REGIONAL STRATEGY FOR THE ACHIEVEMENT OF HEALTH FOR ALL BY THE YEAR 2000

Report of the Sub-Committee of the Regional Committee on the General Programme of Work

Part II

The Regional Committee Sub-Committee on the General Programme of Work met on 18 and 19 June 1980. The present document, which is Part II of the report of the Sub-Committee, presents for consideration by the Regional Committee, the proposed regional strategy for achievement of the goal of health for all by the year 2000 prepared after review of the reports received from Member States on national policies, strategies and plans of action. Annex 2 contains the proposed regional strategy and Annex 3 a draft resolution prepared by the Sub-Committee which the Regional Committee may wish to consider adopting.
The Sub-Committee endorsed the tenet that the main goal for governments and WHO in the coming decades, as defined by the World Health Assembly, 1 is the attainment by all the peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life; that the main objective of the Organization's activities will be to support national, regional and global strategies for attaining health for all by the year 2000; and that such support should promote the self-reliance of Member States in health matters. In that context it noted resolution WHA33.24 adopted by the Thirty-third World Health Assembly (Annex 1).

The Sub-Committee supported the proposed regional strategy, attached as Annex 2, which recognizes the need to strengthen the capacity of national health organizations to plan, implement and evaluate health programmes, emphasizes the importance of community participation and the multisectoral approach, and further advocates the adoption of long-term goals aimed at improving the health status of the population by enhancing the quality and quantity of health care, especially to the underserved population, at a price the community and the government can afford.

The Sub-Committee recommended that the long-term objectives and targets set out in the proposed strategy should be adopted as appropriate for the year 2000 and that they should be published and made available to all government and health agencies. In the development of health services, promotive and preventive health measures should receive special emphasis and, in the development of health manpower plans, stress should be placed on incentives to attract appropriate staff into the community health field and to correct the maldistribution of health manpower by directing it from urban to rural areas.

With the emergence of new approaches to health planning and health care services in the Region, it was evident that there was a need to define the terminology. The Secretariat was requested to provide a working paper for consideration by the Sub-Committee on the General Programme of Work, if so recommended by the Regional Committee at its thirty-first session. In assessing the national health status, when measured in terms of ill health, the behavioural component as well as the accepted environmental and hereditary factors should be taken into account.

The Sub-Committee discussed the proposal to create a regional health development advisory council. Questions were asked with regard to the possible roles, functions, and representation of such a council. Concern was expressed as to the likelihood of costly reduplication of advisory bodies. The Sub-Committee agreed, however, to reconsider the proposal at a later meeting when more detailed information could be made available and the outcome of proposals to establish a global health development advisory council had been determined.

Finally, the Sub-Committee recommended to the Regional Committee that it should consider, with a view to adoption, the draft resolution attached as Annex 3.

RESOLUTION OF THE WORLD HEALTH ASSEMBLY

THIRTY-THIRD WORLD HEALTH ASSEMBLY

FORMULATING STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000:
HEALTH AS AN INTEGRAL PART OF DEVELOPMENT
AND OF THE NEW INTERNATIONAL ECONOMIC ORDER

The Thirty-third World Health Assembly,

Recalling resolutions WHA30.43, WHA32.24 and WHA32.30, and convinced that primary health care as an integral part of the country's health system and of the overall social and economic development of the community, is the key to health for all, equally valid for all countries, whatever their state of social and economic development;

Recognizing the efforts being made by all countries and WHO in formulating strategies for health for all by the year 2000 in response to the Declaration of Alma-Ata;

Recalling resolutions of the United Nations General Assembly 3201 (S-VI), 3202 (S-VI), 3281 (XXIX) and 3362 (S-VII) relating to the establishment of a New International Economic Order;

Welcoming resolution 34/58 of 29 November 1979 of the United Nations General Assembly concerning health as an integral part of development, which endorsed the Declaration of Alma-Ata, welcomed the efforts of WHO and UNICEF to attain health for all by the year 2000, and called upon the relevant bodies of the United Nations system to coordinate with and support the efforts of WHO by appropriate actions within their respective spheres of competence, and in connexion with the preparation for the International Development Strategy to be considered during the Special Session of the United Nations General Assembly to be held in 1980, called for careful attention to be given to WHO's contribution, which will reflect the global strategy for health for all;

Reaffirming that health is a powerful lever for socioeconomic development and for peace and that in turn a genuine policy of peace, détente and disarmament could and should release additional resources for attaining health for all by the year 2000, which is essential for raising the quality of human life; and stressing the role of WHO in promoting such a process;

Bearing in mind the fundamental nature of the New International Economic Order and that its effective establishment will be greatly facilitated if due attention is paid to health and related social development as well as economic development in view of their reciprocally supportive nature;

Concerned by the progressive deterioration of the economies of many developing countries and the consequent stagnation of their social development, including health, and solemnly proclaming that for the establishment of a just and equitable New International Economic Order and the formulation of an International Development Strategy with tangible and positive results for the developing countries, increased efforts of the international community in health and related social fields are vital;

Welcoming the fruitful outcome of the technical discussions at the Thirty-third World Health Assembly on the contribution of Health to the New International Economic Order;
1. **CALLS on Member States**

(1) to respond in concrete terms to the substance and the spirit of the resolutions mentioned in the preamble, as adopted, and to use them constructively in order to promote health and development in the spirit of the Alma-Ata Declaration, including the principles of national political commitment and self-reliance in health matters;

(2) to urge their delegates to the Preparatory Committee for the International Development Strategy to take active steps to ensure that, in the light of resolution 34/58 of the United Nations General Assembly, health receives prominent attention in the debate, in the final document and in resulting programme activities;

2. **THANKS the Executive Board for its progress report on "Formulating Strategies for Health for All by the Year 2000",**\(^1\) welcoming the cooperation that is taking place among Member States and between WHO and its Member States for the development of these strategies;

3. **REQUESTS the Executive Board**

(1) to ensure that the Organization's programmes constantly support the formulation and refinement of national, regional and global strategies for health for all as well as the monitoring of their implementation;

(2) to ensure that the programmes of WHO in the fields of its competence are formulated and implemented in the spirit of the New International Economic Order wherever applicable, with due regard to activities in national, multinational and international trade and industry in the health sector, the transfer of resources and technology, as well as other factors relating to health, that would contribute to accelerated harmonious and balanced human development in developing countries.

4. **REQUESTS the Director-General**

(1) to take full advantage of the international climate of support at all levels and in all sectors for achieving the health goals of the Organization, through the recognition by all Member States and the whole United Nations system of the essential role of health in development and their endorsement of the declaration of Alma-Ata and of WHO's main goal of Health for All by the year 2000;

(2) in particular, to respond effectively to the request of the United Nations General Assembly in resolution UN/GA34/58 concerning WHO's contribution to the International Development Strategy and the work of international organizations with primary responsibilities in other sectors;

(3) to continue to support Member States both individually, and collectively in the Regional Committees and the Health Assembly, in their efforts to formulate, implement and monitor strategies for health for all;

(4) to report to the Thirty-fourth World Health Assembly in 1981 on steps taken for the implementation of the United Nations General Assembly resolution 34/58 and resolution WHA32.24.

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\(^1\) Document A33/5.
REPORT ON
REGIONAL POLICIES AND STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000

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CHAPTER 1: MAIN HEALTH AND HEALTH-RELATED PROBLEMS

1.1 Introduction

The strategy to achieve a level of health permitting all citizens of the Western Pacific Region to lead a socially and economically productive life must address both current and potential problems likely to impede health development. As the status of health is a result of factors which are behavioural, environmental and hereditary, the strategy should focus on those behavioural and environmental problems that are amenable to change.

Socioeconomic factors in the environment and the lifestyle of the people play a determining role in their health status and health development. It is therefore precisely to those factors that a strategy for health should be addressed.

Elements of the strategy should accordingly consider:

- the growth, composition and movement of the population
- the level and phase of economic development
- the social values and forces shaping society's behaviour, and
- the health status of the people of the Region.

1.2 Population

Population growth, although it has slowed down in most countries of the Region, remains a problem which affects health both directly and indirectly. According to even the most optimistic projection for the next two decades, this problem will continue to be felt by the year 2000.

The population structure of the Region is characterized by a predominantly young population. Longer life expectancy will result in an increased proportion of elderly individuals (age-group 65 and over). The present high dependency ratio will thus increase further.

Population characteristics and projections from country reports and other sources are given below:¹

The annual growth rate during the period 1975-1980 in the 32 countries or areas of the Region ranged from close to 0% to 3.35%; the predicted range by the year 2000 is from close to 0% to 2.74%. 14 countries had annual growth rates of 2% and over in the same period.

¹Figures given in this and other sections of the document have been obtained from different sources. They should be interpreted with caution.
In terms of actual population size, the 1980 population ranges from 6000 to 960 million, giving a total population of 1.3 billion. In the year 2000, the total population is predicted to reach 1.6 billion with a range of from 7000 to 1.2 billion.

In 1975-1980, the crude death rate varied from 4.2 to 20.3 per thousand, with 7 countries reporting values of over 10 per thousand and 24 of over 8 per thousand. It is predicted that in the year 2000 3 countries will still experience a crude death rate of over 10 per thousand and 20 a rate of over 8 per thousand.

The birth rates in 1975-1980 ranged from 15 to 44.1 per thousand, with 22 countries having birth rates of 30 per thousand or more. The predicted range in the period 1995-2000 is from 14.1 to 31.9 per thousand, with only 5 countries or areas having rates of over 23 per thousand.

In addition to population growth and changes in the age structure, movement of population should be noted. The trend of rural/urban migration is expected to continue and to aggravate social problems related to the disadvantaged caused by substandard housing, unemployment and poor water supply, among them juvenile delinquency and drug and alcohol-related problems. Emigration, particularly from small island countries towards larger and industrialized ones, may be expected to continue.

1.3 Socioeconomic situation

Uncertainty of peace, political instability and social unrest characterize the beginning of the two decades in the course of which a New International Economic Order is to be achieved. Shifting value systems are giving rise to new social relationships and new expectations. Economic systems are unable to respond adequately to these rising expectations, resulting in the unemployment, underemployment and low incomes characteristic of a period of financial insecurity and leading in extreme cases to social unrest. In 1977, the per capita GNP of the Region ranged from US$90 to US$7340, while the annual growth rates varied from 1.9% to 7.7%.

The rate of food production has at best been keeping pace with population growth; the food supply has not increased to the levels expected to meet the dietary requirements. Moreover, the problem is the uneven distribution among countries and within countries, as well as the increasing cost to the consumer. Malnutrition of varying types and grades exists in developing countries and in certain areas of developed ones. Safe potable water is still not available to a great segment of the population.
Educational systems in the Region are not able fully to meet the demand and do not always provide the relevant education to enable people to gain an adequate livelihood.

24% to 97% of the school-age population is enrolled in primary and secondary schools. Statistics indicate that the problem of adult illiteracy exists in some countries.

Women in many societies are confined to traditional occupations and roles.

The problems affecting most countries in the Region can be summarized as follows:

- continuing high rates of inflation punctuated by periods of recession
- chronic fluctuations in economic growth
- uneven distribution of income within and between countries
- continuing high levels of unemployment and underemployment
- increasing dependency on, and rising costs of, imports
- uncertain value of major export commodities (largely agricultural in most developing countries)
- social pressure and stress brought about by rapidly changing life styles.

1.4 Health problems

In addition to the crude death rate, which was described earlier, the following observations on infant mortality, maternal mortality, life expectancy and causes of mortality and morbidity describe the health status of the Region.

There are 13 countries with infant mortality rates of over 50 per thousand and 9 with rates of over 20 per thousand.

The maternal mortality rates range from 0.1 to 17 per thousand.

The life expectancy at birth varies from 42 years to 77 years in 1980, and is expected to be from 52 years to 78 years in the year 2000. There are 8 countries with a life expectancy of less than 60 years in 1980. This is expected to change to 5 countries in the year 2000.
In summary, the Region presents a variety of health problems, ranging from those found in agricultural countries to those of the industrial countries and comprising:

- communicable diseases and malnutrition
- chronic degenerative diseases
- accidents, environmental pollution, stress conditions and mental health problems
- health problems of the elderly
- problems related to high fertility.

The socioeconomic environment also determines such factors as the nature, composition and distribution of the high-risk groups, the population deriving least benefit from economic growth, the population of remote areas, the rural and urban poor, and, within those groups, mothers and children and elderly people.

1.5 Problems related to the health care system

The reports of most countries expressed varying degrees of satisfaction regarding the quality and quantity of coverage of the population with health care activities, as well as deep concern for the rising cost of medical care. The other problems reported in a way shed light on these two basic problems and may be enumerated as follows:

1.5.1 In a number of agricultural/rural countries

- Technology. Unsuitable, cumbersome, limited in impact and diffusion and expensive or unacceptable to the population. Certain necessary technology is either absent or at a limited stage of development. This is the case, in a number of instances, with health administration, planning/programming, information systems, repair and maintenance of medical equipment, and the architectural design of health facilities.

- Manpower. Inadequate in quantity and quality, inefficient, maldistributed, lacking in motivation, and subject to an unsatisfactory career structure and difficult conditions of employment. In a number of instances, the development of health manpower has no relevance to the needs of the local situation. Furthermore, the possible contributions of traditional healers, birth attendants and herbalists have not been adequately explored or considered.
- Health facilities. Insufficient, inadequately supported, poorly located, of unsuitable architectural design and badly maintained.

- Operational procedures. Cumbersome and time-consuming, rigid, difficult to understand and unresponsive to service demands.

- Organization. Overlapping, duplication or conflict between related services, insufficient intersectoral coordination, inadequate integration of functions, imbalance.

- Policy. Lacking, unrealistic or outdated.

- Accessibility. Problems are related to geography, transport difficulties, etc. Logistic problems lead to shortage of drugs and supplies.

- Financial. Some of the problems are insufficient funding, uneven distribution of funds, and inefficient and inequitable provision of drugs, medical supplies and equipment.

- Motivation. The population in a number of instances is unaware of, or dissatisfied with, the services available.

1.5.2 In a number of urban/industrialized countries

- Technology. Inappropriate and inefficient investment in high cost technology, especially in the private sector.

- Manpower. Overemphasis on training of highly specialized medical personnel and senior level health workers. Overcentralization of training facilities. Proliferation of categories of health personnel.

- Facilities. Overinvestment in hospital buildings and inadequate facilities for basic health services.

- Operational procedures. Underutilization of health personnel at certain levels. Inappropriate use of staff, supplies and equipment.


- Policy and planning. Lack of proper health problem identification mechanisms to ensure proper allocation of resources.
1.6 Degree of awareness of the above-mentioned problems among policy-makers, health workers and the public

There seem to be varying degrees of awareness of the above-mentioned problems among policy-makers and the public, who, it appears, are more prone to think of health in terms of hospitals and clinics. It also appears that, in some countries, the health ministries require strengthening in order to influence top-level decision-making to a greater extent. In some countries, there appears to be a gap in communication within the health ministry between operational level staff and policy level staff.

CHAPTER 2: HEALTH AND SOCIOECONOMIC POLICIES

The social objective of health for all by the year 2000, which was collectively adopted by the Thirtieth World Health Assembly,¹ is accepted by the leaders of all Member States and is explicitly mentioned in the policy statements of many countries. The mission of the health ministries in the Region, in pursuing the goal of raising the level of health of the people, is to improve the quantity and quality of health care available, especially to the underserved population, at a price the community and the nation can afford. The national policies to that end have not yet, however, been incorporated in existing national health plans.

It is recognized by Member States that the social goal will be realized through the primary health care approach in the spirit of the Alma-Ata declaration. The trend is towards a broader, more holistic, approach to health development, viewing health as an integral part of national social and economic development. Health leaders are thus in the process of reinterpreting the concept of health and broadening their mission to include development of the people's capabilities for leading a socially and economically productive life, thereby achieving community self-reliance in health. This trend is discernible in the thinking of health experts in all countries or areas of the Region.

The concept of community involvement is a vital element in the extension of health care coverage, providing for the mobilization of community resources in both the planning and the management of health care. It is recognized by practically all Member States that vigorous efforts must be made to encourage local communities actively to participate

in health and development actions in such a way as to establish a working partnership between communities and government and private agencies. However, experience in developing such a partnership is as yet limited, though the principle of community self-reliance is universally accepted.

Another new dimension is the recognition of the interdependence of health and socioeconomic factors and the need for a multisectoral approach in health development. Although interest in the multisectoral approach has been expressed by practically all Member States, a beginning has yet to be made in developing an effective mechanism for continuing intersectoral coordination at all levels. In many cases, analysis of the priority problems is still confined to health sector activities and does not fully take into account the related social and economic problems.

Given the limited resources available and the determination to expand and improve the coverage and quality of health services, much interest has been expressed in the development of appropriate health technology and research.

Attempts to translate political will into action have led to the realization that the new approach, based on an active and continuing partnership between communities and government agencies, will demand a new outlook, orientation and skills on the part of health and related staff, who will have to develop qualities of leadership and managerial skills in order to facilitate and support the community development approach in health and to strengthen both intrasectoral and intersectoral coordination.

This recognition of the need for appropriate technology and health manpower development has brought into sharp focus the necessary interdependence of countries, who must share their limited resources for the training and reorientation of health manpower, development of appropriate technology and research, and exchange of information and experience.

In their efforts to evolve and implement policies and strategies for attaining the goal of health/2000, health ministries in several countries are reexamining and adapting their structures and resources to meet this challenge during the next two decades. The main focus and area of concern is the improvement of managerial processes for health development. In searching for solutions, some countries have embarked on the process of country health programming with a more holistic and broader view of health and its relationship to other aspects of social and economic development. However, the process is slow, problems encountered are many and the resultant structural and legislative changes and reallocation of resources needed are only beginning to emerge. The lack of reliable information and appropriate indicators is impeding progress.
In the light of the above-mentioned policy issues expressed by Member States, the regional strategy should aim at collaboration in: improving and developing managerial processes for health development; reorienting and training health and related personnel, particularly in management, organizational development, communication skills and community development approaches; developing research on appropriate technology and health care delivery systems; devising practical evaluation procedures to monitor both the processes for implementation and the impact of health development strategies; exchange of information and development of effective information systems; and mobilization of external resources in support of national efforts for health development.

In the sphere of economic development, there is a discernible trend towards the integrated area development approach, with the balanced development of various sectors. The value of traditional economic indicators such as GNP and per capita income is being questioned and concern has been expressed that development should be conceived to mean not only economic development but also the well-being of the broad masses. It is in this context that Member States place emphasis on health as an integral and vital part of development, benefiting by and contributing to economic development, as expressed in United Nations General Assembly resolution 34/58 on Health as an integral part of development.¹

In the spirit of the New International Development Strategy, the economic interdependence of countries has been recognized, regional groupings, such as the Association of South-East Asian Nations and the South Pacific Forum, are being strengthened and emphasis is being placed on the need for improved trade relations, transfer of technology and resources and regional planning.

CHAPTER 3: CONCEPTUAL FRAMEWORK FOR ACTION

The successful coordination of initiative and effort directed towards the attainment of the long-term objectives will largely depend on the collective and individual ability of Member States to function intersectorally.

Thus, a general framework within which action is to be taken to achieve health/2000 must be responsive to the conditions under which health services are provided to the population, such as:

(a) the prevailing socioeconomic and health situation, which calls for a more balanced delivery of curative, preventive, promotive and rehabilitative health care, to meet the health needs of the majority of the people; and

(b) an increasing population and the resultant demands for health services, which call for a reallocation of resources within the health and other sectors.

These considerations imply that the conceptual framework must essentially address itself to directing health knowledge and resources towards:

(a) laying the foundations for health, namely, providing adequate food, water and shelter;

(b) developing individual and community self-reliance in health; and

(c) providing appropriate and affordable health technology for the sick, the disabled, the chronically ill and the socially maladjusted.

In the light of the above-mentioned conditions and directions, a partnership involving the community, the government and private health organizations is suggested as a desirable conceptual framework for attaining health/2000. The partnership concept focuses on the mutual responsibilities, risks and rewards of all parties involved. From the point of view of the health authorities and the national governments, a number of important elements should be considered:

(1) The government must lead and assume initial responsibility for building community capability to plan, organize and implement health development activities.

(2) Reliance must be placed on community initiative, commitment and resources in identifying and resolving health development issues.

(3) The government must permit and promote the adaptation of approaches or technology to suit the needs or the situation in the community.

(4) Intersectoral and intrasectoral approaches must be adopted in problem solving, planning, implementation and development of appropriate technology.
(5) The government and communities must work together in monitoring the results of community health development programmes.

(6) The government must provide communities with resources in terms of manpower skills, technology, information and funds for the planning, implementation and monitoring of health development activities.

In this way, the health care systems will become:

(a) more responsive to the needs of communities;

(b) more capable of influencing other sectors and also more receptive to influence from other sectors;

(c) more holistic and integrated in their approach to the planning and management of programmes; and

(d) more concerned with the continuous professional and personal development of staff.

In brief, this will require government and private health workers to play the roles of health technician or scientist and facilitator in developing community self-reliance in health.

CHAPTER 4: LONG-TERM OBJECTIVES, TARGETS, AND APPROACHES

4.1 Introduction

Interpretation of the current regional situation as it affects the health of the population should be considered in the light of Member States' commitments to health development and the constraints on meeting such commitments. These commitments are themselves determined to a great extent by what is perceived to be a socially and economically productive life in this Region by the year 2000. At the very least, such a picture will suggest that the basic needs of food, water and shelter will have been met by all governments of the Region. The total fulfilment of those needs will be reflected in a well-informed population with shared social values, the widespread availability of food and drinking water, the sanitary disposal of human and animal waste, the control of environmental pollution, the absence or reduction of preventable communicable diseases, the reduction of chronic diseases, and the psychosocial well-being brought about by harmonious lifestyles.

However, this picture remains incomplete. Without social justice, health and its contribution to the quality of life can have little meaning. To ensure social justice, people must accept responsibility for their own health and develop their capacity for self-reliance.
4.2 Country statement synthesis

The statement of objectives was extracted from national progress reports, the speeches of delegates of Member States of the Region at the Thirty-third World Health Assembly, and the country programme statements on national health/2000 strategies submitted to the Regional Office in connexion with the proposed programme budget for 1982-1983.

Though all Member States expressed their commitment to the goal of health for all through primary health care, some statements understandably stopped short of providing specific details or time-bound objectives. Among the objectives reported were:

4.2.1 Objectives related to the health status

- Improvement of nutritional status
- Provision of safe drinking water and a sanitary environment
- Control of environmental pollution
- Access to appropriate health care
- Control of communicable diseases
- Control of noncommunicable diseases (cancer, heart diseases, cerebrovascular diseases, dental conditions, metabolic diseases and health problems of the elderly were among those commonly mentioned)
- Promotion of lifestyle and habits conducive to health
- Promotion of psychosocial well-being
- Fertility regulation
- Drug production, essential drugs and drug policies
- Rehabilitation

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4.2.2 Objectives related to the health care system

- Health services development, including for example, reorganization, development of health facilities and support mechanisms, development of referral systems, regionalization, integration
(b) Health manpower development, including strengthening of institutions, curriculum review and revision, reorientation of existing staff to primary health care, training of lay workers and medical assistants, training of specialists, control of specialization, improvement of working conditions of staff, effective use of health manpower, more effective correlation of supply and demand for certain types of personnel

(c) Health services research, development and use of appropriate technology, biomedical research

(d) Development of planning and managerial skills, establishment of planning units, development of supervisors, improvement of managerial processes, including health management information systems

4.3 Regional objectives, targets, and approaches

Taking into account the expressed objectives of individual Member States, a regional framework for health objectives to be attained by the year 2000 has been developed as follows:
Objectives, targets, and approaches

<table>
<thead>
<tr>
<th>Overall societal image by year 2000</th>
<th>Broad objectives</th>
<th>Specific objectives</th>
<th>Activities</th>
<th>Health status target</th>
<th>Health services targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socially and economically productive individual/population with:</td>
<td>1. A well-nourished population</td>
<td>1.1 Nutritious food available</td>
<td>a. Formulation and implementation of food and nutrition policy</td>
<td>a. Minimum calorie and protein intake for all</td>
<td>1. Overall targets</td>
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<tr>
<td>1. Longer life expectancy</td>
<td>1.2 Good dietary habits established</td>
<td>b. Nutrition education, both formal and informal</td>
<td>b. Goitre and xerophthalmia reduced to lowest manageable levels</td>
<td>All communities with health committees/councils at various levels participating actively in the management of health services;</td>
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<td>2. Low infant mortality</td>
<td>1.3 Healthy child-feeding practices</td>
<td>c. Development of nutrition surveillance and care</td>
<td>c. Nutritional anaemia in pregnant and lactating mothers reduced to minimal manageable levels</td>
<td>At least 3% of the GNP expended in the area of health care with emphasis on prevention;</td>
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<tr>
<td>3. Low maternal mortality</td>
<td>1.4 Services available for the prevention and care of malnutrition</td>
<td>d. Fortification of food</td>
<td>d. Proportion of low birth-weight babies reduced to 10% level</td>
<td>An effective mechanism for intersectoral collaboration in the area of health established in all countries</td>
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<td>4. Less disability</td>
<td>1.5 Endemic goitre, nutritional anaemia, and xerophthalmia no longer public health problems</td>
<td>e. Supplementary feeding, with particular attention to high-risk groups</td>
<td>e. No third degree malnutrition in children</td>
<td>2. Nutrition and maternal and child care</td>
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<td>5. Adequate shelter, education, and means of livelihood: through strategies with the following essential characteristics:</td>
<td>1.6 Number of low birth-weight babies reduced</td>
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<td>At least 80% of pregnant mothers, deliveries, infants and young children receiving appropriate health care, including immunization;</td>
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<td>through strategies with the following essential characteristics:</td>
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<td>Services for nutrition surveillance, care, maintenance and education available in all communities</td>
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<td>1. Community involvement</td>
<td>2. Safe drinking water for all</td>
<td>2.1 Safe water at a cost affordable to all available and accessible</td>
<td>a. Feasibility studies for community water supplies</td>
<td>a. Incidence of waterborne diseases reduced to the current levels of countries with safe drinking water: 200/1000 a year (diarrhoeal diseases)</td>
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<td>2. Intersectoral coordinated efforts</td>
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<td>2.2 Safe storage and use of drinking water</td>
<td>b. Establishment/expansion of community water supply systems (piped)</td>
<td>b. Incidence of diarrhoeal diseases among children under 5 years of age reduced by 50%</td>
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<td>3. Equitable distribution of health and other resources</td>
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<td>c. Further development/improvement of other sources of water, i.e. wells, springs, rain water</td>
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<td>4. Health systems development</td>
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<td>d. Quality control</td>
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<td>5. Development and use of appropriate technology at a cost the community can afford</td>
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<td>e. Maintenance and repair of water systems</td>
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<td>6. Development of sound managerial processes for health development</td>
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<td>f. Community education and involvement</td>
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<td>7. Development of necessary health manpower</td>
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<td>8. Research</td>
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<td>Overall societal image by year 2000</td>
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<tr>
<td>3. Sanitary disposal of human and animal waste</td>
<td>3. Sanitary toilets available for all families</td>
<td>3.1 Sanitary toilets available for all families</td>
<td>a. Development of facilities (materials and technical guidance) and appropriate technology</td>
<td>a. Incidence of faecal-borne diseases reduced to current levels of countries with safe waste disposal facilities: 200/1000 (diarrhoeal diseases)</td>
<td>3. Water 100% of the population using safe drinking water in all communities</td>
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<td></td>
<td>3.2 Proper disposal of refuse, garbage, and animal wastes</td>
<td>3.1 Proper disposal of refuse, garbage, and animal wastes</td>
<td>b. Education and motivation for safe waste disposal</td>
<td>b. Incidence of diarrhoeal diseases among children under 5 years of age reduced by 50%</td>
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<td>4. Minimal environmental pollution and hazards</td>
<td>4.1 A code on pollution established and enforced</td>
<td>4.1 A code on pollution established and enforced</td>
<td>a. Formulation and implementation of policy</td>
<td>a. Targets shared with other activities, the impact of which will be on the overall health status of the community measured by means or indices to be developed</td>
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<td></td>
<td>5. Communicable diseases no longer a major problem</td>
<td>5.1 The following absent: smallpox, faucial diphtheria, tetanus neonatorum, poliomyelitis, measles, congenital rubella syndrome, mortality from whooping cough and rabies, the advanced stage of filariasis (elephantiasis), new cases of blindness due to trachoma</td>
<td>a. Immunization</td>
<td>a. Incidence of smallpox, faucial diphtheria, tetanus neonatorum, poliomyelitis, measles congenital rubella syndrome reduced to zero; mortality from whooping cough and rabies, the advanced stage of filariasis (elephantiasis) and new cases of blindness due to trachoma absent</td>
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<td>5.2 The following controlled: schistosomiasis, malaria, filariasis, tuberculosis, plague, parasitic infestations of the skin and intestines</td>
<td>b. Chemoprophylaxis</td>
<td>b. Morbidity from the following not to exceed the specified levels in any country or area: Malaria - 10/10 000 annual parasite incidence rate (MPI)</td>
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<td>c. Surveillance</td>
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<td>d. Case/contact finding</td>
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<td>e. Specific treatment/case management</td>
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<td>f. Education</td>
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<td>g. Environmental control, including control of vectors</td>
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<td>cholera, typhoid,</td>
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<td>target population,</td>
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<td>leprosy, viral</td>
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<td>including immunization,</td>
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<td>hepatitis B,</td>
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<td>trachoma, tetanus</td>
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<td>chemoprophylaxis,</td>
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<td>5.3 The following no</td>
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<td>case/contact</td>
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<td>longer major public</td>
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<td>health problems:</td>
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<td>detection, specific</td>
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<td>diarrhoeal diseases,</td>
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<td>treatment/management,</td>
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<td>respiratory infections in children,</td>
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<td>environmental control including vector control, and</td>
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<td>sexually transmitted diseases, viral hepatitis A</td>
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<td>health education</td>
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<td>Filariaisis - 5%</td>
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<td></td>
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<td>prevalence rate</td>
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<td>Tuberculosis - 5%</td>
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<td>infection rate of school entrants</td>
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<td>Parasitic infestation - 15% in age group below 15 years</td>
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<td>Cholera - 1/100 000 incidence</td>
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<td>Typhoid - 1/100 000 incidence</td>
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<td>Diarrhoeal diseases - 200/1000 incidence</td>
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<td>Viral hepatitis A - less than 25% population at age 20 with antibody</td>
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<td>Viral hepatitis B - 1/1000 HBsAg carrier rate</td>
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<td>Tetanus - 10/100 000 in age group up to 10 years</td>
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<td>Leprosy - 0.5/100 000 incidence</td>
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<td></td>
<td>Schistosomiasis - prevalence reduced to at least 40% of current level in endemic areas</td>
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<td>c. Mortality from the following not to exceed the specified levels in any country or area:</td>
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<td>Pneumonia/influenza - 100/100 000 in infants; 10/10 000 for age group 1-4 years</td>
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<td>Cholera - 0.1% case fatality rate</td>
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<td>Typhoid - 0.1% case fatality rate</td>
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<td>Diarrhoeal diseases - 0.1% case fatality rate</td>
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<td><strong>6. Chronic diseases reduced</strong></td>
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<td>6.1 The following reduced: congenital heart diseases, rheumatic heart diseases, degenerative cardiovascular diseases, chronic bronchitis, pulmonary emphysema in the younger age group (below 50 years), preventable cancer, peptic ulcer, cirrhosis of the liver</td>
<td>a. Education for behavioural change b. Counselling c. Early detection d. Case management e. Establishment of registers f. Control of environmental factors</td>
<td>a. The following reduced to specified levels: - congenital heart diseases - rheumatic heart diseases - degenerative cardiovascular diseases (under 50) - chronic bronchitis (under 50) - pulmonary emphysema (under 50) - preventable cancers - peptic ulcer - cirrhosis of the liver b. All diabetics and hypertensives controlled medically c. An average of 3 DMF or less per child at age 12 years maintained</td>
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<td>6.2 Diabetes and hypertension controlled</td>
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<td>6.3 Oral health in children at a satisfactory level</td>
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<td><strong>7. Psychosocial well-being and lifestyle conducive to health</strong></td>
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<td>7.1 The following reduced: alcohol-related problems, accident-related deaths and problems, stress-related diseases</td>
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<td>7.2 Smoking and drug dependence controlled</td>
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<td>7.3 Good personal hygiene and dietary habits established</td>
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<td>7.4 Physical fitness activities undertaken</td>
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<td>7.5 Human sexuality better understood</td>
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<td>7.6 Discrimination based on ethnic, social, physical and age factors not encountered</td>
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<td>8. No pockets of ill-health</td>
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<td>8.1 The following disadvantaged groups given adequate attention: slum dwellers, economically disadvantaged populations, populations in remote areas, the elderly and disabled</td>
<td>a. Identification of disadvantaged groups b. Equitable distribution of services and opportunities</td>
<td>a. Health status of disadvantaged groups should improve at a faster rate than the national average to achieve equity in health</td>
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<td>9. Fertility regulated to ensure better health and social well-being</td>
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<td>9.1 Access to knowledge and to safe and effective means of fertility regulation available to all</td>
<td>a. Formulation and implementation of population policy b. Facilities for fertility regulation made accessible c. Education in population and family planning</td>
<td>a. Population growth rate reduced to at least 1% b. Incidence of pregnancy in adolescents reduced to zero</td>
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<td>9.2 Pregnancy in adolescents reduced</td>
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<td>9.3 Contraceptives used for spacing of births and fertility regulation</td>
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<td>9.4 Population growth reduced in harmony with economic development</td>
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<td>d. Incidence of neurosis, suicides, and other forms of maladjustment reduced to manageable levels</td>
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<td>e. Social justice in health achieved</td>
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<td>Overall societal image by year 2000</td>
<td>Broad objectives</td>
<td>Specific objectives</td>
<td>Activities</td>
<td>Health status target</td>
<td>Health services targets</td>
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|                                   | 10. Access to appropriate health care for all | 10.1 An adequately functioning health service network accessible to all in terms of reach and financial consideration, delivering an acceptable level of care with active involvement of the people | a. Development of community participation/partnership for health  
b. Development of health care delivery system  
c. Health manpower made available  
d. Essential drugs made available  
e. Development of financing schemes, including efficient use of resources  
f. Development of appropriate technology for health  
g. Development of management and support systems  
h. Formulation and enforcement of supporting legislation | a. Targets shared with other activities, the impact of which will be on the overall health status of the community measured by means or indices to be developed |
CHAPTER 5: REGIONAL SUPPORT MEASURES

Country reports indicate various existing and planned support measures for health/2000 policies and strategies. Political support is explicitly stated in some cases, while in others it is implied through the government's support of Health Assembly and Regional Committee resolutions. Requirements for economic support are indicated. Country reports emphasize in particular existing and future needs with regard to managerial support, research and information.

5.1 Political support

Political support will be obtained through the involvement of political and social leaders in appropriate regional and country activities. This will be effected through both regional and national forums. The latter might include legislative meetings at all levels, cabinet meetings, political party meetings and citizens meetings. National health councils, which are essentially intersectoral, could play a significant role in enlisting political and legislative support.

Intergovernmental groupings, such as ASEAN, will also contribute to the promotion and formulation of national policies and strategies by determining joint action in health development and bringing health development issues to the attention of Member States and other regional forums.

The Regional Committee has the task of formulating, monitoring and evaluating regional policies and strategies. In so doing, it also serves as a very important political mechanism for support of the regional strategy. In this connexion, the role of a regional health development advisory council could also be considered, should a similar body be established at global level.

In addition to the World Health Assembly and the Executive Board of WHO, global forums, both within and outside the health sector, should be used for the promotion of health development efforts and, in particular, the concept of health as an integral part of socioeconomic development.

5.2 Economic support

Economic support will be secured from international development banks (World Bank, Asian Development Bank) and multilateral and bilateral agencies (Colombo Plan, South Pacific Forum, USAID, ADAB, JICA, DANIDA, SIDA, SPEC) as well as from voluntary donors such as the Japan Shipbuilding Industry Foundation. The strategy will be to channel resources into activities for integrated health development, in particular to emphasize the health component of development projects funded by international cooperation. It is important to stress that economic support should be used for development activities which will foster self-reliance and not solely for the import and maintenance of technology.
It will be necessary to develop and strengthen regional and global mechanisms for attracting bilateral and multilateral funds and to ensure that they are channelled to priority activities and countries.

5.3 Technical support

Technical support will be ensured through promoting, in training institutions for medical and allied health personnel, the concept of equal right to health and primary health care. The teaching of specific subjects related to health development, such as health planning and management with emphasis on primary health care, will be strengthened or introduced in schools of public health.

It will be of particular importance to obtain the support of health professionals through associations of doctors, nurses and through other technical nongovernmental organizations dealing with health and health-related problems. Activities to enlist such support will focus on mobilizing the health professionals and directing their activities towards the objectives and strategies of health/2000, both at national and regional level. Promotion and exchange of information through personal contact, formal and informal meetings, written communications and publications will be encouraged.

Special efforts will be made to promote the support of medical and related industries by encouraging them to produce equipment for appropriate technology and to manufacture essential drugs at reasonable cost. In those efforts, UNIDO, UNICEF and ESCAP will play an important role. Specific mechanisms for this are being developed in the Region.

The global strategy should develop mechanisms to promote collective action at high international level involving governmental and nongovernmental organizations, to mobilize the health related professions and generate the active support of the media worldwide.

5.4 Managerial and administrative support

Managerial and administrative support for the development and implementation of strategies will be directed towards the following:

(1) Review and revision of health policies to give a clear and more specific direction to health resources and activities.

(2) Improved planning, implementation and evaluation processes which will ensure the more effective delivery of health care and provide the means by which new knowledge with regard to the health development needs of the people can be converted into appropriate action. The new knowledge will also be used to change the role of health workers and to equip them with essential understanding and skills so as effectively to support health development.
The regional strategy will include the establishment of, and support for, national health development networks and national health councils, or similar intersectoral coordinating bodies, and efforts to strengthen capabilities to develop and apply the managerial process.

Initially five national health development systems are proposed (Malaysia, Papua New Guinea, Philippines, Republic of Korea and South Pacific). Close cooperative relations will be established among them as well as with other selected institutions in other countries of the Region, thus constituting a regional network for health development. Relations will also be established with similar networks in other Regions to form a global network.

(3) Provision of support to Member States in dealing with administrative problems, such as logistics, personnel matters, budgeting, accounts, reorganization, etc.

The global strategy should develop support for managerial and administrative processes by providing technical expertise and exchange of information between Regions and obtaining financial assistance for national and regional health development networks.

5.5 Research support

Research will be particularly oriented towards the solution of problems related to the goal of health/2000. Emphasis will be placed on research in primary health care and health services development, appropriate technology, tropical diseases, human reproduction, chronic diseases and environmental health. Research will, therefore, be coordinated at national level by health research councils or their equivalent (existing health research councils will be strengthened if strengthening is indicated, and where no such council exists establishment will be encouraged). At regional level, the Western Pacific Advisory Committee on Medical Research and its subcommittees will advise the Regional Committee on identifying priorities and improving coordination of, and extending support to, health and medical research. Health services research will be promoted as an integral function of national health development networks.

The global strategy will include: coordination through the global Advisory Committee on Medical Research, support to regional advisory committees on medical research and establishment and strengthening of relations with global institutions concerned with research in health and related areas.

Of particular importance in a global strategy is the use of national expertise through WHO expert advisory panels.

5.6 Information support

To support the development and implementation of national policies and strategies, exchanges of information among countries will be promoted and supported, using the TCDC and similar cooperative efforts already mentioned under Sections 5.3 and 5.4.
Of particular importance is the provision of relevant technical information. The WHO Secretariat, with WHO collaborating centres, will ensure that countries are provided with relevant technical information for national health development. In that connection, research findings and information on experience gained, for example, the formulation and implementation of national policies and strategies, the introduction of administrative reforms and the development and use of indicators, will be widely disseminated.

Provision of information to the public will be a major component of support strategies. Public opinion will be mobilized at both regional and national level through the development of appropriate health education methods and approaches in community organization. The public will be kept informed through the mass media and through personal contacts with health sector personnel.

CHAPTER 6: GENERATION AND MOBILIZATION OF RESOURCES

6.1 Human resources development

The development of health manpower will include (1) manpower planning, and preparation of an adequate number of health personnel to promote a more balanced delivery of curative, preventive, promotive and rehabilitative health care, in order to meet the needs of the majority of the population; (2) an intersectoral approach to achieve effective long-lasting solutions, which implies an adjustment in present approaches to health, in that knowledge and resources must be directed towards building the foundations for health, namely adequate food, water and shelter; (3) developing individual and community self-reliance in health; and (4) developing and using appropriate health technology.

Particular attention will be paid to the following:

(1) Strengthening training programmes and institutions in terms of faculty development, reviewing curricula to improve their relevance and to emphasize promotive and preventive health care, developing local guides/manuals/textbooks, strengthening library facilities and teaching equipment, improving the assessment of students' progress, and developing national institutes.

(2) Where small countries or areas predominate, continuing the practice of sharing the training facilities of one of the larger countries, with the prospect that the demands on its facilities will continue to increase. This applies particularly to the South Pacific.

(3) Training in health management and administration, which is expected to be provided in health development systems or networks (see Section 5,4).
The need for special efforts to attract appropriate staff into the community health field and to correct the maldistribution of health manpower by directing it from the urban to the rural areas is stressed in a number of country reports.

Re-orientation of health workers and other workers, such as teachers and community workers, towards primary health care and coordinated cooperative action at the community level, for the development of community self-reliance, constitutes an essential activity planned by developing countries in their primary health care programmes.

Health education of the public is emphasized in all the country reports. Attempts to develop more effective approaches, with a view to obtaining a wide spectrum of community participation and organized community action in health, are considered important.

Action will be needed to identify the strengths and weaknesses of training institutions and to establish reciprocal arrangements whereby an activity in one institution can compensate for a weakness in another. Meetings of heads of certain institutions, such as deans of public health schools, of medical schools, and of nursing schools, are considered very useful in this regard. Support will be needed for national training courses and institution strengthening. To ensure the highest level of relevance in teaching, training institutions will be encouraged to engage in health services research.

The needs for developing short and intensive courses will be further studied.

6.2 Financial and material resources

Though information on the resources required to implement programmes to attain the goal of health/2000 is limited at present, Member States will soon be determining, with the development of activities in detail, the magnitude of the resources required. Particular attention will have to be given to the preferential allocation of resources to underserved population groups and least developed countries.

Various mechanisms or possibilities will be tried to generate funds and to ensure that effective and coordinated use is made of whatever funds become available:

(1) National health councils or analogous bodies, with their expanded role, will be expected not only to stimulate multisectoral collaboration but also to take active steps to generate funds for health development and to ensure the effective use of external resources. The latter can be promoted through joint programming at national level, preferably preceded by country health programming.

(2) Bilateral and multilateral agencies for international cooperation will be urged to make strong representations to their governments for a further increase in their budgetary allocations and to rationalize the use of their resources.
(3) Private foundations functioning at international level will likewise be urged to increase their aid.

(4) The possibility of creating mechanisms at regional level (for example, donors' meetings, focal groups at the WHO Regional Office, advisory bodies) to attract funds and ensure that they are used rationally will be studied. In the same way, mechanisms to improve the coordination and effective use of funds available from other agencies will be considered, such as periodic meetings, at the regional level, of United Nations agencies and voluntary organizations (see Section 7.2.1).

(5) The global strategy should include establishment of global mechanisms to ensure continuous monitoring of the availability and generation of funds and their distribution to priority problem areas throughout the world and priority programmes. The recently established Health Resources Group is one such mechanism.

CHAPTER 7: COLLABORATIVE MECHANISMS

7.1 Intrasectoral and intersectoral collaboration

7.1.1 Country reports stress the importance of collaboration and coordination between components of the health sector and sectors closely related to it, such as education, agriculture, works, transport and human settlements.

Preparation of an inventory of agencies covering the health and health-related sectors, and an analysis of their resources and functions, has been mentioned or implied in some reports as an initial activity towards the establishment of a collaborative mechanism. The issues to be considered by the analysis would include: delineation of the responsibilities of the health ministry and the medical care insurance or social security system; the effectiveness of cooperation between the private and the public health sector as regards referral systems, extension of services, use of health facilities, and area/population coverage; the formulation of relevant curricula for the education and training of health manpower; policies with regard to nongovernmental organizations, their participation in national decision-making, their complementary and supplementary roles, and the support they need from, as well as what they can give to, the health ministry.

Countries are unanimous in their opinion that health/2000 cannot be achieved through the health sector alone. Intersectoral collaboration and coordination are expected to resolve policy and operational difficulties in many areas, including the development and maintenance of community water supplies, the control of environmental pollution, the promotion of nutrition and food production, the drug industry, education and housing, the construction of health facilities, drug and alcohol problems, and road traffic accidents.
Country reports recognize the need for advice, coordination or collaboration in health development activities at different levels of government, but especially at policy level. Some countries consider that new mechanisms should be developed, while others believe that existing ones are sufficient but need further strengthening. Some countries are apprehensive with regard to the proliferation of coordinating mechanisms and believe that rationalization of such mechanisms through an "umbrella" council would be useful. It is also quite likely that the mechanisms will be given different names, such as health councils, health advisory committees, or health advisory boards, and that they will include representatives of other sectors as members. Intersectoral governmental committees are planned by some countries; for example, an interministerial body for primary health care, or an interministerial body for programme reviews.

7.1.2 Regional action will consist in supporting countries in the establishment or strengthening of their national mechanisms, through promotional efforts and through advisory services on the nature, composition, level, function and work process of such mechanisms. Information will be disseminated on the experience of countries with such mechanisms.

The need (a) for a better understanding of the role of health development in general social and economic development and for multisectoral support for health/2000 strategies and (b) to provide expertise in these matters, points to the importance of establishing a mechanism to facilitate multisectoral consideration of health development policies. One such mechanism might be a regional health development advisory council. Such an advisory council would help the Regional Director to support the Regional Committee adequately on all issues involving multisectoral policy and action for health development. A regional health development advisory council would derive support from, and in turn support, existing multisectoral national health councils or those that may be established in the near future by Member States.

7.2 Intercountry collaboration

Support to the implementation of national strategies for health development could be provided by a variety of organizations and institutions at regional level.

7.2.1 Intergovernmental organizations, voluntary agencies, agencies within the United Nations system

(a) Intergovernmental organizations such as the Association of South-East Asian Nations (ASEAN) and the South Pacific Forum offer opportunities for promoting intersectoral coordination of health-related activities and could identify resources and funds to facilitate TCDC processes for health development.

(b) The Southeast Asian Ministers of Education Organization (SEAMEO) could provide resources for undertaking research, particularly in the areas of biomedical and appropriate technology, and means for the exchange of information and training of health workers;
(c) The Southeast Asian Medical Information Centre (SEAMIC) could cooperate in the exchange of technical information, the support of technical studies and the promotion of activities for health development.

(d) The South Pacific Economic Bureau (SPEC) and the South Pacific Commission (SPC) could provide promotional support to intersectoral coordination and technical support to health development activities in countries or areas of the South Pacific.

(e) The development banks, such as the Asian Development Bank (ASDB) and the World Bank (IBRD) are sources of funds for development and could be means for integrating health with other development projects.

(f) Bilateral agencies such as the United States Agency for International Development (USAID), the Australian Development Assistance Bureau (ADAB) and the Japanese International Cooperation Agency (JICA), could play important roles in terms of technical and financial contributions.

(g) Nongovernmental and voluntary organizations at the regional level could be seen as mechanisms for promotional activities, technical support and exchange of information, including fund-raising from private sources as contributions to health development; as an initial step, a list of such organizations will be developed.

(h) Agencies and organs of the United Nations system provide direct technical cooperation, support TCDC activities, integrate health with other related development activities and resources, including the coordination and mobilization of funds, and help implement national health development strategies. These include UNDP, UNICEF, UNFPA, UNEP, UNIDO, ILO, FAO, ESCAP.

(i) The WHO Regional Committee for the Western Pacific, exercising its coordinating function in international health work, is expected to provide policy support, to play an important role in promotional activities, especially in bringing about important reforms in national health systems, and to monitor progress.

The multisectoral advisory body mentioned under Section 7.1.2 would be a means of providing technical support to national health councils and health development networks.

The Regional Committee Sub-Committee on the General Programme of Work will provide technical support and joint technical monitoring of WHO collaboration in health systems development.

Resources and mechanisms to support national health development efforts to attain the goal of health/2000 exist in abundance at the regional level. However, the organizations and agencies concerned have varying, and at times diverging, philosophies and approaches to, and concepts for, development. Accordingly, the principal strategy for implementing regional support for
national health development processes will be to draw the regional bodies towards a common understanding, so that efforts and resources are mobilized, synchronized, and directed towards the goal of health/2000. It is proposed to organize coordination meetings and to strengthen mechanisms for closer cooperation with the agencies mentioned.

7.2.2 Technical cooperation among countries

Technical cooperation should always be an essential consideration in any programming activity of an international agency. Member States are also urged to take this into consideration in formulating their health plans and programmes. National and regional mechanisms will have to be strengthened or developed in such areas as information exchange, training, procurement and manufacture of equipment and supplies, intercountry exchange of expertise and collaborative research.

In many instances such cooperation is already being developed, including, for example: the exchange of information on appropriate technology for health; the development of a South Pacific Pharmaceutical Service and the ASEAN Task Force on Drug Policies and Management; the strengthening of national training programmes and institutions in which other countries have a share, such as the training of health educators in Papua New Guinea and of assistant health inspectors in Solomon Islands; training in primary health care and traditional medicine in China; collaborative research in dengue fever; and the increased use of expertise from one developing country in another developing country.

The important contribution developed countries can make by supporting the health development efforts of developing countries is well recognized. This will be encouraged and facilitated by providing information on the health situation in developing countries and the magnitude and types of resources needed on a priority basis.

7.2.3 Economic cooperation among developing countries

This will stimulate and facilitate cooperation in the area of health. Moreover, certain activities in the health field, such as drug production and manufacture of equipment, will foster economic cooperation. In both these areas, health ministries have an important role to play.

CHAPTER 8: MONITORING AND EVALUATION

8.1 Framework

Strategies formulated at national and regional level are expected to overcome constraints, to enable programmes to respond adequately to the need to solve the main health and health-related problems. Thus monitoring and evaluation will have to focus on the following:
(1) Development activities. Close attention will be given to achievements in the areas of managerial processes for development, appropriate technology, health manpower development and health systems development, and their combined impact on community self-reliance and on programme delivery.

(2) Programme delivery. The operational output of programmes will be monitored and evaluated through selected indicators.

(3) Health status. The impact on health status will be monitored and evaluated through selected indicators. Two types of impact will have to be considered: on a specific health problem and on total health, such as the infant mortality rate, life expectancy at birth or the maternal mortality rate.

8.2 Level and process

Monitoring and evaluation will be carried out at national, regional and global level.

8.2.1 National level

The guiding documents will be the country reports on national policies and strategies for health/2000 and the medium-term plans formulated, or to be formulated, within that context, special attention being given to the three elements mentioned under Section 8.1 above.

Monitoring and evaluation will be carried out routinely, at fixed intervals, as part of the administrative process; for example in connexion with the formulation of annual budgets, the preparation of annual reports, mid-term reviews of the medium-term plan, or formulation of a new plan. It may need to be carried out at various levels, including the community level, by the health authorities themselves and national health councils and agencies specially assigned for the purpose.

8.2.2 Regional level

Monitoring and evaluation will be carried out collectively by Member States, through the WHO Secretariat, with emphasis on the involvement of participating countries. The WHO Secretariat is expected to carry out appropriate tasks, such as requesting national authorities for progress reports, and to submit its findings to the Regional Committee, either directly or through any body that may be constituted or supported by the Regional Committee, such as the Sub-Committee on the General Programme of Work. It is recognized that there are at least two instances when Member States come together and report on their work in the field of health: sessions of the Regional Committee and the World Health Assemblies. It is proposed that reports should be so structured as to be evaluative in nature as well as prospective. An intensive evaluation of impact will be conducted in the third year of each general programme of work period, a regional analysis of the health situation being carried out in the final year.
The guiding documents for the WHO process will be the regional strategy for health/2000 and the medium-term programmes of work as approved by the World Health Assembly.

In addition to the three elements mentioned under Section 8.1, evaluation will focus on the coordination and mobilization of external resources and implementation of the regional medium-term programmes.

8.2.3 Global level

Monitoring at this level could be concerned with the progress of regions in:

(a) formulating regional strategies;
(b) implementing planned measures for support to Member States;
(c) achieving a given level or range of health status as reflected by selected indicators, such as the infant mortality rate and life expectancy.

An intensive evaluation of impact could be conducted in the middle of each general programme of work period, a global analysis being undertaken towards the end of the period.

8.3 Support needed

Support to Member States in improving or strengthening the planning process will serve as an initial contribution in the development of monitoring and evaluation. Further support could be provided by promoting evaluation exercises, strengthening the existing evaluation process and training staff.

Strengthening the monitoring and evaluation process will necessitate the selection of a few simple but meaningful indicators of accomplishment and impact. Health information systems at national and regional level must be further developed if the information relevant to the indicators is to be generated.

8.4 Indicators proposed

8.4.1 Indicators to monitor implementation of health/2000 strategy (national level)

The following indicators could be considered, depending on their appropriateness and the information available at national level:

(a) Social and socioeconomic development indicators
   - quality of life index (QLI) - disparity reduction ratio
   - primary school enrolment
- secondary school entrance/completion
- unemployment
- measures indicating change in the social status of women
* - GNP per capita
* - calorie consumption per capita
* - population growth
- dependency ratio
- urban/rural population ratio
- adult literacy rate

(b) Health status indicators - overall community health status
* - life expectancy at birth
* - infant mortality
  - toddler mortality
* - maternal mortality
  - industrial absenteeism
  - absence from school
* - weight at birth

(c) Specific health problem indicators - measures of reduction in specific health problems to a level acceptable technically and to the community.
* - incidence/prevalence of communicable diseases
* - incidence/prevalence of chronic/degenerative diseases
* - anthropometric measurements (height and weight development in children)
  - incidence of specific nutritional deficiencies (nutritional anaemia, xerophthalmia and goitre)
  - disease specific mortality
  - indicators for oral health status
(d) Health services improvement indicators

(i) Index of equitable distribution of health resources - social justice in health

* - health services coverage and accessibility
- health services quality and appropriateness
- community satisfaction with health services
* - provision of essential drugs

(ii) Measures of community participation and support

* - measures of community resource allocation for health action
- measures of the health habits of the people (use of latrines and safe water, personal hygiene, child-rearing practices, fertility regulation and immunization)
* - measures of community participation in the management of health services

(iii) Measures of the development and use of appropriate technology

* - index of the use of local resources in the production of essential drugs and construction of health facilities
- transfer of knowledge and skills to members of the community in the spirit of self-reliance

(iv) Measures of intersectoral collaboration

- horizontal integration at various levels (including national level) in the planning and management of health and health related programmes
* - establishment of intersectoral coordination councils

(v) Measures of development of managerial processes

* - mechanisms for developing national health/2000 policies, strategies and plans of action, i.e. national health councils, national health development systems
- measures of decentralization of programme planning and management to provincial, district and community levels
(vi) Measures of development of health manpower programmes

- establishment of mechanisms for continuous monitoring of training needs
- measures introduced to improve the status and career prospects of health manpower
* - indices of adequacy and distribution of health manpower

(vii) Resource allocation for health development

* - budgetary allocation to the health sector in absolute and relative terms
* - proportion of GNP for health
- changes in the pattern of resource allocation to curative, preventive, promotive and rehabilitative services for health care
- priority of disadvantaged groups

(viii) Measures of improvement in the delivery of health care

* - coverage with immunization
- deliveries conducted under appropriate health care
* - pregnant mothers covered with minimal antenatal care
- provision of nutrition supplements
* - coverage with safe water supply
* - coverage with sanitary latrines
- index of health legislation and enforcement

(e) Indicators of political commitment. These indicators are already included under the different categories already enumerated.

8.4.2 Indicators for regional and global use

Which indicators will be included in a short list to be agreed upon for regional and global use will depend on whether reliable information is available in Member States. The items most likely to be included in the list are those marked with an asterisk in Section 8.4.1.
CHAPTER 9: ROLE OF WHO WITH RESPECT TO REGIONAL STRATEGY ISSUES

9.1 Issues for WHO

In accordance with the Constitution, the role of WHO includes coordination of the action which Member States undertake to attain the goal of health/2000 and the provision of technical cooperation. The coordinating function is the basis for, and is reinforced by, the technical cooperation function, which may cover both cooperation between Member States and WHO and cooperation among countries.

Previous chapters of the present document have outlined the proposed regional strategy for achieving the goal of health/2000. This chapter will describe how WHO intends to fulfil its role, given the functions described above.

Several major issues will have to be faced by WHO in following the proposed regional strategy. Changes will be necessary both within the Organization and with respect to the relationship between WHO and Member States.

The issues identified in previous chapters are the following:

(1) To realize the goal of health/2000, Member States will adopt a broader approach to health development, which will bring together the community and all government sectors concerned.

(2) Member States and WHO are now aware that the health/2000 strategy must take into consideration demographic, economic, social and behavioural, and epidemiological factors affecting health.

(3) To implement the new holistic approach to health development, changes will be required in the existing health systems, and above all in existing managerial processes. This of course applies to Member States and to WHO.

(4) The innovations required to carry out the strategy will need to be introduced on the basis of correct and relevant information.

To deal with the above-mentioned issues and to modify its role accordingly, WHO has been given full authority by the World Health Assembly\footnote{See resolution WHA33.24.} and the Regional Committee.\footnote{See resolution WPR/RC30.R11, Handbook of Resolutions and Decisions of the WHO Regional Committee for the Western Pacific, Vol. II, 2nd ed., 1980, pages 1-2.}
A framework for action for the strategy has already been presented in Chapter 3. The framework is built on the concept of a partnership between the community, the government and the private sector. The steps involved in this partnership have been described. For WHO, a similar framework will be followed.

9.2 Guiding principles for WHO action

To develop the issues described in the previous paragraphs, certain principles can be listed, which will assist WHO in focusing its role in implementation of the regional strategy.

(1) The health objectives expressed by Member States in the country statement synthesis will be used by WHO in establishing its own priorities when planning future technical programmes (see Sections 4.2.1 and 4.2.2). The objectives form the basis of the regional objectives, targets and approaches (Section 4.3).

(2) At regional level, political, technical, economic, research and managerial support (including information) will be sought for the strategy.

(3) Emphasis will be placed on satisfying the basic need for adequate food, water and shelter as a foundation for health, as well as on the development of community self-reliance.

(4) Joint planning, monitoring and evaluation of national health strategies and programmes should be undertaken with health and health-related sectors at national level, including external bilateral and international agencies as required.

(5) The use of technical cooperation among countries in developing and implementing national strategies should be promoted. This should play a major role in the context of regional support for the strategy.

(6) In the spirit of the New International Economic Order, the resources of WHO, from both the regular budget and extrabudgetary resources, should be allocated according to the priorities established by the strategy.

9.3 Nature of WHO collaboration

The nature of WHO collaboration has already been considered in Chapters 5, 6, 7 and 8. It involves regional support measures, generation and mobilization of resources, collaborative mechanisms, and monitoring and evaluation. Mechanisms for collaboration need to be reviewed and developed.

At the regional level, WHO will:

(1) enlist political support for programmes related to the implementation of national health/2000 strategies;

(2) identify and mobilize sources of extrabudgetary funds to support the implementation of national strategies and coordinate the effective use of such funds;
(3) organize multidisciplinary teams to provide Member States with direct support in the development of national strategies and plans of action for achieving health/2000;

(4) ensure the monitoring of WHO support by the Regional Committee.

At national level, WHO will:

(1) support national officials in developing national health/2000 strategies and plans of action;

(2) cooperate in implementing plans of action, including:

(a) the introduction of managerial processes for national health development;

(b) initiation of the primary health care approach, including research and development activities at community level where applicable;

(c) the strengthening of human resources development programmes in ministries of health;

(d) the design and development of coordination mechanisms for human resources development and for health research;

(e) the design and development of national health development systems;

(f) the design and development of mechanisms to coordinate and monitor the implementation of national health strategies through the establishment of adequate health management information systems in the ministries of health;

(g) the design and development of national health advisory councils;

(3) initiate, encourage and maintain the implementation of priority technical programmes within the context of national strategies, for example, expanded immunization programmes, water supply and basic sanitation;

(4) identify and mobilize sources of extrabudgetary funds to support the implementation of national strategies.

9.4 WHO's programme for the future

In the light of the foregoing, WHO will need to develop its programme accordingly.
For the first time, a planning perspective of 20 years has to be considered. Planning must be undertaken in the light of incomplete information and uncertainty with regard to future trends in the Region.

At present WHO plans its programmes in six-year periods known as General Programmes of Work. The current General Programme of Work ends in 1983, after which there will be three further General Programmes of Work up to the year 2000. For each WHO programme, there is a medium-term programme covering the six-year period of the General Programme of Work. The future programme structure and content, as far as the Region is concerned, will have to be reviewed in the light of the proposed regional strategy. WHO is already undertaking activities in preparation for the Seventh General Programme of Work (1984 to 1989) and the strategy for attaining the goal of health/2000 will be, and will continue to be, the theme for this.

The future programme structure and activities of WHO will therefore have to take into account the following:

9.4.1 Organizational structure

At the regional level, the structure will allow WHO to:

(a) influence heads of state and other national authorities politically, to take the necessary steps to ensure that the goal of health/2000 is attained;

(b) communicate and promote its vision of health/2000 in all sectors;

(c) establish intersectoral linkages between and among organizations, nationally and internationally, for mutual collaboration and support in health development;

(d) attract extrabudgetary funds for national and regional health development activities;

(e) establish a learning posture which will generate and accept new ideas, critically review its experiences and develop a capacity for problem solving; and

(f) respond appropriately and quickly to government requests for cooperation, having regard to the priorities established through the General Programme of Work.

At national level, WHO will be organized in the following manner:

(a) WHO Programme Coordinator

- Facilitator and technical adviser in the development and implementation of national policies and strategies for health/2000.
- Manager of WHO activities and support programmes at national level.

- Supervisor and supporter of all WHO staff and staff assigned to his area of responsibility.

- Coordinator and technical adviser with respect to other agencies, national and international, including efforts to attract extrabudgetary resources.

(b) Health programme teams

- Multidisciplinary groups of WHO staff, formally or informally assembled:

  (i) to support the WHO Programme Coordinator in the development and implementation of national policies and strategies for health/2000; and

  (ii) to coordinate WHO technical collaborative activities under various programmes.

9.4.2 Management of the strategy

While the scope for initiating managerial processes for health development is broad, a dual approach is proposed as an initial step in the implementation of the strategy.

At national level, the approach will be to engage national health administrators in the formulation and/or integration of national health policies consistent with the goal of health/2000, through primary health care.

At the periphery, the approach will be to engage the health system in developing interactive processes with selected communities leading to primary health care and to establish a monitoring system for the management of health development.

WHO will provide timely and relevant support to national health systems by coordinating and functionally integrating national managerial processes for health development with health services development and primary health care. Such support will be provided by multidisciplinary teams working in close coordination with a regional health development group established at the Regional Office. Teams will have the following expertise:

(i) community health development;

(ii) policy and programme development;

(iii) organizational development and planning;

(iv) health systems development;

(v) health economics and behavioural sciences;

(vi) health manpower development.
The teams will work with the WHO Programme Coordinators and the WHO health services planning and management projects within countries. For practical purposes, the teams will be composed of both Regional Office and field staff implementing a joint plan of action.

The role of such teams will be to act as:

(a) facilitators in initiating and supporting national managerial processes for health development;

(b) points of coordination for international and national management resources; and

(c) collaborators in the development of appropriate managerial approaches and methods, techniques, programmes and structures for health development.

The functions of the teams will include:

- training
- consulting services
- research and development.

9.4.3 Programme content

To summarize the implications of the proposed regional strategy for WHO's programme content, the managerial activities required should include, at regional, national and subnational levels:

(a) health policy and strategy formulation, planning and evaluation as a means of providing leadership from national to community level;

(b) human resources development as a means of selecting, training, and managing the human resources of the health system;

(c) information systems as a means of providing decision makers and managers at all levels of the health system with relevant information for its maintenance and development;

(d) research and development as a means of monitoring health at the community level and providing appropriate and affordable health technology to meet the community's needs;

(e) health development systems, as a means of facilitating the process of intersectoral collaboration and providing health systems with training, consulting and research support in the management of health development.

For WHO, this does not detract from the importance of its technical programmes. The objectives listed in Sections 4.2.1 and 4.2.2 provide guidance with regard to the regional priorities as stated by Member States.
CHAPTER 10: TENTATIVE PLAN FOR IMPLEMENTATION OF REGIONAL STRATEGIES, INCLUDING A TIMETABLE

The major milestones and targets for the formulation, implementation, evaluation and updating of policies, strategies, and plans of action for health/2000 at national and regional level include the following:

1. Initial reports on national policies and strategies for health/2000 prepared
   - April 1980

2. National progress reports reviewed and a proposed regional strategy developed by the Regional Committee Sub-Committee on the General Programme of Work
   - June 1980

3. Regional strategy for health/2000 reviewed by the Regional Committee
   - September 1980

4. Commitment obtained by the Regional Committee for Member States, with cooperation from WHO, to implement, monitor and evaluate the regional strategy
   - September 1980

5. Extrabudgetary resources identified through joint planning; for example, joint programming with UNDP for the period 1982-1986
   - September 1980

6. Policies and strategies reviewed and updated by Member States and plans of action developed
   - March 1981 and subsequently as required (see (9))

7. Regional strategy reviewed and updated by the Regional Committee
   - September 1981 and thereafter every 2 years

8. Monitoring and evaluation process introduced by Member States and the necessary mechanisms established for evaluating strategies
   - June 1982

9. National policies, strategies and plans of action periodically reviewed and updated by Member States
   - 1983 and thereafter every 2 to 4 years

10. The following established:
   
   (a) intersectoral national health councils or similar bodies
       - by December 1983

   (b) national health development networks
       - by December 1985

   (c) appropriate and relevant indicators to monitor and evaluate progress
       - by December 1981
(11) The primary health care approach introduced in selected areas of Member States by December 1982

(12) National health information systems established or strengthened to permit monitoring, evaluation and updating of strategies by December 1985

(13) Health systems development policies formulated and manpower and other requirements identified by December 1982

(14) Manpower policies developed, personnel reoriented and institutions strengthened by December 1985

(15) Total coverage with primary health care in all countries, supported by health systems by December 1990

(16) Regional mechanisms established for the following:

(a) promotion and strengthening of technical cooperation among developing countries by December 1981

(b) coordination with multilateral, bilateral and regional groupings in resource mobilization and implementation of strategies by December 1982

(c) coordination and collaboration within the United Nations system for developing a shared understanding and joint planning and regionalization of resources (for example with UNDP) by December 1981

(17) Medium-term programmes developed in the Regional Office for the Western Pacific for supporting countries in the formulation, implementation, monitoring and updating of national strategies and plans of action by December 1981

(18) The Seventh and the two subsequent General Programmes of Work developed to support the implementation of regional and national strategies 1981 and subsequently as required

(19) A regional strategy for managerial process for national health development formulated 1980
ANNEX 3

STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000

The Regional Committee,

Having considered Part II of the report of the Sub-Committee on the General Programme of Work containing proposals for regional policies and strategies for health for all by the year 2000, based on the reports submitted by Member States on national policies and strategies;

Recognizing that health is a prerequisite for socioeconomic development and for raising the quality of human life;

Recognizing also that primary health care, as an integral part of national health systems and of the overall social and economic development of the community, is the key to health for all;

Bearing in mind the role of health in the establishment of the New International Economic Order;

1. THANKS the Sub-Committee on the General Programme of Work for its report;

2. ADOPTS the regional policies and strategies, including the tentative plan for implementation and support mechanisms as considered necessary, one of which might be a regional health development advisory council;

3. RECOGNIZES that such strategies should not be considered as final but will have to be revised and updated periodically in the light of new developments;

4. URGES Member States to implement, monitor and evaluate their national strategies, reviewing and updating them from time to time;
5. RESOLVES to monitor and evaluate implementation of the regional strategies and the manner in which they are supported by regional policies and programmes, through its Sub-Committee on the General Programme of Work, using the indicators developed by the Sub-Committee and taking into account operative paragraph 3 above;

6. REQUESTS the Regional Director to:

   (1) transmit the report to the Director-General so that he may take it into consideration in developing global policies and strategies;

   (2) continue to support Member States both individually and collectively in the Regional Committee in their efforts to implement and monitor strategies for health for all.