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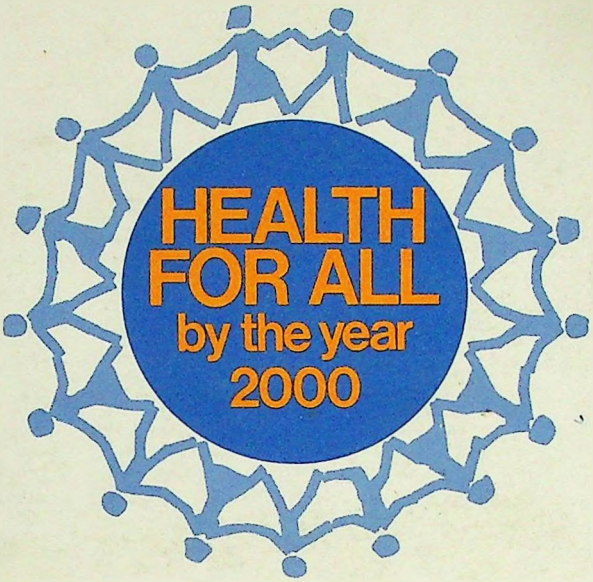

HEALTH FOR ALL
LEADERSHIP
INFORMATION MATERIAL

WORLD HEALTH ORGANIZATION

International Conference on Primary Health Care Alma-Ata 1978

The International Conference on Primary Health Care was held from 6-12 September 1978 in Alma-Ata, capital of the Kazakh Soviet Socialist Republic. The Conference was attended by delegations from 134 governments and by representatives of 67 United Nations Organizations, specialized agencies and non-governmental organizations in official relations with WHO and UNICEF. The Conference was jointly organized and sponsored by the World Health Organization and the United Nations Children's Fund and was preceded by a number of national, regional and inter-regional meetings on primary health care, held throughout the world in 1977 and 1978.

Objectives of the Conference:

(i) to promote the concept of primary health care in all countries;

(ii) to exchange experience and information on the development of primary health care within the framework of comprehensive national health systems and services;

(iii) to evaluate the present health and health care situation throughout the world as it relates to, and can be improved by, primary health care;

(iv) to define the principles of primary health care as well as the operational means of overcoming practical problems in the development of primary health care;

(v) to define the role of governments, national, and international organizations in technical cooperation and support for the development of primary health care; and

(vi) to formulate recommendations for the development of primary health care

The Conference declared that the health status of hundreds of millions of people in the world today was unacceptable; and it called for a new approach to health and health care, to close the gap between the "haves" and "have-nots", achieve more equitable distribution of health resources, and attain a level of health for all the citizens of the world that would permit them to lead a socially and economically productive life.

The International Conference on Primary Health Care therefore called for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urged governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference called on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

The Declaration of Alma-Ata

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all 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. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary Health Care...

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care,

including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

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In 1979, the Thirty-second World Health Assembly endorsed the Report and Declaration of the International Conference on Primary Health Care and launched the Global Strategy for Health for All by the Year 2000. The Assembly also invited the Member States of WHO to formulate their national policies, strategies and plans of action for attaining this goal and to act collectively in formulating regional and global strategies.

The Global Strategy for health for all by the year 2000 was adopted by the Thirty-fourth World Health Assembly in 1981.

Since 1979, Primary Health Care has been firmly implanted in the world political scene. There is international agreement on the adoption of a worldwide primary health care policy and strategy with the goal of making essential health care available to all people of the world.

Leadership internationally and nationally is now required to sustain support to countries in accelerating the process of primary health care, maintaining its momentum and cooperating in overcoming obstacles.

References

1. *Alma-Ata 1978 Primary Health Care* - WHO/UNICEF, "Health for All" Series, No.1
2. *Formulating strategies for health for all by the year 2000*, WHO, Geneva, 1979. "Health for All" Series, No.2
3. *Global Strategy for Health for All by the Year 2000*, WHO, Geneva, 1981 "Health for All" series, No.3.

Health for All and Leadership

Health for All by the Year 2000 — A Vision of the Future

The goal of Health for All by the Year 2000 is a vision founded on social equity; on the urgent need to reduce the gross inequality in the health status of people in the world, in developed and developing countries, and within countries. *It is a vision based on the principle that health and development are closely interlinked. It is a vision whose range of view encompasses fundamental change — in the way health is perceived, promoted, protected, and delivered.*

And these changes, which represent *a fundamental shift in values*, include:

- change in how people, individually, take greater responsibility for the protection and promotion of their health;
- change in the way people participate collectively in health, organizing themselves into action groups and enhancing self-reliance;
- change in the perception and value systems of the health providers — in which the health professionals have to be socially concerned, de-mystify health, involve people, empower them so that they may assume greater responsibility for their own health. They also have to broaden their understanding of health, no longer confined mainly to medical care or traditionally-defined preventive health care services.
- change in the organization and administration of the health system, going beyond the physical design involving redefinition of objectives of the principal institutions, reallocation of responsibilities and even of the power structure; getting health closer to the people by decentralizing and delegating authority, by revolutionizing the health care delivery system, emphasizing bottom-up planning and forging linkages, and by bringing other health-related sectors into closer alliance;
- finally, change in the attitudes and perception of policy makers in which health has to be seen and pursued as an integral part of development emphasizing a greater concern for social equity, bolstered by the courage to choose health care systems which are affordable, which give preferential attention to the underprivileged and vulnerable, and which provide rational means for deploying resources.

Values

By "values" we mean the fundamental principles or ideas that people stand by or prize, the reasons and beliefs which empower people and enable them to work continually towards a particular goal. Values influence, in a profound way, people's behaviour. They make up the inspiration or belief system that is the driving force which gives people their energy, enthusiasm and motivation from within. When values are shared, they enable people to work together.

The perspective of Health For All assigns new *values* to health. "Health" is no longer just the availability or the access to health services but rather a state of personal well-being going beyond the absence of medical problems. It means promoting healthy life styles and ameliorating the environment in which we live; preventing illness, accidents and disability with all the means at our disposal; and providing care and cure to all using relevant technology. "For all" means that health is to be brought within reach of everyone. It emphasizes equity, social justice and cooperation.

Central to these new values is that health is a fundamental human right and a worldwide social goal; it is an integral part of development; and, people have a right and the duty to participate individually and collectively in the planning and implementation of their health care and thus they must be encouraged and prepared to become self-reliant.

Leadership and "Health for All"

Leadership is essential to new values in society, particularly values that are concerned with social progression. The goal of Health for All is concerned with such new values. And strong leaders who are value driven are necessary, to help people and systems undergo significant change. Not just good managers or executors, but strong leaders.

New sets of questions need to be raised concerning social responsibilities and also the directions and quality of health care.

Those in leadership positions in health, in the health-related sectors and in the community will need to play a crucial role in meeting the challenges ahead. Their leadership qualities will be marked by a concern for social justice; compassion for the under-privileged; dedication to the growth of self-reliance; commitment; ability to communicate; courage to take risks and make bold decisions; and faith in people's capabilities. These have emerged as the crucial leadership qualities for Health for All.

Leadership is vital for the wide articulation of change and the consistent initiation of the processes and activities by which change can be brought about. *Some of the assumptions about the "leadership tasks" related to the changes needed for HFA are:*

Leaders should be *fully informed* about Health for All, and the strategies for its achievement *and be able to communicate it to others*;

They should be able *to identify central issues* affecting implementation of their national strategies;

They should be able *to specify their own personal role* in resolving those issues which fall within the scope of their responsibilities;

They should be able *to define strategic actions* to resolve these issues;

They should be able *to initiate* the process of change required and create networks of support for the implementation of change;

They should be able *to involve and mobilize others*, enable them by infusing a sense of purpose, commitment and a focus of action;

They should be able *to identify and support the development of leadership.*

Information Package for Health for All Leadership Development

This folder contains short papers on the following subjects:

1. **Evolution of Primary Health Care**
2. **International Conference on Primary Health Care, Alma Ata 1978**
3. **Meaning of Health for All**
4. **Prerequisites for "Good Health"**
5. **Partners in Health**
6. **Organization of Health Systems Based on Primary Health Care**
7. **Community Participation**
8. **Resources for Health**
9. **The Managerial Process**
10. **Measuring Progress Towards the Goal of Health for All by the Year 2000**
11. **Collaboration with Non-Governmental Organizations in Implementing the Global Strategy for Health for All**
12. **The Role of Universities in the Strategies for Health for All**

The papers contain, in a non-technical language, brief information about Health for All and Primary Health Care, with emphasis on the process and main issues concerned. Each of the papers also contains a suggested list for further reading. The papers are intended for anyone interested in Health for All but they have been specifically aimed at persons participating in workshops, colloquia or seminars on Leadership in health. Their purpose is to clarify the basic ideas and concepts contained in the Health for All policy and strategy so that they may be applied as suitable to specific needs and situations.

The contents of this package will be updated periodically and completed with new additions relevant to the evolving circumstances in health. Comments and suggestions both on content and presentations, as well as on other health issues for which similar papers would be useful are most welcome and should be sent to:

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Evolution of Primary Health Care

Primary health care has become a widely disseminated concept, but many people are still unclear as to its current meaning. When the term "primary health care" is used to refer to a wide variety of situations, many substantially different from the context of the agreed definition, confusion can result both within countries and internationally. Lack of understanding of the concept has even led to resistance in some circles.

How did the Primary Health care concept evolve?

The primary health care concept emerged from a series of ideas which evolved gradually with the re-examination of existing approaches to health care and the assimilation of new experiences.

As early as 1951, when the efforts of many developing countries were centred on specialized mass campaigns for the eradication of diseases, the Director-General of WHO observed that these efforts would have only temporary results unless they were followed by the establishment of permanent health services in rural areas to deal with the day-to-day work in the control and prevention of disease and the promotion of health.[1] True, there were some successes, like the reduction of yaws, the control of malaria in some areas and, later, the eradication of smallpox; but many debilitating and killing diseases like tuberculosis, gastro-enteritis, measles, etc., continued to prevail.

Disenchantment with traditional approaches

The enthusiastic application of new knowledge and technology did not always achieve the results expected, and this became evident as more vertical programmes were implemented - less successfully. And people became disillusioned with the part that medical care and services played in improving their health.

Health and Development interlinked

Parallelly, during the 1960's and early 1970's there was increased understanding that the causes of poor health were not primarily the common diseases but rather low health status which is a product of the prevailing socio-economic conditions; political structures and philosophies; nutrition and the environment. Thus, the links between health and development became clearer and led to further questioning of the purpose, relevance and social significance of health care within the broader context of social and economic development.

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[1] WHO Offical Records, No. 38, 1952, page 2.

It was then realized that the world's priority health problems required a fresh look and new approaches for their solution. Clearly this did not imply just injecting more technical knowledge.

Need for a new Approach

Rather it meant that fundamental changes were needed in the way health was perceived, promoted, protected and provided. And that such changes also had to take into account peoples' perceptions, values and attitudes towards health besides being able to adapt to their evolving circumstances. What this required was sustained motivation and commitment on the part of those who had the political and economic power to introduce such change.

Emerging Experience

The emerging experiences of a number of developing countries which had initiated new approaches to meeting the health needs of their people further confirmed this conviction. In countries which achieved considerable success in their nationwide endeavours, a strong political will was evident; health had been given a high priority in the government's general development programme, and a fundamental decision had been taken to bring about substantial changes instead of looking for solutions within the existing system.

Enterprise and leadership characterized the successful experiences in limited areas of some countries; and in all cases, the leading role of a dedicated person could be clearly discerned. *In most cases, changes led to major shifts of emphasis in the health services: from a curative to a curative-preventive approach, from urban to rural populations, from the privileged to the underprivileged, and from vertical mass campaigns to a system of integrated health services forming a component of overall social and economic development.*

The Basic Health Services Approach

On the basis of this evidence, during the early 1970's the *Basic Health Services Approach* was conceptualized. *It focused on increasing access and availability of health services to the rural populations of developing countries.* Case studies of national health systems in a few countries namely: Bangladesh, China, Cuba, Tanzania, Venezuela, Yuogoslavia, India, Niger and Nigeria helped to formulate a series of approaches that could be implemented to meet the basic health needs of people of the developing countries.

Two relevant international publications* were released in 1975 by the WHO, as attempts to publicize information about such policies and the countries in which they were being put into effect.

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*1. Djukanovic and Mach, 1975, *Alternative Approaches to meeting basic health needs in developing countries* - A joint WHO/UNICEF study - WHO 1975.
2. Newell, *Health by the People*, WHO 1975

The Primary Health Care Philosophy

The concept of Basic Health Services paved the way for Primary Health Care which, at first, was essentially an expansion of the ideas contained therein, i.e., accessibility, availability, acceptability, affordability and appropriateness of health services. *This earlier narrow concept of PHC was later broadened to encompass a philosophy which went much further than the simple provision of first contact health services.*

The Conference on Primary Health Care in Alma Ata in 1978 gave the PHC Philosophy a Political dimension with five underlying principles:

- Equitable distribution
- Community involvement
- Focus on prevention
- Appropriate technology
- Multisectoral approach

This *political philosophy* has dominated discussions about PHC since the late 1970's, and it is distinguished from the original narrow definition of PHC by being referred to as the *Primary Health Care Approach*

The Primary Health Care Approach

The meaning of the five basic principles which provide the framework of the primary health care approach can be summarized as:

Equitable distribution

Health services must be more equally accessible, not neglecting rural and isolated population or peri-urban dwellers.

Community involvement

Active participation by the community in their own health decisions is essential.

Focus on Prevention

Preventive and promotive services rather than curative services should be the central focus of health care.

Appropriate Technology

The methods and materials used in the health system should be socially acceptable and relevant.

Multisectoral Approach

Health must be seen as only part of total care; nutrition, education, water supplies and shelter are also essential minimum requirements to well-being.

A new course of Action for Health

The Primary Health Care (PHC) approach thus constitutes a *qualitative break* with the past, a new course of action for health. Far from being just the addition of yet another layer to the health service - at the bottom, in the communities, using community resources - PHC implies a reordering of priorities that should permeate all levels and sectors concerned with the promotion of health. Such a reordering has, above all, three main implications.

Implications of the Primary Health Care Approach

First, in terms of *understanding health problems*, the PHC approach stresses that health promotion involves a set of issues much wider than those which health services have conventionally tried to tackle. Therefore the PHC approach is qualitatively different. It involves political action and the efforts of many sectors other than health.

Second, the PHC approach emphasizes *the use of certain policies to translate that understanding into practice.* These policies include other relevant socio-economic issues which develop a framework for intersectoral action; they emphasize the need for an integrated approach to health care within the health service itself; they encourage a progressive shift from centralized planning and decision-making to decentralization and active involvement of people in health matters.

Thirdly, the PHC approach calls for *shifts in the allocation of resources* to give greater emphasis to the preventive and promotive health activities and to the underserved and disadvantaged population groups.

It should be clearly understood that it is the *primary health care approach which is being promoted internationally as the key to attaining the goal of health for all by the year 2000.* The approach advocates that health care be brought as close as possible to where people live and work. It stresses that primary health care be an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It therefore requires a strong political will and support at both national and community levels reinforced by a firm national strategy.

Therefore, the following questions posed by the Director-General of W.H.O., Dr Halfdan Mahler at the opening ceremony of the International Conference on Primary Health Care held in Alma-Ata in September 1978 are still valid for the health leadership today.

1. Are you ready to address yourselves seriously to the existing gap between the health "haves" and the health "have-nots" and to adopt concrete measures to reduce it?

2. Are you ready to ensure the proper planning and implementation of primary health care in coordinated efforts with other relevant sectors, in order to promote health as an indispensable contribution to the improvement of the quality of life of every individual, family and community as part of overall socioeconomic development?

3. Are you ready to make preferential allocations of health resources to the social periphery as an absolute priority?

4. Are you ready to mobilize and enlighten individuals, families and communities in order to ensure their full identification with primary health care, their participation in its planning and management and their contribution to its application?

5. Are you ready to introduce the reforms required to ensure the availability of relevant manpower and technology, sufficient to cover the whole country with primary health care within the next two decades at a cost you can afford?

6. Are you ready to introduce, if necessary, radical changes in the existing health delivery system so that it properly supports primary health care as the overriding health priority?

7. Are you ready to fight the political and technical battles required to overcome any social and economic obstacles and professional resistance to the universal introduction of primary health care?

8. Are you ready to make unequivocal political commitments to adopt primary health care and to mobilize international solidarity to attain the objective of health for all by the year 2000?

Note

The following references may be consulted on the above subject.

1. *Alternative Approaches to meeting basic health needs in developing countries. A joint UNICEF/WHO Study*, WHO 1975
2. *Alma-Ata 1978. Primary Health Care*, UNICEF/WHO, 1978
3. *National Decision-making for Primary Health Care, A Study by the UNICEF/WHO Joint Committee on Health Policy*, WHO 1981

Meaning of Health for All

The road to Health for All

International discussion in the 1950s emphasized the social aspects of health and disease. In many countries programmes of social and community medicine were developed to incorporate a series of public health and social hygiene measures. But the links with social and health policy were not very strong. It was more a question of an expanded view of public health.

Dissatisfaction with health care systems

In 1972-73 a WHO study on the development of health services concluded that there was widespread dissatisfaction among people with their health care systems, which were failing dismally to cope with primary health problems in countries at all stages of development.

Developed countries

In some developed countries health care systems had become and are still today extremely complex enterprises being run on a gigantic scale and at a staggering cost. But despite their expensive and impressive infrastructure and highly specialized technologies, the emerging health problems of people were not being solved. The principal reason for this discrepancy is that these new health problems require a completely new approach to health which emphasizes individual self-reliance and commitment to good health.

Developing countries

At the same time, most developing countries which were also often newly independent, still faced major problems with the control of infectious diseases, the provision of safe water and basic sanitation services, the provision of care during pregnancy and delivery and the elevation of the standard of living to a minimum acceptable level.

In the rural areas and the rapidly expanding urban areas millions of people still remained without access to essential health care and lifesaving measures.

The above mentioned WHO study led to a continuing discussion of *how* health care systems should evolve and how WHO could best support countries struggling to improve their systems.

International concern

The overriding concern of the international community and the WHO governing bodies was that the world was faced with a magnitude of severe but preventable health problems, and at the same time with an inadequate and intolerably inequitable distribution of resources for health. Moreover, the majority of the world's people did not benefit from the health and medical solutions that existed.

Expressing the ideas that were dominating the international discussion during the 1960s and the early 1970s the World Health Assembly decided in a groundbreaking resolution in 1977 that "the main social targets of governments and WHO in the coming decades should be the attainment of all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." *With the adoption of this resolution the Health-for-All movement was born, and a slogan was created.*

International Health Policy

The central issue of this international health policy was the provision of health ***for all***, emphasizing solidarity in the use of resources for health; equity in the development of possibilities for health and human justice in all parts of the world. Equity and solidarity do not concern only medical care but also health promotion, and disease prevention. This requires a forward-looking strategy, a prospective approach to balance the customary retroactive tradition in medicine.

The perspective of the ***Year 2000*** was introduced to provide orientation for achieving the goal and to underline the urgency for future oriented action. The turn of a century has always appealed to people's imagination, because it stands out as a landmark in the counting of time. And a deadline was needed as a target date for the evaluation of progress. In 1977, when the movement was born, the year 2000 was still far enough ahead to give time for action, and close enough to start immediately and work diligently.

The Meaning of Health for All

To some people Health for All is yet another slogan. Of course, Health for All is a slogan, but not an empty one. It is a short, striking and imaginative set of words which, given the right context, serves as a rallying point for concerted social action within and between countries, a public relations watchword that fires people's imagination, a quick reference to a complicated set of activities and a list of specific health targets. It is an expression of the cry for social justice from all those who suffer inequity in health. It is intended to draw attention to the importance of health, to a serious search for new ways of solving the problems of health, and to help mobilize all available resources for health.

Health for All does not mean that as of the year 2000 we shall all be free of disease and disability and eventually die in a "state of health" at the end of our biological life span. "Health for all" means that health is to be brought within reach of everyone in a given country including the remotest parts of the country, and the poorest members of society. And by "health" is meant not just the availability of health services but a personal well-being and a state of health that enables a person to lead a socially and economically productive life. "Health for all" implies the removal of the obstacles to health - that is to

say, the elimination of malnutrition, ignorance, contaminated drinking water, and unhygenic housing - quite as much as it means finding solutions to problems such as a lack of doctors, hospital beds, drugs and vaccines.

The Strategy for Health for All

The achievement of the health-for-all goal calls for dramatic changes, a social revolution in health development. It aims at changing the mentality of people, influencing the structure of health systems, and reorienting the way in which health professionals are working. To bring about these changes, the HFA movement had to be activated, and the slogan had to be given practical content through the development of a strategy.

The Alma-Ata Conference in 1978 set down the principles of Primary Heath Care. Through consultations within countries, regions and at the global level, a Global Strategy for Health for All by the Year 2000 was developed. That strategy defines the broad lines of action to be undertaken at policy and operational levels, nationally and internationally, both in the health sector and in other social and economic sectors. For the first time, a global strategy had been formulated not at a top level international conference but painstakingly built from country level upwards. Once the general principles for action were agreed, the work of developing indicators for monitoring and evaluation was set in motion; and countries started detailing their plans of action and their lists of activities.

The global strategy is necessarily rather general as it has to be based on the lowest common denominator; the specific targets set and activities suggested in the strategy have to be such that they can be reached by all Member States within a reasonable period of time. It is based on the following fundamental principles.

Fundamental Principles

- Health is a fundamental human right and a worldwide social goal.
- The existing gross inequality in the health status is of common concern to all countries and must be drastically reduced.
- People have the right and the duty to participate individually and collectively in the planning and implementation of their health care.
- Governments have a responsibility for the health of their people.
- Countries must become self-reliant in health matters.
- Health is an integral part of overall development. Energy generated by improved health should be channelled into sustaining development.
- Better use must be made of the world's resources to promote health and development, and thus help to promote world peace.

In fulfillment of the above principles concerted efforts have had to be made to develop health systems based on primary health care.

These ideas provided some guidance for the development of national health care systems. However, since health needs vary considerably between the six regions of WHO, each region has developed its own specific strategies.

Is Health for All progressing?

Most Member States of WHO have formulated national HFA strategies and are now at varying stages of implementation. The first evaluation report was presented to the World Health Assembly in May 1986. This report shows that the new concepts of health and the new approaches to reach them have gained worldwide acceptance and that a high level of political commitment has been achieved. The progress reports from countries show not only great successes, but also many problems to be solved and obstacles to be overcome. Twenty years ago it would have been inconceivable for nations to admit that there were such problems and obstacles. That these problems are now publicly presented and seriously discussed shows that Health for All has taken roots and is starting to have its effects.

Paradoxically, until now the developed countries are among those who have most benefitted from the health for all concept because of their capacity to use the information and the ideas generated through WHO. But a start has been made in most developing countries, and Health for All has proved to be a slogan that has helped set free the social energies needed for health development.

National, regional and local actions

In many countries national, regional and local meetings involving all ministries concerned as well as health professions and representatives of the people have discussed health for all. Specific national policies for health for all have been developed. In Europe, a set of regional targets has been agreed upon, and the target document translated into several languages. Top international health journals are seriously debating health for all. National health information systems are being revamped to suit the new types of targets.

Where do we go from here?

It is recognized that Health for All has successfully taken off. Commitment and strong leadership are now necessary to sustain the progress made so far and to further accelerate the process of implementation of national strategies so that by the year 2000 countries can provide Primary Health Care to ***all*** their people. Only then will the principles of equity and social justice be reflected as the true meaning of Health For All.

References

1. Mahler, Halfdan. The meaning of "health for all by the year 2000". *World Health Forum* 2(1): 5-22 (1981)

2. *Formulating Strategies for Health for All by the Year 2000,* WHO, Geneva, 1979. "Health for All" Series, No. 2

3. *Global Strategy for Health for All by the Year 2000,* WHO, Geneva 1981, "Health for All" Series, No. 3

Prerequisites for "Good Health"

Universal Consensus

The achievement of Health for All by the year 2000 involves setting into motion a process for which a number of prerequisites are essential. At the outset *it has been necessary to create a broad consensus among people of all nations that it is an objective that should, can and will be attained by the year 2000.* Much will have to be done to improve the delivery of health care, for example, in maternal and child care including family planning, immunization, prevention and control of locally endemic diseases, appropriate treatment of common diseases and provision of essential drugs. However, such improvements will not be enough unless certain fundamental conditions are met.

Peace and Social Justice

Without peace and social justice, and without providing each and all with a useful role in society and an adequate income, there cannot be health for all for the people, no real growth and no social development. The main responsibility for attaining those objectives lies outside the health sector. This responsibility must be fully recognized at all levels of policy-making in countries so that priorities in overall national development take into account the need to strengthen those aspects of life that are prerequisite for health. *Given the magnitude of the task of attaining health for all, strong political will and the mobilization of public support are fundamental prerequisites for launching the necessary action.*

Freedom from Fear of War

War is the most serious of all threats to health. The devastation that a war entails in terms of people killed, wounded and permanently disabled is difficult to imagine. But peace is not just the absence of war. It is also a positive sense of wellbeing and security for people of all countries, implying the opportunity to freely determine their own destiny and fully exploit their human potential.

It assumes the possibility of all nations actively participating on a basis of equality and in a true spirit of solidarity and reciprocity in the development of a more satisfying world for all people.

It is not only war itself that presents health problems, but also the fear of war. The increasing international tension in recent years has raised this level of apprehension to a point that severely hampers the opportunities for all people of the world to work together in harmony for a better future. Therefore, the international community should make every effort to end wars and to remove the threat of war.

There are some things that the health sector can do that fit its basic role and that can help to reduce international tension. *Each national health sector should take responsibility for creating a better understanding of what wars really mean for health, and thus strengthen the motivation for peace.* By analysing objectively the extent of human destruction, suffering and disability that a war would entail in their country, by giving a realistic analysis of how little its health services would be able to do to treat the civilian and military casualties, and by making these facts known and understood by politicians and the general public, the health sector could help to encourage a more active search for ways of preventing war.

Equal Opportunity for All

In the commitment of the Member States to Health for All lies a fundamental principle of social policy: *all human beings have an equal right to health.* That right will be ensured by providing all the people of the world with an equal opportunity to develop health to the fullest and to maintain it. *This principle has two aspects: equity among nations and equity among the people within each country.*

The wide disparities in health status between the developed countries and the large majority of developing countries as reflected in their profiles of ill-health, mortality, sickness and age and social groups most at risk show the links of affluence and poverty to health. In developing countries, the predominant risks are closely associated with conditions of poverty: insufficient food and nutrition, poor social and physical infrastructure for satisfying basic minimum needs and lack of knowledge to cope with problems of ill-health. In such a situation, problems of survival acquire the greatest urgency, since the very young are most exposed to health risks.

While inequality exists at the global level, the health disparities are even more serious within countries, particularly in the developing countries, the most visible gap being between urban and rural populations. This reflects how health related resources are distributed within the countries, including access to health services, education and income-earning opportunities.

Usually the people in urban areas are better off than in remote rural areas. They are often better served with basic services including health. However, the people who have to live in slums and shanty towns, with their disorderly expansion, are deprived of a healthy environment. Those living in peri-urban slums tend to have the poor health profile of deprived rural areas.

The health status of women and the disparities in health between genders is often a critical indication of health equity in a society. In a number of developing countries, problems of health are exceptionally severe for women.

The facts and experiences presented above call for explicit policies and strategies to reduce inequities in health. There is no simple way to tackle the cumulative health hazards and thus reduce morbidity and mortality.

The health sector can contribute by identifying the disparities in health, together with the vulnerable groups that are involved, and by placing these in their different socio-economic contexts.

One driving force in this work is active community participation, as well as a greater awareness in society of existing health hazards and ways of reducing them by individual and community actions.

Secure Work and a Useful Role in Society

Secure work and a useful role in society have always been fundamental human needs. Unemployment and underemployment take a human and social toll on individuals, their families and communities that is also damaging to health. Also, to these problems there are no easy answers, particularly as the economic prospects are uncertain. And the countries which need most to reduce unemployment and underemployment and to improve the health of the people have the least amount of resources allocated for these tasks. Employment policies, including responses to the economic recession by training of young people, should provide people with an opportunity for choosing satisfying social and economic activities while maintaining living standards and fulfilling social and family roles.

Research efforts should be devoted to finding new ways of redistributing work and work opportunities as economic and industrial patterns change. The political challenge is to find acceptable means of promoting this development. The health sector has to pursue the optimal strategies in which available resources produce the most equitable health outcome. The constraints themselves provide the opportunity for reinforcing two major reorientations in health policy which were emphasized in the Alma-Ata Declaration.

First, this means a further strengthening of preventive health and the primary health care approach. Second, health strategies would have to pay greater attention to intersectoral linkages. In addition, adjustment resources should be mobilized where and when appropriate in close collaboration with aid donors and international agencies.

Political Will and Public Support

Given the magnitude of these tasks, strong political will and the mobilization of public support is essential for launching the necessary Health for All action. The ministries of health or other authorities responsible for promoting and sustaining health policies should take a strong line in ensuring the clear commitment of the country as a whole to the objective of health for all. This is in conformity with Resolution 34/58 of the United Nations General Assembly, Resolution WHA30.43, calling on countries to develop their national strategies for health for all and take the necessary steps to ensure their implementation. *The process of mobilizing support should preferably be set in motion by political decisions taken at the highest level and confirmed in all sectors throughout the country. This should be in all sectors with an impact on health, acknowledging that safeguarding the people's health is an overriding concern in their own particular field as well.*

The European Example

A Common Regional Health Policy

The countries of the European Region of WHO agreed on a common health policy in 1980. The strategy called for a fundamental change in countries' health development and outlined four main areas of concern: lifestyles and health; risk factors affecting health and the environment; reorientation of the health care system itself; and, finally, the political, management, technological, manpower, research and other support necessary to bring about the desired changes in those areas. Calling for a basic change in countries' health policies, the strategy urged that much higher priority be given to health promotion and disease prevention; that not merely the health services but all sectors with an impact on health should take positive steps to maintain and improve it; that much more stress should be laid on the role that individuals, families and communities can play in health development; and that primary health care should be the major approach used to bring about these changes. The strategy also called for the formulation of specific regional targets to support its implementation.

Targets and Indicators

These events represented a landmark in health development among the European peoples. Never before had the countries of the Region agreed to adopt a single health policy as a common basis for subsequent development, both in individual Member States and in the Region as a whole. The 33 countries of the Region went even further, urging Member States to review their health developments and bring their health policies and programming in line with the health for all strategy.

Targets for the region were developed through the active participation of national health and social institutions, in consultation with their health authorities. In spite of the great differences in socio-economic development, in health status and in political orientation, a common set of 39 targets was agreed upon and adopted in 1984. While not legally binding on individual countries, they are intended to help them at their own national targets, reflecting their specific needs, priorities and values.

Specific indicators were then developed for each of the targets, and texts with problem statements and suggested solutions were prepared. This was published as a regional publication (1), which has been translated into several national languages and has resulted in widespread debate on national health development in European countries, and already in the adoption of national health for all strategies and plans in some.

Reference

1. *Targets for health for all,* WHO Regional Office for Europe, Copenhagen, 1985

Partners in Health

Equity is the unifying theme of a policy for Intersectoral action for health. The main policy priorities, whether they are related to the quality of life, problems of survival in developing countries, or disease patterns in urban industrialized societies, concern the disparities between and within countries. They also reflect on how reduction of these disparities can improve the health of vulnerable groups.

The equity-oriented approach in the health sector has been firmly based in primary health care both in terms of objectives of coverage and priorities in health care. *The implications of this equity-oriented approach for national development strategy and sectoral policies stresses that equity in health cannot be achieved by the health sector in isolation. Linkages are needed with other sectors that control and influence factors that determine health; such as agriculture, food and nutrition, education and information, environment and physical infra-structure. The health sector must cooperate in the management of these factors for the promotion of health.*

Many of these relationships have already been recognized and, in a few instances, used successfully in pursuit of health -promoting goals in widely varying political systems. However, there is a need for more initiative by the health sector in enhancing intersectoral collaboration, and for greater response by the other relevant sectors.

Health and Development

Improvements in the health status of a population cannot be achieved simply by expanding and developing the health services. More than ever before policy-makers and planners are recognizing that a country's health forms part of an integrated process of development. *The linkage between health and development has been amply demonstrated by both the experience of developed countries and the improvement in the quality of life in several low income countries.* In developed countries, the communicable diseases, which were the principal causes of mortality, were controlled before major discoveries for their cure and treatment were made. The health gains were mainly due to better living conditions, which reflected improvements in nutritional status, sanitation

and health behaviour. In low income countries, health development is increasingly becoming part of a strategy aiming at satisfying the basic needs of the population by giving the poor access to resources and economic opportunities, raising educational levels, ensuring availability and distribution of food, improving the status of women, and providing the basic infrastructure of transportation and other public amenities.

Partners in Health

There is awareness in the world today that the health sector cannot do it alone. Partners in health are needed. Many other ministries, services, institutions, government and non-government organizations, and all levels of administration down to the community and the family must become involved in health. *So the drive towards the goal of Health for All by the year 2000 can only be inspired and fuelled by concerted interaction of all relevant partners namely: agriculture, food and nutrition, education, culture, information and life patterns, water and sanitation, habitat and industry.*

Agriculture, Food and Nutrition, and Health

Agricultural policies, products and processes are major determinants of people's health in both developed and developing countries. More than two thirds of the people in developing countries derive their livelihood from agriculture. Most of their working time is spent in agriculture, and most of their income on food.

The processes of agricultural development affect health in diverse ways. By increasing food output these processes improve the nutritional status of both farmers and consumers in rural and urban areas. On the other hand, raising output may create new health hazards, or exacerbate existing ones. Yet agricultural policies can improve health, by taking into account health implications of the agricultural methods and by providing food supplies which can ensure a balanced diet for the population.

Generally, agricultural planners collaborate readily in the elimination of known, existing, and clearly visible health risks. However, there are health risks which are not readily detectable, and require specialized analysis. In the absence of this, agricultural technologies may be selected (e.g. in the area of pesticide use, irrigation systems, farm storage, and the use of labour — especially work overload of women), which can produce serious health hazards and contribute to the deterioration of the health and nutritional status in the region. It is within the framework of these interrelationships that the health and agricultural sectors need to work together.

Education, Culture, Information and Life Patterns

In view of the decisive role that the education sector has to play in the promotion of health and the urgent need to improve the health of vulnerable groups, much greater attention should be focused on the expansion of educational programmes aimed at these groups, the strengthening of their quality and the inclusion of education relating to health.

Formal and Non-formal Education

Formal education provides an excellent platform for creating and nurturing those activities which lead to human development. Providing teachers and students with opportunities to learn about health and health-related matters can contribute to the achievement of better health for the whole nation. Non-formal educational programmes such as functional literacy, adult education and parents' education have had particular success in improving quality of life.

Nevertheless, more efforts need to be given to targeting such programmes towards health issues of direct relevance to the individual, the family and the community.

Female Education

The vital role of female education in accelerating the decline in mortality means that communities with high adult female illiteracy are most vulnerable and at greatest health risk. The prevailing situation requires that a much greater effort be made to impart functional literacy and non-formal education. Such programmes should address concrete life situations of illiterate women, the efficiency of their household and resource management in conditions of scarcity, their work, whether on farms or elsewhere, and their skills for family care.

University Education

The health link in university education has different dimensions. Institutions of higher learning provide a country with professionals, some of whom will be destined to become health leaders and promote scientific knowledge on health. Training of professionals who will work in sectors whose activities will directly influence health should include an adequate level of awareness of, and competence in, health matters.

Cultural Factors

Health programmes also need to take in account cultural factors, which include deeply-held notions about basic health matters such as food, pregnancy, childbirth, diseases and hygiene. In both developed and developing countries, people, especially the youth, are increasingly exposed to problems of addictions, which comprise drugs, alcohol and smoking. Preventive strategies need to involve education, information and value formation.

The Role of the Media

The media can create public awareness about health issues and foster community involvement by reflecting public opinion, encouraging dialogue and facilitating feedback from the community. Media can influence policy-makers about health development, and publicize relevant information for wider use.

In many instances, media help set social norms and lifestyles which are relevant to health. It is vitally important, therefore, that the media and the health sectors are forging a partnership.

Environment, Water and Sanitation

Ministries or agencies concerned with *housing, public works, urban and regional planning and environmental protection all have important roles to play in helping to improve people's health status — especially the health status of the poorer and disadvantaged groups. In all actions to improve shelter, health and environment, the special needs of women in their triple role as income earners, household managers and child rearers must be recognized.*

Habitat and Industry

The lack of infrastructure and services as well as poor quality of housing in the majority of settlements in rural areas, small urban centres and on the fringes of large fast growing cities relate to a high prevalence of diseases. The effects on health of the lack of basic services and poor quality housing must be identified and acted on by health, housing and public works agencies. Virtually all endeavours to increase production imply changes in the environment. The qualitative deterioration and quantitative depletion of resources, including the capacity of the environment to absorb wastes, and their negative health impacts, tend to be disregarded. There is a need, therefore, for dialogue between all parties involved, so that appropriate modifications are made in time and negative health impacts avoided. In most nations, intersectoral action has already contributed to the protection of the health of workers through occupational health programmes in which the state, employers and trade unions each play a role. However, there is abundant evidence to show that many people, including women and children, work without that protection in an environment that can seriously be detrimental to their health.

Legislation and regulation with respect to housing, air, water and food quality, infrastructure provision, workplace and health protection, should be reviewed and improved, where and when necessary, with the aim to reduce the most serious threats to people's health status, especially to disadvantaged groups.

Involving the Community

Community participation has been identified as an important means of overcoming sectoral barriers. *It is the community and its involvement that best motivate collaboration between sectors; through the community, health goals can be linked to and reinforce other goals of wellbeing.* This has been repeatedly demonstrated in community level projects that have incorporated health in multisectoral programmes, whether in the field of nutrition, water supply and sanitation, or education. Community participation is the means by which additional resources available within the community are mobilized for health. It may not be easy to motivate the community to participate or to sustain such participation. Support is needed from community level workers and all sectors to promote and develop self reliant community level organizations that can form the base of an institutional framework. Another dimension of community involvement is the participation of non-governmental organizations active in health or health-related issues.

Collaboration with Non-Governmental Organizations

People in all walks of life, including individuals, families, communities, non-governmental organizations, and other associations of people concerned, should become involved in action for Health for All. Partnership is the most important element in the Global Strategy. Non-governmental organizations (NGOs) as representatives of groups of people have a long tradition of providing health care. *Where the principle of partnership has been accepted, governments have recognized that NGOs are indispensable allies because they supplement government resources with publicly raised money and volunteer staff.*

Non-governmental organizations are close to the people, responsive to their needs, and able to act quickly. They can operate cost-effectively, because they use their limited funds more for field work and less for overheads. Non-governmental organizations usually are innovative and flexible, not inhibited by rigid programming.

NGO's and Governments

While worldwide voluntary action for health is considerable in volume and magnitude, it is mostly ad hoc, often unrelated to national health strategies, plans or programmes, and invariably uncoordinated. Few NGOs relate to each other or to the government's programmes, and this results in a lack of concerted action which could have a real impact on health problems. There is an urgent need for governments to share responsibilities with NGOs so as to benefit from their experience and expertise, to draw lessons from their innovative experiences and to support them in their work. There is a similar need for NGOs to show better understanding of national plans and priorities, to be good partners in the larger task of implementing Health for All strategies and to use their natural strength of closeness to the community to help stimulate the development movement amongst the people. *The partnership approach demands that governments be willing to support NGOs through allocation of resources and to consult them in formulating plans and programmes. This collaboration between partners is most likely to succeed if there is open two-way communication. To facilitate such a dialogue, mechanisms of consultation can be created.*

References

1. *Intersectoral Action for Health*, World Health Organization, Geneva, 1986.
2. *Inequalities in health and health care*, The Nordic School of Public Health, Gothenburg, Sweden, NHV-Report 1985:5
3. *Intersectoral linkages and health development*, WHO Offset Publication No.83, WHO, Geneva, 1984
4. *Collaboration with non-governmental organizations in implementing the global strategy for health for all, Report of the Technical Discussions*, (WHO document A38/Technical Discussions/4)

Measuring Progress Towards the Goal of Health for All by the Year 2000

"Health for All" by its very definition is not just one single, quantifiable entity for all people. It means many different things to different people, reflecting their sense of the concept as it echoes in their own consciousness. It is therefore necessary to illustrate to those concerned in different situations that they are making progress towards reaching a level of health that is the highest achievable in their particular circumstances.

Monitoring and Evaluation

It is necessary to introduce a systematic monitoring and evaluation process as part of national strategies for health for all. Whatever the precise nature of the process, it should include: monitoring progress in carrying out the measures decided upon, the efficiency with which these measures are being carried out, and the assessment of their effectiveness and impact on the health and socioeconomic development of the people. In applying this process, indicators that help to measure changes directly or indirectly are needed.

Indicators

*Four broad categories of indicators are considered of value to countries in monitoring and evaluation of their national strategies.*These include:

a) **Health policy indicators** to measure trends and changes in political commitment for HFA resource allocation, degree of equity of distribution of resources, community involvement, degree of decentralization in decision making and organizational framework, and managerial process.

b) **Indicators of the provision of health care** to measure progress in availability, accessibility and use of health care services and quality of care. These have to be related to the specific types of services that the national health strategy aims at providing.

c) **Health status indicators** to measure changes and trends in health status of the population.

d) **Social and economic indicators** to measure demographic and economic trends, income distribution, education, housing and food availability.

As part of their process of evaluation, countries are expected to select indicators that are appropriate to their individual social, economic and health situation. *Indicators selected should be able to measure change towards attaining the objectives and reaching the corresponding targets.* They also have to be closely related to the means available for data collection and processing and should be gathered as an intrinsic part of the system for delivering health care.

Information Support

Many countries still lack reliable *information support* for measuring their progress towards health for all. Often the information is collected at various levels but it is not systematically processed, analyzed and used. Most countries do have many potential sources of data which are capable of providing the information required for monitoring and evaluation of their national strategies, such as: vital events registers, population and housing censuses, routine health service records, epidemiological surveillance data, sample surveys and disease registers. However, lack of coordinating mechanisms in the collection and processing of information by different sectors not only makes the process uniquely difficult, it severely limits knowledge as to what information is available or even to duplication of efforts. Above all, a positive attitude and a genuine desire, particularly at the policy and decision making level to measure progress towards health for all are basic requisites.

Making Use of Information

Information should be perceived as a tool for decision making and policy reorientation. The available information needs to be converted and presented in such a way that it can be used by policy and decision makers, by managers and by the community to learn what progress is being made, to identify areas where changes are needed, and to specify actions that must be taken to bring about such changes. In this way, monitoring and evaluation will promote learning from experience, and using the lessons learnt, will improve both current activities and future planning, and will guide the allocation of human and financial resources in order to achieve equity in health the essence of the goal of health for all.

Global Indicators

It is understood that countries will select indicators that are most relevant to assessing national progress of their national strategies for health for all. When endorsing the Global Strategy for Health for All (1981), countries also agreed to cooperate in assessing progress being made collectively in regions and globally towards attaining the goal of

health for all. For this purpose, a short list of *global indicators* were selected. These constitute a *minimal list* so that all countries may be in a position to use them. Since average global values of indicators have little meaning, monitoring and evaluation at the global level will be based on the *number of countries* in which these indicators comply with pre-determined values.

The following list of 12 global indicators was adopted by the Thirty-fourth World Health Assembly in 1981.

The number of countries in which:

Health Policy Indicators

1. Health for all has received endorsement as policy at the highest official level;
2. Mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning;
3. At least 5% of the gross national product is spent on health;
4. A reasonable percentage of the national health expenditure is devoted to local health care;
5. Resources are equitably distributed
6. Well-defined strategies for health for all, accompanied by explicit resource allocations, whose needs for external resources are receiving sustained support from more affluent countries.

Indicators of Provision of Health Care

7. Primary health care is available to the whole population, with at least the following:
   - safe water in the home or within 15 minutes' walking distance, and adequate sanitary facilities in the home or immediate vicinity;
   - immunization against diphtheria, tetanus, whooping cough, measles, poliomyelitis and tuberculosis;
   - local health care, including availability of at least 20 essential drugs, within one hour's walk or travel;
   - trained personnel for attending pregnancy and childbirth, and caring for children up to at least one year of age.

Health Status Indicators

8. The nutrition status of children is adequate, in that:
   - at least 90% of newborn infants have a birth weight of at least 2500g;
   - at least 90% of children have a weight for age that corresponds to reference values given in Annex 1 to Development of Indicators for Monitoring Progress towards Health for All by the Year 2000.[1]

[1] Health for All Series No.4

9. The infant mortality rate for all identifiable subgroups is below 50 per 1000 live-births.
10. Life expectancy at birth is over 60 years.

Social and Economic Indicators

11. The adult literacy rate for both men and women exceeds 70%.
12. The gross national product per head exceeds US$ 500.

Some Pertinent Questions

In measuring progress towards health for all, active involvement of all authorities involved in the national strategy is crucial. *For HFA leadership this implies an informed awareness of: the health needs and priorities; a knowledge of the process involved in application of appropriate health development measures; and an objective appraisal of issues and difficulties in implementing the process, thus raising the critical and pertinent questions aimed at providing adequate indices of effectiveness. Furthermore, commitment to resolve these through corrective action is final proof of the usefulness of any monitoring and evaluation effort.*

Thus, leadership in health at different levels must raise a number of questions pertinent to the national situations. Some examples of these questions are:

1. In which aspects do the national health policies require revisions and/or further clarification or strengthening?
2. Is there sufficient evidence of commitment to the national health strategy at the political level; the technical and managerial level; the community level?
3. What actions have been taken to strengthen/orient the health system towards primary health care? Have these led to desired results in terms of improving availability of health care to the people and/or improving distribution and use of the health resources?
4. What policies of other sectors are contributing (negatively or positively) to health development?
5. What measures have been taken to increase people's understanding of their health problems and for involving them in health activities? What have been the main stumbling blocks?
6. Has progress towards an equitable distribution of health manpower been achieved in urban and rural areas? What have been the main obstacles?
7. What initiatives have been taken to improve the economic support for the strategy? Are these proving adequate?
8. What progress has been made in improving availability of health services?

9. What is the infant mortality rate? Have there been any changes over the past 10 years?
10. What progress has been made in improving literacy among women?

Pertinent questions should be asked in order to determine the reasons for not achieving acceptable progress and targets and to determine what corrective actions are proposed.

Progress towards the goal of health for all should be measured by the communities, by health and public administrators, and by national policy/decision makers. An active and constructive dialogue among all groups concerned is crucial for identifying progress or lack of progress and seeking participatory measures towards accelerated progress.

Note

The following WHO references may be consulted on the above subject:

1. *Global Strategy for Health for All by the Year 2000,* (1981), "Health for All" Series, No.3, pages 73-76
2. *Development of Indicators for Monitoring Progress towards Health for All by the Year 2000,* (1981), "Health for All" Series, No.4
3. *Health Programme Evaluation - Guiding Principles,* (1981), "Health for All" Series, No. 6.
4. *Managerial Process for National Health Development - Guiding Principles,* (1981), "Health for All" Series, No.5, pages 50-55

Organization of Health Systems Based on Primary Health Care

In fulfilment of the Strategy of Health for All by the Year 2000, concerted efforts have to be made to reorient and develop health systems of which primary health care is the central function and main focus.

Health Systems Based on Primary Health Care

The health system can be broadly defined as the coherent whole of many interrelated component parts, both sectoral and intersectoral, as well as the community itself, which produces a combined effect on the health of the population. Action taken within any one component affects the action to be taken within the others. The ideal may be to have a unified health system encompassing promotive, preventive, curative and rehabilitative measures, and care of the extremely disabled and incurable. Whether unified or not, a health system should consist of coordinated parts extending to the home, the workplace, the school and the community.

Structural Organization of the Health System

The health system is usually organized in levels. Primary health care pays particular attention to the point of initial contact between members of the community and the health services. Properly conceived, the notion of levels implies a regionalized system within which the highest priority is given to primary health care at the local level. Prevention, health promotion and the care of common problems should constitute the main line of action. More expensive and specialized needs should be referred to higher (district, regional or national) levels. It is at the local level that health care will be the most effective within the context of the area's needs and limitations, duly recognizing the users of health systems as social beings in a particular environment.

Outreach

A health system based on primary health care should particularly be concerned with ensuring that such care is readily available to all, with appropriate support at the intermediate and national levels, as well as more specialized referral services when required. Thus a well-balanced system will provide specialized skills as extension of the essential health services available to all in need. Rather than waiting passively for problems to appear in the emergency or ambulatory services (the "come-and-get-it" approach), the health system should actively reach out to the whole population to promote health and prevent illness as well as to treat problems when they do appear.

Essential Characteristics of the Health System

Any particular health system embodies the characteristics of the country in which it operates. Among the approximately 160 sovereign countries of the world there are, of course, no two exactly alike. Therefore no universal blueprint can be composed for countries. The following principles have been defined as applicable to all health systems based on primary health care:

- The system should encompass the entire population on a basis of equality and responsibility.
- It should include components from the health sector and from other sectors whose interrelated actions contribute to health.
- Primary health care, consisting of at least the essential elements included in the Declaration of Alma-Ata, should be delivered at the first point of contact between individuals and the health system.
- The other levels of the health system should support the first contact level of primary health care to permit it to provide these essential elements on a continuing basis.
- At intermediate levels more complex problems should be dealt with, more skilled and specialized care as well as logistic support should be provided, and more highly trained staff should provide continuing training to primary health care workers, as well as guidance to communities and community health workers on practical problems arising in connection with all aspects of primary health care.
- The central level should coordinate all parts of the system, and provide planning and management expertise, highly specialized care, teaching for specialized staff, the staffing of such institutions as central laboratories, and central logistic and financial support.

Administrative Levels

The Individual or the Family

The primary health care approach has broadened the concept of the health system to include not only health facilities but also communities and families as important agents of health. The most basic unit is, therefore, the individual or the family.

The Community

Effective primary health care action at the level of community demands a well organized community. Whether derived from traditional patterns or from local, political or other groups some clear structure is essential. Where a community is without any clear structure, such a structure may need to be developed before further steps can be taken. It should also be noted that a community need not always be defined geographically, but can also stand for a group of people with some common interest. Particularly in urban and periurban areas, where the sense of geographical community may be weak, social, ethnic or religious communities may provide appropriate starting points for primary health care.

The Community Health Worker

The community health worker can be considered as the next level of the health system after the community itself. This term is used to refer to workers whose special characteristic is that they are administratively responsible to the community rather than the health service and should be selected by the community from among its own members.

The Basic Health Service Unit

The next level may be called the basic health service unit — a term that covers health centres and their satellite clinics and outreach units, dispensaries, ambulatory clinics, and similar facilities staffed by full-time health workers.

The First Referral Level

Beyond the basic health service units is the intermediate or first referral level (generally a district), which usually has a clearly defined local responsibility for the planning and management of all health activities within its particular area. This level is the main focus of concern, since it is usually the most peripheral level capable of providing wide-ranging technical and administrative support for primary health care.

Referral System

Effective mechanisms for referral should be developed. The scope of referral has been broadened over the years and includes both the problems of communities as well as those of individuals requiring medical care. The main principle of proper functioning is that the first referral level is not overloaded with problems that could be dealt with by primary health care in the community, thus patients and problems are referred back to those who

number of these areas and groups. Yet other nations will provide a complete range of health programmes to the total population, progressively improving quality. Countries concentrating on a limited number of programmes at the outset, such as malaria control, immunization, or diarrhoeal disease control, should deliver them through the general health infrastructure, thus strengthening it and acting as a spearhead for the progressive delivery of a wider range of primary health care activities through it.

Intersectoral Support and Involvement

To develop health systems and to change them where and when required, countries will have to take into account first, that the support of individuals and communities, political and social leaders, as well as health workers is mobilized. Primary health care demands a greater opportunity for local participation in decision-making. Therefore, ways will have to be devised for involving the communities in the process of reorientation of the health system. Then action will have to be taken in other sectors, and the responsible authorities will have to be motivated for collaboration.

Coordination

Furthermore, greater coordination will be needed to see that the available resources are used to meet the priority needs of primary health care. The logistic system will have to be improved, health manpower will have to be planned, trained and deployed; and appropriate health care facilities will have to be planned for, designed, constructed and equipped so that they are readily available, accessible and acceptable to all the population; and health technology will have to be selected that is scientifically sound, adaptable to various local circumstances and maintainable with resources the country can afford.

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Community Involvement

The Concept of Community Involvement

Community involvement is central to all aspects of human development of which health is but one. Although the nature of community involvement varies from society to society, it is essentially a process by which people strive to better themselves and seek legitimacy for their actions. People have the right to participate and this right is not a newly discovered feature of society but one which has recently received renewed recognition as a central value of all human activity. Various formal movements and approaches have emerged since the last three decades emphasising the concept and techniques of self help. In some countries the whole development thrust is based on participatory principles where emphasis is on people's own ability to act, to change and control their environment. *Self-reliance is the term used to indicate that people cannot be developed or educated. They must develop and educate themselves through a process of thinking, problem solving and acting.*

During the last two decades it became obvious that *people's participation is not only beneficial but essential in the pursuit of better health objectives.* Participation is often synonymous with cooperation as people involve themselves in activities which include disease eradication programmes, mass health education campaigns, construction of health facilities or donation of financial and material resources.

The term "awareness of health" is used to imply that at all levels of health from global through to community level, awareness is the first critical step towards the goal of HFA. From awareness emanates commitment, and commitment can lead to action. But this process is a complex one and involves, inter alia, the feeling of concern or relevance on the part of the individual for a particular problem or symptom. Conflicting and mitigating factors such as timing, availability of resources, ability to make changes or take action etc. also come into play.

At the Alma Ata Conference in 1978 Community Participation was described not as an optional extra but as an essential component of PHC. "Participation is not only desirable, it is a social, economic and technical necessity". The implications were clear: without underestimating the overall responsibility of governments for the health of their people, individuals, families and communities were asked to assume greater responsibility for their own health and welfare. Individual and collective participation was described as a 'right and a duty'.

Definition of Community Involvement

> The term 'community involvement' in health is a process in which partnership is established between government and local communities in planning and implementation of health activities. It aims at building local self-reliance and gaining social control over primary health care infrastructure and technology.

Successful Community Involvement

Such a definition, however, is not globally applicable and different countries have taken the concept of community involvement and sought to adapt it to their own particular circumstances. More importantly, the concept of community involvement has begun to be put into practice within a wide range of countries and health systems and is beginning to provide concrete evidence of how this practice works and what issues it raises. Among the factors which affect its success are:

- the need to see involvement of community in health as a *development process* and not a one-time activity or a utilization device for extending the coverage of public health services;
- the understanding that community involvement in health must *build upon the existing mechanisms* for wider community participation;
- the need to *examine the term 'community'* and recognize that different groups of people may get involved on a different basis.

Government Support

For effective community involvement, governments need to give their full support to the concept and its practice. However, the role of the government is not to use the community to impose its view or legitimize its actions, but rather *to use involvement as a mechanism through which the ideas and concrete suggestions of local people can be brought to influence the policy and functioning of health services. Political leaders and health professionals need always to be open and responsive to dialogue with local people in order to facilitate their involvement.* Specifically:

- Involvement needs to be continually interpreted in different contexts so that the form it takes can be relevant to each context.
- Great attention needs to be paid to existing political and cultural traditions in local communities and to their potential use as the basis for involving the community, rather than importing external structures.

- Similarly, governments should both encourage local communities to assume the necessary responsibilities and empower them adequately to undertake this involvement.
- Scientific and other technical information provided by government and health professionals must be pertinent to the community's wishes and expressed in a manner intelligible to local people. Only then can local communities accept and fully identify with the proposals being put forward.

The "Community"

The process of involving community in health must begin with a deep understanding of the 'community' element, its characteristics and the nature of its contacts with the health services. The responses and capabilities of the community are the central issues.

In general terms the kinds of action required revolve around the twin needs *to study and determine the potential for involvement at the community level and to develop the mechanisms to facilitate this involvement.*

Local level involvement is, in fact, a widespread characteristic of most communities and should form the basis of further action. For example:

- The study of the characteristics of the community should not be only anthropological in nature but should also examine the political and cultural factors which influence involvement. *The responses and potential effects of the involvement of different groups should be examined, as well as the influence and control that some groups have over others.*
- *Strengthening of community-based organizations is a key aspect.* Strong community organizations and the delegation of authority to such organizations can effectively facilitate community involvement.
- *Countries should mobilize their communities to broaden the base of involvement so that the whole range of health care issues, e.g., housing, sanitation, water supply, nutrition etc. are covered.*
- There should be a clear and understandable *division of responsibilities between the community and the health system for different aspects of health care.* It is important that both sides understand their specific responsibilities and that an effective dialogue is established to determine this division.
- It must not be seen as a *one-way process* in which the health services determine the policy, deliver the goods and then seek the communities' involvement. The basis of community involvement have to be established from the very beginning. It might be useful to establish a set of principles to govern the exchanges between health services and community organizations.

Support Mechanisms

Successful involvement of the community cannot emerge and develop without the support of *appropriate mechanisms at different levels*. Such mechanisms operate at both national and local community levels. Experience to date suggests that, in the first instance, *political commitment is essential, as this provides the basic impulse to such issues as decentralization and inter-sectoral coordination which are fundamental support mechanisms of the process of involving the community*. Where successful involvement has occured, it has done so with the assistance of a whole range of organizations, e.g., local organizations, NGOs, etc., which have helped the process to emerge. The main issues concerning support mechanisms are summarized as follows:

- In developing support mechanisms emphasis should be placed on the *existing infrastructure*. At the local level, *community-based organizations provide the basic infrastructure*.
- *Intersectoral coordination at the local level is important*. Although there is widespread awareness of this, in fact, little intersectoral coordination actually takes place when policy decisions are made or resources allocated at the community level.
- *A common problem is that of logistics support*. The health system often has limited means to reach communities and similarly, appropriate technologies are not available in adequate supplies. Lack of such support reduces the chances of success.
- It is also evident that *administrative decentralization is critical*. Much has been written and said about decentralization, but it remains largely unimplemented and local communities continue to lack the decision-making authority which is crucial to their involvement.
- In many countries *vital support mechanisms for community health activities have been provided by NGOs*. The NGOs, and cooperation between government and NGOs have had considerable effect upon health services, particularly in remote underserved areas.
- Similarly, *mass campaigns can be successful in mobilizing widespread support for health programmes*. Such campaigns are particularly effective in promoting community involvement where community-based organizations already exist to carry on the activities.
- Professional Medical Organizations are also a very useful support. In more developed countries, such organizations have helped promote positive attitudes towards community involvement among the professional health workers.

Education and Training

Since community involvement in health is an ongoing and evolving process, it is important to educate and train people in content and methodology. *Clarifying the principles underlying the concept of community involvement is a basic way of 'increasing people's faith' in the idea and promoting positive attitudes towards its acceptance. Because this implies a radical change from much conventional medical practice, education and training are indispensable to create a favourable climate for this change.* And these activities should become an integral part of all health training.

- A persistent issue is the balance in training. *Health service training concentrates overwhelmingly on medical aspects, whereas involving communities in health demands different areas of knowledge.* There is a need, therefore, to balance the content of staff training, particularly at the community level, so that health workers are better prepared to promote community involvement.

Methodological Problems

Given that community involvement is a relatively new concern there are several methodological problems which confront health services. The most pertinent issues which have to be resolved are:

a) *the rigid professionalism of health services* and the corresponding reluctance to produce the staff and develop the skills required;

b) the *reluctance of professional health staff to involve the community in the decision-making process;*

c) *the monopoly of health knowledge by health service staff* and the ensuing lack of practical flexibility and innovation in solving local problems.

A key element in community involvement is the community health worker (CHW). The notion of a local-level health worker as the pivotal force in the community is crucial, but there is still much debate as to the exact role and skills required by the CHW. This aspect needs to be further examined by the countries.

Conclusion

Community involvement in health is still very much at an experimental stage in most countries and therefore there is little substantial experience which can, as yet, serve as example. However, as an essential component of the Primary Health Care Approach, it is expanding in many parts of the world. Also, a number of lines of action have been identified in order to promote the concept of community involvement as a mechanism for self-reliant socio-economic development using health as an entry point. Among them are:

- improving intersectoral collaboration at the local level, with health as an integral part of community development activities;
- renewing efforts to motivate local people in the area of health so as to ensure their willingness to become actively involved;
- placing emphasis on the training of Community Health Workers as key mobilizers of the community;
- developing the organizational base within local communities which is a prerequisite for their active involvement in health activities.

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Resources for Health

> Health for All Strategy, through Primary Health Care icalls for a dramatic shift in health resources towards a more equitable distribution in countries. This requires "strong political commitment (will and support) at both national and community level reinforced by a firm national strategy"
> (WHO-UNICEF 1978).

Implications of the Economic Climate for Health for All

While there is a great deal of agreement about the underlying principles of the HFA approach, *there are many political, planning and managerial difficulties involved in creating this shift in resource distribution.* In fact, the world economic recession has had important implications for adjustment policies which governments have had to adopt in order to keep a reasonable balance between economic growth and social development. This has not been easy for the poorest countries of the world many of which have experienced severe reductions in their health budgets at a time when additional resources are required to sustain and build national health systems based on primary health care to meet the priority health needs of all their people, especially the underprivileged and vulnerable groups.

Some countries have made substantial efforts to promote socioeconomic development, especially in the areas of food production, water supply and education. The benefits however, have sometimes been less significant than expected because of factors such as political instability, financial crisis, fluctuating exchange rates, natural disasters and high population growth. Nevertheless, the first evaluation of the Global Strategy for Health for All in 1986 has shown that governments have begun to invest in health services, especially through the expansion of health facilities and manpower development. But new capital investments have also increased the burden of recurrent expenditures in the health budgets. At a time when additional resources are required to strengthen health system infrastructure so as to extend primary health care such expenditures appear difficult to fund.

Efficiency and Cost Benefits vs Equitable Distribution

Moreover, in many countries aspects such as the impact of available health care as well as concerns with efficiency and cost benefits are being balanced against more equitable distribution of health-related resources in order to bring care to the underserved. The

danger of this balancing act is that *concern with equity can give way to concern for "cost containment" which can mean reduction in social expenditures for those who need them most.* The manner in which the health goal is incorporated into the overall strategy as a goal for development also affects the allocation of resources and in turn, the issue of equity which is the fundamental principle of Health for All.

Lack of Political Determination

But external factors cannot be entirely blamed for the underachievement in health. *Many governments have not yet seriously taken up the strategic actions required to generate and mobilize all possible resources for health.* Very few countries have attempted to make an estimate of the magnitude of resources required for their national HFA strategies. Altogether very few new initiatives have been undertaken to mobilize resources internally which can have national impact. Few countries have been able to reallocate their existing health budgets preferentially to primary health care. Inefficient use of existing health resources persists; effective actions to reduce waste or to improve cost effectiveness have been too few to have a substantial positive impact on the resource situation. *And the health sector remains a weak partner in influencing socio-economic development policies or in mobilizing effective support from other related sectors for health activities.*

These problems need to be discussed among health development leaders. A greater understanding of resource issues and a better identification of alternative options for action are essential to accelerate the implementation of Health for All strategies.

Options for Financing HFA

How to finance health plans and how to make best use of resources have both become critical issues in the attainment of Health for All. In the long run, the search for additional and new resources, particularly domestic resources, and making the most efficient use of all that is available offer the best options for financing HFA. Improved financial planning and management and bold administrative and organizational measures are also required. The strengthening of national capability, especially that of the Ministries of Health or equivalent bodies, in developing and implementing policies based on sound economic analysis and strong financial management are a prerequisite to effective national action.

Traditionally, Health has not been accorded a strong position in the hierachy between ministries. In the competition for resources, the Health Ministry usually has lower status than others. *Finance and Planning Ministries need to be convinced that primary health care is the right strategy to meet basic needs of people and promote socioeconomic development so that resources for health may be consequently expanded and existing resources allocation patterns changed.*

In order to effect a national change in resource allocation, national and local leaders can promote policy-making mechanisms to progressively correct imbalance in the maldistribution of resources.

Government Responsibility

At the national level political agreement on the magnitude and the type of government responsibility in health financing should be reached. Most of the costs in training, transport, supervision, evaluation, equipment, spare-parts, building of referral centres and wages of health professionals should be met by governments. Special attention has to be paid for support services to primary health care which are expensive, such as transport for supervision and logistics, and which are too often underweighted. Communities also may bear part of the financial burden and make small payments for some services.

Economic Strategies

After identifying government responsibilities the subsequent political step is to determine appropriate mechanisms to mobilize additional resources. Several options for economic strategies could be considered by health leaders from the political point of view:

- reducing the rates of hospital investment for the benefit of the operating budget;
- reducing the growth of additional hospital expenditures by improving their efficiency (including reduction of waste, e.g. drugs) and making additional resources available for primary health care support services from existing health resources;
- developing new cost-sharing mechanisms (social security schemes, community participation, etc.);
- exploring the use of non-governmental institutions from profit and non profit-making sectors; and
- mobilizing external funds from international aid agencies or private voluntary organizations.

Each of these possible solutions presents serious political implications which have to be carefully analyzed, not only in the short-term but in the long-term as well.

Political implications are not limited to national levels. At the regional, district or even village levels, there may be conflicts between various groups or classes (including health professionals) which could impede the development of Health for All plans by allocating scarce resources to a limited number of people.

Clarifying the values, expectations, administration and organization, that justify such radical changes in the distribution of resources, is extremely difficult.

Planning Difficulties

Even if there is a political commitment to allocate more resources for the health benefit of the greatest number of people, *elaborating or developing a national resource plan which includes community involvement, and consequently community resources, is the next challenge.*

A New Planning Approach

"Bottom-up" resource planning could help health leaders to know of local conditions. These are defined not only by disease patterns, but also by the perception of needs, ability and willingness to participate and pay for services, modes of work, religious-cultural and social norms, etc. On the basis of such information, which requires a new planning approach, it is possible for health leaders to develop their resource plans more appropriately.

The following issues could be considered:

- Obtaining and maintaining a full picture of the existing sources of finances in the health sector and their distribution.
- Costing alternative patterns of health care delivery systems, for example: institution-based and community-based systems, in order to determine which pattern or which mix of complementary patterns, will be the most socially and economically advantageous to all people in the long-term.
- Ensuring the economic feasibility and sustainability of long-term health plans to achieve Health for All.
- Determining the total recurrent costs implications for all past and new capital investment schemes.
- Articulating the criteria that can be used in establishing various financing options, within the overall perspective of equity and effectiveness. On the basis of this planning exercise, budgeting could be more adequately worked out. *Budgets need to be formulated by geographical areas, by level of care and on a per capita basis. The review of year-to-year budgeting can then be used progressively to create resource shifts that are acceptable and feasible and to monitor whether or not the actual expenditures are reflecting the planned expenditure projections for Health for All.*

It should be pointed out that in order to develop long-term planned strategies it is often necessary to undertake some legislative action, e.g. in the area of new health personnel categories, essential drug supply, new cost-sharing mechanisms, etc. which also involves health leaders.

Managerial Difficulties

Resource planning remains a paper practice if plans are not put into effect. *In the final analysis, the success of primary health care depends on effective management and organization. Community activities may succeed or fail, depending on the support and supervision received from the back-up health services. The same is true for each level of the health system.*

Health leaders, politically committed towards Health for All, and guided by a long-term resource plan have also to be involved in the management of resources. Areas for main concern and emphasis could be the following:

- improving the efficiency of existing services at all levels, especially support services to Primary Health Care;

- ensuring the preferential allocation of resources to the most vulnerable groups through an appropriate balance between preventive and curative approaches, primary health care facilities and hospitals, and rural and urban services;
- examining alternatives to improve the cost-effectiveness of health services, including the use of appropriate technologies and manpower mixes;
- developing mechanisms for cost-control and cost-containment, and considering ways of reducing all waste in the use of health resources; and
- defining indicators of resource allocation which could be used to monitor actual resource shifts year-by-year in comparison with the planned projections.

Conclusions

The Health for All Strategy implies a shift in the pattern of resource allocation and distribution for the benefit of disadvantaged groups. *But resource allocation policies have to consider not only what goes into health care but also to other determinants of health such as education, environment and food, with due considerations to principles of equity.*

The issue should not only be where the money is going to come from to pay for health care, but more importantly what broad policy framework is needed to expand the economic support for health for all. *This support must come from individuals, families, communities, the private sector, non-governmental sectors and, of course, governmental sources. The issue is not just how many more resources are required and how to mobilize them, but also how can the existing available resources be used more efficiently and productively.*

Achieving health for all will require sacrifices. The mechanisms and methods used to finance and support services will continue to be imperfect. *The task of finding long term solutions is difficult but must be faced if the health of future generations is not to be jeopardized.*

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The Managerial Process

The Need for a Managerial Process

The World Health Organization, in fulfilment of its function as the coordinating authority in international health work, is playing an important role in providing a common framework to formulate policies, strategies and plans of action for Health for All by the year 2000. *This role includes promoting worldwide understanding that Health for All by the year 2000 is feasible, and facilitating the coordinated development of strategies to reach the target.* To this end, WHO will ensure the availability of relevant and valid information, support technical cooperation among countries, and provide technical and managerial support to national efforts. *However, even though the broad goal and the key to reaching it have been identified, a managerial process has to be applied by each individual country in order to formulate and implement the strategy for reaching the goal in a manner that is adapted to the country's own health situation and resources, social and economic conditions, and political and administrative mechanisms.* It is clear that Health for All is to be attained *within* countries.

Formulation of National Policies, Strategies and Plans of Action

First and foremost countries themselves should formulate their policies, strategies and plans of action which should be directed at solving national problems. Moreover, specific national targets should be formulated and quantified. And what is equally important, political commitment to and support for the health for all goals will have to be mobilized. Without such commitment and support, national policies and strategies for Health for All will not be translated into action.

Naturally, national policies, strategies and plans of action will vary widely according to the aspirations and capabilities of countries. To begin with, "Health for All" may be interpreted differently by each country in the light of its cultural, social, economic and political-administrative characteristics, health status and morbidity patterns of its population and state of development of its health system.

National Targets and Approaches

In the process of setting national targets, countries may vary greatly in their interpretation of what is an acceptable level of health. In addition, while attempting to promote health for all, widely different approaches could be used, such as providing, on the one hand, the full range of services required, starting with those in greatest need and progressively reaching the whole population, or at the other extreme, providing limited services to the total population from beginning and progressively extending the range of these services. Periods of economic scarcity and the changing economic circumstances of nations will determine and influence the "context" in which the managerial process has to be carried out.

The Managerial Process

The managerial process is a continuous process of national planning and programming. It includes policy formulation and the definition of priorities. It involves the preparation of programmes to give effect to these priorities, the preferential allocation of budgets, and the integration of the different programmes within the overall health system. It also deals with the implementation of strategies and plans of action, the programmes, services and institutions for delivering them, as well as with their monitoring and evaluation with a view to modifying existing plans to prepare new ones as required, as part of a continuous cycle. Finally, it outlines the information required through the process.

There are many possible entry points to the whole process. In all cases, it has to be realised that the way to Health for All is not a simple one, but that, if the various issues involved are dealt with adequately, whatever the entry point, the attainment of this goal by the year 2000 is realisticfor many countries.

Some Common Components of Managerial Processes

Most countries already have some form of managerial process for national health development. Although these processes differ widely across countries, certain common components or stages can be identified. These stages define the structure of the managerial process.

Formulation of National Health Policies

A national health policy is an expression of the goals for improving the health situation, the priorities among these goals, and the main directions for attaining them. Each country will have to develop its health policies as part of overall socio-economic development policies and in the light of its own problems and possibilities. *Whatever the process, each country has to specify its health goals and priorities following the identification and careful analysis of its health problems and socio-economic capacity to deal with them.* In the light of this analysis, it will be able to indicate the main directions for attaining these goals.

Broad Programming

A national strategy, which should be based on the national health policy, includes the broad lines of action required in all sectors involved to give effect to that policy. *The development of a national strategy can be considered as the selection and subsequent formulation of broad health programmes. A health programme is generally understood as a series of interrelated actions aimed at attaining a defined policy such as the improvement of child health or the provision of safe drinking water.* Each country-wide programme should include targets, quantified if possible, as well as the organization, manpower, technology, facilities, equipment, drugs and supplies required, cost estimate and financial plan, a rough time table of action, means of monitoring and evaluation and ways of ensuring appropriate correlation among all of the above.

Programme Budgeting

For any strategy to be viable, *it is essential to make resources available for priority activities where and when they are needed. The process for doing so is called in many countries "programme budgeting", i.e., making sure that budgets are available to attain the programme objective.* Without this, plans are merely dreams on paper. *Budgeting is a means of ensuring that programme decisions become budget decisions.* Actually, programme budgeting has to begin during policy formulation, and particularly during the phase of broad programming, once priorities are known. These priorities will have to compete for resources not only among themselves, but also with the existing programmes and institutions in the health system, as well as with other sectors. Therefore it is crucial to make rough calculations of the budgetary consequences early in the process ensuring at least that additional resources are allocated to defined priorities, since it is rarely possible to reduce resources available for ongoing activities in the health services.

Establishment of a National Plan of Action

When broad programming has been completed, including the programme budgeting outlined above, the national plan of action can be prepared in a document summarizing the product of the programming process. *A national plan of action is a broad intersectoral master plan for attaining the national health goals through implementation of the strategy. It indicates what has to be done, who has to do it, during what time frame and with what resources. It is a framework leading to more detailed programming and budgeting, implementation and evaluation.*

Detailed Programming

When the government has approved the master plan of action, the different items have to be specified in such detail that the programme can be implemented. *Detailed programme formulation generates the working documents for individual programmes, providing essential indications for setting these programmes in action and later operating them.*

Implementation

On the basis of these documents, programmes have to be brought to life and by doing so, implementation is set in motion.

However, unforeseen circumstances and problems may arise that necessitate revision of the plan of action. Orientation to action and flexibility will, thus, be needed. The resources needed for all programme activities should be secured in the right places at the right time so that programmes can be implemented successfully. Like finance, manpower is a key resource. Whatever has been planned and set in motion has to be managed on a day-to-day basis.

Monitoring

Throughout implementation, the way resources are used and activities carried out must be monitored. *Monitoring is the day-to-day follow-up of activities during their implementation to ensure that they are proceeding as planned and are on schedule. It keeps track of ongoing activities, milestones achieved, personnel matters, supplies and equipment, and money spent in relation to budgets allocated.* Reliable information on these matters must, therefore, be provided by those performing the activities. Monitoring makes it possible to identify deviations so that activities can be put back on the right track.

Evaluation

Evaluation is a part of the managerial process for national health development. It should be based on information gained from monitoring the implementation of the policies, strategies and plans of action. *Evaluation has to be built into the entire managerial process for national health development and has to be applied periodically. It therefore has to be carried out throughout the planning and implementation of programmes and the operation of services and institutions for delivering them so that their effectiveness in terms of improvement of the health status of the population and their socio-economic impact can be assessed.* Reprogramming may have to be initiated in response to the results of evaluation.

Information Support

The decision-making process, involving all relevant components of the managerial process for national health development outlined above requires relevant information. This information may come from routine statistics, but it may be necessary also to carry out special or ad hoc surveys for data collection.

National governments may find it useful to develop or strengthen their national information systems so as to ensure the timely availability of the right kind of information.

Administrative Reform

The strengthening and adaptation of administrative structures and systems at all levels and in all sectors, not only the health sector, may be required including intersectoral coordination between health and other related sectors. To achieve such coordination, countries may wish to review their administrative systems to ensure that coordination can take place at the central, intermediate and local levels. As part of this review, they may wish to assess the degree to which they need to strengthen local and intermediate levels of the national administration, by delegating responsibility and authority to the community and intermediate levels as appropriate, and by providing sufficient manpower and resources. In some countries it may be necessary to provide incentives to manpower for service at the peripheral levels, especially in remote and neglected areas. Governments may find it also useful to involve non-government organizations in the managerial process and to create appropriate mechanisms of consultation for that purpose.

Training in Health Management

Training considerations are some of the most important elements in the planning of a national development strategy. *Appropriate training in health planning and management at all levels is urgently needed to prepare and sustain the capabilities of manpower to formulate and implement national policies, strategies and plans of action.*

The health sector in general and the health administration in particular has problems in attracting managers of high competence and skill.

Where health administration is dominated by physicians in decision-making positions, management often suffers from lack of skills in administration, finance and management.

In spite of general agreement of the importance of middle level management, there is a great deficiency of trained middle level workers who are able to design workable local plans and implement them.

The issues above indicate the importance of training all categories of health personnel and particularly doctors in management skills.

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Collaboration with Non-governmental Organizations in Implementing the Global Strategy for Health for All

The Need for Partnership

There is growing recognition that partnership between governments and non-governmental organizations is an inescapable necessity for the attainment of Health for All by the year 2000. It is also felt that the time is opportune for intensifying such partnership, based on mutual understanding, identification of appropriate roles, complementarity of actions, mutual learning by doing and full-fledged cooperation. *The World Health Organization is promoting, fostering and strengthening such partnership.*

Voluntary Action and Health

Historically, voluntary organizations were based on the human impulse to help other human beings in need and to reduce suffering. This fundamental human trait has expressed itself universally in social measures, in philanthropy, in science - particularly medicine - and also in spontaneous initiatives undertaken by individuals or organized groups.

The concept of helping the needy is alive and growing today but the emphasis has shifted. *The focus is now on promoting self-help and assisting individuals and communities to become self-reliant to achieve a better quality of life.* Political systems, culture, religion, literacy, and economic factors, all have an influence on the growth of voluntary groups and their activities.

Expansion of NGOs

This century has witnessed the origin and growth of literally thousands of self-care and self-help groups in communities, organized national voluntary bodies, societies and other private associations, professional groups and, on the global level, international nongovernmental organizations, with overall objectives of promoting and fostering health

A necessary condition for sustaining this human energy is the governments' willingness to share responsibilities with people and people's involvement in government-initiated development activities.

Many national NGOs have international affiliates who provide them with professional, material or financial resources, usually for specified health programmes such as the control of leprosy, the prevention of blindness, the acceptance of family planning or training in nursing and child care. Many of these international bodies provide a direct link with WHO with which they have a special formal relationship. Because of these affiliations, *International NGOs are an important element in the promotion of the global Health for All concept through their role in advocacy, mobilization of expertise, education and health development. Individually they can raise and channel much needed funds for the promotion of Primary Health Care.*

Collaboration between WHO and NGOs

Over the years, *WHO's collaboration with NGOs has greatly expanded, covering a wide range of health interests. There are now over 130 international nongovernmental organizations in official relations with WHO and, NGO/WHO collaborative activities relate to all aspects of primary health care.* They range from dissemination of information through NGO networks and data collection in support of specific activities, to the preparation of manuals, organization of training courses for all categories of health workers, collaboration in specific health programmes such as control of tuberculosis, leprosy, cancer, cardiovascular diseases, mental health, environmental health, oral health, clinical laboratory and radiological technology, and health education.

Since the adoption of the Global Strategy for Health for All by the Year 2000, *collaboration with NGOs has assumed a new urgency and meaning. It has become clear that the this sector has crucial contributions to make at the local, national, regional and international levels.*

Strengths and Assets of NGOs

The strengths and assets of nongovernmental organizations are summarized in the following:

- *many NGO's are operational mainly or exclusively at the community level, and as such are often more sensitive and responsive to the needs of the people, especially the health needs of the more disadvantaged populations.* Thus they offer an organized means for interpreting popular needs to the often more distant government, and can serve an advocacy role for necessary changes and initiatives,
- *they have the flexibility to experiment with innovative and alternative approaches to solve health problems, often achieving cost-effective breakthroughs which could provide new models for national planning,*
- *through the effective deployment of manpower resources, and with many varied training programmes, NGOs can significantly contribute to national health manpower development with particular emphasis on primary health care,*
- and, with their simpler managerial structures, it is often possible for them to operate with remarkable cost effectiveness for the increased benefit of the ultimate beneficiary, the people,

- the many professional associations and organizations working for the prevention and control of specific health problems offer possibilities for concrete technical support to governmental training and service programmes. *Many local or national NGO's represent the effective mobilization of women, youth, disabled persons and other groups to support their own self-reliant efforts and thus play a dynamic role in national development. Other NGOs are able to play a similar role in supporting community level self-help and self-care groups. Even more important are the groups which arise spontaneously at the grass-roots level in response to local needs, promoting self-reliance and calling attention to inequities and the maldistribution of resources.*

Obstacles to Effective Collaboration with Governments

Internationally, NGOs have made their experience available to the global struggle to improve health conditions working closely with WHO and other agencies on policies, programmes, training, standards and public advocacy for the health for all strategy. However, *there are several problems and obstacles impeding effective collaboration with Governments. The impediments vary from country to country. Some of them are identified in the following:*

Lack of Mutual Understanding

There is lack of understanding by many governments of the resources which NGOs have to offer. Much NGO work is not visible and there is sometimes mistrust of NGOs and their intention. This is more evident where the financial and programmatic aspects of these NGOs, both local and external, are not fully understood.

For their part, NGOs often fail to understand government policies, long-term responsibilities and development priorities. Some distrust the governments and do not fully appreciate the need for a certain measure of accountability to the government. Often they are impatient with bureaucratic constraints and thus avoid an open dialogue. Furthermore, many NGOs fear a loss of identity and freedom of action, arising out of government coordination efforts.

Certain NGOs find themselves diverging from the priority concerns of national policy when they embark on rigid or preset programmes, or when they deal exclusively with emergency actions. Such a "take it or leave it" approach is difficult for governments and hinders operational partnership.

Lack of Resources

Scarce resources including money, trained personnel and managerial capacities on both sides make close working relations difficult in many countries. Often procedural or bureaucratic difficulties prevent a timely and strategic transfer of funds from governments to an operational NGO, or from an NGO to a government programme, a support that might give new life to a vital programme.

Some NGO's are even reluctant to be partners in a joint effort with other associations working voluntarily in the health field. *There is therefore the question of partnership not only between NGOs and governments, but also amongst NGOs themselves.* In many countries there are large numbers of organizations in the health field, many of them with very specific objectives. In many cases there is no available information on them and governments are often unaware of their activities, their variety or even of their existence. These problems have been solved in certain countries by an initiative on the part of the NGOs in coming together collectively to approach government; in others, governments have taken the initiative of calling together the representatives of a wide range of organizations. *However, for this process to be successful, a national health plan and a strategy in which all can participate is essential.*

Lack of Dialogue and Appropriate Mechanisms for Collaboration

Underlying the above, *is the lack of appropriate mechanisms for encouraging dialogue and joint collaboration between NGOs and governments.* Differences in policy perceptions, both apparent and real, often are difficult to resolve. NGOs expertise and experience are not readily available for policy development, planning and evaluation of national strategies. *Competition among NGOs and the seeming competition between NGOs and governments are not conducive to partnership.*

Conclusion

The focus on any partnership in health and all the questions arising therefrom must bear on one essential fact: the concern with people and the urgency of reducing human suffering. Even though there are some difficulties in establishing collaboration between governments and non governmental organizations, these are by far outweighed by the numerous positive experiences which show that meaningful collaboration at all levels is not only possible but actively sought. The energetic engagement of a whole range of NGOs in the planning, execution, monitoring and evaluation of health action has led to the development of appropriate mechanisms for collaboration at country level in many parts of the world.

Therefore, in order to encourage and facilitate the implementation of Health for All and to make best use of the natural strength of the non-governmental sector, ways and means must be continuously sought to overcome the difficulties and obstacles that still prevent their full participation and collaboration in the process.

Forging better Partnership between Governments and NGOs

There are new opportunities to forge better partnership between NGOs, governments and WHO. Steps need to be taken within countries to examine the present circumstances of NGO activity and to see what must be done to strengthen collaboration at the national level, and to intensify the alliances that are needed for effective cooperation at the village, local and district levels. *Regional and inter-country mechanisms which are now weak in this area need to be developed in the spirit of technical cooperation among developing countries and in the context of regional strategies. Global and international coordination in the extremely complex world of NGOs needs to be examined and work must begin on exploring new modalities for cooperation among international NGOs in rationalizing their goals and programmes, their technical cooperation with countries and in their mobilization of resources to support Health for All strategies. It is now time to conceive and launch a bold new global alliance of NGOs to mobilize and influence the flow and direction of international resources for the implementation of Health for All Strategies.*

References

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The Role of Universities in the Strategies for Health for All

The Potential of Universities in Health for All

A broad range of institutions for higher education, referred to simply as universities hereafter, stand out as potentially strong assets in the Health for All effort and its specific challenges regarding health care and health manpower development. *The historic mission or purpose of universities, ie: assist through education with programmes in professional manpower development; advance knowledge through research, both basic and applied; and provide service through constant interaction with the community are all highly suitable for improving the health of populations.* Universities can play crucial roles in establishing effective systems for pursuing the health for all objectives. Their academic and technical competence as well as their capacity to elicit cooperation of relevant national and international institutions can be brought into bold relief for the benefit of societies both within and between nations.

Health for All and Universities - A Partnership of Opportunity

Some universities have already recognized that health is an important area of concern in social justice and human development and they have therefore devised appropriate mechanisms to make their inputs meaningful in the national and global efforts to promote health. In doing this they have developed effective links between disciplines, and built bridges between universities and governments on the one hand and universities and society on the other. In reorienting their traditional education systems they have shifted their priorities to community-oriented problems and given serious research attention to areas of national development and world health.

Through these examples they have shown that Universities can contribute substantially in reducing the burden of illness by improving the living conditions and broadening the coverage of health care systems; by focussing on preventive actions; by formulating health policies in the light of such concerns; and by being open to innovation. In research, they can further reduce heavy burdens of illness by extending the field of health sciences to its full extent - from the community to the patient's bedside to the laboratory bench. Moreover they can bring together new talent to find solutions to the complex issues in human resource development and provide continuously improving answers to health-related problems.

Network of Universities

Universities can involve the scientific and academic community more deeply in these issues than it is now engaged. *They can systematically link this community with leadership groups in different countries. Universities can play a useful role in bringing decision-makers together, across disciplines, sectors, and national boundaries to focus on these problems and to follow-up with ways to study, test, and disseminate ideas.* They can also explore ways to encourage the scientific and technical community to exercise more leadership in moving technically-advanced nations towards solutions to problems in human development.

Research and Action in Health and Behaviour

An important focus for research and action lies in the social, economic and behavioural environments which influence the life of the community and in which decisions are made about health care, for example infant and child care. Maternal education is a crucial factor in reducing infant and child mortality. Maternal understanding and support for health-promoting behaviour can be enhanced by basic literacy or health specific education. *There is great need to strengthen the knowledge in health and behaviour in the developing world through research that is relevant to the characteristics of the country, with special emphasis on ways in which public education could be effective in fostering patterns of living that protect against major risk factors.* Of particular importance is the clarification of the relationship between health and behaviour, with reference to breast-feeding, nutrition, child care, sanitation, water use and family planning. What is fundamentally needed is a greater awareness within the scientific community of the opportunities that exist, because even a modest shift of attention to such problems could yield major benefits. Universities can play the role of catalyst and conveners in bringing the world's attention to these needs and opportunities.

Some developing countries have made much progress in education, health, family planning, and nutrition. Other countries have accomplished much less. It is important to sort out these experiences and to learn lessons about the underlying factors and general principles which contributed to their success or failure. *Universities can seek effective ways to get the nature and sources of such progress better understood, to identify particular models which have potential for application elsewhere and on a larger scale, and to develop clearer understanding of how such lessons might be absorbed and applied by other countries.*

Internationally Coordinated Research

In the late sixties it became clear that there was an urgent need for increased research efforts for better methods of prevention and treatment for many diseases especially in the tropical countries. This has led to explosive developments in the research activities of the World Health Organization. *More than 500 university departments and many thousands of scientists are actively involved in internationally-coordinated research efforts on some of the main health problems of the world. They cover the whole range from the most*

sophisticated laboratory work and field research. The projects are not limited to departments of medical faculties but also involve departments in the natural sciences, social sciences, technology and industry. In addition to these research projects, institution strengthening in developing countries is also an important long-term investment that aims at establishing viable research units.

The Role of WHO in Research and its Application

A quite different question is the utilization and application of the new knowledge by health authorities in a given country. This is where WHO has a leading role as catalyst in the process. In various ways, WHO has stimulated the involvement of the academic communities in research efforts. With the direction of a minute part of bilateral aid into multilateral support of such activities, scientific progress and its health applications could be considerably accelerated.

Involvement in Community Health Services

Leadership responsibility within the university for its involvement in community primary health care service programmes has varied, but medical schools have been predominant. *They have until recently concentrated on providing hospital-based speciality care services. The addition of new concepts of primary care service however, has now broadened and extended the context of service to involve the total community health care system.* Schools of public health have often contributed to an understanding of population-based concepts of health problems and health services as well as the academic disciplines necessary to support research and education on these issues. Schools of nursing can substantially contribute to these efforts, particularly given the increased attention to community-oriented primary health care by nursing internationally.

Some examples of interaction in Community-based health activities

Primary health care service involvement of the university commonly is multi-disciplinary; the specific mix varies among institutions depending on specific requirements of the community programme but usually includes some combination of service, teaching, and research in local, community-based activities. Although schools of medicine, nursing, public health and allied health professions predominate, schools of the other health professions, the behavioural and social sciences, civil engineering, and public administration also have participated. *Examples include the following:*

- technical assistance in planning, organizing, implementing, and evaluating the community programme;
- continuing education for all health professionals in the programme, including the development and operation of accessible, up-to-date information and materials resource centres at field locations;

- delivery of primary health care services at field locations by faculty preceptors and students in clinical training;
- research in basic and applied clinical epidemiology for:

  assessing community health needs, determining priorities in resource allocation, setting interim goals, measuring progress, and evaluating programme effectiveness; assessment of cost effectiveness of alternate primary health care technologies, and organizational arrangements for primary health care services delivery.

Obstacles to effective collaboration

While there is no doubt of the potential or importance of university contributions to Health for All efforts, there are still obstacles that stand in the way. Some obstacles have to do with the universities themselves. They are often seen as:

- trying to model themselves narrowly after established institutions,
- heavily focused on their traditional hospital-based, speciality-oriented, medical activities and isolated from other health needs of society;
- bound by tradition and resistant to change
- assuming that community-oriented teaching and research will lower standards;
- compartmentalized so that collaboration between different parts of the university is difficult;
- not closely related to their communities or regions, and having only a dim perception of world health problems or opportunities;
- misunderstanding the concepts of academic freedom and autonomy in ways that contribute to their isolation, rather than engaging creatively in societal problems while retaining control of decisions on the nature of their involvement.

The concept of purpose and service

Perhaps more fundamental are the views of universities about their own purposes. *Some universities believe their purpose to be met by traditional education and research, unrelated to urgent problems of society; others believe it is imperative that the university be integrally involved in clarifying societal problems and pursuing their solutions.*

The concept of service also presents problems to universities, some seeing it as a drain on resources and an infringement on academic flexibility; others as an essential route for the university to effectively engage its research and educational capacities in problems of broad importance.

Problems in relationships

There are also serious problems in relationships between the university and the health services (referred to here as the Ministry of Health):

- The university and ministry usually have limited communication with one another;
- the university may not invite the ministry to advise on the training of its students, despite the fact that many will be employed by the ministry;
- the ministry may not invite the university to participate in planning and policy-making, even though the universities have relevant competencies and resources;
- the university may not initiate and the ministry may have no interest in having the university pursue health services research that could be important in ministry decision-making;
- they both tend to have constricted views of the universities - about the kinds of research and education universities should or could do; these restrictions tend to limit the flexibility of response that the universities should have, and to miss opportunities of considerable significance for health.

The concept of Health for All places aspirations for certain developments on both ministries and universities - that there be universal coverage with effective services, and that the community be actively involved in the planning and provision and of health services. But often neither the ministry nor the university knows how to proceed in practical ways towards fulfilling these aspirations. Yet they could both benefit by collaborating with one another in efforts to improve health. They need effective structural mechanisms for interaction with each other in order to do so.

The Prospect of Shifts in Relations Between Universities and Governments

The reasons for the distant relationships between universities and ministries of health have largely to do with attitudes and values of both sides. Changes in attitudes and perceptions about the appropriateness of their interactions which would allow both sides to use their ingenuity and resources to address the problems of health for all in mutually supportive ways need to be brought about.