activities in countries will have to be applied in a flexible manner until such time as the expressed needs of governments become synonymous with their needs as perceived in the light of the policies they have adopted in WHO.

Programme criteria

— Criteria for selection of programme areas for WHO involvement

69. The following criteria will be used to select programme areas for WHO involvement:

- (a) the problem with which the programme area is concerned is clearly identified;
- (b) the underlying problem is of major importance in terms of public health, in view of its incidence, prevalence, distribution and severity; or in terms of its related adverse sociocultural and economic implications;
- (c) the programme is of high social relevance and responds to identified components of national, regional and global strategies for health for all;

- (d) there is a demonstrable potential for making progress towards the solution of the problem;
- (e) there is a strong rationale for WHO's involvement because the programme area is specifically mentioned in the Constitution, or resolutions of the World Health Assembly, Executive Board and regional committees; WHO's involvement has been clearly indicated in national, regional and global strategies for health for all; WHO is in a unique position to deal with the underlying problems in view of its constitutional role in international health work; WHO's involvement could have a significant impact on the promotion of health and improvement of the quality of life; WHO's involvement will promote self-sustaining programme growth at national level; the problem requires international collaboration for its solution; the programme has potential for generating intersectoral action for health development; or WHO's status as a specialized agency of the United Nations system requires collaboration with other agencies of the system for the solution of the problem;
- (f) WHO's non-involvement would have serious adverse health repercussions.

— *Criteria for determining organizational level or levels for implementation of programme activities*

70. The following criteria will be used to determine at which organizational level or levels programme activities should take place.

- (a) Country activities should aim at solving problems of major public health importance in the country concerned, particularly those of underprivileged and high-risk populations, and should result from a rational identification by countries of their priority needs through an appropriate managerial process. They should give rise to the establishment and sustained implementation of countrywide health programmes.
- (b) Intercountry and regional activities are indicated if: similar needs have been identified by a number of countries in the same region following a rational process of programming or a common awareness of joint problems; the pursuit of the activity as a cooperative effort of a number of countries in the same region is likely to contribute significantly to attaining the programme objective; cooperating countries, whether developing countries cooperating among

themselves (TCDC/ECDC),¹ developed countries doing so, or developed countries cooperating with developing countries, have requested WHO to facilitate or support such cooperation; for reasons of economy the intercountry framework is useful for pooling selected national resources, e.g., for the provision of highly skilled technical services to countries; the activity encompasses regional planning, management and evaluation or is required for regional coordination; or the activity is an essential regional component of an interregional or global activity.

- (c) Interregional and global activities are indicated if: similar requirements have been identified by a number of countries in different regions following a rational process of programming; the activity consists of facilitating or supporting technical cooperation among countries in different regions, and its pursuit is likely to contribute significantly to attaining the programme objectives; for reasons of economy the interregional framework is useful for pooling selected resources, e.g., for the provision of highly specialized and scarce advisory services to regions; the activity encompasses global planning, management and evaluation; the activity is required for global health coordination and for central coordination with other international agencies.

— *Resource criteria for programme activities*

71. The following are the most important resource criteria:

- (a) the programme activity can be satisfactorily developed and maintained by Member States at a cost they can afford and with human resources that are either currently available or could become available if appropriate training were provided;
- (b) the programme activity is likely to attract external resources from bilateral, multilateral or nongovernmental sources to well-defined national strategies for health for all, particularly in developing countries, but also as necessary to WHO in support of such strategies.

72. An approach is understood in this general programme of work as a means, expressed in broad terms, for attaining an objective. There are various means for attaining the same objective, and ideally each of them

Approaches

¹ Technical and economic cooperation among developing countries.

should be considered separately and in conjunction with others in order to arrive at what appears to be the best combination at the lowest cost. Some approaches for attaining health objectives lie outside the health sector, for example, housing or development schemes which sweep away the ecological factors creating disease situations.

73. Within the health sector very many approaches are available. WHO, in view of its international nature and limited resources, is unable to apply all of them, but it is attempting to broaden its conceptual armamentarium and extend its technical and managerial skills for the purpose. It is in a unique position to promote international political action for health, encourage action by other social and economic sectors, and coordinate the channelling and use of external resources for health.

74. Two *general approaches* will be especially emphasized in the Seventh General Programme of Work, namely: *coordination* and *technical cooperation*. These two approaches, which constitute the inseparable essence of WHO's role in international health work conferred on it by its Constitution, can on no account be considered as being separate. On the contrary, their mutual support will form part of every programme, as recognized by resolution WHA34.24 (1981) on the meaning of WHO's international health work through coordination and technical cooperation. The mutually supportive application of these approaches can be summed up as fulfilling the coordinating role of collective generator and guardian of international health policy and the technical cooperation role of working together with countries to apply that policy.

75. The meaning of WHO's international health work can best be reflected by a consideration of WHO's unique constitutional mission; the Organization was created as the intimate international health partner of every Member State, indeed as an international extension of each country's health sector and the collective expression of the health aspirations and actions of all Members. WHO acts both as a neutral platform which enables Member States to take collective decisions on health policies, doctrines and programmes, and as a vehicle which enables them to cooperate with their Organization and among themselves in putting into practice what they have decided collectively. It is this combination of worldwide coordination in health matters and cooperation in applying the fruits of these coordinated efforts that gives rise to the uniqueness of WHO's role in international health.

76. The distinctive features of coordination and technical cooperation, and the ways in which they support each other, are illustrated in further detail in the paragraphs that follow.

— *Coordination*

77. The first of the Organization's twenty-two constitutional functions is "to act as the directing and coordinating authority on international health work". Whereas WHO's technical cooperation is primarily a process of two-way action between WHO and its Member States, WHO's coordinating function in international health is carried out primarily through the collective action of its Member States. This collective action takes place in the Health Assembly, the Board, and the regional committees, with the support of the Secretariat, as prescribed in the Constitution. These structures are supported by a wide range of mechanisms for providing scientific, technical and managerial expertise, whose generation or synthesis WHO coordinates on a worldwide scale. The application by individual Member States of policies and principles adopted collectively by them in WHO illustrates well the voluntary acceptance of the Organization's leadership role in international health work. This role is a proper manifestation of direction and coordination, a function of WHO made possible by the fact that it is fulfilled through the collective action of Member States.

78. Coordination implies, essentially, WHO leadership aimed at bringing to bear the right solution on the right problem with the right amount and quality of resources at the right time and place.¹ It thus lies within the Organization's coordinating function to identify health problems throughout the world that deserve high priority and for whose solution international action is required. The right solutions include the formulation of socially relevant international health policies in response to these problems, the definition of principles, capable of local adaptation, for interpreting policies and the development of international strategies, plans of action and programmes for giving effect to these policies. They also include the reaching of agreement on priorities for implementation. In support of the above, the Organization's coordinating function encompasses the promotion of health research and development, and the definition of the scientific and technical bases for health programmes, including norms and standards. It does so through identifying the world's most important health research goals and promoting the collaborative efforts of the world's most suitable health research workers to fulfil these goals. The right place for WHO's activities is principally within countries, activities at other levels supporting country endeavours. As for the right time, this implies a forward-looking approach.

¹ WHO Official Records, No. 233, 1976, Annex 7, p. 73.

79. As part of its coordinating function, the Organization tries to match needs in some countries with resources in others and to mobilize, rationalize and secure the international transfer of resources accordingly. The coordinating function also includes the strengthening of relationships with international nongovernmental organizations working in the health sector. In addition, it includes joint action with other sectors at the international level, both inside and outside the United Nations system, in common endeavours for health and socioeconomic development.

80. An important aspect of WHO's coordinating function is the generation and international transfer of valid information on health matters, the Organization serving as a neutral ground for absorbing, distilling, synthesizing and disseminating information that has practical value for countries in solving their health problems. In this way, WHO can provide the world with an objective assessment of what is really valuable for health development, and it can identify those health problems for which there is as yet no suitable answer. The Organization also has an important role in ensuring the proper use of this information. This last aspect forms part of WHO's technical cooperation functions, and the complementarity of these two aspects of information transfer also illustrates well the mutually enhancing nature of the Organization's two major functions of coordination and technical cooperation.

— *Technical cooperation*

81. Technical cooperation implies joint action of Member States cooperating among themselves and with WHO to achieve their common goal of the attainment by all people of the highest possible level of health, and in particular the goal of health for all by the year 2000. Member States can best attain these goals by implementing the policies and strategies they have defined collectively in WHO. Technical cooperation is characterized by equal partnership among cooperating parties, developing and developed countries alike, WHO and, where applicable, other intergovernmental bilateral, multilateral and nongovernmental organizations participating in technical cooperation; respect for the sovereign right of every country to develop its national health system and services in a way that it finds most rational and appropriate to its needs; mobilizing and using all internal as well as bilateral and other resources to this end; and for this purpose making use of scientific, technical, human, material, information and other support provided by WHO and other partners in health development. Cooperating parties are mutually responsible for carrying out jointly agreed decisions and obligations, exchanging experience and evaluating results obtained, both

positive and negative, and making the information thus generated available for the use and benefit of all.

82. There are four interlinked types of technical cooperation, which together form an organic whole. Their characteristics are outlined below.

83. Technical cooperation between WHO and its Member States is an approach whereby Member States cooperate with their Organization by making use of it to define and achieve their social and health policy objectives, through programmes that have been determined by their needs and that are aimed at promoting their self-reliance for health development. WHO's role in technical cooperation between itself and its Member States is thus to support national health development that has been defined in countries by countries in line with policies adopted collectively in WHO.

84. Technical cooperation among developing countries (TCDC) means cooperation between two or more developing countries.¹ This cooperation is for the purpose of social and economic development and is part of the drive of these countries towards individual and collective self-reliance. It conforms to the principles formulated by the United Nations Conference on Technical Cooperation among Developing Countries, held in Buenos Aires from 30 August to 12 September 1978, which considered TCDC as a vital force for initiating, designing, organizing and promoting cooperation among developing countries so that they can create, acquire, adapt, transfer and pool knowledge and experience for their mutual benefit and for achieving national and collective self-reliance, which are essential for their social and economic development. TCDC in the field of health encompasses the examination by each country of its own needs, the review of existing resources and capabilities and, through discussion and mutual agreement with other interested countries, the selection of ways and means for the exchange and transfer of specific resources which lend themselves to cooperative activities and joint ventures. This might include, for example, the production, procurement and distribution of essential drugs and medical equipment, the development of low-cost technology for water supply and wastes disposal, joint training programmes for manpower development, and collaborative research. Whereas the financing of TCDC activities should be mainly the responsibility of the countries themselves, WHO may cover certain costs required to facilitate such activities. TCDC for health may take place

¹ Since technical cooperation and in particular TCDC are essential approaches to be applied throughout all programmes they are not mentioned specifically in each programme described in Chapter 7, to avoid repetition.

without WHO involvement. At the same time, WHO has a duty to support countries in their cooperative endeavours for health, and will do so whenever the opportunity arises and the countries concerned are interested in WHO's involvement. Indeed, such support to the cooperative endeavours of countries should be the basis of WHO's intercountry activities.

85. Mention should also be made of technical cooperation among developed countries, in which WHO will continue to be an active catalyst of cooperation with respect to a wide range of health problems of particular interest to them. Such cooperation often takes the form of intercountry activities carried out under the aegis of WHO at minimal cost to the Organization. WHO also maintains technical relationships with geopolitical groupings of developed countries, such as the Council for Mutual Economic Assistance (CMEA) and the European Economic Community (EEC).

86. Finally, a fourth type of technical cooperation for health is technical cooperation between developed and developing countries. Such cooperation has been a feature of international health for many decades, but in recent years it has been taking a new form of trilateral or multilateral cooperation for health development, which is in keeping with the principles of the New International Economic Order.

— *Specific approaches*

87. Well established approaches, such as the formulation of standards and norms and the development, adaptation, application and transfer of appropriate methods and techniques which are socially relevant to countries, will continue to be used by the Organization. To this end scientific research, whether biomedical or behavioural in nature, will be widely promoted and efforts made to foster collaboration among research workers in national institutions, and thus help to build up national capabilities and national infrastructures for health research. Technology used for medicine and health will be assessed and efforts made to arrive at health technology appropriate for countries with different socioeconomic and epidemiological characteristics.

88. WHO will pursue the promotion of international understanding of the concepts of the strategies for health for all by the year 2000 and of health systems based on primary health care, and will offer a permanent forum for the formulation of further international policies for health and social development. A related approach will be collaboration with other organizations and institutions for this purpose, especially within the

framework of the New International Development Strategy for the Third United Nations Development Decade with a view to establishing and maintaining the New International Economic Order. Wider and closer collaboration will take place with nongovernmental organizations.

89. The following are illustrations of approaches that might be used at country level.

90. It is again stressed that the fundamental approach is to induce governments to make WHO their active partner in matters of health by carrying out individually the policies they have agreed on collectively in WHO. This implies in particular using the Global Strategy for Health for All by the Year 2000, which reflects national and regional strategies, and which was agreed upon collectively in the World Health Assembly, in order to develop and implement national strategies for health for all.

91. To do so implies using WHO's resources to promote relevant countrywide programmes with in-built self-sustaining growth, health infrastructures based on primary health care, technology and behavioural alternatives that are appropriate to the conditions of the country concerned, the requisite intersectoral action, and adequate community involvement in shaping and controlling the health system. From this description, it is clear that the emphasis must be on the development and operation of national activities for health development, in which government execution is self-evident and active public support is crucial. However, the government may wish WHO to cooperate closely in the planning and implementation of some of these activities, and WHO may even agree to considerable participation in the implementation of some of them during their initial phase until such time as national personnel and other national resources can fully take over, provided this takes place as an integral part of, and does not undermine, government execution.

92. In addition to government execution of national health programmes in whose planning or implementation WHO is cooperating, national personnel in health and related fields should be engaged to a greater extent in the work of WHO at regional and global levels, and exchange of national health staff and experts more widely carried out.

93. One of the prerequisites for promoting health is the formulation of national health policies, strategies and plans of action. Methodological support will need to be strengthened in relation to these. Of great importance in this connexion is the application of an appropriate managerial process for national health development and the related health systems research.

Legislation too is often required for the implementation of national health strategies.

94. Fostering of community involvement in the development and control of health strategies and of the delegation of responsibility and authority to communities to organize their own primary health care or selected elements of it is crucial for the success of these strategies. Public education and information on health is essential to stimulate people's interest in the promotion of their health and political interest in solving health problems. But such information is often inaccurate and sensational. WHO should be more active in helping ministries of health to provide accurate yet stimulating information on health to the mass media and through them or in any other way to lay groups and the public at large.

95. Of equal importance is the fostering of intersectoral action through cooperation between ministries of health or analogous authorities and other ministries concerned, for example by establishing multisectoral national health councils, interministerial committees, arrangements between ministries of health and other ministries and sectors concerned. Particular attention will therefore be given by WHO to collaborating with countries on the development of measures for promoting health to be taken in other sectors. These may be political, social, economic, cultural, or educational in nature. In all these endeavours, maximum use will be made of existing individuals and institutions in both the health and other sectors.

96. The provision of fellowships and support to training courses and institutions continue to be important approaches for training national health personnel. To be effective, fellowships and training courses should conform to coherent national plans for health manpower development, based on health services' needs. The role of external consultation has changed as technical assistance has given way to technical cooperation. Whenever external consultation is requested by a Member State, it should take the form of cooperative review with the national health administration or institution concerned, and should make use of valid information generated through WHO or agreed upon collectively in WHO.

97. National health authorities, institutions and individual scientists will be widely consulted in order to identify research requirements and will be selectively invited to collaborate in the pursuit of relevant research. In view of the importance of reducing the time lag between scientific and technological discoveries and their practical application, WHO will make special efforts to ensure that the knowledge of scientific and technological advances

that it is accumulating becomes widely known at national level for possible application.

98. The need for collaboration with other organizations and institutions at the country level as well as at regional and central levels is becoming increasingly recognized. Such local collaboration should facilitate the channelling of the attention and resources of these organizations into priority health programmes at national levels. The channelling of other resources towards national, regional and global priorities identified in the strategies for health for all by the year 2000 can be one of the most effective approaches of the Organization during the Seventh General Programme of Work, as it is recognized that most developing countries will find it difficult to finance completely with their own resources the programmes and plans of action emanating from their Strategies.

99. The general programme of work provides a framework for the Organization's total programme; this is made up of a number of specific programmes, each consisting of an organized aggregate of activities directed towards the attainment of specific objectives. It is possible to group such activities in smaller or larger aggregates and to call any of these aggregations a "programme". An "optimal size" has to be defined, so that the programme can be powerful enough to have an effect, yet of such a size as to be properly manageable. The definition of such "optimal sizes" is arbitrary. Moreover, similar programmes can be grouped under broader headings if deemed necessary. The totality of the programmes organized as described above is called a "classified list of programmes". The principal programmes of the Seventh General Programme of Work have been organized in such a classified list. The list will be used not only for the general programme of work but also for all the components of the WHO managerial process: medium-term programming, programme budgeting, financial control, evaluation and information support, as well as for certain other administrative purposes.

Classified list of programmes

100. While no universal blueprint of a health system can be imposed on countries, the classified list of programmes adopted for the Seventh General Programme of Work reflects a generalized model of support to national health systems, organized in such a way as to facilitate the development and operation of health systems based on primary health care in conformity with the Alma-Ata Report and the Global Strategy for Health for All by the Year 2000. In addition, the model includes programmes that are specific to the management of WHO. The classified list comprises four broad interlinked categories:

- Direction, coordination and management,
- Health system infrastructure,
- Health science and technology, and
- Programme support.

101. Close interaction will take place between these programmes as necessary, with a view to supporting the build-up by countries of comprehensive health systems based on primary health care.

102. These categories of programmes will have the following broad functions.

***Direction,
coordination and
management***

103. **Direction, coordination and management will concern itself with the formulation of the policy of WHO, and the promotion of this policy among Member States and in international political, social and economic forums, as well as the development, coordination and management of the Organization's general programme.**

***Health system
infrastructure***

104. **Health system infrastructure will aim at establishing comprehensive health systems based on primary health care and the related political, administrative and social reforms, including a high degree of community involvement. It will deal with:**

- **the establishment, progressive strengthening, organization and operational management of health system infrastructures, including the related manpower, through the systematic application of a well defined managerial process and related health systems research, and on the basis of the most valid available information;**
- **the delivery of well-defined countrywide health programmes;**
- **the absorption and application of appropriate technologies that form part of these programmes; and**
- **the social control of the health system and the technology used in it.**

105. Now that the principles for developing health systems based on primary health care have been made abundantly clear in the Alma-Ata Report and the Global Strategy for Health for All, overriding emphasis will be given in the Seventh General Programme of Work to providing support to the reinforcement of the infrastructures of such national health systems, for without such infrastructures national strategies for health for all will remain paper strategies. Those dealing with all other programmes will therefore always have to bear in mind the technical, social, economic and managerial feasibility of having them delivered by the health infrastructure.

They will have to do so in close consultation with those dealing with health infrastructure programmes, for the health infrastructure cannot remain a mere passive receptacle for health programmes and the technology applied in them; in the final analysis, it is the infrastructure that has to deliver these programmes and apply the technology. So it must be involved actively in the preparation of countrywide programmes and must take the lead in forging the different programmes into a unified system. WHO's programmes will give supreme attention to fostering and supporting this process.

106. Health science and technology, as an association of methods, techniques, equipment and supplies, together with the research required to develop them, constitutes the content of a health system. Health science and technology programmes will deal with:

Health science and technology

- the identification of technologies that are already appropriate for delivery by the health system infrastructure;
- the research required to adapt or develop technologies that are not yet appropriate for delivery;
- the transfer of appropriate technologies;
- the search for social and behavioural alternatives to technical measures; and
- the related aspects of social control of health science and technology.

107. They will thus involve a high degree and wide variety of scientific research, aimed at the validation, generation and application of knowledge, and will include the identification and definition of standards and norms. Since the identification, development, transfer and application of appropriate technology will be an integral part of every programme, there will be no separate programme of appropriate technology for health.

108. Programme support will deal with informational, organizational, financial, administrative and material support.

Programme support

109. The classified list of programmes, giving the order in which the programmes will be presented in the programme budget, is attached as an Annex.

6. Main Thrusts of the Programme and Determination of Priorities

Main thrusts of the Programme

110. The following are the main thrusts of the Seventh General Programme of Work, which will be the first of three providing WHO's support to the Global Strategy for Health for All by the Year 2000.

111. The principal objective of the Programme will be to promote, coordinate and support the efforts of Member States individually and collectively in implementing the Global Strategy for Health for All.

112. The Programme will aim at fostering national and international action so that by 1984 all Member States will have developed national strategies for health for all, by 1985 they will have developed plans of action for implementing the strategies, by 1986 these plans of action will be fully operational, and by 1989 they will be at an advanced stage of implementation.

113. WHO will promote and undertake action in the health sector, and will foster action in other sectors concerned, to support national, regional and global strategies for health for all. In carrying out its constitutional responsibilities, it will pay particular attention to fulfilling, in a mutually supportive way, its functions of directing and coordinating authority on international health work and of technical cooperation. Thus, policies, programmes and knowledge about health arrived at collectively in WHO will form the basis of technical cooperation between WHO and its Member States.

114. The Programme will aim at promoting and strengthening health systems that are based on primary health care for the delivery of health programmes that make use of appropriate technology and that have a high degree of community involvement. To this end, it will emphasize the systematic build-up of operational infrastructures of health systems and the delivery by them of a variety of health programmes in an integrated manner. This will be approached through close interaction between four broad categories of programmes—Direction, Coordination and Management; Health System Infrastructure; Health Science and Technology; and Programme

Support. At the same time, each of these categories of programmes will have its own characteristic features:

- *Direction, coordination and management* will formulate the policy of WHO, promote this policy among Member States and in international political, social, economic and professional forums, and develop, coordinate and manage the Organization's general programme. It will thus form a policy and managerial basis for all other programmes.
- *Health system infrastructure* will promote and support the development by all Member States of comprehensive health systems based on primary health care.
- *Health science and technology* will generate, collate, and disseminate valid information on health technology that is appropriate for use by health systems in a variety of political, social and economic situations, including social and behavioural alternatives to technical measures, and will cooperate with Member States in helping them to absorb such technology and adapt it to the specific needs of their people and of their health infrastructure development.
- *Programme support* will provide informational, organizational, financial administrative and material support to WHO's programmes as required.

115. To ensure proper direction, coordination and management, the process, already initiated and set forth in resolution WHA33.17 (1980), whereby the regional committees, the Executive Board and the Health Assembly function in a mutually supportive manner, will be fully applied.

116. To support the establishment by countries of health systems organized along the lines described in the Global Strategy for Health for All, the Organization will disseminate valid information on the development of comprehensive health systems based on primary health care in a variety of political, social, economic and epidemiological settings, and will cooperate with Member States to strengthen their health systems on the basis of that information.

117. Thus, the provision of information, and cooperation with Member States on the basis of this information, will aim at the progressive strengthening of countries' health infrastructures on the basis of primary health care, the managerial process needed to this end, the multisectoral action required to build up such health systems, and community involvement in planning, developing and operating them, leading to social control of the system and the technology it applies. People, including health manpower, will be considered as the backbone of the health system, and their

orientation towards their social responsibilities in this respect, their education and their training will be shaped accordingly.

118. To ensure the availability of health technologies that are appropriate to a variety of national circumstances, sound methodology will be developed for assessing their usefulness in various social, cultural and economic settings. Assessments will be made of existing technologies and of social, economic and behavioural alternatives for the essential components of primary health care and its immediate referral level, and priority areas selected for the generation of any new technology required.

119. To identify and develop appropriate health technology, the Organization will promote and cooperate with Member States in pursuing a wide variety of scientific analysis, assessment and synthesis aimed at the validation, generation and application of knowledge; this will include the identification and definition of standards and norms. Technologies considered suitable by the different science and technology programmes for application by the health infrastructure in countries with different social, cultural, economic and epidemiological situations will be indicated. To facilitate their absorption and application by health infrastructures at various operational levels, they will be analysed in terms of the feasibility of delivering all of them simultaneously or in stages. To this end, dialogues will be maintained between those proposing these technologies and those dealing with their application. The social and economic implications of the proposed technology will always be kept in mind.

120. Information on appropriate technology and on the possibility of adapting it will be widely disseminated. Requirements will be indicated for training, education and information of different categories of people in homes, workplaces, communities, the health sector and other sectors concerned. Training, educational and informational activities will be developed accordingly through the collaborative efforts of health infrastructure and health science and technology programmes.

121. Through its support programmes, the Organization will selectively disseminate information that is of high relevance for the Strategy for Health for All, particularly through its publications and documents. Criteria will be further developed for defining what is highly relevant in this context and what target audiences should be aimed at. It will streamline its administrative and financial support with a view to ensuring prompt, effective and efficient support at all organizational levels, and particularly at country level. In ensuring the provision of equipment and supplies for Member States at their request, it will encourage them to define priorities in connexion with their health for all strategies.

122. Priority activities within the Programme will result from careful analysis with countries of their needs in support of their strategies for health for all by the year 2000, translating these needs into WHO's response under each of the WHO programmes concerned; such priorities will also result from careful selection of the approaches to be used, individually or in combination as appropriate, for each programme, with a view to ensuring that all programmes do in fact support the progressive development by countries of comprehensive health systems based on primary health care. In addition, the selected criteria presented in paragraphs 68 to 71 will be applied to identify programme areas for WHO involvement, to determine the organizational level or levels for implementation of programme activities and to select the most appropriate types and sources of resources for financing programme activities. The proper application of these criteria should go far to determine the ultimate priority activities of the Organization, particularly during the sequentially linked processes of medium-term programming and programme budgeting. However, in the final analysis, the setting of priorities among the different components of the programme, and the nature and extent of WHO's involvement, will depend on the priorities fixed by the Member States themselves. At the country level, the setting of priorities among the different programmes is a national decision which governments normally take after considering the country's epidemiological, environmental and socioeconomic conditions and the state of development of their health system, taking into account what is practicable for them, through methods that are readily available and at a cost they can afford. At the regional and global levels an important role in setting these priorities is played by the regional committees, the Executive Board and the Health Assembly.

Determination of priorities

123. Closely linked to the question of priorities is the establishment of targets. Targets for WHO can only be meaningful if they are based on national targets but, at this stage, few countries have defined these clearly enough in connexion with their strategies for health for all to make it possible for WHO to define global targets on the basis of them. The targets for each programme in the Seventh General Programme of Work appearing in Chapter 7 should therefore be considered as aspirational targets which the Organization considers that its Member States could feasibly attain by the date indicated. Once more, in the final analysis, such targets will only become realistic when they result from the synthesis of national targets defined by countries as part of their health strategies. The application of an appropriate managerial process for health development by countries will help them to arrive at feasible national targets.

7. Programme Outline According to the Classified List of Programmes

A. DIRECTION, COORDINATION AND MANAGEMENT

124. Given the unique and formidable challenges facing WHO, its Member States, governing bodies and Secretariat, in seeking to attain the target of health for all by the year 2000, the period 1984 to 1989 covered by the Seventh General Programme of Work will have a particular impact on the ultimate attainment of the target. For it will be during this period that the Organization at all levels will be struggling to develop and put into place the basic strategies and tactics needed to guide it, both within itself and in its dealings with the many other sectors that bear on health, along frequently uncharted paths towards the accomplishment of what may appear to some as an impossible task. Buttressing this viewpoint, and indicating the enormous dimensions of the task ahead, is the fact that despite the tremendous efforts made over the past 30 years, nationally and internationally, the health status of so many of the world's population is so precarious. To redress imbalances and achieve the hitherto unthinkable in a mere 20 years will thus require the utmost in firm, sound and humane policy direction, promotion and management.

1. Governing bodies

125. Maintaining unity of policy direction and action amid the diversity of WHO's Member States is the sometimes daunting task of the governing bodies: the World Health Assembly, the six regional committees and the Executive Board. Although WHO's unique regional structure should in theory enable the Organization as a whole to respond sensitively and effectively to the needs of individual Member States, in practice the disparity between, on the one hand, the expressions of intent as embodied in resolutions of the Health Assembly and regional committees and, on the other hand, health action at the national level is too often too great to be acceptable. Although many such defects are being remedied, it will be the task of the governing bodies to sustain and increase the Organization's momentum towards health for all, despite unforeseen and unforeseeable obstacles to translating health policy into action and inevitable setbacks.

— *Objective 1*

126. To determine and give effect to the policies of WHO and, in particular, to monitor the implementation of strategies for health for all, promote and coordinate their implementation by countries and other sectors, and evaluate their effectiveness.

— *Approaches*

127. Within the collectivity of WHO's Member States, the World Health Assembly will act as the supreme authority in determining WHO's policies, and especially in concentrating the Organization's activities on the development, implementation, monitoring and evaluation of the global strategy for the attainment of the target of health for all by the year 2000. It will continue to ensure that the Organization's directing, coordinating and technical cooperation functions are mutually supportive of each other and that the work of the Organization at all levels is properly interrelated.

128. For their part, the six regional committees will have increased responsibility for developing regional health policies and programmes in support of national, regional and global strategies for health for all, and for updating them as necessary. They will ensure, through their monitoring, control and evaluation functions, that regional programmes and their implementation properly reflect national, regional and global policies.

129. On behalf of the Assembly, the Executive Board will continue to be responsible for giving effect to the Assembly's policies and decisions and for monitoring the way the regional committees reflect the Assembly's policies in their work, and the manner in which the Secretariat provides support to Member States, both individually and collectively.

130. The World Health Assembly, the regional committees and the Executive Board will correlate their activities in such ways as to strengthen the roles of the Organization in promoting action for health, in addition to indicating how such action might be carried out, and in developing and ensuring the availability of health technologies that are effective, socially acceptable and economically feasible. In so doing the governing bodies will give active support to technical cooperation among Member States, both developed and developing. They will use their political and moral influence to strengthen ministries of health or equivalent bodies so that they will become the directing and coordinating authorities for national health work in implementing national health strategies.

131. As regards the Organization's cooperative activities within the United Nations system, the governing bodies will focus attention on joint efforts to support health as an integral part of development and of the International Development Strategy for the Third United Nations Development Decade. This will entail taking specific bilateral and multilateral action with other agencies of the United Nations system in the areas of health and development to promote an intersectoral approach to development.

132. The governing bodies will play a major role in influencing the channelling of all available resources for health, including those of other relevant sectors and of nongovernmental organizations, into support for strategies for health for all at all levels, especially to those countries most in need.

2. WHO's general programme development and management

133. The disparity between the work of the governing bodies and health action at the national level has been faithfully, and understandably, mirrored in the activities of the WHO Secretariat. Here, the departure from past approaches of piecemeal technical assistance projects and vertical disease control programmes to the renewed emphasis on coordination and real technical cooperation has struck with especial vigour because it has required wholly new ways of thinking and doing in the Secretariat's designated role of providing coherent and integrated support to Member States, individually at the national level and collectively in the governing bodies at the regional and global levels. Much of the methodology for this new way of attacking health problems has already been developed and is partly in place but it remains for this process to be completed during the six-year period of the Seventh General Programme of Work. The same applies to the effort needed to give force and effect to the concept of health as an integral part of development as WHO works on an intersectoral basis to bolster its own activities in the health sector.

— *Objective 2*

134. To develop and manage effectively the Organization's Programme, and to coordinate the Organization's activities with those of other bodies to this end.

— *Approaches*

135. The executive management of WHO will ensure Secretariat support to the governing bodies for the determination and implementation of the Organization's policies, specifically with respect to the Strategy for Health for All. Thus it will assume responsibility for the implementation of the

Seventh General Programme of Work. To ensure this, the Programme will be converted into medium-term programmes in such a manner that its various programmes at the different organizational levels are linked together in the best way to provide coherent and useful programmes at the national level. This will be done through a continuous managerial process. As part of this process, programme budgeting will lead to the selection of activities to be undertaken during the biennium for implementation of the medium-term programmes, special emphasis being given to the proper application of the process of programme budgeting of WHO's resources at the country level. Consequently, programme budgeting will influence the scope and speed of implementation of the General Programmes of Work and their related medium-term programmes. Evaluation will be an integral part of the total process. It will be used mainly to assess progress made in carrying out the activities as well as the effectiveness of WHO's programmes in facilitating the implementation of the Strategy for Health for All and the efficiency with which they do so. Each component of the managerial process, as well as the process as a whole, generates information and demands information. The WHO Information System supports these managerial information requirements through ensuring the use of appropriate information systems methodology, as well as modern data and text processing technology. Briefing and orientation will be arranged for staff at all levels to enable them to participate actively and effectively in the managerial process, and to support countries in carrying out their strategies for health for all.

136. The Director-General's and the Regional Directors' Development Funds will be used to provide seed money to countries for start-up costs of genuinely innovative programmes or other important activities that have a high degree of relevance for the implementation of their national strategies for health for all, including activities that are likely to attract substantial external funding. The regional and global strategies for health for all and the plans of action for their implementation indicate the kinds of innovative national action that might qualify countries to receive initial support from these funds.

137. Selective collaborative arrangements will be made with other United Nations organizations concerned. These arrangements will aim at promoting intersectoral action in support of the strategies for health for all and at ensuring the contribution of these strategies to socioeconomic development in general and to the establishment and maintenance of the New International Economic Order. They will include collaborative efforts with the United Nations and its regional economic commissions, UNICEF, the

World Bank and the regional development banks, UNDP, UNEP, ILO, FAO, WFP, UNESCO, UNFPA and UNIDO, individually or in groups, in relation to specific matters aimed at furthering health and socioeconomic development. Similarly, arrangements will be made with intergovernmental organizations, with nongovernmental organizations in official relations with WHO and, together with the governments concerned, with national nongovernmental organizations, with a view to involving them in the implementation of these strategies.¹ Bilateral and multilateral funding agencies will be approached with a view to attracting external funds for developing countries to help them implement well-defined national strategies for health for all. Coordination will be ensured between the mechanisms for attracting external funds for health at all organizational levels; support will be given to developing countries to formulate their requirements for external resources in a manner acceptable to funding agencies, and the attention of these agencies will be drawn to the priority needs of developing countries.

138. WHO will take part in the health aspects of emergency relief operations to tide countries over difficult periods, as well as in efforts to prepare countries better for such emergencies.

139. The executive management will ensure that all of the Organization's activities are carried out in conformity with the Constitution and the dictates of international law, and are properly audited.

B. HEALTH SYSTEM INFRASTRUCTURE

140. Systematic efforts are required to build up health system infrastructures based on primary health care for the delivery of health care in an integrated manner to all people. Without such infrastructures it will not be possible to deliver health programmes in an effective and efficient way, no matter how carefully these programmes have been planned. There is a need for information on the health situation and trends as a basis for the planning of such health systems. Such planning forms an essential part of a continuing managerial process ranging from policy making to implementation, monitoring, evaluation and ensuring information support. Closely related is the need for health systems research to arrive at optimal

¹ Since collaboration with nongovernmental organizations is an important approach for all programmes it is not mentioned specifically in each programme described in Chapter 7, to avoid repetition.

ways of organizing a health system and integrating a variety of programmes into it. Health legislation is often required to enable policies to be defined and implemented. But even when decisions have been taken about the desired pattern of a health system, unremitting efforts are required to organize the system, ensure the proper functioning of its component parts and the relationships between them, and manage the system efficiently. Central to all this is health manpower without which the rest of the infrastructure cannot be planned, organized, operated and managed, so health manpower development and health system development and organization have to go hand in hand. For most countries health systems of the type indicated above are radically different from those in existence. The introduction and maintenance of such systems will therefore depend on their acceptance by policy-makers, health workers and the public at large. For this reason, intensive efforts will be required to motivate them all and give them a good appreciation of what the health system aims at attaining. In view of the fundamental importance of health infrastructures for delivering programmes for the attainment of the goal of health for all, the monitoring and evaluation of the development and strengthening of such infrastructures will be particularly relevant during the period of the Seventh General Programme of Work.

141. Few countries anywhere have a national health system based on primary health care in which all components function in an integrated and coordinated way. Health institutions frequently exist side by side, serving the same populations with little or no cooperation or exchange of information between them. Health goals are pursued by workers in health, education, water supply, communications, environmental control, food production and other sectors, often acting on their own and unaware of each other's interrelated activities. Valid information about health problems and trends is often unavailable, and information for assessing the health system itself is inadequate even in many developed countries. When reliable information is available, it is often used insufficiently—or not at all—by planners and decision-makers. Methods for arriving at optimal ways of organizing health systems under given circumstances, such as health systems research, are frequently neglected, resulting in waste of scarce resources.

142. Health policies require special support in strategic areas. The need for new or revised legislation is often recognized too late and programmes are delayed or blocked in implementation. Lack of political or financial support is often equally devastating to new developments in the health system. The loosely knit health systems that do exist are often poorly planned and managed and fail to meet even their own stated goals and objectives.

3. Health system development

Plans are made and not implemented. Programmes are launched and not supported. Promises are made but for too many people a healthy life remains an elusive dream because the health system is unsuited to its task.

143. To meet the challenge of health for all, emphasis will be placed on improving the managerial process required to develop health systems based on primary health care. This process includes formulation of policies, strategies and plans of action in coordination with other sectors, and continuing assessment of the implementation of these plans. It will be supported by strengthening the gathering of reliable, relevant health information, generating appropriate ways of organizing health systems, through health systems research, and using such knowledge to improve planning and management. Special attention will be given to developing legislative support for the health system.

— *Objective 3*

144. To support countries in the progressive development of their health systems based on primary health care.

3.1 Health situation and trend assessment

— *Targets*

145. This programme's activities will aim at fostering national and international action so that by 1989:

(1) most countries will have well developed mechanisms for collecting relevant information and using it to assess their health system, health situation and health trends, thus providing a sound basis for epidemiological surveillance and for decision making for health development;

(2) WHO will have an established mechanism, based on information from countries, for monitoring progress towards the goal of health for all, which includes health and related socioeconomic indicators, and epidemiological surveillance data on communicable and noncommunicable disease and environmental hazards.

— *Approaches*

146. WHO will cooperate with Member States to develop and strengthen national capabilities for assessing the general health situation and trends. This will include human growth and development, major health problems

and the main factors involved, the identification of high-risk problems and high-risk groups that may deserve priority attention, and resources being expended on health and likely to be required in the future. It will support countries in developing and maintaining epidemiological surveillance of communicable and noncommunicable diseases, of nutritional and mental health status, of social pathology such as alcohol and drug abuse, and of occupational and environmental hazards.

147. WHO will strengthen the capacity of countries to collect valid and timely statistical and other information for planning, operating, monitoring and evaluating their health systems. This will necessitate the use of monitoring procedures which should be as simple and inexpensive as possible and the choice of indicators that are appropriate to the socioeconomic and health situation and that are sufficiently selective to be meaningful. To ensure that information produced is relevant to needs and is being used to improve planning and decision making, better communication between producers and users of health information will be promoted. At the international level, WHO will establish mechanisms for information exchange among countries regarding their health situation and trends, based on epidemiological and other available information. It will ensure the proper feedback to countries of information derived from the data supplied by them.

148. In training health personnel, emphasis will be placed on the collection, analysis and use of information for health management, especially those with epidemiological, statistical and managerial responsibilities, and in the use of information on health trends to reshape training programmes according to present and foreseeable needs. The training of epidemiologists will stress the synthesis of information based on epidemiological analysis in such a way that it can be used for planning and operating health systems.

149. Supplementing these efforts will be the development and improvement, based upon the experience of countries, of such standard tools as the international classification of diseases and of other health problems, methodology for lay reporting of health information and simple community surveys best suited to local conditions. Ways appropriate to different national settings will be developed for countries to gather and use the information required by them in connexion with their indicators for monitoring and evaluating health strategies. Emphasis will be laid on generating information as an integral part of health activities and not as a separate enterprise. WHO will assess and synthesize regional and global health situations and trends on the basis of national reports, surveys and other studies, making

use of indicators selected by the regional committees and the World Health Assembly for monitoring progress. It will produce periodic reports for review by these governing bodies, and ensure the publication and dissemination of global and regional analyses.

3.2 Managerial process for national health development

— *Target*

150. This programme's activities will aim at fostering national and international action so that by 1989 most countries will have started or strengthened a permanent systematic managerial process for the formulation of national health policies and plans, in collaboration with other concerned sectors, and for programming, budgeting, implementation, monitoring, evaluation and reprogramming for the development of a more effective health system.

— *Approaches*

151. WHO will cooperate with Member States to improve the national managerial process for developing and operating their health systems. In particular, methods for decentralized and intersectoral planning and management will be developed and tested. The managerial process entails the formulation of health policy according to defined priorities and the preparation of programmes and budgets to put the policy into effect. It implies the assessment of manpower requirements and the preparation of plans to meet them, together with the integration of well-formulated countrywide programmes into the general health system. Operational effectiveness will be sought through proper management of programmes and the services and institutions for delivering them and through the application of appropriate health systems research and use of the results to improve planning and management. Finally, monitoring, evaluation and continuous feedback of information will provide the basis for modification of plans and programmes. Careful attention will be paid to methods for planning and management of countrywide programmes for delivery by the health infrastructure, for example in relation to health manpower and specific programmes such as maternal and child health, environmental health or communicable disease control.

152. Because of the many innovations implicit in this managerial process, it will be necessary to develop and provide training in it, particularly the training of trainers and senior public health officials. It will also be necessary to establish and strengthen permanent mechanisms for applying the managerial process both within the health sector and outside it by

engaging networks of individuals and institutions to work together with planning units in ministries of health under the overall coordination of the ministry or an equivalent authority.

— *Target*

153. This programme's activities will aim at fostering national and international action so that by 1989 most countries will have an increased capability for health systems research, will have undertaken relevant health systems research and will be using the results to improve the development, organization and functioning of the health system.

— *Approaches*

154. The application of health systems research as an integral part of the managerial process will be encouraged in order to generate the kind of knowledge required to improve the planning, organization and operation of the health system. Subjects for such research may include the analysis of alternative approaches to the development and organization of health systems at each level; organization and integration of the various components of the health system (particularly at the primary care level); cost-effectiveness of alternative ways of organizing health systems; efficiency of the operational management of health systems; selection and application of appropriate technologies; identification of appropriate rôles for various health workers (including self-care and community activities); improvement of training and health education methods; improvements in managerial processes and structures; mechanisms for community involvement in planning and implementation of health activities; studies of intersectoral planning and management; identification of the interaction between the health system and socioeconomic, cultural and political factors; assessment of the quality of health care; and other topics related to the development of effective health systems based on primary health care.

155. Suitable methods for studying these topics and analysing results will be developed and information on their application will be made available. Networks of workers and institutions involved in health systems research will be developed and strengthened; training needs to increase health research capability in countries will be identified to this end. Special efforts will be made to ensure that research activities are relevant to needs, and that results are made available to and are used by planners and decision-makers. To facilitate this, the effect of health systems research on health policy and health services, and the barriers to utilization of research information will be studied, and the results applied appropriately.

3.3 Health systems research

3.4 Health
legislation

— *Target*

156. This programme's activities will aim at fostering national and international action so that by 1989 most countries will have health legislation that facilitates the attainment of their health objectives, particularly through the development of primary health care and other supporting components of a comprehensive health system.

— *Approaches*

157. WHO will cooperate with Member States to promote the strengthening of national capacities to identify health legislation needs and to draft the new legislation required. Particular attention will be paid to supporting countries in introducing national legislation that may be required to carry out policies that have been collectively endorsed in the World Health Assembly. Countries will be encouraged to strengthen existing mechanisms for identifying and drafting the legislation required, whether in ministries of health or justice or the like, as well as to use other mechanisms such as national health councils and development networks. WHO will support countries in the training of national experts in health legislation.

158. WHO will promote the international exchange of health legislation information that has been analysed by the WHO Secretariat and by a network of collaborating agencies and institutions. This will include national experiences of ensuring the implementation of health legislation. Information will be disseminated in particular through the *International Digest of Health Legislation*. The information will be used in the Organization's technical cooperation with its Member States. Cooperation will be promoted among countries at all stages of development. Particular attention will be given to the adoption of legislation that facilitates the introduction of promotive and preventive health measures, is conducive to healthy life-styles, ensures greater equity in access to health care, reorients the health budget towards more relevant technologies, supports the development of new types of health workers where necessary, and facilitates the employment of traditional practitioners and birth attendants where applicable.

**4. Organization
of health systems
based on primary
health care**

159. Once goals, policies and priorities have been established, resources must be allocated purposefully and efficiently to carry them out. Yet in many countries existing health systems consist of diverse institutions geared to providing services to those who come to them rather than to the needs of the community as a whole. They are often distributed inequitably in relation to population and operate in isolation from one another, concerning themselves with only a narrow set of health problems instead of broader

health goals. Their activities are seldom coordinated with those of other health-related sectors. In short, existing health systems typically lack the kind of coherent and coordinated organization needed to meet the full range of promotive, preventive, curative and rehabilitative health needs of entire populations of all ages.

160. Moreover, in many countries, the ability to manage even these fragmented services is very limited. Priorities, even when identified, rarely form the basis of planning and organization of the system. Information necessary for adequate planning and management is frequently not available. Resources are limited, and those available are not used in the best ways. Referral and support between various levels of the system are often inadequate. Management and decision-making are usually centralized and seldom involve either communities or peripheral level workers. It is thus clear that achievement of health for all will require the development of health systems with more coordinated and appropriate organizational patterns and more effective management than presently exist.

161. To support countries in so doing, WHO will draw on national experience to develop the kind of knowledge needed in organizing self-care, family care and community care, all supported by active community involvement. This will include reorganization of the supporting levels of the health system and the referral possibilities throughout it, together with the organization of health facilities and the necessary logistics of equipment and supply. It will also include defining the policies and associated legislation needed to bring to bear on health development the work of other sectors that influence health.

162. WHO will help countries make use of this cumulative store of knowledge, both for organizing and for deciding on the content of their health systems. In turn, firsthand experience, as it is gained, will be continuously fed back and used to modify this knowledge in the light of the most effective national practices. This approach will also be applied in helping in the selection of health technology, including social and behavioural alternatives to technical measures, for use by individuals of all ages, families, communities, and the health and health-related sectors. WHO will encourage improved financial management of health systems and the review of organizational procedures, such as decision-making, supervision through guidance, and monitoring to provide effective support for primary health care.

— *Objective 4*

163. To promote and support the appropriate organization and effective operation of comprehensive health systems that provide the essential

elements of primary health care to entire populations, along with referral and specialized support when necessary, and that involve communities and health-related sectors in responsible and coordinated ways.

— *Targets*

164. This programme's activities will aim at fostering national and international action so that by 1986:

(1) most countries will have made organizational plans for their health systems based on primary health care and for providing the necessary support to make them readily accessible and their services equitably distributed to the entire population according to need;

(2) most countries will have devised ways of encouraging community involvement;

and that by 1989:

(3) most countries will have implemented their operational plans mentioned above;

(4) most countries will have functioning mechanisms for community involvement in health care.

— *Approaches*

165. In order to widen coverage and to increase operational capacity, particular attention will be paid to the organization of health systems, and to identifying the changes needed to transform existing health systems into health systems based on primary health care. It is stressed that at least the essential elements of primary health care will have to be integrated into such health systems.¹ Alternative patterns of organization that increase the effectiveness of health systems and make the best use of available resources will be developed, including those needed to cater to the special requirements of different situations such as sparsely populated areas, mining communities or the underprivileged areas of major urban centres. This will imply a substantial broadening of health systems. Approaches will take into

¹ In accordance with the Declaration of Alma-Ata, these elements are: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

account the geographical distribution of populations and of various types of health facilities and workers, the administrative organization into levels providing different combinations of activities and different degrees of specialization, and the physical design and organization of health facilities.

166. WHO will provide information on national, and especially innovative, experience in the various ways of organizing health systems based on primary health care. This will include the organization of self-care and family and community health care, the integration of vertical programmes, such as those for malaria and other parasitic diseases, dental health care and rehabilitation. It will also include the organization of the supporting levels of the health system, e.g., hospitals, district health offices and laboratories. Attention will be given to the organization of referral services and to the logistics of equipment, drugs and supplies throughout the health system, as well as to the planning, design, organization and management of health facilities, and the maintenance of such facilities and the equipment in them. Approaches will be developed to achieve greater support to primary health care from hospitals and environmental health facilities. This will form part of a broader approach for ensuring adequate coordination among all the establishments, nongovernmental organizations and personnel within the health sector in support of primary health care. Above all, the full application of the "health services and manpower development" approach will be promoted, whereby health workers become socially responsible and technically trained to fulfil the functions they will have to perform in the health system.

167. WHO will support the development and application of innovative approaches to increasing community involvement in the health system. This will include the development of mechanisms that foster involvement in planning and operating health systems, taking part in their activities and ensuring their social control; the application of existing knowledge regarding community organization and behaviour, and the use of multidisciplinary investigations and examples of community participation to gain new knowledge of how to give effect to this approach.

168. The promotion and support of coordinated intersectoral action for health is another major approach. Efforts will be made to increase the awareness of health workers and those concerned in other sectors, as well as public opinion leaders, of the importance of intersectoral action in support of primary health care. WHO will support the establishment of mechanisms for better coordination between health and related sectors, such as multisectoral health councils at national, provincial and local levels.

Intersectoral activities at the local level that contribute to health will be identified, and models for teamwork between health workers and other related personnel will be developed.

169. At the same time WHO will be concerned with the technologies to be used at each level of the health system to meet identified needs. Particular attention will be paid to selection of technology appropriate for use at the local level by individuals, families and communities, for self-care, and by other workers including traditional medicine practitioners, school teachers and environmental health workers. The identification and use of social, behavioural and cultural factors that contribute to health will be encouraged as alternatives to technical interventions. The role and responsibilities of each type of institution and worker in the health system will be clarified, with particular attention to the allocation of work and co-ordination between the primary health care and the immediate referral level hospitals. Attention will be given to the selection, in collaboration with technical specialists, of suitable technology for use in primary health care, as appropriate, to meet the needs of special high-risk groups and/or other underserved groups, as well as for specific priority diseases.

170. Support will be provided to assess the cost requirements for the development of health systems. Information on efforts to contain costs, particularly hospital costs, will be gathered and disseminated. Alternative means will be developed of financing health costs, including exploration of financing by the private sector, by public sectors other than governmental, such as social security programmes and funding by local communities. The effects of different systems of financing on the quality of health care, its appropriateness and utilization, and on the equity of health financing systems will be studied to establish how different systems influence resource distribution and social justice. These studies will include the effects of health improvement on economic development.

171. The final set of approaches relates to the strengthening of certain organizational processes that are especially important for effective operation of the health system. The decentralization of budgetary and decision-making authority to intermediate and local levels will be promoted to increase the responsiveness of the health system to local needs and initiatives. Alternative approaches to the use of existing hospitals will be studied. Efforts will be made to strengthen the operational management of the health system, particularly at the local and intermediate levels, including management of hospitals, through the appropriate use of training and health systems research, employing national health development networks for the

mobilization and coordination of the technical skills required. Special emphasis will be put on promoting and supporting countries in the development of simple ways of monitoring progress in the implementation of their organizational plans for their health systems.

172. Trained people are the key to the health infrastructure. People can build institutions but institutions cannot function without people. Without the right kind of trained people, the other resources of a health system are underutilized, if not wasted. However, in both the developed and developing countries manpower development in the planning of health services often receives scant attention. In many countries, no manpower policies exist. Where they do, they often have little relevance to the long-term and changing needs of the health system and the communities and individuals within it. Emphasis in cooperation with Member States will therefore have to shift, particularly with a view to promoting political will to change the health manpower development process and make it more relevant to national health development plans aimed at attaining health for all through primary health care.

5. Health manpower

173. Existing problems will be compounded as health systems based on primary health care are developed, with self-care and community involvement as integral parts. Health workers will increasingly be required to provide intelligent guidance and encouragement to communities in prevention and health promotion as well as curative care. Career structures and working conditions will have to provide the necessary incentives to motivate workers to remain in the front lines. Measures to assure their effectiveness, even when working in isolated situations, will have to be taken. Technologies appropriate to community action will have to be developed and incorporated into health training programmes. Moreover, professional resistance to these innovations will have to be transformed into strong support. The present use of manpower is all too often irrelevant to priority population needs, and training is often inappropriate to the tasks required of health workers.

174. Confronted with these problems, the Organization will work with Member States to strengthen the planning and management of manpower resources and to increase the relevance of training to health services based on primary health care and to the health needs of communities as perceived by them. It will promote measures to increase the effectiveness of health workers, such as incentives to increase motivation to work where needed, and to improve working conditions and mobilize professional support. It will emphasize community care through the training of health personnel as agents of change, and encourage countries to involve all who have an

interest in health manpower, including local communities, in the formulation of coherent manpower policies. It will work to strengthen national political commitment to these efforts through promotion of relevant action, in order to ensure progress towards the goal of health for all.

— *Objective 5*

175. To promote, and cooperate with countries in, planning for training and deploying the number and types of personnel they require and can afford; and to help ensure that such personnel are socially responsible and possess appropriate technical, scientific and management competence, so as to develop and maintain comprehensive national health systems based on primary health care for the attainment of health for all by the year 2000.

— *Targets*

176. This programme's activities will aim at fostering national and international action so that by 1989:

(1) all countries will have health manpower policies formulated as an integral part of national health policy; the majority of countries will have health manpower plans based on these policies and will have taken steps to implement and monitor them;

(2) all countries will have developed the training programmes required by their national health manpower plans; they will have strengthened the institutions responsible for implementing these programmes and for maintaining and/or improving the competence of personnel, especially those involved in primary health care;

(3) all countries will have developed the managerial capability to assure optimal utilization of available human resources.

— *Approaches*

177. The fundamental approach will be that of promoting the functional integration of health services and manpower development (HSMD) in countries so as to improve the planning and deployment of health personnel and ensure the relevance of training programmes to community health needs. This will involve supporting the development of manpower policies and strategies as part of national strategies for health development and ensuring that qualitative and quantitative health manpower requirements are taken into account during the development and application of

the managerial process for national health development. Efforts will be made to enlist the support of decision-makers as well as health professionals to strengthen national commitment to HSMD and to improve the planning, distribution and functioning of health personnel. WHO will support the establishment and/or strengthening of mechanisms for coordination of health services and manpower development. It will also support countries in strengthening the capacity of the educational system to respond to the rapidly changing needs for certain types of health personnel. In so doing it will help to ensure appropriate staffing for primary health care and supporting levels of the health system, including practitioners of traditional medicine where relevant and such innovative categories as health generalists, as well as the monitoring and evaluation of manpower deployment.

178. Promotion of community-focused educational programmes with team and problem-oriented methods of teaching/learning will be the second main approach. They will be designed to prepare personnel to perform tasks directly related to identified service requirements of specific concern to the country. This will demand cooperation at all levels between decision-makers in health and education as well as in other sectors that are concerned directly or indirectly with health development. Support will be given to national educational institutions and programmes, especially those involved in the training of frontline workers and their supervisors, the relevance of teacher training being emphasized in this context. The training requirements identified by other programmes—infrastructure, scientific, technical or managerial—will be analysed by the Manpower Development programme, together with the programme of Organization of Health Systems based on primary health care and the specific programmes concerned, to arrive at an agreed distribution of responsibilities for the development of training programmes and career possibilities for different types of manpower contributing to health development, taking into account the repercussions of self-care and community care. Curricula will be drawn up according to the tasks to be performed and to the agreed distribution of responsibilities for the development of programmes. WHO will encourage teachers in the health professions, including those for middle level and primary health care workers, to define the learning objectives of their programmes based on the health needs of their country and develop competence in the planning, implementation and evaluation of curricula. Appropriate teaching and learning materials, including those for self-teaching and audiovisual purposes, adapted to different cultures and languages, will be developed for all categories of health manpower contributing to health development, particularly primary care workers and their teachers and supervisors.

179. WHO will foster cooperation between ministries of health and education, as well as other ministries concerned, for the relevant orientation and training of workers, leaders and decision-makers concerned with health development in other sectors, such as teachers, magistrates, police, engineers, agronomists, agricultural extension workers, and civic and religious leaders.

180. Universities will be encouraged not only to reshape their educational programmes in the light of the above principles, but also to become involved in the different types of research required to support the movement for health for all and to consider appropriate ways of creating a sense of social responsibility among all students and faculty who could contribute to the national strategy for health for all.

181. WHO's third approach will be to cooperate with countries, other United Nations agencies and nongovernmental organizations to improve living and working conditions, job security, labour relations, job satisfaction and social motivation, particularly for frontline health workers, in order to attract and retain needed health manpower and reduce undesirable migration of trained staff. Such cooperation will include the study of methods of providing incentives for service in primary health care, particularly in remote areas, and of analysing those which have proved successful as well as those that have not proved successful in different national circumstances. This will require support to the planning and implementation of national career development schemes, supervision practices, and continuing education systems for all categories of health manpower as part of broader manpower policies. WHO will collaborate with countries in their efforts to develop and strengthen national capabilities in the management of their health systems, and in planning and monitoring the use of fellowships in a manner relevant to national health development policies and plans.

182. In all the above, TCDC is highly relevant, particularly for the training of teachers and for the production and exchange of learning materials.

183. There will be a drive to strengthen national political commitment to health manpower development reform, as well as to create awareness among policy-makers and health personnel, and in particular teaching personnel, of the social responsibilities of all health workers. The support of health professionals will be needed to effect the necessary increase in the relevance of training so as to attain the goal of health for all by the year 2000. The health manpower component of health systems research will be

promoted and coordinated in order to enhance the abilities of staff to perform better in health services, as well as to identify and assess appropriate technologies for application as educational instruments by various categories of manpower. WHO will promote the development of networks of institutions and programmes that will be responsible for trying out innovative methods of health manpower development and resource pooling, carrying out research on common problems, and exchanging staff and students as well as information on accumulated experience and views in various aspects of health manpower development.

184. The existence of a public that is aware of actions it can take to promote its own health and that is motivated to undertake such actions is essential to the primary health care approach. Without this, the effectiveness of the other components of the health system will be greatly diminished. In fact, the Declaration of Alma-Ata on primary health care mentioned education concerning prevailing health problems and the methods of preventing and controlling them as the first of eight essential components of primary health care.

185. Numerous obstacles impede individual and community action for health. They range from lack of knowledge of basic hygiene, cultural taboos, unhealthy life-styles and insufficient encouragement of cultural factors that promote health to inadequate and ineffective health education, motivation and public information efforts, all too often operating in isolation from the mainstream of the health systems. In addition, aggressive advertising of products harmful to health usually overwhelms the feeble educational efforts aimed at fostering healthy life-styles, particularly among the young.

186. Health education and health information activities by the public and private sectors are often uncoordinated, under-financed and have not been developed as a fully integrated, essential element of national health strategies.

187. These activities are an important part of such strategies, for they mobilize political, financial, managerial, technical and popular support. Countries will be encouraged to develop health education and public information support for all health programmes as an integral part of their health system. WHO will promote the establishment of interdisciplinary and intersectoral working groups in countries to ensure that health education and information efforts are coordinated and mutually supportive. These groups should include representatives from mass media, the educational sector and voluntary organizations, and should work closely with

**6. Public
information and
education for health**

national health councils or similar bodies, since all healthy behaviour cannot be promoted through action within the health sector alone. WHO will support this process by mobilizing global public opinion and political commitment, popularizing and disseminating information appropriate for national use, collaborating with countries in educational and information activities, assisting in the training of the personnel required, and fostering appropriate health education and communication research.

— *Objective 6*

188. To foster education and information activities which will encourage people to want to be healthy, to know how to stay healthy, to do what they can individually and collectively to maintain health, and to seek help as needed.

— *Targets*

189. This programme's activities will aim at fostering national and international action so that by 1989:

(1) most countries will have coordinated and mutually supportive public health information and education efforts involving ministries of health, information, education and other related sectors, which reach their entire population;

(2) all countries will have coordinated programmes that disseminate relevant and technically sound information to increase individual and community capabilities for involvement and self-reliance in health and to promote healthy behaviour, particularly regarding family health and nutrition, environmental health, healthy life-styles and disease prevention and control.

— *Approaches*

190. Health education and information of the public are two aspects of the same discipline; similar messages have to be delivered by whatever media are most appropriate to do so. Messages for delivery through the mass media will be prepared in such a way as to stimulate without unduly frightening, and as to maintain a proper balance between individual and community needs. WHO will prepare such messages and will help countries to translate them into their cultural and language needs and to apply them in the ways most appropriate to them. Two lines of development will be pursued. The first will broaden the avenues available for dissemination of health information through promoting greater participation of health and other related sectors in coordinated efforts. WHO will promote and support the

development of strategies and procedures to increase coordination between ministries of health, education, communications, agriculture, rural development and related sectors, community groups, industry, the mass media and concerned nongovernmental organizations with regard to health education and information at both the national and international levels. Consistent efforts will be made to promote acceptable self-care practices by individuals and communities. All types of health workers will be expected to take part in the health information and education of the public. In addition, innovative approaches to involve teachers in primary and secondary schools, agricultural and rural development workers, literacy and adult education programmes, labour and industry groups and traditional health workers in the dissemination of health information will be encouraged and supported.

191. The second type of approach will seek to improve the effectiveness of the education and information programmes, wherever they are carried out, through improving methods and materials, including the introduction of training in health education into the curricula for training all categories of health workers. In addition to strengthening the use of existing methods, the development of new methods and exploration of alternative media and methods, including the use of traditional media, will be encouraged to reach individuals and communities which have no contact with the media currently in use. WHO will provide information and support in the development of appropriate materials for education of the public and for training personnel of all types to provide health education and information to the public.

192. Information materials will be developed, locally adapted and field-tested, particularly as they relate to the need to develop positive and adequate eating habits and for exercise and for outdoor leisure activities and sports, and to the risks connected with the health effects of smoking and the use and abuse of alcohol and drugs. Self-help activities will be emphasized. Guidelines and training material for health and other workers will be adapted to different target groups in all major languages in each region, aiming to make people aware of the health, as well as economic, advantages of healthy behaviour, which will open possibilities for alternative use of resources. This can be carried out with the collaboration of United Nations agencies, particularly UNESCO, ILO, FAO, UNICEF, and nongovernmental organizations concerned. Support will be provided to develop and improve training in health education and information for all concerned workers in health and related areas. The inclusion of skill development in communication and in stimulating behavioural change in such training programmes will be encouraged.

193. In the implementation of the above approaches, the information content will be determined collaboratively with the technical specialists concerned. Particular emphasis will be placed on reaching children and adolescents. Attitudes and behavioural patterns are formed early in life; consequently, particular emphasis in the programme will be on the young and the involvement of the educational sector will be vital; specific curricula will be developed not only for health educators but also for all other workers in the health and other sectors who are in contact with parents and young people. Material will be developed and incorporated in media, such as pictures, comic books, and cartoons. The needs of other high-risk and underserved population groups will also be emphasized.

194. The dissemination of educational and information support materials for primary health care, promotion of healthy behaviour and lifestyles, and the facilitation of individual and community self-care, will be especially encouraged. Support to specific requirements regarding elements of family health, environmental health, and disease prevention and control will be selectively provided wherever necessary, according to local conditions.

C. HEALTH SCIENCE AND TECHNOLOGY

195. The health system infrastructure provides the human and material means for delivering health care, but its impact on health depends on the substance of what is delivered. A vast amount and bewildering variety of health technologies exist but they are not always available to all who need them and they are not always appropriate to those in need. For this reason it is necessary to reappraise health technologies, selecting those that are appropriate in specific circumstances, generating new technologies as required and searching for behavioural alternatives wherever possible. To do so, systematic scientific endeavour is required. Technology reappraisal and development is needed to arrive at suitable ways of protecting and promoting the health of people of all categories and ages, including specific population groups such as young people, workers and the elderly. The promotion of their mental health is no less important than that of their physical health. A healthy environment can contribute to both physical and mental health. No known civilization has been able to eliminate disease whatever the measures taken; so technology for the prevention and cure of disease is highly important and is likely to remain so. This includes technology for diagnosis, treatment and rehabilitation in general, as well as for the prevention and control of specific groups of diseases.

196. The phenomenal growth in the complexity and scope of biomedical and health research has had two major implications. First, there is a compelling necessity for a multidisciplinary team approach that, in turn, demands a high level of organization and coordination. Second, the rapidly rising costs of research have increased the need for, and dependence upon, funding from public sources. This has resulted in a growing demand for research that is directly relevant to the health problems of society and a pressing challenge for governments and the public at large to clarify these problems, meanwhile establishing priorities for their solution. An important area of high social relevance that requires much greater attention is the effect of behavioural patterns in promoting or damaging health. While much is known about the negative effects of such habits as smoking, over-eating and excessive alcohol intake, little is known about behaviour and habits that promote health. Particular emphasis will therefore be given to research on health-promoting behaviour and to the development of suitable methodologies to this end.

7. Research promotion and development, including research on health-promoting behaviour

197. At the national level, the pattern of health research that has evolved in response to these trends naturally varies from country to country. Many countries, especially in the developing world, have not yet developed an effective national organization for the management of health research or even for articulating health research policy, although there is a notable trend towards the development of such mechanisms and to define national focal points for cooperation in international health research. At the national and international levels similar trends have aroused growing concern over the disparities between developed and developing countries in research and development investment and the lack of coordinated global research efforts that are relevant to worldwide health problems. Special attention will therefore be given to the development and strengthening of the health research capacities of the developing countries.

198. Increasingly concerned about this widespread lack of opportunity for health research, WHO recognizes that attempts to strengthen research capabilities can ultimately succeed only to the extent that governments themselves deal effectively with the problem. This includes setting up career structures that will provide incentives for scientists to undertake lifelong research on priority health problems in their own countries.

199. WHO is concerned about the frequently lengthy delay between research discoveries and their application for the health of people. This makes it difficult for health research to compete for national resources on equal terms with other enterprises that provide more visible short-term gains.

Yet well chosen health research is among the decisive factors for the attainment of the goal of health for all by the year 2000 and, in a wider sense, long-term investment in research is a concrete expression of hope for the future.

200. This is the basis for the commitment to promote research and development and to strengthen national research capabilities. During the period of the Seventh General Programme of Work the efforts of WHO will therefore concentrate on building up national manpower and facilities for biomedical, epidemiological, behavioural, health systems and related socio-economic research. This will be done by involving in such research national personnel and institutions providing information and training on the requisite methodologies and collaborating with countries in their application. However, at present much greater resources are invested in clinical than in other forms of research. WHO will therefore take measures to promote the redressing of this imbalance.

— *Objective 7*

201. To promote research related to health, and coordinate the development of relevant scientific activities in this area.

— *Targets*

202. This programme's activities will aim at fostering national and international action so that by 1989:

(1) most Member States will have strengthened their national health research capabilities so as to be able to carry out health research required for the implementation of their strategies for health for all;

(2) most countries will have developed adequate mechanisms to carry out health research.

— *Approaches*

203. WHO will continue to support the building up of research capability by Member States and will intensify its efforts to promote effective and efficient systems for health research management including information support for research. A central function of health research at the national level is to assess existing technology for suitability in the light of local conditions and health priorities. It will take into consideration all alternatives—social, behavioural, preventive and clinical—cost considerations will be included as an important part in the evaluation of the technology. Such

an assessment will enable countries to decide what existing technology, in its present or adapted form, is usable and what are the gaps needing to be filled by research leading to new technology.

204. WHO will emphasize that the corner-stone of any national health research effort is a coherent policy that will permit a rational allocation of resources, however limited they may be, and sustained work towards clearly defined objectives. The Organization will stress the inclusion in such policies of career structures and incentives for scientists to undertake research in their own countries rather than elsewhere. It will point to the need to identify priorities that are socially relevant to the country concerned and to the corollary that training of research workers be provided in those specialties needed to tackle national health problems. The international exchange of workers will broaden their perspectives and enable them to benefit from research work being done in other countries. Participation in international collaborative research will contribute to the same end. Attention will be paid to the ethical aspects of health research, particularly with regard to research involving human subjects.

205. Encouragement will be given to the inclusion of health-related research in the work of other sectors whose activities have a direct effect on health, such as agriculture, education and public works. One important area of research which is receiving far too little attention is the influence on health of social and economic factors, including unemployment, poverty and social injustice in all its forms, as well as behavioural factors. Thus, decisions taken in fields apparently unconnected with health, such as selective taxation, employment policies, and the use of leisure, can all have important effects on health. Behaviour, which is influenced by cultural, social, economic and physical circumstances, is a prime factor in maintaining good health and preventing many diseases and, together with active preventive measures, forms the basis of one of the most cost-effective approaches for improving health. WHO will therefore promote and support research on social, economic and behavioural determinants of health. It will do so both through the stimulation of other programmes to seek social and behavioural alternatives to health technology, and through specific studies on social and economic factors and behavioural patterns that may affect health positively and negatively. These will include, where relevant, studies on the effects on health of poverty, unemployment and social injustice.

206. WHO's special research and research training programmes initiated at the international level have responsibilities for strengthening national

health research capabilities through collaborating in the design and implementation of research. These programmes enhance research manpower training at all levels. They make equipment and other logistic support available for national institutions, foster the development of peer review mechanisms and cover ethical aspects of research.

207. WHO will develop further its capacity for ensuring the prompt and relevant dissemination of research findings. The Organization will bring together and widely disseminate experience on the use of different types of research methodology, particularly those that have evolved recently, such as epidemiological studies and clinical and community trials. It will disseminate information on various methods of research management including the information support required for conducting research and disseminating research findings. It will support countries in developing and/or strengthening national mechanisms for research on health matters, such as medical research councils, health research councils and health research sectors in broader scientific and research councils.

208. The Advisory Committees on Medical Research (ACMRs) at the global and regional levels, being linked with WHO's governing bodies and with medical and health research councils at the national and international levels, provide an essential mechanism for the coordination of research, for the correlation of national, regional and global priorities and for overseeing the entire research complex to make certain that its output is brought effectively to bear at the national level. Consequently WHO will sponsor periodic meetings of representatives of ACMRs, of national research councils and analogous bodies in order to promote international coordination of goal-oriented health research, to disseminate the concept of national research programming as part of the managerial process for national health development, and to enhance existing mechanisms for regional and inter-regional coordination of health research.

8. General health protection and promotion

209. The way people behave, the style of life they lead, the food they eat, the care they take of their teeth and gums, and the risks they take, voluntarily or involuntarily, can all greatly influence their survival and their health. As mentioned above, the programme of Research Promotion and Development, including Research on Health-promoting Behaviour, will promote research to generate new knowledge on the social, economic and behavioural determinants of health and, in consequence, alternatives to health and medical technology. Those research efforts are expected to generate the knowledge required to conduct a viable programme on health-promoting behaviour in general. Moreover, the promotion of behaviour conducive

to health will form part of many other programmes such as those on accident prevention, health of the elderly, psychosocial factors in the promotion of health and human development, the prevention and control of alcohol and drug abuse, of sexually-transmitted diseases, of parasitic diseases and of cancer, and studies on the simultaneous prevention of a number of noncommunicable diseases. The programme of Public Information and Education for Health will promote the use of available knowledge and new knowledge, as it becomes available, concerning the positive and negative influences on health of people's behaviour and life-style. In addition, specific activities are required to ensure health protection and promotion through adequate nutrition, oral health and accident prevention.

210. Nutrition is one of the most important factors influencing the quality of human life in most parts of the world. Undernutrition is and will likely remain one of the main contributing causes to the very high rates of infant and young child deaths; and in those who survive it retards growth and development, and lowers resistance to infections or environmental hazards. It is estimated that around 200 million children under the age of five are moderately or severely malnourished. Maternal malnutrition is widespread, being especially important because of its serious implications for the health of the women and their infants. The causes of malnutrition are rooted in underdevelopment, and at the same time, undernutrition is a serious impediment to socioeconomic development. Improved use of available foods can significantly help to combat undernutrition and can have widespread health promoting effects, although support is needed through better production, distribution and storage of food if full benefits are to be gained.

211. Oral health, which is essential for good nutrition and a feeling of wellbeing, can be promoted through individual behaviour in the areas of hygiene and nutrition, supported by preventive policies and measures, especially in making fluoride available. In spite of this, two major oral diseases, dental caries and periodontal disease, affect almost 100% of mankind and absorb vast amounts of health resources.

212. Accidents are among the ten highest causes of death in most countries. They also result in disability and loss of income, and the care of injured and disabled people consumes much of the health budget in many countries. Their prevention, whether on the highway or farm, in the factory or, especially, at home, will require the systematic application of epidemiological knowledge, much of which is still to be generated.

— *Objective 8*

213. To support the development, adaptation, and use of methods for promoting proper nutrition, oral health and accident prevention.

8.1 Nutrition

— *Targets*

214. This programme's activities will aim at fostering national and international action so that by 1989:

(1) all countries with significant problems of undernutrition will be implementing programmes for improving the nutritional status of mothers and children so as to allow healthy growth and development of children and adolescents, increased resistance to infection and reduced risks for childbearing women;

(2) all countries with significant levels of specific nutritional deficiencies will have undertaken programmes aimed at controlling them;

(3) all countries with significant problems of nutritional excess and imbalance will have embarked on programmes to minimize these health hazards.

— *Approaches*

215. WHO will stimulate the coordinated action of the health and other sectors concerned at the international level to support countries in defining and implementing coherent food and nutrition policies, with a view to improving the nutritional health of all population groups; support and collaboration will continue with the ACC Sub-Committee on Nutrition, with FAO, the World Bank and UNICEF, among others.

216. WHO will promote the development and adaptation of appropriate methods for the integration of nutrition activities within primary health care, including early detection, prevention and treatment of malnutrition. It will promote methods for the surveillance of nutritional status, including identification and refinement of useful indicators, and for the forecasting of food availability as basic approaches to enable countries to plan and monitor their nutrition programmes. This will be coupled with identification and adaptation of simple and appropriate technologies for handling of food in the home. Research on how to mitigate and control malnutrition in developing countries will concentrate on community studies, involving a combination of social, cultural, economic, agricultural, epidemiological, nutritional and managerial expertise. Particular emphasis will be placed on

improving nutrition of infants, children, pregnant or lactating women and other vulnerable groups, such as the elderly, as well as on using locally available food and on attempts to improve food supply programmes. Special attention will be given to the promotion of breast-feeding and adequate weaning practices for the improvement of infant and young child nutrition.

217. The nutritional side-effects of rapid urbanization in developing countries and of over-eating and dietary imbalance in affluent ones will be combated through promotion of more healthy life-styles and eating habits and improvement of mass catering practices. To generate the knowledge required to this end, further research will be carried out on food requirements for people at different ages and with different occupations.

218. WHO will encourage the incorporation of appropriate nutrition concepts and technologies in the curricula of health workers at all levels and of workers in other sectors, particularly agriculture and education. This will include the development and testing of educational materials on nutrition for health workers, families and communities. The programme will be carried out in close collaboration with related programmes such as the control of diarrhoeal diseases, rural water supply and the Expanded Programme on Immunization.

— *Targets*

8.2 Oral health

219. This programme's activities will aim at fostering national and international action so that by 1989:

(1) at least 55% of Member States will have achieved an oral health status in their population equivalent to that defined by the global indicator of no more than 3 decayed, missing or filled teeth at the age of 12 years;

(2) 95% of the countries will have collected sufficient data on prevalence of oral diseases to assess accurately the oral health status of their populations.

— *Approaches*

220. The focus will be on prevention, especially at pre-school and school ages, by all available means including recourse to the effective use of fluoride. Dietary control and oral hygiene will be promoted to reduce oral disease. Appropriate materials for oral health education will be prepared in collaboration with the programme of Public Information and Education for Health for use in primary health care.

221. The identification of priority issues for research into oral health problems and ways of preventing them and into alternative methods of delivery of oral health services, particularly through primary health care and to underserved groups such as young mothers and the elderly, as well as promotion and coordination of such research and its implementation, will be of major importance for achieving the targets. This will include updating, development and field testing of methods for surveys of disease prevalence and oral health status and for coordinated planning of oral health services and also research on various methods of prevention. Essential material for surveys, guidance and analysis of results will be provided and a global data bank maintained.

222. Collaborating centres will be identified and encouraged to participate in this work, especially in the development and evaluation of alternative approaches to oral health care, and to adapt these approaches to local conditions in field demonstration programmes. These programmes will be utilized for regional training courses for teachers of dental personnel, including dental auxiliaries.

223. The supply and rate of training of manpower for dental care will be monitored, including different categories as appropriate for alternative approaches to oral health care, taking into account cost-effectiveness. The redeployment of excess personnel to areas of shortage will be promoted.

8.3 Accident prevention

— *Targets*

224. WHO will have:

(1) set up by 1984 a multisectoral task force in each region, and by 1985 at the global level, to strengthen existing national intersectoral bodies in accident prevention, and promote the establishment of such bodies in countries where they do not exist, so that by 1986 such bodies will exist in at least 20% of the countries in each region;

(2) published by 1985 a review and assessment of technology for accident prevention, including home accidents, and identifying priority research areas especially with regard to the influence of behavioural and sociocultural aspects and life-style on accidents;

(3) produced by 1986 guidelines on the planning and management of prevention programmes for all types of accidents, and by 1987 guidelines on the organization of services for care and rehabilitation of the injured, emphasizing the integration of accident prevention and treatment in primary health care programmes and giving special consideration to vulnerable population groups such as children, adolescents and the aged.

— *Approaches*

225. The nature of accident prevention is essentially multisectoral, involving several ministries at national level as well as industry and many other private bodies. However, the initial emphasis of the programme will be on the promotion of national policies for accident prevention, the improvement of epidemiological knowledge about accidents and of information on preventive technologies; and collaborative work with major nongovernmental organizations and intergovernmental organizations for programme coordination and strengthening of impact at national level. WHO will identify priority research areas, especially with regard to the influence of behavioural and sociocultural aspects and life-style, on accidents. The programme will aim to promote epidemiological analysis of accidents at country level to obtain a better picture of their extent and characteristics; development of a uniform system of injury classification will be encouraged. Emphasis will be given to the development of strategies for accident control at primary care and community level; to consideration of the content of health information and education programmes, particularly those targeted towards children, adolescents, the aged and the family as a whole, and to the role of specific groups, such as consumers, in the control of product safety and of different categories of health workers in accident prevention and treatment.

226. Some of the immediate lines of approach will be the production of guidelines for epidemiological surveys and educational material ensuring expert advice, organizing scientific meetings between decision-makers and technical experts, providing fellowships and establishing panels of national experts involved in accident prevention or related fields at the programme planning or similar levels in the relevant sectors concerned, such as public health, transport, education and housing. WHO will cooperate with national institutes and collaborating centres and will foster cooperation among them in order to generate information and use it to support countries as well as to provide technical support to research in specific relevant areas.

227. Different population groups of different ages and different occupations and preoccupations each have their own specific health problems in addition to those that affect them all. They therefore require health education, support and care that is specific to them, and such measures have to be included in primary health care and the supporting levels of the health system. In addition, these groups in various combinations comprise families whose patterns of organization vary widely in different countries. Yet common to all countries is the need to care for families as a whole and in particular those with young children and old people. Proper family health care will also contribute to the implementation of national population policies.

9. Protection and promotion of the health of specific population groups

228. Among specific population groups, the protection and promotion of health of mothers and children is singled out because of the special biological and psychosocial needs inherent in the process of human growth that must be met to ensure the survival and healthy development of the child. By meeting these needs and solving problems at each stage of development it is possible to minimize subsequent health problems or disabilities and bring about a substantial improvement in the overall health of the population and in the quality of life of individuals. For women of reproductive age, pregnancy-related complications are among the most common causes of death and morbidity, with both infection and poor nutrition increasing the risks of low birth weight and neonatal mortality and morbidity. Too many pregnancies or having them at too early an age create socioeconomic problems as well. The investment in child health is a direct entry point for improvement in social development and productivity; these efforts have to be followed up to take into account the particular health needs of adolescents, including school and university students. There is a great need for health policies and legislation aimed at improving the status of women and children.

229. As regards workers, a healthy labour force, whether settled in one place or migrant, is a major prerequisite for economic development; yet the work environment on the farm or in the factory may present special health hazards, including unnecessary risk of accidents. Moreover, the well-being of the whole family is dependent on maintaining the health of wage-earners so that they can provide for the family's needs.

230. Concerning the elderly, the process of aging with its increased risk of disease underlines the need for a healthy life-style, and preventive measures become all the more important. In many countries geographical mobility, including urbanization and migration, makes it more difficult for the family to take care of its elderly members and necessitates new community and family approaches to provide health and social care for this increasing population group. The interaction of the elderly members of the family with the other members, in particular children, might influence family functioning and the health of the family as a whole.

231. It is important that priority be given to populations living in extreme poverty. Also important are the needs of such special groups as migrants, refugees and the disabled.

232. Technologies meeting the health needs and problems specific to these population groups have been developed during the last few decades, but much remains to be done in adapting them to national conditions.

New technologies will have to be developed in some areas and over-reliance on sophisticated technology will have to be reduced through changes in behaviour.

— *Objective 9*

233. To support the continuous evolution and adaptation of technologies and approaches aimed at protecting and promoting the health of specific population groups, particularly women of childbearing age, children, workers and elderly people.

— *Targets*

234. This programme's activities will aim at fostering national and international action so that by 1989:

(1) all countries will have strengthened or expanded programmes for care during pregnancy, childbirth, childhood and adolescence, including family planning, with the aim of ensuring that at least two-thirds of births are attended by trained health workers, trained traditional birth attendants being also considered as such, and that at least 80% of all children have access to essential preventive and curative care;

(2) WHO will have promoted the inclusion, in all countries, of appropriate training in maternal and child health and family planning in the curricula of all health workers and of at least 70% of those in other health-related sectors, such as school teachers and social workers;

(3) WHO will have developed or adapted appropriate health technologies applicable to at least four major worldwide health problems specific to maternal and child health, such as complications of childbirth, hypertensive disease of pregnancy, low birth weight, and perinatal problems related to infection and nutrition. Particular emphasis will be laid on technologies for care in the home and at immediate referral level.

— *Approaches*

235. The Organization will provide technical and methodological support to strengthen the maternal and child health and family planning component of primary health care. Increased emphasis will be laid on collaborating with countries in the assessment, adaptation, development and field testing of appropriate technologies to cope with problems specific to pregnancy, delivery, the neonatal period and growth and development during childhood and adolescence. Special attention will be given to: (a) the

9.1 Maternal and child health, including family planning

promotion of behavioural and nutritional patterns that foster healthy pregnancies; (b) the promotion of maternal nutrition and appropriate infant and young child feeding, with special emphasis on breast-feeding, in view of the protection it affords to infants (this will include support to countries in taking suitable measures for the implementation of the *International Code of Marketing of Breast-milk Substitutes* and other related measures); (c) the prevention and treatment of the complications of pregnancy, including those that may give rise to high perinatal mortality and morbidity; (d) the prevention, control and treatment of prevalent perinatal and childhood infections, including diarrhoeal diseases, acute respiratory infections and infections that can be controlled by immunization.

236. The application of the risk approach particularly suited to maternal and child health/family planning will be promoted, where applicable, as a health systems research method and managerial tool to guide the distribution of resources and the formulation of specific socially relevant strategies for maternal and child health and family planning. Care will be taken to foster the application of closely related maternal and child health technologies in an integrated manner through primary health care supported by the rest of the health system infrastructure.

237. WHO will disseminate information widely on health aspects of family planning, including infertility, and on alternative ways of providing such planning. It will ensure technical cooperation in this field with countries that so desire, so that at least 60% of all couples of reproductive age in these countries can make use of services for birth spacing. These should help couples to decide on the timing of the first birth at a biologically and socially acceptable maternal age, to ensure adequate spacing of subsequent pregnancies and to choose the family size they desire. WHO will widely disseminate information on other aspects of maternal and child health, including trends in breast-feeding.

238. WHO will intensify work on the development of appropriate curricula and training material for maternal and child health and family planning care for all categories of health and health-related workers, including traditional medical practitioners and birth attendants. The relevance of the content of the training to the actual needs of families and communities will be emphasized. Increasing efforts will be made to promote self-reliance and enhance family and individual self-care as they relate to reproductive health and to optimal growth and development of children and adolescents.

239. The programme will promote intersectoral activities that especially affect the health of women and children. These will include social support

to families; health aspects of population policies; school health and day care of children; policies against exploitation of child labour; participation of youth and women's organizations in primary health care; and promotion of health aspects of policies and programmes related to women and development, as well as of the satisfaction of the specific needs of women in all other health programmes where relevant. The collaboration and joint programming with UNICEF, UNFPA and ILO are of particular importance to these activities.

— *Targets*

9.2 Human reproduction research

240. By 1989, the WHO programme will have:¹

(1) determined the long-term safety of methods of fertility regulation that came into use between 1970 and 1977, and assessed the acceptability and side-effects in different populations of more recently developed methods introduced before 1985;

(2) brought to completion for use in family planning programmes at least six new methods currently being developed; reached an advanced stage of clinical testing with another three methods, including one for male users, and developed simplified methods for diagnosis of causes of infertility;

(3) strengthened, to the point of self-reliance, at least one research facility in each of those developing countries that, by 1984, will have national policies on and services for family planning;

(4) devised, through service and psychosocial research in as many countries as have requested collaboration, the means of integrating family planning into primary health care in the manner most appropriate to local conditions;

(5) clarified the etiology of certain common diseases of reproduction, such as trophoblastic diseases, and improved approaches to their therapy.

— *Approaches*

241. The Special Programme on Research, Development and Research Training in Human Reproduction will bring together administrators, policy-makers, scientists, clinicians and the community to identify priorities for research and for the strengthening, in developing countries, of research

¹ To the extent that an adequate level of resources is made available for this programme.

institutions. It will marshal the scientific community to conduct activities, and to evaluate and feed back results to policy-makers, administrators and the community. The pharmaceutical industry will be involved as and where appropriate.

242. The Programme will ensure coordination of efforts in this field in the form of exchange of information, joint planning and joint activities among national, nongovernmental and international agencies involved in institution strengthening and research in human reproduction and family planning.

243. The results of the research will be synthesized and disseminated to policy-makers, programme administrators, health workers, scientists and the public, in close collaboration with other WHO programmes.

9.3 Workers health

— *Targets*

244. This programme's activities will aim at fostering national and international action so that by 1989:

(1) at least 50% of the countries will have developed occupational health programmes to provide preventive health care to workers at their places of work in various occupations, based on appropriate technology and on workers' participation;

(2) a network of at least 30 occupational health institutions will be actively collaborating with WHO in the international exchange of information and in technical cooperation and research on identified priority problems in occupational health;

(3) WHO will have developed a series of guidelines on health surveillance in workplaces, occupational exposure limits, control measures, early detection and appropriate care of occupational and work-related diseases concerning various groups among workers.

— *Approaches*

245. WHO will collaborate with countries in identifying their occupational health problems and in developing and adapting techniques for early detection, prevention and control of workers' health problems including psychosocial problems related to adverse working conditions and the health problems of special groups among the workers, including children, adolescents, working mothers, migrant workers, miners, seafarers, the aged and the partially disabled. In collaboration with ILO, UNIDO and other

agencies in the United Nations system, attention will be given to the occupational health problems of countries in early stages of industrialization. Particular attention will be given to underserved sectors such as agriculture, small-scale industry and construction. Innovative and integrated programmes will be developed catering to the health needs of high-risk groups among workers. Support will be given to the training of various types of occupational health manpower.

246. In close cooperation with ILO and occupational health institutions in various countries, an internationally coordinated research and development programme will be undertaken on priority health problems identified in occupational exposure to hazardous chemical, physical, biological and psychosocial factors, as well as on work physiology and ergonomics and related health legislation. This will include identification, adaptation and testing of appropriate technology for prevention of occupational and work-related diseases, occupational hygiene and improvement of the working environment. Control of delayed effects on workers of hazardous exposures, e.g., occupational carcinogenicity and mutagenicity will be given special consideration.

247. International consultations, scientific groups and expert committees will be organized to develop a series of guidelines, manuals and other teaching materials for occupational health, including guiding principles and standards for occupational exposure limits to widely used toxic substances as well as for exposure to hazardous physical factors. WHO will explore the potential and the opportunities that work has in health promotion and highlight those factors that could be used for the improvement of the health of working people through adaptation of work demands and methods to human capacities and limits. Special emphasis will be placed on the development and application of educational and informative materials for the workers themselves in order to encourage their self-care and participation in their own health care programmes.

— *Targets*

248. These programme activities will aim at fostering national and international action so that:

- (1) by 1985, WHO will have established advisory bodies to identify priority health problems of the elderly and to promote relevant and humane policies and programmes for their health and social welfare;
- (2) by 1987 those countries that have identified the care of the elderly as an important issue will have formulated such policies and programmes;

9.4 Health of the elderly

(3) by 1989, technical guides, specifically relating to the elderly, will be produced in collaboration with the other programmes concerned in the following areas: life-style, nutrition, accident prevention, prevention and treatment of mental disorders, essential drugs and vaccines, rehabilitation, cardiovascular diseases and blindness.

— *Approaches*

249. During this programme period WHO will intensify its efforts to create awareness of the specific needs and problems of the elderly in changing societies and will encourage the continuation of cultural patterns that favour the care of the elderly within the family. It will collaborate with countries in formulating policies and programmes for community-based health care of the elderly, with special attention to their social integration in the community. This will include identifying and determining the extent of the main health and social problems of aging populations as well as appropriate technologies for preventing or ameliorating these problems. Particular attention will be paid to the promotion and support of self-care and self-reliance among the elderly. The types of medical and rehabilitative care that are specifically needed by the elderly will be reviewed and information on them disseminated, emphasis being laid on home and day care. At the same time, any specific hospital care for the elderly will be studied with a view to promoting speedy diagnosis, the shortest possible period of inpatient care and immediate return to community care, and rehabilitation as necessary. The availability of services for the elderly will also be studied and community participation in the dissemination of relevant information will be encouraged.

250. Mechanisms for carrying out this programme will include promotion of the establishment of national multidisciplinary committees on the care of the aged and collaboration with institutions to reorient their research towards priority problems of the elderly, whether social, psychological or biological in nature.

251. Technical guidelines and learning materials will be developed or adapted and the programme will promote the inclusion of health and social problems of and care for the elderly in the curricula of all health workers, covering such subjects as life-styles, nutrition, accident prevention, mental disorders, medical care and rehabilitation.

**10. Protection
and promotion of
mental health**

252. In many countries, increasingly rapid social change resulting from economic development, industrialization, urbanization, and related processes has had profoundly detrimental effects on the structure of communi-

ties, the functioning of families, and the psychological wellbeing of individuals. Among the immediately evident consequences are insecurity among children from broken homes, juvenile delinquency, unhealthy life-styles, and violence, all of which are in turn exacerbated by social disorganization. The erosion of traditional psychosocial support systems reduces the capacity of individuals, families and communities to cope with disease and disability and impedes them in the performance of their other social roles.

253. These psychosocial problems place additional burdens on already overextended mental health programmes that too often lack sufficient resources and technology to deal with them or with neuropsychiatric disorders and problems related to drug and alcohol abuse.

254. Some idea of the magnitude of the problem can be gained from the fact that at least 40 million people in the world suffer from severe mental illness and at least twice as many are seriously disabled by drug dependence, alcohol-related problems, mental retardation, or organic disorders of the nervous system. Epilepsy alone affects some 15 million people. Estimates vary as to the number of people affected by less severe but nevertheless incapacitating mental disorders; none, however, are lower than 200 million. Mental disorders make up a substantial proportion of all morbidity seen in the general health services of both developing and developed countries, among both adults and children.

255. Dealing with these problems requires multisectoral commitment, wide application of available technologies and research to develop new and better ones, legislative action and measures, and incorporation of a mental health component into health care at all levels of action and training; the latter must go hand-in-hand with decentralization of care and greater selectivity in problem definition.

256. During the Sixth General Programme of Work the emphasis of the Mental Health programme was on efforts to create a WHO-supported technical base for the development of mental health programmes within and among countries and to make them aware of mental health needs. The programme will now concentrate on development of technology for programme implementation. The types of WHO involvement in mental health programmes at national and international level will vary according to national circumstances, ranging from mainly promotional to predominantly technological and behavioural activities.

— *Objective 10*

257. To reduce problems related to mental and neurological disorders, alcohol and drug abuse and to facilitate the incorporation of mental health knowledge and understanding in general health care and social development.

10.1 Psychosocial factors in the promotion of health and human development

— *Targets*

258. By 1989:

(1) the results of the evaluation of psychosocial intervention trials as part of prevention programmes for at least one group of communicable diseases and one group of noncommunicable disorders will have been made available to Member States;

(2) in at least one country in each WHO region, guidelines for the incorporation of psychosocial knowledge and skills in the training curricula of various categories of health workers will have been applied and evaluated.

— *Approaches*

259. During the Sixth General Programme of Work WHO identified general target problems where behavioural approaches can be instrumental in prevention and treatment, such as promotion of healthy life-styles to prevent stress-related diseases, the reduction of disability by enhancing the coping capacity and social support, and disease prevention through immunization. Now, the main thrust will be directed towards identification of critical links in health programmes and in general socioeconomic development where the application of behavioural science would have greatest impact. WHO will aim at elaborating general principles of the psychosocial approach and identifying appropriate methodological tools. It will also develop principles for dealing with the problems of underprivileged populations such as migrants and refugees.

260. New psychosocial knowledge will be sought, primarily using the experience of those developing and developed countries which have introduced innovative community approaches to health and social problems. Evaluation and analysis of such experience will help WHO to articulate new ways of defining and resolving psychosocial and other health problems. This knowledge will be widely disseminated, so as to create awareness and to ensure that the psychosocial dimension of health effectively becomes the concern of all sectors and participants in the health system.

261. The integration of this knowledge and understanding of psychological factors of health into the training programmes of all categories of

health personnel will receive special attention and to this end WHO will develop guidelines and teaching material for such programmes. Such material may help in attaining agreed language and concepts across cultural and sociopolitical barriers.

— *Targets*

262. By 1989:

(1) the results of the evaluation of national policies and programmes for the prevention and control of drug abuse problems in at least five countries that have adopted such measures will be disseminated to all Member States;

(2) technologies for the prevention and management of alcohol and drug abuse problems will have been identified and the effects of their application in at least one country in each region will have been documented and evaluated.

— *Approaches*

263. Such work will involve continued efforts to identify and to increase awareness and understanding of the nature and extent of alcohol and drug abuse problems, and of strategies to reduce their occurrence and severity. Emphasis will be laid on problems of and preventive measures directed towards young people, families and employment settings.

264. During the period of the Sixth General Programme of Work studies were carried out on community and national responses to alcohol-related problems and reviews were made of trends in alcohol use, alcohol-related problems, and policies and programmes to prevent these problems. This work will be further extended, in collaboration with local and national research and coordinating bodies. It will include the development of prevention and treatment methods and the study, together with other United Nations agencies concerned, of the consumption patterns of alcoholic beverages and their determinants, with a view to facilitating national efforts at introducing appropriate measures for reducing alcohol abuse.

265. In the area of drug-related problems, priority will be given to assessment of the problem, facilitating the exchange of information, and special mechanisms to monitor changes and trends in the drug abuse situation in countries, including efforts to discourage the promotion, production and distribution of dependence-producing drugs. Emphasis will be given to the development of treatments that are effective in developing

10.2 Prevention
and control of
alcohol and
drug abuse

countries and integrated in the general health care. Operational research will be promoted on how to optimize the use of resources and evaluate the impact of intervention programmes.

266. In support of country programmes, identification, adaptation and testing of appropriate technologies for prevention and control of alcohol and drug abuse will be performed, largely using WHO collaborating centres, and in collaboration with the United Nations Division of Narcotic Drugs and such agencies as the United Nations Fund for Drug Abuse Control. Appropriate information about existing methods for diagnosis, prevention and treatment will be incorporated in training curricula and learning materials for various categories of health workers.

10.3 Prevention and treatment of mental and neurological disorders

— *Targets*

267. By 1989:

(1) the effect of such programmes as immunization, tropical disease prevention and accident prevention on the prevalence of mental and neurological disorders resulting from organic brain damage will have been documented, evaluated and disseminated in reports and publications used by health planners;

(2) technological guidelines will have been designed for the prevention and clinical management within primary health care of selected mental and neurological conditions in children, adults and the elderly; at least one country in each WHO region will have introduced them on a national scale and documented their effectiveness.

— *Approaches*

268. The work of WHO in the preceding programme cycle has contributed to increasing the fund of knowledge available to Member States as regards the prevalence and nature of mental health and neurological problems in different parts of the world. Countries are now in a better position to define their own priorities, and many governments in developing and developed countries have initiated programmes based on an awareness of the role of mental health in national health development.

269. In this programme period WHO will first focus on translating the information and the technologies that already exist into action programmes, while continuing to promote timely measurement of these disorders. The main emphasis will be on preventable disorders of brain structure and

function due to infections and parasitic, nutritional, metabolic, toxic and traumatic causes. Most of these causes can be controlled through public health programmes ranging from immunization to environmental protection and the prevention of accidents. WHO will aim at promoting projects to demonstrate how, at little additional cost, special foci on the prevention of mental and neurological disorders can be developed within such programmes and lead to very appreciable benefits by reducing problems such as epilepsy, mental retardation, chronic encephalopathy and peripheral neuropathy.

270. Second, WHO will aim at the development of new, or better, technologies for prevention, treatment and management of disabling mental and neurological disorders that cannot be prevented or adequately controlled through existing knowledge. In view of the heterogeneous causation of these disorders, the Strategy will be selective. For children the focus will be on disorders in conduct and retarded development, conditions that are often associated with delayed socialization and that carry a high social cost. For adults, priority will be given to conditions such as schizophrenia, epilepsy and recurrent affective disorders, and for the elderly to conditions such as depressions and dementias. Effects of these conditions on individuals, their families and the community will be given attention. Emphasis will be laid on identification, adaptation and testing of effective, low-cost methods and strategies for the prevention and treatment of these disorders within the family or the community as well as within the general health care system.

271. A major prerequisite for health development in all countries is the improvement of environmental health. The lack of safe drinking-water, the insanitary disposal of solid and liquid wastes and the prevalence of contaminants in the environment continue to be important problems. Priority attention must be given to the underserved populations, both in rural and urban areas, linking improvements in water supply and sanitation with other developments in other sectors such as health education and housing. The complementary relationship between sanitation and water supply is now recognized, as is the need to raise levels of basic sanitation in communities by well-defined and complementary programmes so that the health benefits of improved water supply can be fully realized. Difficulties in meeting the global goals of the International Drinking Water Supply and Sanitation Decade, i.e., of safe water and adequate excreta disposal for all by 1990, are caused by a shortage of trained manpower, inadequate institutional development, difficulties in operation and maintenance of existing facilities, and lack of infrastructure for ensuring water quality.

11. Promotion of environmental health

272. The development of national programmes for prevention and control of environmental hazards has not, in general, kept pace with the increase in environmental health problems brought about by rapid industrialization and urbanization, or by introduction of new technology. There is a need for policy, legislative and institutional framework to support the implementation of national control programmes in many countries.

273. Foodborne diseases continue to be an important cause of morbidity in both developing and industrialized countries. Biological contamination is responsible for spoilage and the resultant discarding of vast quantities of food. Foreign agents found in food, including food additives, pesticide residues, and biological and chemical contaminants, also create serious health risks.

274. The possible long-term harmful consequences for health of chemical substances, for example in giving rise to cancer, genetic mutations and changes in the human embryo, have recently come to the fore. This relates to the thousands of chemicals already in existence and the scores more being developed almost daily. International cooperation for the assessment of chemical safety, that is, of the health and environmental effects of new and existing chemicals, will therefore assume an increasingly important role in WHO's work with countries. In view of the large number of chemicals to be assessed, this programme will have to be developed on a steady long-term basis if results are to be regularly forthcoming.

275. Since problems of environmental health are being dealt with at national and international levels not only by the health sector but also by many other sectors, WHO will collaborate with United Nations agencies and nongovernmental organizations concerned on all the above issues and will foster such collaboration at the country level.

— *Objective 11*

276. To protect and promote human health through national, community, family and personal measures for the prevention and control of conditions and factors in the environment that adversely affect health.

11.1 Community water supply and sanitation

— *Target*

277. This programme's activities will aim at fostering national and international action so that by 1989 Member States will have implemented programmes of improvement of drinking-water supply and sanitation towards

the global goal of safe water and adequate excreta disposal for all by 1990, as set forth for the International Drinking Water Supply and Sanitation Decade.

— *Approaches*

278. WHO will be active in getting across the message that improvements in community water supply and sanitation are inseparable from each other and from other action aimed at improving health, particularly through primary health care. Thus, action for the improvement of water supply and sanitation must be complementary, and combined with health and hygiene education, as well as being closely related to other health programmes and programmes in other sectors. Achievement of full coverage for replicable, self-reliant and sustaining programmes will imply, among other things, decentralization of institutions, a broad-based approach and greater reliance on community resources and community-based manpower. The community will be involved at all stages in programmes the success of which will depend, in the final analysis, on the way people make use of them. This will necessitate public information activities, health and hygiene education, and support from the government infrastructure.

279. At the country level a prerequisite will be the development of national plans and programmes, the identification and implementation of projects and the strengthening of national institutions and capabilities, to all of which WHO will lend its support. WHO will provide information on ways of strengthening the health infrastructure and that of other sectors to plan and implement these programmes and to ensure that immediate and long-term plans for improving facilities and services for rural and urban fringe populations are fully integrated with the national primary health care efforts, with due regard to the impact on programmes for control of diarrhoeal diseases, nutrition and food protection. Operation and maintenance factors will be emphasized.

280. WHO's role in cooperative action for the International Drinking Water Supply and Sanitation Decade (IDWSSD) will comprise, among others, support to national action committees and technical support teams for IDWSSD, and other national mechanisms set up for health for all by the year 2000; and technical support for mobilization of external resources, mainly for the development and implementation of national plans and programmes, institution strengthening and manpower development. Within the United Nations system WHO will continue to assume the central technical responsibilities for the Decade and to provide the permanent secretary

to the IDWSSD Steering Committee. It will collaborate closely at the country level with the resident representatives of the United Nations Development Programme.

11.2 Environmental health in rural and urban development and housing

— *Targets*

281. This programme's activities will aim at fostering national and international action so that by 1989:

(1) most countries will have undertaken environmental impact assessments in relation to both rural and urban development and housing;

(2) at least one-third of the countries should have developed policies and strategies to ensure that environmental health aspects are incorporated in rural and urban development and housing programmes.

— *Approaches*

282. Efforts will be concentrated on preparing sound principles for environmental health as they relate to rural and urban development and housing in countries at different stages of social and economic development. WHO will exercise its role of coordinating authority on international health work to bring together the experts required in various sectors in order to generate these principles. It will use every suitable opportunity within WHO and in appropriate national and international forums to gain acceptance of these principles. However, realizing that their application will depend in large measure on sectors of government other than the health sector and on other United Nations agencies and nongovernmental organizations, it will use its powers of persuasion, both moral and technical, to induce these sectors and agencies to apply them.

283. The emphasis will therefore be on promoting a better understanding in other governmental sectors of environmental health factors and the impact on people's health and psychosocial wellbeing of housing conditions and of specific environmental factors such as noise and air quality, including the quality of indoor air and the disposal of solid waste. Studies will be initiated in order to establish environmental health criteria for housing and for urban and rural settlement programmes, from the small village to the large conurbation, adapted to different climatic conditions and socio-cultural contexts. Particular attention will be devoted to the health needs of special groups, such as the elderly and disabled, children, migrant or refugee families and the inhabitants of urban slums. Further to its own recommendations WHO will make available information on low-cost health technologies in housing, local materials and self-help programmes.

284. WHO will encourage the development of the health component of town planning, with due regard to zoning, housing, traffic, recreational facilities, playgrounds and parks. Based on established norms and criteria, guidelines and information material will be developed for the protection of human health in housing and urban and rural development projects and on appropriate technologies for environmental health impact assessment and control measures. WHO will promote the incorporation of this technical information into the professional training of such personnel as engineers, architects, town planners, social scientists and economists. Legislative and control mechanisms will be promoted.

285. The Organization will pursue the study and analysis of situations in which ecological changes, particularly those resulting from urban and rural development, might give rise to health hazards. For this purpose it will promote the study and analysis of, and the collection of information on, types of ecological changes that might create such hazards; research on the prevention of communicable diseases that are spread by deficient sanitation and are associated with rural and urban development, as well as on factors that might promote and adversely affect the quality of life that are associated with such development; and the participation of health experts in the planning of rural and urban programmes to make the control of hazards due to ecological changes an integral part of such plans.

— *Targets*

286. This programme's activities will aim at fostering national and international action so that by 1989:

(1) in more than 50 Member States, further to previous evaluation, the national policies and programmes for the health protection of people against environmental hazards will be effectively formulated and implemented with the active participation of health agencies and other agencies concerned;

(2) international capacity will have been created, with the active participation of some 25 Member States, to assess the possible adverse health effects from chemicals in air, water and food that are of international significance because of their ubiquity, severity and persistence in the environment, and methods for their testing will have been made globally available.

— *Approaches*

287. WHO will establish and review periodically, in consultation with national experts, a list of pollutants and hazards (including various forms of radiation) with potentially adverse effects on human health. It will

11.3 Control of environmental health hazards

conduct or participate in international reviews of new technological developments (such as those related to energy including nuclear power projects) to identify major impacts on human health and welfare and will publish the results of the above reviews. It will encourage lending and development agencies to incorporate adequate health protection measures in their projects and plans. It will support intercountry cooperation in controlling the pollution of international waterways.

288. WHO will support national environmental monitoring systems in the collection and analysis of data to provide up-to-date assessment reports identifying high risk areas and groups and will encourage further development of monitoring techniques towards this end. These national reports will form the basis of regional and global trend analyses. System components that need to be internationally compatible will be identified, and guidelines for harmonizing regional monitoring systems will be developed.

289. The WHO/ILO/UNEP International Programme on Chemical Safety will prepare and disseminate up-to-date reviews of research on the health effects of chemicals (including those suspected of giving rise to cancer, mutation of genes, changes in the human embryo and spontaneous abortion), guiding principles on exposure limits and on appropriate methods for exposure measurement and assessment, toxicity testing, epidemiological and clinical studies and risk assessment, information on methods for coping with chemical accidents, and information on the development of manpower in the field of chemical safety. The same applies to biological and physical agents in the environment and to food additives.

290. Recommendations for minimizing the risks of chemical accidents in specific situations will be provided, based on a survey of past accidents and their causes. Guidelines for rehabilitation of areas affected by the accidental release of toxic chemicals will be published.

291. Support measures, such as the development of appropriate curricula and training mechanisms for locally needed environmental health staff, of information on legislative aspects and environmental control, and of principles of standards setting, risk identification and assessment, and the testing and evaluation of the health effects of chemicals, will be incorporated in the formulation and implementation of national policies.

11.4 Food safety — *Target*

292. This programme's activities will aim at fostering national and international action so that by 1989 more than 50% of Member States will have

adopted policies, strategies and technologies to ensure the safety of food with a view to reducing foodborne morbidity, whatever the cause, and food losses, and improving nutritional and hygienic quality.

— *Approaches*

293. A review and analysis of national needs will identify problems related to unsafe food with a view to developing national food safety policies and programmes. WHO will collaborate in the preparation of specific health programmes related to basic food hygiene and foodborne diseases of biological origin, as well as to the chemical contamination of food. In so doing, it will assist in strengthening or establishing food contamination monitoring programmes, and the collection, evaluation and dissemination of information on contaminants in food. The Organization will continue to assess the effects on health of food additives and pesticide residues in food.

294. In its cooperation with Member States, WHO will ensure the use of the norms and standards for food safety developed under its aegis by experts in these fields. Training programmes for environmental health and other personnel will insist on the proper use of this knowledge. Adequate information will be provided to the health services for the development of effective food control mechanisms. To help solve specific national problems WHO will provide governments with information that will help them to develop appropriate food laws and progressive changes in existing food legislation where appropriate. It will stress the need to complement measures for enforcing such legislation by appropriate education of the public at all levels, with special emphasis on food handlers and controllers.

295. Coordination and collaboration with FAO in the Codex Alimentarius Commission will continue to increase the output of the *Codex Alimentarius* as regards Codex standards and codes of practice. Coordination and cooperation will also continue with the International Atomic Energy Agency, FAO and other interested bodies on the assessment of new technology for food preservation and the value of irradiation of foodstuffs.

296. Clinical, laboratory and radiological techniques are essential for the diagnosis and treatment of disease and injury, and thus for primary health care. However, the ever-increasing complexity of clinical care, and the laboratory and radiological procedures associated with it, while resulting in increasing costs, have not always resulted in corresponding improvements in health, even in the most affluent nations. It is thus necessary to

12. Diagnostic, therapeutic and rehabilitative technology

identify those elements of clinical care that are essential, especially at the primary and immediate referral levels. This means concentrating on the commonest disease conditions and injuries, adapting, modifying and simplifying technology, emphasizing the role of allied medical professional and auxiliary personnel and improving their training, and providing for physical, mental and social rehabilitation, meanwhile taking into account the contribution that traditional medicine can make.

297. Another major contributor to increased costs is the price of drugs that are too often produced in response to the marketing imperatives of pharmaceutical firms rather than to health policy and systematic and regulated prescribing practices. As a result, the concept of essential drugs has emerged, linking drug priorities with main health problems and the elaboration of drug policies, leading to the optimal use of finite financial resources of developed as well as developing countries.

— *Objective 12*

298. To promote and support the use, development, and adaptation of diagnostic, therapeutic and rehabilitative technologies and the proper use of medicinal drugs, appropriate for specific national systems and institutions.

— *Targets*

299. This programme's activities will aim at fostering national and international action so that by 1989:

(1) most countries will have taken measures to identify and arrive at standards for clinical, diagnostic and treatment methods (including surgical and manipulative methods) that are appropriate for provision to individual patients through primary health care and the immediate supporting levels of the health system. These will include the distribution among various members of the health team of responsibility for administering these measures, especially at the primary and secondary levels of the health system, and for promotion of self-care wherever feasible;

(2) most Member States will have developed and will manage clinical, public health, laboratory and radiological services as an integral part of their health systems.

— *Approaches*

300. WHO will collaborate with countries in the selection and adaptation of the most essential clinical diagnostic and treatment measures for

12.1 Clinical,
laboratory and
radiological tech-
nology for health
systems based on
primary health care

providing effective patient care under varying national conditions, particularly through primary health care and the immediate support levels. This will include the specific clinical needs of infants and children, obstetric and gynaecological care, general medical care and essential surgery and related anaesthesia. These efforts will involve the assessment of various clinical technologies from the simplest to the most complex and the wide dissemination of the results of such assessments.

301. WHO will promote the integration of appropriate clinical and public health laboratory and radiological technology within national health systems, particularly in support of primary health care. This will include laboratory support to epidemiological surveillance and, where applicable, blood bank technology and basic immunological techniques in the diagnosis and treatment of communicable diseases and diseases related to immunological factors. The development or improvement of systems for the local preparation of laboratory reagents and of manuals for local production and quality control of reagents and equipment will be part of the programme.

302. WHO will collaborate with Member States in the selection of appropriate laboratory, radiological and other diagnostic and therapeutic technology, as well as the assessment of basic radiodiagnostic equipment particularly for the level of direct support to primary health care. Training materials will be provided and training offered on the correct use of these technologies to physicians and other health workers prescribing them. This will include orientation towards cost consciousness with a view to containing costs. Training will also be provided in the sound management of laboratories and radiological services.

303. The development of training programmes for trainers and managers in the use and maintenance of appropriate laboratory and radiological technology and equipment will include the preparation of appropriate manuals and short-term training schemes for technicians and operators of such equipment and for the general health personnel to enable them to interpret X-ray films, clinical laboratory findings and relevant information necessary for more adequate diagnosis and treatment of patients.

304. WHO will assist in the design, selection and procurement of basic and appropriate laboratory and radiological equipment and supplies for countries.

— *Targets*

305. This programme's activities will aim at fostering national and international action so that by 1989 most countries will have:

12.2 Essential
drugs and vaccines

(1) formulated drug policies and strengthened national capability for their implementation, to ensure quantification of needs, procurement, production as necessary, distribution, and management of essential drugs;

(2) ensured the regular supply at the primary health care level of the most effective, frequently used, and affordable essential drugs and vaccines.

— *Approaches*

306. WHO will promote the establishment of national drug policies suited to each country's health needs and resources as part of national health programmes, including the selection of essential drugs, quantification of drug needs, drug supply and management, quality control, control of drug utilization, and the proper use of medicinal plants where applicable. It will do so through developing guiding principles for the formulation of national drug policies by governments, including such matters as methodology for estimating needs for essential drugs and for establishing sound distribution systems and logistic support. WHO will collaborate with Member States in applying these principles. To facilitate the establishment and implementation of these policies, WHO will provide information on drug legislation and support to countries for developing their own appropriate legislations.

307. WHO will foster collaboration among Member States in the field of essential drugs and vaccines, particularly among developing countries within regions and subregions, in such areas as: pool procurement; exchange of information on relevant aspects of drug policies and management, particularly on sources of supply of bulk drugs and raw materials; establishment of regional or subregional networks of national establishments, including national vaccine and serum laboratories, for production, supply and quality control of essential drugs, vaccines and sera; transfer of pharmaceutical technology; and exchange of trainees and expertise.

308. In order to implement national drug policies, strengthening of manpower capabilities in the different components of the programme will be organized by WHO. Cooperation with nongovernmental organizations and industry will be pursued to implement the above-mentioned approaches.

309. In cases of special need, the Organization will ensure the provision of essential drugs for primary health care for developing countries in collaboration with UNICEF and other donor agencies.

12.3 Drug and vaccine quality, safety and efficacy

— *Target*

310. This programme's activities will aim at fostering national and international action so that by 1989 most countries will have developed the

means for monitoring and maintaining the quality, safety and efficacy of the drugs and vaccines needed by the national health system infrastructure.

— *Approaches*

311. For biological products it will be necessary to pursue the establishment of international biological standards and reference preparations for antibiotics, blood products, enzymes, hormones, vaccines and sera, or replace these standards where needed. Countries will be able to establish national standards through their national control laboratories. Where these do not exist, however, the Organization will assist national producers to calibrate the potency of working standards in international units. Emphasis will be put on the transfer of technology for the production, calibration and testing of biological reference materials. Formulation of requirements and guidelines for the production and quality control of vaccines and sera will be continued. Such requirements and guidelines will be reformulated as new technology demands modification; this will include the review of the production of biological substances through the application of modern technology, such as genetic engineering.

312. The WHO Model List of Essential Drugs will be updated periodically and related information for prescribers at the different levels of health care as well as for nonprofessional primary health care workers will be disseminated to Member States. Relevant pharmacopoeial specifications will be prepared for these substances and basic quality tests will be developed for simple dosage forms. The Organization will promote and facilitate the rapid dissemination of evaluated information on all drugs and in particular on those widely available, through the designation of international non-proprietary (generic) names, and through issuing drug information circulars and drug bulletins.

313. WHO will keep under review standards for good manufacturing practices. As decided by the Health Assembly, the Organization will continue to recommend to Member States that they apply the requirements for *Good Practices in the Manufacture and Quality Control of Drugs* and that they participate in the *Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce*.¹

314. The Organization will encourage collaborative efforts among Member States as well as with the pharmaceutical industry to ensure prompt provision of information for wide dissemination on all matters concerning drug efficacy and safety, including adverse reactions to drugs. To this end

¹ For texts see WHO Official Records, No. 226, 1975, Annex 12, p. 88.

it will foster collaboration not only among Member States but also between internationally renowned pharmacologists, clinicians and health managers.

315. The Organization will intensify its collaboration with governmental drug regulatory agencies and interested nongovernmental organizations on concerted collaborative approaches for specific technical issues. It will develop curricula and materials for the training of personnel responsible for drug control at all levels, particularly in developing countries.

12.4 Traditional medicine

— *Targets*

316. This programme's activities will aim at fostering national and international action so that by 1989:

(1) those countries in which traditional medicine is widely practised will have incorporated useful traditional practices into their general system for delivering health care;

(2) at least two centres for research on traditional medicine will have been identified in each region and as many traditional medicinal plants or treatments as possible will have been identified and tested for effectiveness and safety for treatment of people as part of their cultural pattern.

— *Approaches*

317. Traditional medical practices vary widely in different countries in keeping with their social and cultural traditions, which is their strength. WHO's programme will promote such traditional self-reliance. At the same time it will identify ways in which traditional practitioners and birth attendants can be trained and mobilized to play their proper role in the general health system without destroying their individuality. It will do so by fostering and supporting national activities to this end. Thus, studies will be promoted to identify useful and effective traditional practices, potentially harmful ones, and the related legal aspects. Encouragement and support will be given to local studies on traditional medicinal plants. Information on the results of these studies will be widely disseminated and technical cooperation based on it offered to countries. Such activities will serve to strengthen the role of the traditional systems as a linkage between the community and the more formal health systems; they will be reinforced where applicable by the integration of traditional health workers into the health team.

318. Institutions will be identified in developing and developed countries to carry out research in ethnopharmacology and traditional systems of

medical practice such as acupuncture, as well as epidemiological follow-up of their use. They will seek *inter alia* to identify potent herbal drugs for such purposes as fertility regulation and treatment of cardiovascular disease and diabetes, and test the best and safest ways of using them.

319. On the basis of such research WHO will promote the use where appropriate of effective traditional medicines and practices at all levels of the health system but particularly through primary health care. Where relevant it will encourage programmes for the setting up of herb gardens, particularly at the family and community level, to facilitate the use of safe herbal remedies in self-care.

320. Support will be provided to interested countries to strengthen appropriate training mechanisms both for the continuation of existing useful traditional practices, for example breast-feeding and culture-based mental health care, and for the introduction into them of more modern methods of preventive and curative health care, such as proper nutrition, family planning, immunization and the care of infants with diarrhoea and acute respiratory infections. Training curricula, training materials, and any general guidelines and manuals will lay overriding emphasis on the local character of the practices concerned so that cultural patterns are fully respected.

— *Target*

321. This programme's activities will aim at fostering national and international action so that by 1989 at least 50% of all countries will have initiated community-based rehabilitation programmes that are available and acceptable to all sectors of the population, especially the rural and urban poor, concentrating on the major categories of disabilities or handicaps caused by locomotor, speech, hearing, seeing and mental disorders.

— *Approaches*

322. Existing information on the prevalence of the most common disabilities and handicaps and their prevention, treatment and rehabilitation will be made available to Member States, so as to promote understanding of the issues and initiate action programmes on a multisectoral basis. WHO will promote the concept of physical, mental and social rehabilitation as an integrated approach through primary health care.

323. Research for the identification and adaptation of appropriate technology for disability prevention and rehabilitation will be promoted

12.5 Rehabili-
tation

and supported through institutions in both developing and developed countries. Emphasis will be laid on community-oriented methods and individual self-care rather than conventional approaches with their emphasis on institutionalized care. As much as possible education and training of handicapped persons in ordinary schools will be encouraged for better integration into the community.

324. . Development projects for rehabilitation will be promoted and supported in countries, when required. National capacity for planning and management of disability prevention and rehabilitation programmes will be strengthened, and exchange of experiences among countries facilitated, through various regional and intercountry training activities for existing and potential managers of such programmes.

325. The integration of disability prevention and rehabilitation with primary health care, as well as development of special manpower, including volunteers, when required, will be supported by development of appropriate curricula and teaching/learning materials for various categories of health worker. The manual *Training the Disabled in the Community*, developed during the period of the Sixth General Programme of Work, will be updated in the light of the experience gained with its use and widely distributed.

13. Disease prevention and control

326. The heavy burden of disease, communicable and noncommunicable, continues to absorb an unduly high proportion of health budgets of both developing and developed countries. A reduction of mortality and morbidity in both children and adults is essential, not only to the improvement of the health status, but in support of economic development.

327. Communicable diseases, complicated by malnutrition and other adverse socioeconomic factors, are major contributors to the inordinately high levels of morbidity, mortality and disability, particularly in the under-five age group, in all developing countries. More than 30% of deaths in children in their first five years are due to acute diarrhoeas, resulting in as many as three to five million deaths annually. Acute respiratory infections, primarily pneumonias, are another major killer, with a worldwide estimate of 2.2 million deaths per year. Malaria continues to take its heavy toll, with some 150 million people affected annually, and about one million children dying every year in tropical Africa alone. Tuberculosis still remains a major public health problem in all developing countries.

328. Sexually-transmitted diseases are everywhere on the increase with a general shift towards the teenage group, and the rising incidence of their

complications is causing high social and economic costs. Where blindness is concerned, 80% of the world's estimated 42 million blind people live in developing countries where the main causes of blindness are mostly avoidable. Diseases resulting from pathogenic protozoa and helminths cause a broad spectrum of diseases of major socioeconomic importance, with 600 million people at risk from schistosomiasis and 200 million from filariasis, including onchocerciasis. There are still real threats of epidemics and pandemics of viral and bacterial origin, made more likely by inadequate epidemiological surveillance, deficient preventive measures and man-made disruptions of ecological or other factors. Of increasing concern are acquired resistance and natural insensitivity to chemotherapeutic agents, nosocomial infections and vector resistance to chemical pesticides, that impede progress in disease reduction and increase costs of control operations. Rapid urbanization and the expansion of travel and population movement and of trade in human and animal foods within and between countries all have increased the risk of introduction of diseases.

329. Noncommunicable diseases also represent a growing and costly public health problem, well established in highly developed countries and rapidly encroaching on developing countries. Cancer is one of the three leading causes of death in all countries, with prevalence conservatively estimated at over 20 million worldwide at any one time and annual mortality at over 6 million. Cardiovascular diseases, in developed countries, are the leading cause of death among men and second or third among women. Hypertension is ubiquitous and prevalence rates of around 150 per 1000 exist in both developed and developing countries. Rheumatic fever, though eminently preventable, still has prevalence rates of up to 10–20 per 1000 among underprivileged children. Chagas' heart disease affects several million patients in South America; other cardiomyopathies are an important cause of morbidity and death in Africa and South-East Asia.

330. Stroke is a worldwide problem especially in older age groups. Concerning other noncommunicable diseases, diabetes mellitus affects at least 30 million people throughout the world and the numbers of cases reported are increasing rapidly. Mortality data grossly underrepresent the real magnitude of the problem. Chronic rheumatic conditions put a considerable social and economic burden on societies with a high life expectancy, and chronic respiratory diseases represent a large part of the huge total of respiratory disease in mankind. Genetic factors may account for as many as 10–20% of perinatal and infant deaths and more than one-third of all admissions to paediatric hospitals.

331. In response to these problems, it is essential to evolve epidemiologically-based and monitored control strategies as part of primary health care. These would be centred on prevention to avoid high human and financial costs of curative medicine and rehabilitation, and would include changes in life-style, prevention by available vaccines, collective and environmental measures, education of the public, and participation of individuals as members of a community.

— *Objective 13*

332. To prevent and control major communicable and noncommunicable diseases.

— *General approaches*

333. In order to achieve this objective, there are approaches common to most programmes such as the development of simple tools for epidemiological surveillance and monitoring of diseases and rapid simplified diagnostic techniques at all levels and particularly in district and rural health centres, in addition to specific approaches described in sections 13.1 to 13.17 below for individual diseases or groups of diseases.

334. Programmes will aim at ensuring that disease control technologies that are most effective and economical for each country are properly integrated into the health systems of countries concerned. This will include integrating technologies from certain sectors, other than the health sector, within these same health systems.

335. For all major communicable and noncommunicable diseases methods for the development and improvement of epidemiological surveillance will be used to help define problems, establish priorities, and indicate coordinated, appropriate and timely action. Problem identification will enable research to be undertaken to develop new and improved tools for prevention and treatment. From the epidemiological profile it will be possible to determine the health and socioeconomic parameters that justify control action and possibilities of preventing or controlling the diseases concerned.

336. Selection of and research on diagnostic, prophylactic and therapeutic substances of recognized quality, safety and efficacy will enable the health system to concentrate its resources on the most relevant supply of such substances for disease prevention and control.

337. Collaboration with the manpower development and training programmes will enable skilled manpower to be produced according to curricula

based on the needs for prevention and control of the most prevalent diseases in each country. Special attention will be paid to the promotion of training in epidemiology; training in immunology and related areas will be considered because of the importance of the research on, and the development of, new vaccines.

338. Exchange of technical and other relevant information both within and among countries will facilitate all the above. In case of outbreaks of disease or epidemics, Member States will be aided by the provision of emergency assistance in the form of professional and technical advisers, supplies, relevant information and by the mobilization of national and international resources.

339. The research component for the six diseases (malaria, schistosomiasis, filariasis, trypanosomiasis, leishmaniasis and leprosy) included in the Tropical Disease Research programme is covered by that programme.

* * *

Communicable Disease Prevention and Control

— *Targets*

340. This programme's activities will aim at fostering national and international action so that:

(1) by 1986, all countries will have developed means for estimating the immunization coverage being achieved and the morbidity and mortality attributable to those of the six target diseases of the Expanded Programme of Immunization (EPI) (diphtheria, pertussis, tetanus, measles, poliomyelitis, and tuberculosis) that are included within the national programme;

(2) by 1988, all countries will have established morbidity and mortality reduction targets for the period 1990–1995 and for the EPI target diseases included within the national programme;

(3) by the end of the decade, significant reductions will have been achieved in morbidity and mortality from the EPI target diseases; immunizations against these diseases will have been made available for all children of the world and immunization against tetanus will have been made available as needed for women of childbearing age.

— *Approaches*

341. During the period of the Sixth General Programme of Work the emphasis of the programme was on developing the managerial capacities of

13.1 Immunization

senior and middle level programme managers responsible for implementation of EPI. Now the programme will move on towards promotion of the complete integration of immunization into the curricula of all relevant health workers and the development and adaptation of learning materials for them.

342. Research will be conducted (in collaboration with the programme on drug and vaccine quality, safety and efficacy, 12.3) on how to improve vaccines and cold chain material and methods, on techniques for the sterilization of equipment and for vaccine administration as well as on strategies for vaccine delivery. The focus will be on methods or strategies that can both increase the programme impact and reduce the programme costs. Assessment will be made of the appropriateness of introducing additional vaccines within routine immunization programmes.

343. Through collaboration with relevant programmes, EPI will be developed in consonance with other specific health care interventions within primary health care. Particular emphasis will be laid on integration with the programmes directed towards improving the health of mothers and children, so as to reinforce mutual impact and reduce costs.

344. Appropriate approaches to periodic national programme evaluation will be further developed and tested. The aim will be to provide objective data on immunization achievements in relation to established targets as a basis for reformulating research, training and operational priorities and/or reviewing relevance and effectiveness of the approaches.

13.2 Disease vector control

— *Target*

345. This programme's activities will aim at fostering national and international action so that by 1989 at least 50% of the countries severely affected by vectorborne diseases will have acquired means for self-reliant development, implementation and evaluation of vector control strategies, involving communities in their self-protection.

— *Approaches*

346. The approaches to vector control developed in the past for the prevention of vectorborne diseases have not always been suited to the socioeconomic conditions of countries most affected by these diseases, the widest gap between technological development and available resources being found in the rural areas of tropical zones. The action already initiated to remedy this imbalance will be speeded up. High priority will be given to the strengthening of institutions in the endemic countries to further develop a network of collaborating centres for vector research, training and advisory

services so that appropriate control strategies may subsequently be developed under every set of epidemiological and socioeconomic conditions. Seminars on an integrated control strategy and pilot trials at the village level will be organized. Community involvement in vector control will be encouraged through appropriate motivation and education.

347. Cooperation with FAO, UNEP, UNIDO and industry will be intensified to develop more cost-effective materials and methods, due consideration being given to their human and environmental safety and social acceptability. Priority will be given to preventive measures based on environmental management whenever possible.

348. Specific investigations on vectors will be sponsored and coordinated when required for the development of improved control strategies, employing, where indicated, combinations of physical, biological and chemical control methods. The dissemination of information on this subject will be further streamlined.

— *Targets*

13.3 Malaria

349. This programme's activities will aim at fostering national and international action so that:

(1) by 1986 most countries where malaria exists or threatens will have developed programmes to prevent and control it;

(2) by 1989 all countries with established countrywide programmes for control and/or eradication will have substantially reduced the annual malaria morbidity with the aim of attaining less than 1% morbidity. In all countries, effective measures will have been taken at least to reduce the mortality from malaria in special groups, such as children under nine years of age and pregnant women;

(3) by 1989 measures to prevent the re-establishment of malaria will be operating as part of the general health system in all areas that have been freed from the disease.

— *Approaches*

350. In order to attain these targets, the programme will collaborate with Member States to determine an appropriate stratification of areas and populations into ecologically, epidemiologically and operationally homogeneous zones, and to ensure the development and implementation of realistic plans for malaria control and, where feasible, eradication. These will include

the effective provision and utilization of appropriate chemotherapy, health education and active involvement of the community, as well as implementation of insecticide spraying operations whenever appropriate, particularly through primary health care. They will also include cooperation between neighbouring countries and territories.

351. In support of this, the Organization will emphasize the application of effective technology for determination and monitoring of malariogenic potential and of effective surveillance mechanisms. This includes the development of warning systems for early detection of epidemics, strengthening of response capability to eliminate foci of infection, as well as the preparation and implementation of emergency plans.

352. WHO will encourage epidemiological studies and applied research to improve the use of known methods and technical tools and find alternative methods for malaria control as part of primary health care. Such research will be coordinated with the Special Programme for Research and Training in Tropical Diseases.

353. These approaches will be supported by efforts to develop coordinated regional malaria training programmes designed to facilitate, at national level, the development of appropriate curricula related to malaria prevention and control for various categories of health workers and other manpower needed. WHO will continue to identify, further develop and field test appropriate and cost-effective technologies including operational approaches built on active community involvement.

13.4 Parasitic diseases

— *Targets*

354. This programme's activities will aim at fostering national and international action so that:

(1) by 1989 those countries affected by major endemic human parasitic infections not liable to epidemic outbreaks will have developed programmes for control of these diseases and achieved an overall reduction of the incidence of 40% for schistosomiasis and gastrointestinal parasites and of 25% for filariasis.

(2) by 1986, sufficient capacity will be developed to detect, intervene and control epidemic outbreaks of major human endemic parasitic infections, such as visceral leishmaniasis and African trypanosomiasis, so that by 1989 most countries will be in a position to cope adequately with any new epidemics.

— Approaches

355. Epidemiological assessment of the distribution, responsible ecological factors, and extent of each parasitic disease will be studied as a basis for priority setting. WHO will encourage technical cooperation between countries having the same ecological conditions. An important thrust in the programme, relating both to endemic diseases and to those liable to epidemic outbreaks, will be the search for optimal methodologies for their control, applicable at the community level and directed against parasites in man, vectors and intermediate hosts, as well as measures to reduce parasitic contact between man, vectors and intermediate hosts. This will include, wherever applicable, integration of control operations into projects for rural and urban development, water resource development and other projects; examples of this are the systematic investigation of parasitic disease problems associated with water resources development, the improvement of triatoma-free housing and prevention of vector contact for the control of Chagas' disease, and the prevention, through health education, of the consumption of *Cyclops*-polluted water for the control of guinea worm disease.

356. For specific diseases not of an epidemic nature, such as schistosomiasis, the emphasis will be on population-wide chemotherapy supplemented by improved water supply and sanitation, combined, where needed, with snail control operations. Previous reliance on vertical programmes of mass chemotherapy for single diseases will be redirected to diagnosis and treatment at primary health care facilities, accompanied by vigorous health education to influence people to change their habits and thus avoid contact with contaminated water.

357. An important approach will be the development of skills and capability for control of parasitic disease by integrating these aspects into the curricula for various categories of health workers and selected workers from other sectors.

358. For specific diseases liable to epidemic outbreaks special emphasis will be put on measures such as the distribution of simple test kits for early diagnosis and treatment of African trypanosomiasis in all affected countries through the primary health care system; field research will improve methods of tse-tse fly control and reduction of contact between man and fly by simple self-help methods.

13.5 Tropical
disease research

— *Targets*

359. By 1989:

(1) goal-oriented research and development of new and better tools to control six target diseases—malaria, schistosomiasis, filariasis, trypanosomiasis (both African sleeping sickness and Chagas' disease), leishmaniasis and leprosy—will have reached a stage of:

- (a) field application and/or advanced clinical trials of improved or new chemotherapeutic agents for some of the six diseases;
- (b) large-scale clinical trials of a possible leprosy vaccine and early trials of a possible malaria vaccine;
- (c) field application and/or field trials of new simple diagnostic tests and microtechniques for monitoring drug susceptibility;
- (d) field application and/or trials of new biological methods for the control of disease vectors;
- (e) establishment of the epidemiological, social and economic bases for the development of more effective national strategies for the integrated control of the six diseases;

(2) through the strengthening of national institutions, including training, to increase the research capabilities of the tropical countries affected by the diseases, the programme will build:

- (a) a network of 60–80 self-reliant national research and training centres in tropical diseases and technical collaboration among developing countries;
- (b) through training, a base of 200–300 scientists from tropical developing countries for careers in their home countries.

— *Approaches*

360. To attain the above targets, the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases will adopt the following approaches.

361. Activities will be goal-oriented and will constitute an essential part of the technical, institutional and manpower development required at national, regional and global levels to control the major diseases affecting tropical countries. The programme is global in scope and consists of international technical cooperation, sponsored by WHO, UNDP and the World Bank, and executed by WHO. Therefore, the setting of overall policies, the review and approval of plans and budgets and the procurement of

financial resources will remain the responsibility of the Joint Coordinating Board which includes representatives of governments and of the three co-sponsoring agencies.

362. Scientific and technical review, evaluation and guidance will continue to be provided by a group of 15–18 scientists serving in their personal capacities as the Scientific and Technical Advisory Committee (STAC).

363. National scientists organized into 13 scientific working groups (SWGs), each concerned with a particular disease or subject of research, will draw up goal-oriented strategic plans for research. SWGs' steering committees consisting of 6–8 national scientists will review, implement and monitor projects in national institutions, identified in the plan and in keeping with the goals of the group.

364. The Research Strengthening Group (RSG) of independent scientists, assisted by its Executive Sub-Group, will continue to plan, guide and monitor the institution-strengthening and training activities.

365. Coordination and cooperation are carried out at the national level through: the execution of all research projects by national institutions and their scientists; the strengthening of national research institutions and the training of national research workers within the framework of national plans; and the membership of governments on the Joint Coordinating Board.

366. At the regional and global levels this will be accomplished through: close collaboration with the regional and global ACMRs, and through regional tropical diseases research secretariat committees; and the sponsorship of meetings and the funding of projects to solve health problems of regional significance.

— *Targets*

367. This programme's activities will aim at fostering national and international action so that by 1989:

(1) at least 80 developing countries will have diarrhoeal disease control programmes in operation through the primary health care services, and at least 175 country programme evaluations will have been carried out;

(2) at least 2000 national management and supervisory staff will have participated in training courses which WHO has developed and coordinated in collaboration with Member States;

13.6 Diarrhoeal diseases

(3) the known number of childhood diarrhoeal deaths will be reduced by approximately 1.5 million annually, 50% of all diarrhoeal cases in children under five in developing countries will have access to oral rehydration therapy, and at least 35% of all diarrhoeal cases in developing countries will actually receive oral rehydration therapy.

— *Approaches*

368. The formulation of national diarrhoeal disease control programmes will be promoted as an integral part of primary health care for the purpose of: (a) reducing diarrhoea mortality by the treatment of acute cases with oral rehydration therapy and by education of mothers and other family members for the proper feeding of children during diarrhoea and in convalescence, and (b) reducing diarrhoea morbidity by improvement of maternal and child care practices, especially uninterrupted breast-feeding, preparation of safe weaning foods from locally available food products, good domestic and personal hygiene, and adequate nutrition for pregnant and lactating women; by improvement of environmental health through the proper use and maintenance of culturally acceptable drinking-water and sanitation facilities; and by detection and control of epidemics, especially of cholera, through the establishment or strengthening of national systems for epidemiological surveillance and the introduction of measures to interrupt transmission.

369. Handbooks, manuals, and guidelines will be developed or improved for the conduct and evaluation of all aspects of programme operations. Assistance in programme evaluation will be provided at country request. Training curricula which have already been developed for programme managers will be continually improved in the light of experience, and new curricula will be developed as needed for primary care personnel and village-level workers. Training programmes will be assisted by the identification of instructors with practical experience. The local production of oral rehydration salts will be promoted and assisted.

370. Scientific working groups (SWGs) will continue to function at global and regional levels to guide research activities. Global SWGs will identify priority needs in basic research, and will stimulate and coordinate new research projects. An SWG in each region will provide the same services for locally relevant operational research. Basic research will aim at significantly improved understanding of diarrhoeal disease biology and epidemiology, and of the theoretical basis for prevention and control, and operational research will test managerial and technological innovations for improved programme implementation.

— *Targets*

13.7 Acute respiratory infections

371. This programme's activities will aim at fostering national and international action so that:

(1) by 1985 a set of alternative strategies for intervention at the community level will have been developed on the basis of operational and basic research to meet different national situations for the reduction of mortality from acute respiratory infections, particularly in children;

(2) by 1989 most developing countries will have formulated and, to the extent of available effective diagnostic and treatment facilities, implemented a national programme for the control of acute respiratory disease as an integrated part of maternal and child care within primary health care.

— *Approaches*

372. The development of standards for clinical management will be one of the major approaches of this programme, including controlled evaluation of effects of vaccines, where appropriate, in selected areas. It will comprise the development of criteria for the early diagnosis of various acute respiratory infections, together with the development and application of an agreed terminology, standardized data recording and reporting within the epidemiological surveillance system of each country. When necessary, laboratory capabilities for the identification of etiological agents will be strengthened.

373. Owing to the wide diversity of problems involved in acute respiratory infections, inputs from various disciplines will be necessary to evolve comprehensive and practical control methods for application at the community level through primary health care. This will be achieved through epidemiological surveillance and by coordination with programmes of nutrition and maternal and child health, as well as with programmes dealing with health-promoting behaviour and clinical, laboratory and radiological technology. In this perspective the role played by social, environmental and nutritional factors in the incidence and mortality by age group will be studied.

— *Targets*

13.8 Tuberculosis

374. This programme's activities will aim at fostering national and international action so that by 1989:

(1) morbidity in younger age groups, and the risk of new infection, will be decreasing, in all countries where there is no decrease at present, at more than 2% annually;

(2) all developing countries will have formulated and implemented national tuberculosis control programmes as an integrated component of the primary health care system; BCG vaccination and effective diagnostic and treatment facilities for tuberculosis will be readily available to all persons who require them.

— *Approaches*

375. National programmes will be strengthened by the updating of guidelines for technical norms and administrative procedures, and by improving the training of health workers at all levels. Close cooperation with all programme areas that have an important bearing on the delivery of tuberculosis control activities will be established or strengthened, particularly with the Expanded Programme on Immunization, with other communicable disease control programmes, Health System Development, and Clinical, Laboratory and Radiological Technology for health systems. Procedures for active case-finding and case holding will be developed or improved. Facilities for sputum collection and direct smear microscopy will be made available. Operational and epidemiological evaluation of the effectiveness of control methods, particularly of BCG vaccination and short-course chemotherapy, will be introduced, leading to methods for application by primary health care workers and their acceptability by communities and health staff.

13.9 Leprosy

— *Targets*

376. This programme's activities will aim at fostering national and international action so that by 1989:

(1) 90% of multibacillary cases of leprosy will be under effective treatment;

(2) all countries with endemic leprosy will have national managerial capabilities for planning, implementing, and evaluating leprosy control through the primary health care system.

— *Approaches*

377. Improved technologies for case detection, especially early detection, treatment with chemotherapy, case holding and contact follow-up will be promoted through the development of more effective control planning, programme management and training. Field application will be encouraged of significantly more effective control methods expected from the increase of efforts in leprosy research, such as simple tests for epidemiological

assessment and more potent and cost-effective chemotherapeutic regimens, and from the prevention and control of drug resistance. Curricula incorporating proven approaches will be constructed for the training of all levels of health workers—from medical undergraduates to primary health care personnel. The participation of national experts will be promoted in management and evaluation. Collaboration with international, bilateral and voluntary agencies will be encouraged. Guidance will be provided for the establishment of referral services at intermediate and central levels for diagnosis, laboratory confirmation, treatment of complications and rehabilitation. According to the progress made in the development and field testing of a leprosy vaccine under the aegis of the Tropical Disease Research programme, studies will be initiated for the development of optimal approaches for vaccination.

— *Targets*

13.10 Zoonoses

378. This programme's activities will aim at fostering national and international action so that by 1989:

(1) the strategies and practical methods for surveillance, prevention and control of major zoonoses and related foodborne diseases will have been extended to all countries, with appropriate adaptations;

(2) most countries will have national control programmes concerning priority zoonoses and related foodborne diseases.

— *Approaches*

379. During this programme period, the WHO zoonoses control centres that are currently being established will assume an increasing role in coordination of country and intercountry activities for surveillance, prevention and control of zoonoses. This will include collaboration with Member States in improving their strategies for surveillance, in development of appropriate long-term programmes to control major zoonoses such as rabies, brucellosis, anthrax, hydatidosis, plague, leptospirosis and salmonellosis, as well as emergency action to control epidemic outbreaks. Control and elimination of the risk of transmission of rabies infection to man will receive high priority, particularly infection from domestic animals. Special efforts will be made to help those countries which so request to control and eradicate foot-and-mouth disease. At the national level, the creation of multisectoral coordinating committees for prevention and control of zoonoses will be encouraged.

380. The research activities of the programme will deal with such questions as exploring changing patterns of the epidemiology of zoonoses,

including the effects on human and animal health of extensive changes in ecology brought about by rural or urban development programmes. Research for improvement of vaccines and chemotherapy will be promoted, as well as studies to identify, adapt and test innovative and appropriate technologies for prevention, recognition or control of disease. This will include cooperation with relevant agricultural programmes and public health services with a view to increasing animal production and decreasing animal loss caused by zoonoses. Efforts will be made to ensure technical standards for international trade concerning animals and animal products destined for human use or consumption, to improve technologies for processing foods of animal origin, and to develop uniform codes and guidelines for meat inspection. Technical background material will be prepared for education of the public in aspects of handling and storing food of animal origin, protection against spread of zoonoses, and other health aspects of handling animals.

13.11 Sexually transmitted diseases

— *Target*

381. This programme's activities will aim at fostering national and international action so that by 1989 most countries will have reduced morbidity due to sexually transmitted diseases (STD) through the provision of early and appropriate treatment to 70% of cases suffering from treatable STDs and through the establishment of a human environment less conducive to disease transmission.

— *Approaches*

382. In view of the importance of social behaviour in the spread of STD, development of preventive measures for risk groups will take into account their life-style and will include psychosocial factors, behavioural factors and attitudes regarding these diseases and their complications. The development of preventive measures will be facilitated by close collaboration with voluntary and nongovernmental organizations, especially the International Union against the Venereal Diseases and Treponematoses.

383. One of the major approaches of the programme will be the development of practical and simple technologies to assess STD morbidity patterns at the primary health care level and the relative prevalence of etiological agents causing similar, easily identifiable disease syndromes, such as genital ulcers, urethritis and vaginitis, so that area-specific patient management criteria and simplified approaches, usable in all circumstances, can be designed for use by health auxiliaries; WHO will encourage the

improvement of epidemiological and contact-tracing techniques. WHO will advise on cost-effective standard treatment regimens and will draw upon the techniques developed to maintain the global monitoring network for susceptibility of STD organisms to antimicrobials. Special efforts will be made to control the inappropriate use of antibiotics for STD, within the global framework of national drug policy.

384. Collaborative research will aim towards the development of vaccines (gonorrhoea, syphilis) and of other culturally acceptable prophylactic techniques; the very specific antigens and antibodies isolated in the course of this research will reinforce the programme for simplified diagnostic tests. WHO will support countries in research on factors promoting disease transmission and the development of STD complications and perinatal morbidity.

— *Target*

385. Maintenance of smallpox eradication through continuing surveillance, universal discontinuation of smallpox vaccination in 1984, and evaluation of progress in 1985.

— *Approaches*

386. Maintenance of smallpox eradication will be achieved by implementing the 19 recommendations for the post-smallpox eradication policy formulated by the Global Commission for the Certification of Smallpox Eradication and endorsed by the Thirty-third World Health Assembly.

387. To ascertain that smallpox has effectively ceased to exist as a disease, WHO will continue the investigation of suspected cases of smallpox as well as the control of variola virus stocks in laboratories. It will ensure that reserve stocks of good quality vaccine are maintained.

388. Universal discontinuation of smallpox vaccination will be maintained, except for investigators at risk. Research on, and surveillance of, human monkeypox and other orthopox virus infections will be continued.

389. A monograph on smallpox and its eradication will be published.

— *Target*

390. This programme's activities will aim at fostering national and international action so that by 1987 most countries will have established mechanisms for worldwide vigilance over other communicable diseases to ensure that those that show signs of assuming major public health importance are immediately and properly contained.

13.12 Smallpox
eradication
surveillance

13.13 Other com-
municable disease
prevention and
control activities

— *Approaches*

391. WHO will collaborate with countries in the development of health technologies for the prevention and control of other communicable diseases of major public health importance known or arising, such as meningitis, plague, influenza and arthropod-borne viral diseases, e.g., dengue and yellow fever.

392. WHO will promote and support further the development of more simple and rapid laboratory techniques for diagnosis that can be carried out at the local level and will encourage the subsequent training in those techniques and provision of necessary reagents to regional or subregional laboratories. It will develop the tools for epidemiological surveillance and monitoring of these diseases at all levels, including district and rural health centres. Self-reliance at the regional or subregional levels will enable countries to deal with epidemics of such diseases as viral haemorrhagic fevers, cerebrospinal meningitis and plague, and with emergencies caused by laboratory accidents and transport of infectious specimens.

393. A worldwide network of collaborating centres will provide the backbone for the development and the research component of the Organization's programme and will be instrumental in the transfer of technology. Identification and characterization of emergent strains of influenza virus in any country will be assured by the expansion of the international network of national influenza centres.

394. The International Health Regulations (1969) will be updated from time to time as necessary.

* * *

13.14 Blindness

— *Target*

395. This programme's activities will aim at fostering national and international action so that by 1989 programmes will exist in at least 60 developing countries for the prevention of blindness, the restoration of sight to the curable blind and the provision of essential eye care and access to referral services in presently underserved communities.

— *Approaches*

396. As a step in identifying priority health needs WHO will collaborate with countries in the assessment of the magnitude and major causes of

blindness at the national level. Appropriate technologies for prevention, wherever possible, and treatment of blindness due to such major causes as trachoma, xerophthalmia, onchocerciasis, cataract, glaucoma and ocular trauma, have been identified or are being investigated and will be implemented further at the national and community levels. Research will be carried out to develop and adapt community-based approaches to the delivery of essential eye care within the framework of primary health care, using community workers and workers from other sectors. Support will be given to countries to clear the backlog of patients whose blindness can be reversed through appropriate interventions.

397. A network of collaborating centres will be involved in research on eye health care and the development of curricula for the training of various levels of health workers. The elaboration of training aids and learning material in eye care for these workers will be promoted and tested, as well as educational material for the public on the major causes of blindness and on prevention and control of these diseases.

* * *

Noncommunicable Disease Prevention and Control

— *Targets*

13.15 Cancer

398. This programme's activities will aim at fostering national and international action so that by 1989:

(1) most countries will have developed preventive measures specific to cancers that are preventable in the countries concerned, leading to a significant reduction in the incidence of these cancers;

(2) most countries will have developed appropriate strategies for the control of their main cancers, particular attention being paid to cost and effectiveness;

(3) for incurable cancer patients, most countries will have instituted programmes promoting quality of life and dignity in death.

— *Approaches*

399. WHO will encourage the development by countries of national cancer control policies and programmes and their integration into the existing health system, and to this end will disseminate validated information on cancer prevention and control and the organization of cancer services.

Such programmes will incorporate activities aimed at the reduction of morbidity and mortality from cancer, the promotion of optimal care for persons with cancer and the stimulation of coordinated research on cancer. The improvement in and possibilities of prevention in cancer control will be emphasized during the period 1984–1989 leading to the prevention of as high a percentage as possible of the one-third to two-thirds of cancer known to be preventable. To that end, etiological aspects will be emphasized in epidemiological and surveillance studies; randomized community-based control studies will be conducted to determine the effect of such campaigns as those against smoking and chewing tobacco. This will involve not only biomedical sciences, but also behavioural sciences and public information. The most relevant, scientifically proven preventive measures will be promoted at the national level.

400. WHO will encourage the assessment of the existing technologies for the diagnosis, treatment and rehabilitation of patients with cancer. It will coordinate the search for and dissemination of effective methods in early diagnosis and will encourage studies to find appropriate intervention technologies suited to local conditions and facilities. It will ensure the collaboration of groups involved in generating new approaches to therapy, and will search for original information on realistic, efficient combined therapies for cancer that can be applicable globally. This will be especially aimed at the four-fifths of the world's population not benefiting from existing therapies with acceptable cure rates.

401. The Organization will promote and participate in the collection of data in order to develop, test and disseminate guidelines for pain relief in cancer patients, applicable in developed and developing countries.

402. The International Agency for Research on Cancer (IARC) will continue to be active in the identification of carcinogenic factors in the environment, the definition of various risk groups in respect of such factors, and the description of the epidemiological situation throughout the world. Studies on carcinogenesis and tumour epidemiology will place increasing emphasis on metabolic mechanisms of endogenous influence, as well as life-style factors involved in cancer development. The programme will then disseminate information on the latest advances in research and their practical possibilities of application in the prevention and control of cancer.

403. Close collaboration will take place between the activities of WHO's headquarters and regional offices and those of the IARC and the International Union Against Cancer (UICC).

404. Relevant information transfer, professional training and education of the public aimed at promotion of cancer prevention, early detection and other control measures will be carried out in close collaboration with other international agencies and nongovernmental organizations and in particular UICC.

— *Targets*

405. This programme's activities will aim at fostering national and international action so that by 1989:

(1) improved methods and strategies for preventing cardiovascular diseases and for reducing the prevalence of risk factors in populations will have been identified and tested;

(2) most countries will have made an assessment of the extent of the problems of cardiovascular diseases in their populations and will have consequently selected priorities for intervention;

(3) at least two countries in each region will be implementing programmes in the context of their health services, based on the above methods and strategies, to demonstrate the feasibility of preventing and controlling cardiovascular diseases in entire populations.

— *Approaches*

406. WHO will promote and collaborate in epidemiological research in different populations on the incidence and prevalence of cardiovascular diseases. Research on the etiology and pathogenesis of major cardiovascular diseases, such as atherosclerosis, essential hypertension, rheumatic heart disease and cardiomyopathies will be essential.

407. Particular importance will be attached to exploring precursors of such disease during childhood and adolescence. On the basis of these findings approaches to "primordial prevention" can be developed and evaluated for their efficiency in preventing the development of risk factors in populations where cardiovascular diseases are not yet of major importance. WHO will collaborate with countries to prevent the development of risk-inducing habits, such as smoking and faulty eating. Methods for inducing behavioural changes towards healthy life-styles will first be developed for the younger age-group.

408. WHO will collaborate with countries in developing innovative and community-based approaches to integrated cardiovascular disease

13.16 Cardiovascular diseases

prevention and control programmes within the health services adapted and field-tested in different settings to demonstrate to Member States the feasibility and relevance of such programmes. In so doing it will take into account not only the potential cost-effectiveness but also the extent to which the country concerned can afford the measures required.

409. In collaboration with nongovernmental organizations, classification and standardization of nomenclature, diagnostic criteria and methods in major cardiovascular diseases will be prepared and their use promoted internationally.

13.17 Other non-communicable disease prevention and control activities

— *Targets*

410. This programme's activities will aim at fostering national and international action so that by 1989:

(1) through the strengthening of community-oriented prevention and control measures, most countries will have significantly reduced the socio-economic burden caused by noncommunicable diseases of major public health importance, such as diabetes mellitus and chronic respiratory and rheumatic diseases;

(2) in at least two countries per region programmes will be developed to investigate the possibilities for prevention and control of the most common hereditary diseases;

(3) collaborative studies will have been completed on the combined, integrated prevention and control of a number of noncommunicable diseases on a community basis.

— *Approaches*

411. An integrated programme of prevention and control of noncommunicable diseases will aim at the combined control of a number of noncommunicable diseases in communities. The programme will do so through elucidating behavioural and cultural patterns in different societies that appear to protect people from these diseases, as well as those that appear to give rise to them or exacerbate them. Thus, studies will be made to identify the influence of certain factors on the incidence and prevalence of such groups of noncommunicable diseases as cardiovascular diseases, cancer, diabetes, and chronic respiratory and rheumatic diseases. These factors will include patterns of food composition, preparation and consumption; alcohol intake; tobacco smoking; occupation and work practices; exercise, sport, leisure activities and hobbies; as well as cultural practices. A further aspect will be the study of appropriate ways of inducing com-

munities to modify their habits and life-styles, or to adopt new ones, in the light of existing and newly generated knowledge, with a view to preventing and controlling these groups of noncommunicable diseases. WHO will select suitable research institutions in a number of countries and will coordinate the preparation of agreed study protocols to be pursued as collaborative efforts. WHO will undertake to ensure the coordinated implementation, monitoring and evaluation of these studies, and will widely disseminate their results so that all Member States can benefit from them.

412. In addition, the development of potential methodology for a comprehensive noncommunicable disease control programme will be pursued by the evaluation of existing and newly developed health and medical technology through collaboration with relevant research institutions and nongovernmental organizations, special care being taken to recommend only those technologies that have proved of real value on a cost-benefit basis. This will lead to the development of programmes of community-oriented prevention and control of diabetes mellitus, chronic respiratory, rheumatic, renal and liver diseases and the most common hereditary diseases, in such a way that participating countries can select one or more of these diseases, according to their epidemiological situation and national priorities, and use it as a model for the further development of a comprehensive programme.

413. Assistance will be provided to trainees, on return to their national institutions, for the elaboration and implementation of their research programmes in the form of advice, technical information and specialized reagents. The Organization will continue to promote and coordinate work on the standardization of diagnostic, nomenclature and classification criteria for the above-mentioned diseases.

D. PROGRAMME SUPPORT

414. Underlying all of the Organization's activities in pursuit of the operational objectives of this General Programme of Work is programme support, primarily in the information and general administrative fields.

415. Health and health-related publications, documents and other literature, whether produced by WHO or by others around the world, have a vital support role to play in building national health system infrastructures

14. Health information support

and in providing information about the latest and most appropriate developments in science and technology. But many of the countries with the greatest need for selective access to this vast storehouse of accumulated knowledge and experience have only limited means at their disposal for this purpose. It is thus necessary for WHO to work actively to overcome existing deficiencies in this regard and help maintain the flow of valid information, relevant to national needs, by both direct and promotive efforts.

— *Objective 14*

416. To ensure the availability to Member States of valid scientific, technical, managerial and other information relating to health, in printed and other forms, whether originating within the Organization or outside it, particularly in relation to attaining the target of health for all by the year 2000.

— *Approaches*

417. Mainly through consultation with institutions and individuals, WHO will act as an international clearing-house for valid information, disseminating it to ministries of health, other relevant ministries and bodies, and interested institutions and individuals, both within the health sector and outside it. This will include information on the development of health infrastructures and the related managerial process, as well as health systems research, the delivery of primary health care with the support of the rest of the system, and the selection and generation of appropriate health technologies.

418. During the period of the Seventh General Programme of Work particular attention will be given to information on health systems based on primary health care, on their development and social control through community involvement, intersectoral action and the development of appropriate health technologies through the application of scientific research and analysis of research findings. Special reference will be made to interesting examples of the above. Both textual and statistical information will be included.

419. Technical information will continue to be disseminated through WHO's publications—the *WHO Technical Report Series*, offset and other special publications; and through its periodicals—the *World Health Forum*, the *WHO Chronicle*, and the *Bulletin of the World Health Organization*. Related popular information will be published in *World Health* magazine.

420. To ensure the availability of valid information related to health whether generated inside WHO or outside it, WHO will assist countries in formulating policies and drawing up plans, including the estimation of the type and number of personnel, for the development of national health literature services as an integral part of the health system infrastructure, in encouraging resource sharing through the setting up of national health sciences library networks, and in fostering cooperation between national networks at the intercountry, regional and global levels. All efforts will bear in mind the need to speed up communications and literature exchange.

421. The day-to-day functioning of the Organization depends on a broad range of administrative services, from personnel recruitment and management to the procurement of supplies and equipment. It is thus necessary to maintain efficient and prompt services in this area.

15. Support services

— Objective 15

422. To provide effective, efficient and flexible administrative support and services at all organizational levels.

— Approaches

423. The corner-stone of the Organization's personnel policy is the recruitment of personnel of the highest standards of competence, integrity and efficiency, while paying due regard to geographical distribution, the need to increase the number of women employed, especially at the professional grades, the prospective expansion in the role of nationals in the execution of WHO collaborative programmes in their own countries, and the need for health generalists with experience in health policy and management and in an intersectoral approach to health development. Personnel policies will therefore be adapted to the overall and medium-term goals of the Organization and adopt appropriate criteria for the development, assignment, utilization and evaluation of staff in accordance with these goals.

424. The programme will ensure that facilities and other support services are available on a timely and economical basis to permit the Organization to execute its Programme.

425. It will ensure timely and efficient administration of both regular budget and extrabudgetary funds in accordance with applicable regulations and resolutions.

426. The availability of supplies and equipment organized or facilitated by WHO is often essential to the progress of many programmes. The basic factors are timely supply, low cost, reliability and standardization. Meeting these requirements will be facilitated by making available basic lists, standard specifications adapted as necessary to special requirements, and mechanisms for ensuring supplies and equipment of good quality at the lowest possible cost, as well as by the development of procurement schedules. Promotion of local production whenever technically and economically feasible, and intercountry cooperation in purchasing, are further ways of ensuring the best possible supply service.

8. Programme Implementation

427. For the implementation of the Seventh General Programme of Work, the managerial process for WHO's programme development will be closely adhered to.¹ Medium-term programmes will be worked out simultaneously for all programmes,² to ensure that there are adequate interlinkages. These medium-term programmes will then form the basis of biennial programme budgets, which will be implemented in close collaboration with Member States at country, regional and global levels. The Programme will be subjected to continuous monitoring and evaluation. At each stage of the above process, information support will be provided.

428. Consequently, medium-term programmes for the period 1984-1989 specifying the activities necessary to reach the objectives and targets and to carry out the approaches set forth for the Seventh General Programme of Work will be developed immediately after this Programme is approved at the Thirty-fifth World Health Assembly. Such programmes will be worked out by each region, and these, together with activities to be carried out at the global level, will constitute the global medium-term programmes. Based on these medium-term programmes the three programme budgets for the period of the Seventh General Programme of Work will be elaborated, detailing the activities of the medium-term programmes for a period of two years.

429. The results of permanent monitoring and evaluation of the implementation of the medium-term programmes and the programme budgets will be used to ensure the continuous relevance and validity of the Programme in pursuing the Strategy, and to refine or modify the programmes as necessary. To this end continuous consultation will take place with governments. Particular attention will be given to the programming and budgeting of WHO's resources in countries in support of the national

¹ *The managerial process for WHO's programme development*, Geneva, World Health Organization (unpublished document MPWPD/81.1).

² According to WHO's medium-term programming guidelines, currently under revision.

strategies for health for all. As a result of the above, while the Programme's objectives and targets will be maintained throughout the period of its implementation, the approaches and activities will evolve in a flexible manner.

430. To permit the Organization to implement successfully the Seventh General Programme of Work, its structures will be modified in accordance with resolution WHA33.17 as outlined in paragraphs 56 to 61 above.

9. Monitoring and Evaluation

431. The Organization will systematically monitor progress in carrying out the measures included in the Seventh General Programme of Work; it will evaluate the efficiency with which these measures are being implemented and their effectiveness in improving world health and influencing socioeconomic development.

432. Monitoring will consist of the systematic follow-up of activities described in each medium-term programme and programme budget, during their implementation, to ensure that operations are proceeding as planned, are on schedule and are delivered in an integrated way.

433. At the same time, a continuing process of evaluation will take place of the way in which the Organization's medium-term programmes reflect the Seventh General Programme of Work; the way in which the biennial programme budgets give effect to these medium-term programmes; the efficiency with which activities are carried out, and whether they are having the desired effect. Progress and evaluation reports on various components of the Seventh General Programme of Work will be submitted periodically to the regional committees, the Executive Board and the Health Assembly. The expected outcome of this process of evaluation will be an account of the extent to which the objectives and targets of the Seventh General Programme of Work are being attained through the medium-term programmes and programme budgets and what conclusions can be drawn for updating or revising programmes and modifying approaches and activities if necessary. On the basis of the results of this continuing process of evaluation the role of the Seventh General Programme of Work in supporting the Strategy for Health for All will be assessed.

434. The monitoring and evaluation of the Seventh General Programme of Work will thus be closely related to the monitoring and evaluation of the national, regional and global strategies for health for all. The process and mechanisms for monitoring these strategies are outlined in the *Global Strategy for Health for All by the Year 2000*.¹ Thus, suitable monitoring

¹ "Health for All" Series, No. 3, section VII.

and evaluation processes will be set up by countries as part of their managerial process for national health development. To facilitate the application of the evaluation process, Member States will be able to use the guiding principles for health programme evaluation.¹ Within WHO the provisional guidelines for health programme evaluation will be used.²

435. Indicators will be used at the global level that are useful first of all at the national level; a number of such indicators have been selected based on national and regional strategies.³ Regions and countries will add additional indicators if necessary in the light of their specific circumstances. During the period of the Seventh General Programme of Work particular attention will be paid to those indicators which demonstrate the extent to which countries have developed strategies for health for all and to which primary health care is available to their people.

436. WHO's mechanisms will be used for reporting on progress and assessing the effectiveness of the Strategy for Health for All. But the monitoring and evaluation of the Strategy will not await the process of monitoring and evaluating the Seventh General Programme of Work. The first progress reports on national strategies will be prepared by Member States in 1983. In the light of these, the implementation of regional strategies will be monitored by the regional committees in the same year, even before the Seventh General Programme of Work becomes operational. In 1984, the year in which the Seventh General Programme of Work becomes operational, the Executive Board and the Health Assembly will in turn be reviewing progress in implementing the Global Strategy, particularly in the light of the progress reports of the regional committees. In this way, an early warning will be given of problems encountered, making it possible to identify any action required to ensure the proper implementation of the Strategy, or to adjust the Seventh General Programme of Work if necessary before its very inception.

437. In 1985 Member States will be preparing the first evaluation reports on their strategies and the regional committees will be assessing the effectiveness of the regional strategies in the same year. These will be

¹ *Health programme evaluation—Guiding principles for its application in the managerial process for national health development*, Geneva, World Health Organization, 1981 ("Health for All" Series, No. 6).

² Document HPC/DPE/78.1, *Provisional Guidelines for Health Programme Evaluation* (under revision).

³ *Development of indicators for monitoring progress towards health for all by the year 2000*, Geneva, World Health Organization, 1981 ("Health for All" Series, No. 4).

followed by an evaluation of the Global Strategy by the Board and Health Assembly in 1986. As a result it will be possible to identify any action required to influence the implementation of the Strategy. In addition, only two years after the inception of the Seventh General Programme of Work it will be possible to adjust it again if necessary.

438. Subsequently, reviews of the findings resulting from monitoring progress will take place at biennial intervals, and of those resulting from evaluating effectiveness at six-yearly intervals. On each occasion the extent to which WHO is supporting the Strategy through the Seventh General Programme of Work, and every six years the effectiveness with which it is doing so, will form an integral part of the continuing monitoring and evaluation process.

10. Conclusion

439. The success of any Programme of Work depends on the extent to which it is used by Member States; the Seventh General Programme of Work is no exception. Its targets are ambitious; this contrasts with the somewhat sombre picture of the world health situation that looms behind the Programme. Yet, the means for attaining these targets are highly practical; undoubtedly they are very numerous and varied, thus giving rise to the danger of fragmentation of efforts. Central to the Programme, and aimed at concentrating efforts, is the emphasis laid on the progressive build-up of health system infrastructures for delivering health technologies that are appropriate to countries' needs. But these needs vary. To take account of all of them gives rise to a multiplicity of activities. To carry out these activities wisely implies their careful selection by Member States for, in the final analysis, it is they who will build up health infrastructures to deliver the programmes that their people need. While WHO will make every effort to ensure programme delivery in a coordinated manner, the proper integration of programmes is most important within countries. WHO must help its Member States to achieve such integration. Herein lies the pragmatism of the Programme; the vision lies in the global target of health for all by the year 2000. The attainment of the targets of the General Programme of Work will take the world a great step forward towards attaining this global target. In spite of the formidable tasks that lie ahead, when visionary goals are systematically pursued with pragmatism there is every reason to be optimistic about success.

Annex

Classified List of Programmes for the Period of the Seventh General Programme of Work

A. DIRECTION, COORDINATION AND MANAGEMENT

1. Governing bodies

- 1.1 World Health Assembly
- 1.2 Executive Board
- 1.3 Regional committees

2. WHO's general programme development and management

- 2.1 Executive management ¹
- 2.2 Director-General's and Regional Directors' Development Programme
- 2.3 General programme development ²
- 2.4 External coordination for health and social development ³

B. HEALTH SYSTEM INFRASTRUCTURE

3. Health system development

- 3.1 Health situation and trend assessment
- 3.2 Managerial process for national health development
- 3.3 Health systems research
- 3.4 Health legislation

4. Organization of health systems based on primary health care

5. Health manpower

6. Public information and education for health

¹ Includes Director-General's office, Regional Directors' offices, offices of Assistant Directors-General with Headquarters' Programme Committee Secretariat, office of the Legal Counsel and Internal Audit.

² Includes Directors of Programme Management in regional offices, the Managerial Process for WHO's Programme Development, WHO Information System and Staff Development and Training.

³ Includes collaboration within the United Nations system of organizations, with other organizations and with multilateral and bilateral programmes, and emergency relief operations.

C. HEALTH SCIENCE AND TECHNOLOGY

- 7. Research promotion and development, including research on health-promoting behaviour**
- 8. General health protection and promotion**
 - 8.1 Nutrition
 - 8.2 Oral health
 - 8.3 Accident prevention
- 9. Protection and promotion of the health of specific population groups**
 - 9.1 Maternal and child health, including family planning
 - 9.2 Human reproduction research
 - 9.3 Workers' health
 - 9.4 Health of the elderly
- 10. Protection and promotion of mental health**
 - 10.1 Psychosocial factors in the promotion of health and human development
 - 10.2 Prevention and control of alcohol and drug abuse
 - 10.3 Prevention and treatment of mental and neurological disorders
- 11. Promotion of environmental health**
 - 11.1 Community water supply and sanitation
 - 11.2 Environmental health in rural and urban development and housing
 - 11.3 Control of environmental health hazards
 - 11.4 Food safety
- 12. Diagnostic, therapeutic and rehabilitative technology**
 - 12.1 Clinical, laboratory and radiological technology for health systems based on primary health care
 - 12.2 Essential drugs and vaccines
 - 12.3 Drug and vaccine quality, safety and efficacy
 - 12.4 Traditional medicine
 - 12.5 Rehabilitation
- 13. Disease prevention and control**
 - 13.1 Immunization
 - 13.2 Disease vector control
 - 13.3 Malaria
 - 13.4 Parasitic diseases

- 13.5 Tropical disease research
- 13.6 Diarrhoeal diseases
- 13.7 Acute respiratory infections
- 13.8 Tuberculosis
- 13.9 Leprosy
- 13.10 Zoonoses
- 13.11 Sexually transmitted diseases
- 13.12 Smallpox eradication surveillance
- 13.13 Other communicable disease prevention and control activities
- 13.14 Blindness
- 13.15 Cancer
- 13.16 Cardiovascular diseases
- 13.17 Other noncommunicable disease prevention and control activities

D. PROGRAMME SUPPORT

14. Health information support ¹

15. Support services

- 15.1 Personnel
- 15.2 General administration and services
- 15.3 Budget and finance
- 15.4 Equipment and supplies for Member States

¹ Health information support includes WHO's publications and documents and health literature services.

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