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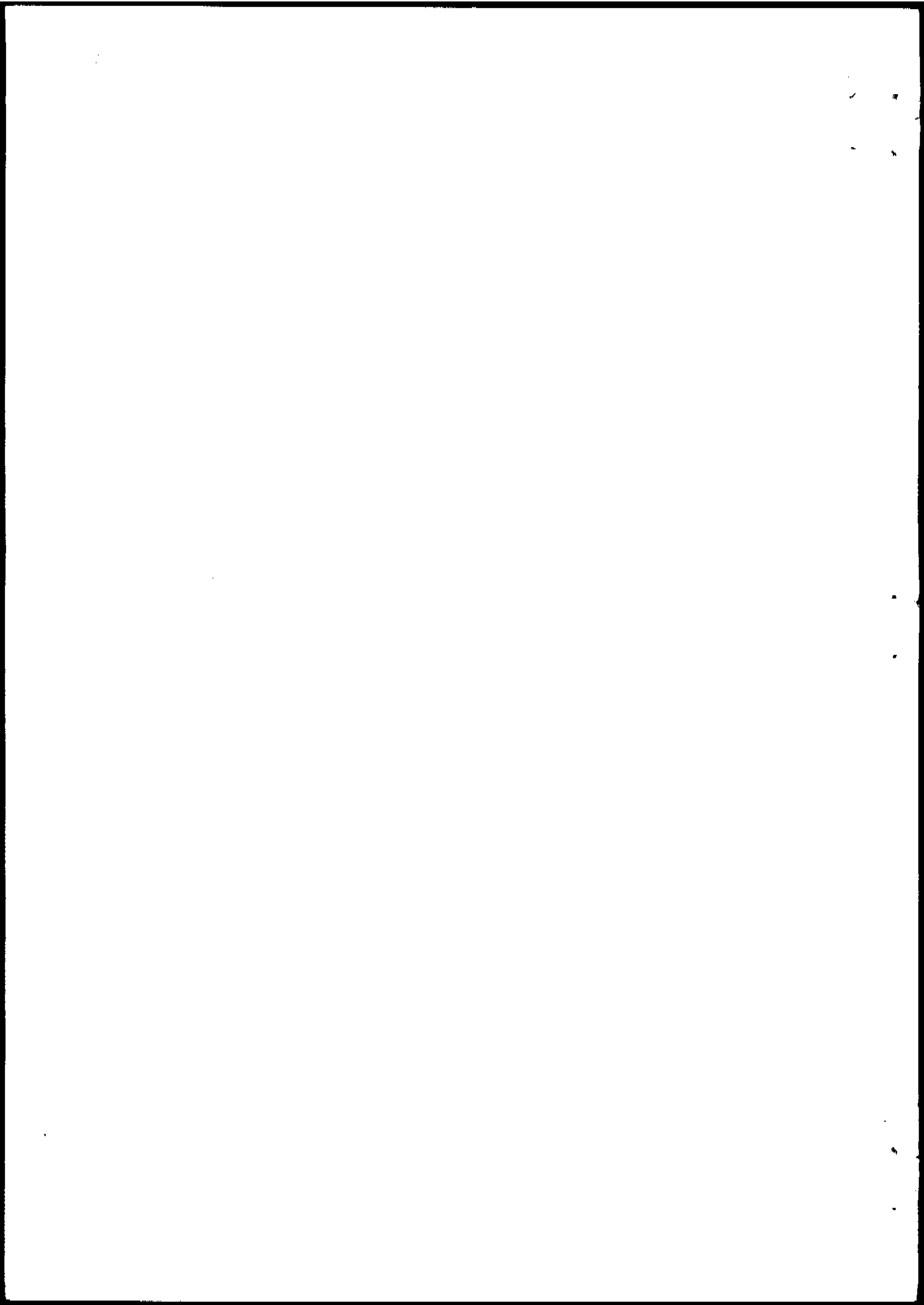
COORDINATED ACTION ON AGING

Report of the
Fourth Meeting of the NGO/WHO
Collaborative Group on Aging

Geneva
9 May 1985

WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTE
ORGANIZACION MUNDIAL DE LA SALUD



CORRIGENDUM

Report of the Fourth Meeting of the
NGO/WHO Collaborative Group on Aging

Geneva, 9 May 1985

Annex III, page 3, List of participants

Under International Epidemiological Association (IEA)

Please replace Dr C. Rumeau-Rocquette by

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Faculty of Medicine, Hebrew University, Jerusalem.

Rapporteur

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Madison, Wisconsin

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Note

This issue of this document does not constitute formal publication. It has been prepared by an NGO representative for distribution to all who participated in the meeting and for other persons concerned with the care of elderly persons.

The views expressed are those of participants in the meeting and do not necessarily reflect the policy of the World Health Organization.

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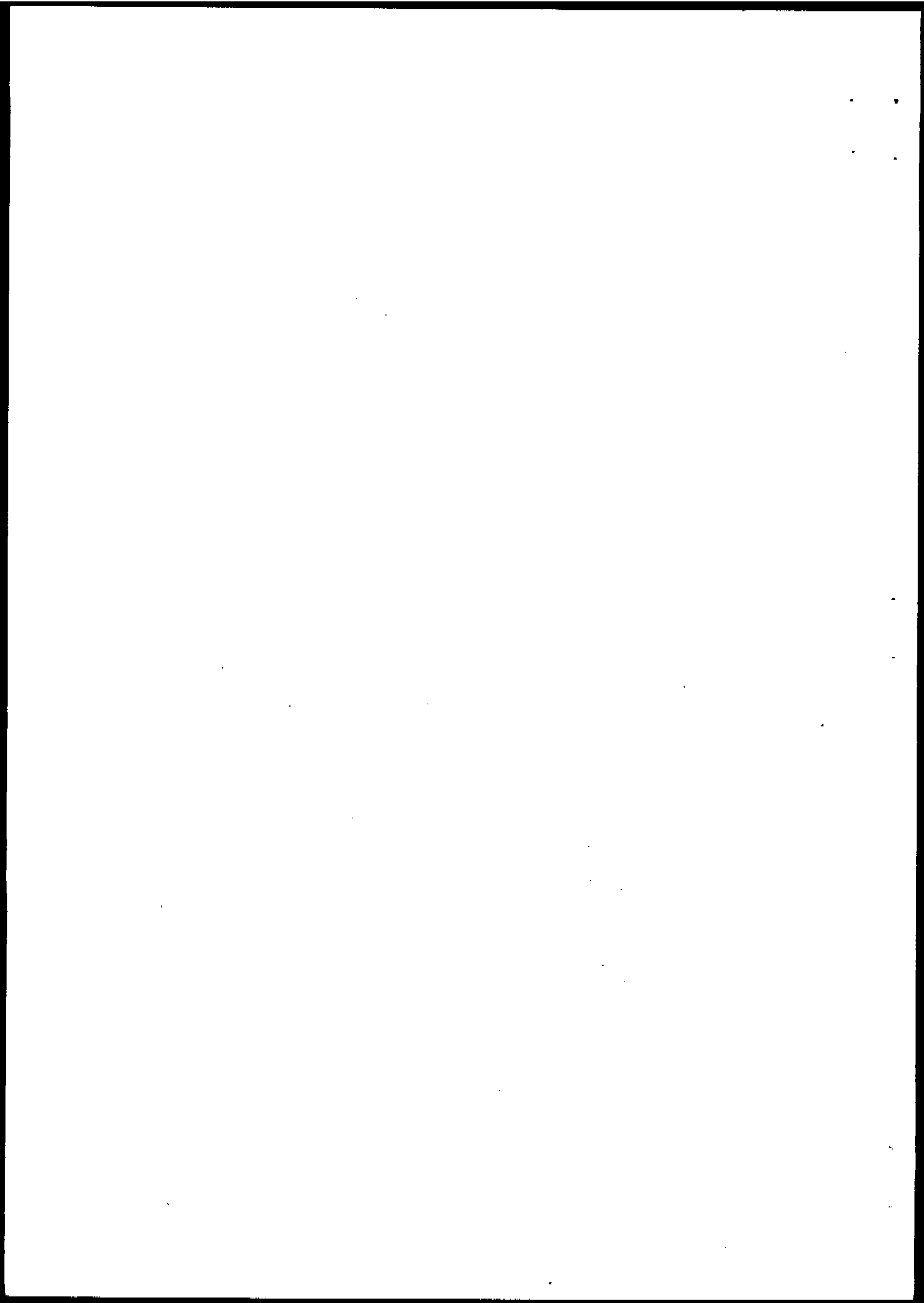

NGO/WHO Collaborative Group

on Aging

9 May 1985

1. INTRODUCTION

The meeting of the NGO/WHO Collaborative Group on Aging was held in Geneva on 9 May 1985 during the thirty-eighth annual World Health Assembly. Representatives of thirty-two nongovernmental organizations (NGOs) and officials of the World Health Organization (WHO) participated in the one-day session.

John Mayo, Director of Help the Aged and Chairman of the 1985 NGO/WHO Collaborative Group on Aging, opened the meeting at 9 A.M. In his opening comments he said that it was a privilege to work with other NGOs in various parts of the world. He noted that the NGOs had a very special and practical role in the work of serving people. He described his own extensive world travels during eighteen months as Director of Help the Aged and said: "I've seen what can be accomplished by NGOs, among NGOs, and by NGOs working with governments."

He assessed the agenda as one rich in content but requiring close adherence to the time schedule. In response to a comment by Dr. Pathak of India, the Chairman acknowledged the important role NGOs from the Eastern and developing nations should and can play in collaborative efforts.

2. REMARKS BY WHO Regional Director for Europe.

Dr. J. E. Asvall, was introduced by Mr. Mayo. His remarks are as follows:

NGO/WHO collaboration in health is no longer a footnote: it is headline news--here in Geneva, in the Regions and in the countries. Indeed WORLD HEALTH devotes its March 1985 issue entirely to articles describing the invaluable partnership existing between Nongovernmental Organizations and WHO in our pursuit of the goal of extending to all people of the world the health that all of us here enjoy.

The WORLD HEALTH issue features an article by Mr. David Hobman on "An Aging World" which, in commendably few words, conveys the idealism we share as partners for making the world we live in better for the elders of today and for the elders of tomorrow--our future selves.

He states that we have to mobilize all the human resources we can muster, if "Health for All" is to be achieved. And he proposes the establishment of a coalition to face this challenge--a coalition of a wide range of organizations with a wide range of characteristics, which would have three main functions: advocacy, service delivery, and self help. These serve as convenient headings for the work of this Group today, and in the period that will lapse before we meet again next year.

I shall begin with "Health for All" advocacy, because this is an activity which our Director-General, Dr. Mahler, is taking vigorous measures to strengthen. This was also a theme which my predecessor, Dr. Leo Kaprio, took up in his address to you last year when he called on you to be the standard bearers for the disadvantaged elderly of the world. And the standard was raised by the International Federation of Retired

Persons, at their meeting in Mallorca in November last. The messages which we advocate are clearly specified in Mr. Hobman's article:

first, that longevity is a bonus to be enjoyed not a burden to be endured;

second, that decent human survival is determined largely by social, economic and cultural factors;

third, that according elderly people respect and a continuing role in their community will powerfully influence their well-being;

fourth that income, housing conditions, diet, medical and nursing skills will add years to life and life to years.

Let me now move from advocacy to service delivery. The expectation of WHO from these annual meetings with you is that we shall build up an inventory of innovative programmes of action by voluntary organizations at the community level. Such actions are illustrated in the Poster Display on Aging, prepared for the Technical Discussions of the Health Assembly; we are grateful to you for providing us with the material used to prepare the Display.

Another illustration, Mr. Chairman, is the catalogue of aging projects in the third world which your own organization, HELP AGE, has brought into the national planning process in Belize and in India. I hope you will share it with the Group this afternoon.

A third example is the national reports of over twenty African countries presented in December last at the Conference on Aging in Africa organized by the International Centre of Social Gerontology in Dakar, which Mr. Flesch will report upon later.

Finally, I turn to self-help. In his WORLD HEALTH article, Dr. Gururaj Mutalik states:

> "Health development pre-supposes creative teamwork involving self-help and self-care by the people themselves, supplemented by adequate health care services based on an appropriate health technology."

One tangible product of our collaboration with you has been a Manual for Public Policy and Programme Development on Self Health Care for Older People. This gives examples of wellness projects or well elderly clinics which I am delighted to see that Mr. David Hobman is promoting in Europe. The Manual proposes health programmes for the elderly, and by the elderly.

Earlier this year, I sat down with Dr. Macfadyen to discuss the further development of the WHO Global Programme on Health of the Elderly. We agreed that the sort of programme we should like to see emerging in the 1990s, would be a WHO programme that was planned, managed and implemented by elderly people.

The process by which a managerial structure might be established would, of course, involve NGOs, especially those which represent constituencies of elders. And we have already initiated the process, by taking informal soundings from some of the Group. There will be opportunities over the next few days, and again over the next few months, to explore this idea further. I raise it now merely to affirm the full support of WHO for this initiative. And I sincerely hope that, when we next meet, we might have a structure whereby this Group can begin to plan with WHO its programme for the elderly for 1988 and beyond so that you

may join efforts with us, at every level of implementation, in our task of improving the physical, mental and social well-being of the world's elders.

Following Dr. Asvall's address, Dr. David Macfadyen, Manager, WHO Global Programme for Health of the Elderly, noted the importance of the Director's comments and urged the Collaborative Group to accept Dr. Asvall's invitation to develop an effective relationship between NGOs and the WHO. He suggested that the NGO/WHO Collaborative Group on Aging, having published a useful manual on self-care, should consider another product such as (a manual on) how to maintain the quality of care in long-term care settings. He noted that there is widespread interest among the six regions in this Collaborative Group and suggested that the Rapporteur's report incorporate the significant discussion of the day for review by those unable to attend.

3. SELF/HEALTH/CARE: A GLOBAL STRATEGY

The Chair recognized David Hobman, the President of the International Federation on Ageing. Mr. Hobman's presentation stressed the importance of considering self health care in its broadest perspective and urged that such efforts not be used to reduce the level of health services on the assumption that individuals can largely care for themselves. He said that the strengths of the voluntary sector include its passionate concern, its impatience for change, and its energetic capacity to work outside of the restraints of bureaucracy. He called on the participants to form coalitions and combine resources rather than compete for scarce

resources. He acknowledged the significant roles NGOs have with governments and with the WHO in representing consumers and transmitting their messages and their needs to those in the public sector best able to respond.

"In practical terms," he asked "what can we do?" Through efforts to gather information, identify successful experiences, develop manuals and printed materials and through scheduling international and regional conferences, NGOs can make a significant contribution to meeting the need for adequate health care for older people, he said. He warned that NGOs must be careful "not to face ourselves," but to face outward to other groups, to influence medical, biological and social welfare organizations. He stated that "we must speak without jargon in the language of those whom we serve." He asked that NGOs and the WHO combine energies in a spirit of partnership to achieve mutual goals.

The Chairman endorsed strongly the partnership idea as a key to the Collaborative Group's future. He noted that in his visit to Columbia he discovered young people teaching older people the lessons of personal hygiene. He supported Mr. Hobman's advice that we speak in a language that is clear, and not technical.

The Chairman emphasized the importance of self-care through community education efforts. He alerted the participants to recognize that inappropriate use of language may lead those in need to feel patronized or as a burden to those who have, in fact, come to serve.

Reactions to Mr. Hobman's presentation included an observation by Dr. J. Deboise, Secretary, Scientific Council of the International Federation of Elderly Associations, that we need to develop two separate strategies

regarding health for the elderly: one for the developed nations and another for developing countries. He pointed to the problem of finding and training individuals to transmit basic health information to people in need. He noted that NGOs are often in a good position to identify individuals for this training. NGOs provide a connection between the people in the community and government decision makers, he said.

Dr. Meropi Violaki-Paraskeva, representing the Hellenic Association of Gerontology, stressed the importance of creating links between generations and giving thoughtful consideration to children's reactions to older people. "NGOs," she said, "can make an important impact on children's attitudes toward older people by sensitizing them to the realities of aging."

Ms. Pnina Herzog, representing the International Council of Women, suggested that even in developed countries there are too few people well trained to work with older people and too few people with basic knowledge of the aging process both within NGOs and in government agencies. She affirmed the importance of involving the young and old together in programmes so that the children will age better and be willing to work as volunteers in programs for the elderly.

Dr. J. D. Pathak of Help the Aged India expressed his delight in discovering that WHO is giving increased attention to the special needs of older people. He described the significant role the family plays in supporting the elders, but, he warned, the family system is breaking down. "If families will teach their children to care, older people will receive better care," he offered, and the government system will not be

required to do more than it can. "If the future man is to live a long time he must be better prepared for his old age," said Dr. Pathak.

Dr. P. Hindson, President of the International Union for Health Education, noted that older citizens have claim to resources equal to that of children and those in their middle-age. He indicated that while health investments in the elderly seem to have a small return, advocates need to understand the ethical issues underlying how resources are allocated and to whom.

Prof. G. Riotton, representing the International Association of Cancer Registries, insisted that recommendations must include plans for implementation. He underlined the importance of using appropriate language for each audience as we talk about the problems of aging and what needs to be accomplished.

Ms. Vita Ostrander, President of the American Association of Retired Persons, pointed out the difficulty in convincing both doctors and their elderly patients that responsibility for one's health is largely one's own. As long as older people think their health depends on doctors, they will overlook or underestimate their own capacity for self-care, she said.

Ms. M. Schwartz of the World Federation of Occupational Therapists used posters and pictures to show the effectiveness of communicating complicated health concepts without words.

The Chairman summarized the discussion. He thanked Mr. Hobman for his thoughtful presentation and the participants for their interventions. He then asked Mr. Sykes to introduce the panel participants on the subject of attitudes toward older people.

4. CHANGING NEGATIVE ATTITUDES ABOUT OLD AGE

Mr. J. Sykes, representing the National Council on the Aging, USA, opened the panel discussion on "How to change the negative attitudes about old age" with the following comments:

In the preamble to the Vienna Plan of Action, we find these words: "The countries gathered in the World Assembly on Aging . . . do solemnly recognize that quality of life is no less important than longevity, and that the aging should therefore, as far as possible, be enabled to enjoy in their own families and communities a life of fulfillment, health, security and contentment, appreciated as an integral part of society." The Vienna Plan succinctly states, "the problem of aging today is not just one of providing protection and care, but of the involvement and participation of the elderly and the aging" and offers a promise: "eventually, the transition to a positive, active and developmentally oriented view of aging may well result from action by elderly people themselves."

Returning to the Vienna Plan's preamble, the phrase, "The aging . . . should be appreciated as an integral part of society," suggests the subject of this panel: How can we reach that goal?

How will the general attitudes about old age be changed so that old age may be regarded as a time of value for both the individual and society?

Given the changing ratio of old to young in our societies, what values need to be identified and strengthened that will lead to solidarity among generations and not to age segregation?

Given the tremendous diversity among mature persons (with individual differences becoming greater as cohorts become older), what can be said about older people that is accurate, leading to useful generalizations and not to stereotypes?

Given the fact that the older population may be divided between the young-old (competent, capable, healthy) and the old-old (frail, at risk, vulnerable, ill), how may we both describe and celebrate the achievements of mature years while sensitizing society to the legitimate needs of those who face infirmities in advanced age? Would it be helpful to--somehow--set age 75 or 80 as the probable time of greatest need, and avoid the assumption that those who are frail characterize all those who are retired?

How may we educate and socialize the young people of today so that they may enjoy a life free of prejudice and stereotypes in their old age?

Myths about aging--the negative stereotypes--have emerged from the activities, the limitations, the examples of older people who suffer from infirmities of aging and suffer also from the acceptance of these stereotypes. But it is equally true that through the portrayal of older people at their best--working, doing, contributing, enjoying, living life to its fullest--we can change attitudes about old age.

Concluding his introductory comments, Mr. Sykes introduced the panelists.

Mr. J. Flesch, President of the International Centre of Social Gerontology, likened the changing aging scene to the cinema and noted that we cannot deal with the need for major behaviour change as though it were a series of still photos. He referred to the Vienna Plan of Action and noted that the demographic imperatives are so overwhelming that without a dynamic planning process, nations will be forced to react to crises which result from dramatic increases in the aging population.

Mr. Flesch called on the industrialized countries to set an example of long-range planning for other countries to show that planning is effective and necessary for the (quality) society we seek. If we are to be successful, NGOs must spend less time "mending problems" and more time undertaking preventive action, he said.

Mr. Flesch criticized the media, generally, for giving too little attention to age and too much to "eternal youth." He noted that while the need is great for more accurate presentation of the opportunities and problems of aging, the amount of resources allocated to programmes to change negative attitudes is small.

Mr. Flesch closed his remarks with a call to NGOs to work at the major task necessary to achieve solidarity among generations. He noted that individuals--as well as societies--must plan for their mature years. He added that NGOs must be very critical of their own programmes to make certain that they are taking appropriate actions to change attitudes towards the aged. This, he said, is a necessary condition for progress toward the goals we share.

Mrs. V. Ostrander, President of the American Association of Retired Persons, described the unfortunate image of aging in America where the elderly are discussed as a burden. Her remarks are as follows:

I am sorry that we felt it necessary to gather these distinguished representatives of other societies together to talk about how to improve the image of older citizens. It saddens me that our apparently shared negative view of the aged is so pervasive.

A recent issue of AGEING INTERNATIONAL asked members of the International Federation on Aging to discuss the image the elderly have in their societies and almost without exception it was a negative one.

Industrialization, better education of the young and rapid urbanization were cited most often as factors in what appears to be a universally poor image of the aging. Societal elders who once held positions of great respect are now being seen as "unproductive dead weight and consumers of public resources," according to Bruno Ricci, secretary-general of Italy's National Federation of Pensioners, who contributed to the article.

David Hobman, Director of Age Concern England, will remember his notation in the article that British Prime Minister Margaret Thatcher has begun to use the term "burden of care" to describe her government's cost of providing benefits to its aging citizens.

And, while I do not believe most Americans resent the cost of caring for our parents and grandparents, I was alarmed at the topic of a recent meeting of women leaders in health care "The Burden of Benefits: For Whom Shall We Pay?"

So, what effect has this attitude on the part of our nation's leaders and policy makers had on our societies and on the elderly themselves?

In America the past four years have seen unprecedented attacks on government programmes serving the aging. In 1983 Congress passed legislation to carve $100 billion out of the Social Security programme by the end of this decade. Similarly, the Medicare and Medicaid health insurance programmes have seen tremendous budget restraints that have forced states to cut back services, limit eligibility for Medicaid and increase out-of-pocket costs for the elderly under Medicare.

Even today members of the American Senate are debating what further cuts will be made to these three programmes.

Would all this be happening if we held the elderly in greater respect? Why does my Congress think it is right to continually gouge programmes for the aging to lower federal deficits while allowing rich corporations to pay no income taxes at all?

While one could spend all day speculating on the answers to those questions, one thing I know for certain, we cannot, we must not let politicians fan the flames of intergenerational conflict as cover to dismantle social programs they do not want to fund.

It is true economics cannot be ignored when examining relations between the young work force and the retired population. But, we cannot allow the notion to gain acceptance that those who do not work are little more than a burden to those who do. We must continually remind ourselves and our youth that it is we, the older generation, who fought wars to protect their freedoms, spent our working lives building the societies they thrive in and paid our hard-earned dollars into the pension systems politicians so love to tamper with.

Perhaps a good way to improve the image of the aging in our homelands is to not allow further deterioration of relations which serve the political means of those in power who may profit by it.

What we need to work toward instead is a reacquaintance of the young with those older and a re-education of our societies and even the elderly themselves who may have begun to believe themselves outmoded and useless.

AARP has this year decided to devote much of its staff and financial resources to improving the image of the older worker to American industry. In America, the poor image of the aging and their ability to be productive has made opportunities for the older worker limited at best.

AARP has launched an aggressive effort to improve that situation with three main areas of emphasis that I believe can be put to work in all areas where age discrimination and negative images of the elderly exist. Those three areas of thrust include: developing, collecting and disseminating new information about the capabilities, needs and rights of older workers (persons); educating employers (all members of society and even older persons themselves) about their capabilities through the media; and implementing advocacy programmes aimed at changing workplace (social) patterns that impede the involvement of older persons not just in business and industry, but in all aspects of society.

Another factor, I believe adds to a lack of understanding between generations - the urbanization that has brought young families into cities, often leaving older generations behind. The transient nature of our culture created by business and industry often spreads families out across the country. A child without daily contact with grandparents, aunts or other older persons is a child dependent upon the media for his knowledge about aging and older persons.

As Mr. Hobman wrote: "The media tend to portray older people in rather negative terms as barriers against progress. They may be caricatured as objects of pity if they do nothing, or presented in amazement if they display characteristics of competence, energy or imagination."

Again, while it is beyond our power to stop the flow of the young to urban centres, or to keep families together in the same town, it is within our power to petition the media for a more fair and accurate representation of people who are older. Where do they get the idea that once advance years are upon us we all become one, homogenous group unable to work, play or function at all for ourselves? As you know people who are 60, 70 or 80 are as diverse in almost all ways as they were in their 20s, 30s or 40s.

Everyone, young and old alike, want their lives to be happy, healthy, financially secure and free of arbitrary discrimination based on their sex, race, religion or age. And, inasmuch as any image of older people depends in large part upon who is being portrayed, who is doing the portraying and who sees the portrait, I believe it is within our power to fulfill that desire and it is our moral obligation to do so.

Dr. J. Deboise, representing the International Federation of Elderly Associations, asked, "At what point should pre-retirement preparation begin?" He suggested that two years before retirement seems to be the usual pattern. Retirement preparation attention should be focused on self-care and preventive strategies, he said and efforts should be made to bring retired people into contact with different generations.

Interest groups and clubs provide retired individuals with the opportunity to be active in their communities.

The shift from full time employment to retirement causes serious problems for many; only recently has this matter been given proper attention, due in large measure to the rapidly increasing numbers of older people. He said that governments and younger people are becoming concerned about the impact this population will have on them. The younger generation sees the older generation as useless, and taking resources from the active generations. Consequently, older people must adapt to these circumstances and stand firm or be pushed aside from living a satisfactory life.

Older people are on the fringe of society, he noted. In France, 71% of retired people do not live with their children. Becoming "marginal," older people become depressed. Dr. Deboise cited statistics showing that among laborers, 25% die within two years of retirement while the rate among a more professional class is about 15%.

There is, he said, a growing recognition that one ought to prepare for retirement. A 1978 survey within the European Economic Community showed that 81% of persons between 50 and 55 think often about retirement; and a third of those were distressed about retirement. Much of this distress comes from the realization that after retirement, older people lose their places in society; they become, in their own perception, without useful social roles, he said.

His Federation recognizes that alone one cannot do much about the attitudes toward older people, but through organizations older people gain the power and the possibility to meet and understand one another and prepare together for the future.

He presented information about how the International Federation of Elderly Associations works to encourage preparation for retirement. He stressed that among older people one's value is not determined by one's work. Retirement is not to be left aside, but accepted as a new period of life which can be as rich as earlier periods of life. Preparation for retirement is preparation for life, he pointed out.

The Federation's strategy is to build on the experience of already retired people to help new retirees. They seek leaders from the local community, a grassroots effort to keep the strategy in proper scale. They seek to include everyone, no matter their status, and work to prevent social stratification in their clubs. The goal is to provide educational information essential to good retirement and an active program which is interesting and varied. They like to involve people two years before retirement to ease the transition between work and retirement.

The programme's goal is to modify the attitudes and habits of people before retirement--to bring their expectations into line with the realities of retirement. He identified three major areas of concern among retired people: health, social and family life, and personal economics. The Federation encourages clubs to schedule workshops and provide information directed toward each of the problems. The Federation recognizes that while attitudes have a great deal to do with successful retirement, such matters as knowing one's rights, knowing what services are available, and becoming involved in activities that broaden and keep one stimulated are also important.

He closed his presentation by saying that these goals--if they are to be reached--require touching, caring, skilled leaders in the clubs. Persons with these qualities should welcome new retirees into the organizations. He suggested that natural groups be identified among retired people at the local level where meaningful relationships can continue following the working years.

Mr. J. Murdock, representing the Christian Medical Commission, offered the following observations on changing general attitudes toward older people.

Earlier in this meeting speakers have said that the three primary roles of non-governmental organizations in working with older people are advocacy, service and promotion of self-care. As we now talk about changing general attitudes toward older people it seems to me that NGOs do the most effective work in such areas of advocacy.

While we do not like to admit it, nearly all societies give value to those people who are economic producers, and to those people who display the abilities and attributes of economic producers, such as physical strength, agility, quick responses and keen senses. This giving of value places many older people at a disadvantage, because they either are dependent or are thought to be dependent.

We grow up with attitudes toward others who are old and those attitudes carry over to our own aging and "agedness." Therefore, preparation for old age and retirement should start in childhood in order that negative and inaccurate attitudes toward aging can be prevented.

More specialized pre-retirement planning seems to be effective in

improving attitudes towards one's own aging even in the last few years before retirement, but it should not be left until then.

In the United States some observers detect improvement in the status of old people, and even to some extent in their roles. They find laws about retirement to be less rigid, recognition of the physical attractiveness of older people to be increasing, and they notice that many older politicians hold power.

It is my opinion that in the final analysis the changing of attitudes toward old people is a matter of power and rights--propaganda will not accomplish our task. And I assume that power must be used by the subject group, in this case, older people.

In my work in a national office of a church we have taken some preliminary steps. For many years we have done a reasonably good job of "ministering to" older people by providing services and facilities for those who needed them. Now we are struggling to find ways to "minister with" older people. Recently we have set up the means for older people to act on their own behalf. We hope that that will help to change attitudes toward older people.

Mr. Sykes thanked the panelists. He described the tasks for each of the sub-groups, and asked for specific proposals on strategies to change negative attitudes toward older people. The participants were assigned to three groups to continue discussions on the subject.

5. REPORTS FROM SUB-GROUPS ON CHANGING NEGATIVE ATTITUDES TOWARD OLD AGE

Sub-Group A noted the importance of including older people in leadership positions at the provincial and local level, and keeping older people in the forefront of public advocacy efforts. The group found that to achieve this objective there need to be special efforts directed at training older advocates and for publicizing their concerns. Until older people receive appropriate status, resources to meet the needs of older people will be severely limited.

While the media is important, the group reported, there need to be community level organizations in which older people are involved in entrepreneurial activities creating arts and crafts, serving in community centres, teaching their skills and sharing their wisdom with young people.

Group A recommended that examples of successful programmes which portray older people accurately and positively should be shared throughout the network. Examples from Columbia, the Netherlands, and the United Kingdom were cited.

Group B took note of the rapidly increasing numbers of older people and reported that in the year 2025 three-fourths of the older people will live in what are now the world's poorest countries. The group also cited the migration from rural areas to already crowded urban areas in most countries leaving the old to fend for themselves without health and social services. The group called for a strategy that integrates the generations through such efforts as community centres and through formal education in gerontology at all levels. The group stressed the

importance of focusing on families and what they can do to enhance the image of older people. The group urged that the Vienna Plan of Action be implemented and the exchange of people and ideas across regional lines be encouraged. Through collaboration, the group noted, the role of NGOs--as providers and advocates--can be strengthened; NGOs can take the lead in humanitarian efforts which, ultimately, improve the conditions of older people, the group concluded.

Group C identified the worksite as an important place where attitudes toward older people need to be improved. The group reported that assertiveness training can go a long way to enable individual older people to recognize their own worth and to help others do so as well. The group went on to emphasize the importance of life-long learning and that while the roles of NGOs vary from country to country, NGOs can stimulate advocacy, community involvement and assertiveness training. NGOs should influence the media to provide accurate impressions of old age.

It was suggested that while the groups have begun discussing a strategy for changing attitudes toward old age, a committee should develop a resolution for presentation at the close of the day's session. Mr. Sykes agreed to convene the group.

6. QUALITY ASSURANCE OF COMMUNITY BASED LONG-TERM CARE: A PANEL PRESENTATION AND VIDEO FILM.

Dr. Macfadyen introduced Professor L. Chambers, a Short-Term

Consultant with WHO, Copenhagen, to chair the session on Quality Assurance.

Following a video presentation of an interview between Dr. D. Macfadyen, Manager, Global Programme, Health of The Elderly, WHO, and Prof. L. Chambers, Associate Professor, McMaster University, Canada, Professor Chambers indicated that an important way to assure quality long-term care services in the community is to assist care providers to assess their own capacity for providing care. He noted different strategies are needed within long-term care facilities and within the community. He suggested such strategies as quality circles for self-evaluation and continuing education provided by and for staff of such facilities are essential.

He referred to the Holland experience where a national quality assurance association provides free counsel to facilities and programmes, building on the teaching nursing home concept and exchanging information around "best practices."

He described government efforts in various countries to encourage professional organizations to develop standards, educational institutions to provide courses and activities for care-givers, and regulatory agencies to use such devices as certification, peer review and accreditation to improve quality of care. He indicated that financial incentives can prove very helpful in these areas.

He introduced a panel of four individuals to comment on the general issue of quality assurance.

Ms. S Greengross, Secretary General of the International Federation on Aging, reported that in the United Kingdom there are two codes of practice, one for residential care and one for nursing home care. She noted the difficulty in achieving cooperation between health officials and social services officials in monitoring and enforcing the codes. She said that rigid spending restraints make it difficult for providers to ensure that all residents and patients receive the quality of care to which they are entitled. She called for a change in practices which permit the managers to do their job while ignoring the impact on the individuals affected. She indicated that a philosophy that "community care is always better than institutional care" does not adequately address the issue for many people for whom there is no choice. She called on institutions to create capacity and flexibility to provide such related services as respite and day care.

Speaking for the International Council of Nurses, Dr. D. Krebs took note of the movement to establish standards for nursing especially as nurses play a central role in the delivery of long-term care services. She noted that such standards should provide for professional accountability, well-defined objectives, continuing evaluation, clear functions, and also have concern for cost. She noted a similar need for standards in the primary health field and for a careful assessment of the number of health care workers required, how they are to be trained, potential use of computers and the importance of achieving a collegial relationship among health care providers. She reported that the ICN is studying laws affecting nursing in various countries. She added that there is widespread interest among nurses on the subjects of

accountability, standards, and ways to assist an elderly person to live as normal a life as possible.

Prof. J. T. Sykes, representing the National Council on the Aging, USA, focused his comments on those older people living in the community and some problems in applying quality assurance standards in the home and in other community-based long-term care settings. His text, "The Problem of Quality Assurance in Community Based Long-Term Care," follows:

Clearly there is a need to establish standards by which to measure the illusive quality of care. Certainly, efforts to introduce rigorous quality evaluation processes reflect concern for the older person's well-being. Arguably, the quality assurance experience generated from acute care and chronic care settings may be applicable to the community setting.

However, we are faced with multiple problems under each of these axioms.

1. The development of standards is a worthy exercise and may result in high-sounding goals and widely accepted principles, their usefulness is limited by such factors as:
    a) The skills and sensitivity of the evaluators;
    b) The fact that outcomes are far more important than procedures, but nearly impossible to measure--given the complexity of chronic conditions, their intractability, and the way in which physical and social (mental) elements interact;
    c) Maintaining relative wellness--or levels of

satisfaction--is a function of multiple services and conditions; causal relationships are nearly impossible to identify;

2. Because care is provided by family members, neighbours and volunteers, the factor of ensuring that care is provided by a well-trained person is nearly inoperative. Who applies quality assurance standards? To whom?
3. While some argue that there is a technology of caring and that caring has procedures, steps, phases, it is very difficult to divide the process into discrete, measurable elements which need to be evaluated for quality.
4. As is so often true, the demand for standards and careful monitoring follows evidence of abuse or neglect; nonetheless, a systems response to specific problems may be inappropriate.
5. The applicability of quality assurance tools developed for acute and chronic care facilities is highly problematic. Charts, diagnoses, treatments, training of staff, length of stay, etc., are available for review and judgement in such settings, but in the community these records are not.
6. The basic concern of quality assurance is the effectiveness and efficiency of health care. To apply tests of effectiveness (outcomes) and efficiency (procedures, costs) there must be acceptable standards, reliable measurements, and competent persons to make the measurements, interpret the data and arrive at supportable conclusions.

Thus, the steps required after setting standards include specifying and quantifying the benefits and then comparing the actual benefits to

the persons with a hypothetical or preferred goal. Each of these steps is difficult to take, but, more importantly, they may lead nowhere.

Let me offer what will appear to be a less scientific, systematic, reliable approach to achieving the goal of assuring the highest possible quality of care provided in the community. Persons with three or four chronic maladies find their well-being has less to do with treatments and more to do with living conditions, the availability of caring family and friends, and their own perception of their condition.

The care they require is multifaceted. Caring for those whose chronic conditions severely limit their range of motion and their ability to cope with the activities of daily living requires concern and presence more than medicine and therapies. The tasks a care-giver undertakes are rather simple: cooking, bathing, dressing, sometimes feeding, always providing attention cheerfully and with love. There are certain skills one needs, but far more important are one's attitudes toward the person in need.

I have written a paper, "Caring with Care," that identifies the attitudes and thoughtfulness a caring son or daughter need. I am convinced that assuring quality care in the community has everything to do with who provides the support, a lot to do with the attitude and health of the one in need, and very little to do with discrete steps that can be identified, quantified and analyzed to establish whether the quality of care has been high or low, adequate or inadequate.

I believe we can take a leaf from the notebook of Carl Rogers, the distinguished psychologist noted for client-centred therapy. He put great faith in identifying caring, empathetic, non-judgemental

counselors, and sensitizing them to the client's needs. He affirmed that good results will be obtained if the therapist truly cares.

To the extent we can train our children, largely by example, to be caring persons, we can count on the highest quality of care from them. As we find ways to sensitize neighbours, including health professionals, to reach out, to give of their time and humanity, to that extent we will be doing something useful and effective in assuring quality care in the community for those in need. We can measure procedures, set hypothetical ideal outcomes, and fill out charts and develop a scientific process without actually reaching our goal of ensuring quality of care.

The field of aging has suffered too long with a tension between medical models and social models--between trying desperately to be scientists when we've needed humanists. While we have spoken out on the limitation of medical models, of "health" as though it is what we have after the doctor visits or a hospital stay, some professionals now seem willing to rely on the tools of quality assurance, developed for physicians, health professionals and acute care facilities for evaluating quality of care in the community.

We know too much about what helps people live with illness, too much about the limitations of medical technology, too much about aging and the human condition to run after the symbols of scientific respectability. It is far better to seek the goal of quality care within ourselves, our children, our neighbors. We should guide the spirit of caring by helping those who carry the heavy burden of constant caring with our personal and public support.

Of course, the attention of skilled physicians, therapists and counselors may be required at different points in a person's life and illness, but in the community, those with disabling chronic conditions must rely on the caring impulse within family and friends. We should not seek the solution to the problem of assuring quality of care among the tools and instruments of peer review, hypothetical outcomes and quantifiable measurements. The receiver and giver of care know when quality is achieved and when it is not--without tests or formal standards.

Prof. A. M. Davies, representing the Association of Schools of Public Health in Europe, noted the important role that NGOs can play in improving the quality of care in long-term care facilities. Despite such problems as dumping the elderly poor in institutions, the poor physical condition of many care facilities (some being phased out without replacement facilities being built) a very large number of untrained people looking after the elderly, there is a great deal that can be done.

He suggested that NGOs should accept responsibility for doing all within their power to upgrade nursing homes, to provide willing hands and assuring that high standards of care be set and monitored.

He stated that attention must be focused on such causes of institutionalization as accidents and falls and that the effective use of screening tools can identify those who need institutionalization and those who don't. He called for a preventive strategy which would include oral hygiene, frequent blood pressure readings and monitoring hearing losses. He said that the field must not neglect what are correctable conditions among the elderly.

Professor Chambers thanked the presentors. He noted that quality assurance can be enhanced by providing technical assistance to those eager to do the job well. Quality assurance should not be confined to such issues as cost effectiveness and other "political" factors. He noted that the desired level of care and the community's capacity to provide that care have to be in balance. He called for the publication of manuals, instructive booklets and papers which enable professionals, non-professionals and others to apply the art and the science of caring.

Dr. Krebs reiterated her position that the development of standards is crucial to an effort in which care, not cure, is the goal and that the principal outcome must be that the patient's dignity is protected.

Mrs. Ostrander discussed the effect of diagnostic related groups (DRGs) and prospective payments on the early discharge of elderly patients and the consequent impact on nursing home. She noted that these discharges into the community are coming before an effective home-care system is in place. "Without adequate community services including day care," she said, "and with cost containment measures taking precedence in the United States, long-term care quality will suffer." She underlined the importance of efforts to inform both the consumers of service and their doctors about the kinds and levels of care that may be required and to provide a mechanism for complaint resolution.

Dr. Macfadyen called for a halt to the warehousing of frail people and suggested that in order to enhance the personal dignity of those in

such settings, NGOs and government agencies must work together to develop the materials and the strategies necessary to prevent indecent treatment of those persons most vulnerable.

Mr. Hobman, while agreeing that standards and codes of practice are essential, said that standards without sanctions against their violation are useless. He indicated that agencies within the community have to play an active part to ensure a high quality of care.

Dr. Davies urged close attention to the concept of autonomy and its relationship to the quality of one's life. Mr. Murdock warned that the "celebration of professionalism" and the drive toward certification are not an effective means to achieve quality of care for those requiring long-term care.

7. REGIONAL REPORTS FROM MEMBER GROUPS

Mr. J. Flesch, reporting for the International Centre for Social Gerontology, commented on the African Conference on Gerontology and reported that excellent recommendations were adopted based on a realistic assessment of problems and opportunities. He noted that most African governments seem aware of the problems in their aging societies. He noted the central place the family plays in African society in protecting aging members.He added that technical developments have placed the elderly at the margin of society, developments exacerbated by

the exodus of younger people from rural areas. African nations have a better chance of avoiding some of the image problems of old people through the thoughtful training of children, he said.

Discussing the International Federation of Aging, Ms. S. Greengross said that the IFA has doubled its membership to 90 countries and that through this diversity of membership, the IFA has access to individuals with important skills necessary for training. She noted the production of training manuals has been a central activity of the IFA and that now it is responding to many requests from developing countries to set up community-based low-cost care programs. "The exchange of information through manuals and individuals is increasing and will continue to be a central part of the IFA program," she concluded.

Mr. J.Mayo, the Director of Help the Aged, reviewed the organization's programme and stressed the importance of recognizing older people as both income producers and consumers in all societies. He emphasized the place of intergenerational activities in building solidarity among generations. Help the Aged believes and builds on the premise that older people must be involved in the decisions that affect them. He mentioned efforts in Belize, in India and Colombia where Help the Aged is involved in projects and programs directed at relieving the plight of the elderly poor. He stated that it is essential that development programmes be divested of any donor-recipient stigma and that they be seen as the practical collaboration of mutually interested parties.

Ms. M. Esnard, representing the League of Red Cross Societies, reported that there are 136 national societies with diverse agendas and action programmes, but all of them are giving increased attention to the needs of older people. She commented on a study taken in the Eastern Mediterranean area on nutrition and famine among national societies. The league publishes materials important to care-givers.

Mr. D. Hobman, speaking for Age Concern, reported that his organization has 1300 groups including 80 national groups working as a coalition in Euro Link-Age. He noted the special arrangements Age Concern has with the Parliament and the opportunities the organization has to influence policy in areas of respite care, mental health in old age, housing, and women's issues. He commented on successes in working with an inter-parliamentary group in the European Parliament. The fact that eight nations sought co-chair leadership positions in this age related issues group points to the high interest.

Dr. A. M. Davies, representing the Association of Schools of Public Health in Europe, reported that in September the Association will hold an international conference in Jerusalem focusing on the role of schools of public health for an aging society. He said they are working to form a world federation of schools of public health and to collaborate with NGOs in various countries on special projects and programmes.

Dr. J. D. Pathak, speaking for Help the Aged, India, discussed the implications of the movement from a rural society to an urban society in

which the traditional systems are being upset. He noted the great need for the problems of Eastern countries to be identified, studied, and resolved. He noted that while economic factors are most important, in developing societies, persons from the lower classes age early and need the most training to take practical steps to create more supportive environments.

He called on NGOs to play coordinating roles for training for the "evening of life," for integrating religious traditions and practices, to provide and train medical aides, and to apply in developing countries what is already known about nutrition, hygiene and prevention. His prepared text is as follows:

India is a signatory to the Alma Ata resolution, "Health for all by the year 2000." This commitment needs careful planning and preparation. Our child as well as adult death rate is higher than other countries. Human life is cut short much earlier than for people of other countries. That is why people surviving beyond 60 years are comparatively few as a percent of total population. It will not be so in the near future.

We have not yet authentic country-wide data on the health of elderly Indians.

Health is the only wealth of elderly. This is the age when more medical attention and facilities are needed. No special geriatric clinics, hospitals or Outpatient Department are thought of in our five year plans. No consideration or priority is given to the elderly for hospital admission even in an emergency. It is almost futile to expect that facilities which are available in developed countries for elderly will be provided in the near future in India.

Compare the budget set aside--by U.S.A.--for its elderly and that of India. The U.S.A. has almost the same number of people 60+ as India, i.e. 33.9 million. The elderly in India have only their joint family system as their shelter. Now with ever-growing hardships of life, the old in course of time are apt to be unpopular, a change that cannot be imagined. The most filial of the sons may not be able to look after their old parents in the future.

(Dr. Pathak provided statistical information comparing U.S.A.'s and India's allocation for health care and manpower need projections. The existing health care arrangements in India for its population are grossly inadequate, he said. There are no special arrangements for geriatric care in India at present. They have to be provided, he added.)

All programmes require financial resources. The main constraint in the achievement of targets and expansion of resources in villages and slums has been paucity of funds. Health and education are part of the social services. Social services have been receiving lowest priority in financial allocation.

It will be unwise for a poor country like India to mimic all such arrangements and set up institutions which even the affluent West finds difficult to afford or maintain. Hence instead of being too idealistic, only a few practical arrangements are mentioned. Some simple steps:

Advisory centres: both prior to retirement and thereafter, especially for economic, health, social adjustments and similar matters.

Small aids: at concession or cost for dentures, spectacles, walking sticks, etc., hearing aids, items of nutrition - proteins, vitamins; common drugs and other articles of basic needs; priority and

concessions in travel, transport; literature, entertainment, recreation; arrangements to assure final rites.

More facilities in existing medical centres: at hospitals, separate counter and some priorities for aged by outpatient department and admission facilities when needed, strengthen physiotherapy, occupation therapy facilities; where possible, instituting day centres, separate speciality awards, departments of geriatrics; training patients and relatives in matters of health, nutrition and ordinary care.

Homes for elderly - Temporary abodes: by adopting idle sanitoria, dharmashalas especially in pilgrim places and providing a few facilities like wholesome food at reasonable cost with some provision for medical emergencies and proper environment.

Gerontology Institution of India: which would provide a model to initiate geriatric education, research, intellectual activities, reference library literature, information, meetings and planning to suit our conditions, etc.

Geriatric Education: introductory type in under-graduate medical years, paramedical courses, postgraduate diploma and degree, refresher courses for practitioners; all women education centres to impart elementary nursing, first-aid teaching; general public - how to keep health/literature, talks, press information, radio, T.V., etc.

Every citizen looking forward to his evening of life should pay attention to his financial, health, social interests and adopt to the changing times, Dr. Pathak concluded.

Mr. J. Murdock of the Christian Medical Commission shared information from the Western Pacific. He cited Dr. Tofaeono Imo's observations relative to old age in Samoa. He reported old people are held in deep affection and given respect because of their age. They hold a secure place in the family.

As a result of these conditions there has been no national legislation for care of aged people. Care is provided through self-care and through the family. However, Dr. Imo sees an inevitable increase in life span as a result of various improvements, and he thinks that an increase in the number of old people and an increase in their years may force the society to provide alternative methods of care and service.

At the same time he reports strong resistance to western-type institutions to provide for older people. Those institutions are not desirable because, it is thought, they cannot replace the family. He finds that problem also exists in acute care hospitals in their care of older patients. Defining health as "being at peace with our family around us," Dr. Imo thinks that healing comes more from human touch than from the manipulation of technology.

He views western-type homes for old people as the least painful place that an indifferent society chooses to put the elderly.

He concludes that change is under way since the past 20 years have shown an important increase in the number of persons over 75 years of age. He sees self-care as being vital to older Samoans, requiring much more activity in health education and health promotion.

Dr. Imo refers to churches as a good source for much of the work since they have shown historical interest in multi-disciplinary approaches.

Dr. M. Violaki-Paraskeva, speaking for the Hellenic Association of Gerontology, indicated that the Association has been investigating the attitudes of children concerning older people. She asked, "when does old age begin?" If there is to be respect toward older people, she said, younger people need a clear understanding about older people and their needs. Members of the Association are giving considerable attention to retirement in Greece, she reported.

Mr. J. Sykes, representing the National Council on the Aging, USA, described numerous activities of the Council in promoting appropriate and positive attitudes toward older people. He indicated that the Council continues to work for the strengthening and preservation of the Social Security system and for a more comprehensive, less costly, health insurance program. He said the Council is addressing the issues surrounding long-term care and the place housing has in the long-term care system. The NCOA's annual conference brings together professionals in the field including representatives from other countries, he reported. Through a coalition of aging groups, considerable public pressure is brought to bear upon the political debates concerning age and retirement issues.

Reporting for the US Committee on World Aging, (a loose confederation of groups interested in implementing the recommendations of the Vienna Plan of Action), Mr. Sykes, the Chairman, said the Committee has urged the Congress and the Administration to work for the implementation of key elements in the Plan of Action. The Committee has undertaken a survey to

determine the extent of international aging courses in universities and colleges, he reported. The US Committee will host the international aging network in conjunction with the International Congress scheduled for New York City in July, Mr. Sykes reported.

Rev. K. Irwin, the Director of the New Zealand Council of Christian Social Services, identified key concerns of the Council: the challenge of providing community-based care for those in need, the tremendous needs of very frail individuals, the problems affecting women and their circumstances. He noted that the church has to face these challenges and work with others to achieve a better life all want and deserve.

Dr. Th. Hovaguimian, speaking for the International Association of Gerontology, noted the Association's goals are to encourage research and to facilitate access to information in biology, medicine and the social sciences as they pertain to older people. He briefly described the Association's history and announced the International Congress scheduled for July in New York City. He said that the Association and its member national groups are dedicated to training qualified personnel and developing educational opportunities for the different gerontological professions. In addition to these research and training efforts, he reported, the Association is committed to protecting the rights of gerontological organizations with national or international problems.

Dr. Hovaguimian noted the Association's numerous collaborative efforts with WHO. He commented on the regional and international forums the Association has planned related to subjects important to aging societies and individuals. He cited an effort to develop a common

scientific vocabulary for international gerontological scholars. He closed by identifying the Association's increasing attention to the issues of aging in third world countries.

Ms. L. Fiori, described efforts of the International Committee of Catholic Nurses to "raise the sensitivities of member associations toward aging people" through articles, conferences and its newsletters. Her Committee is giving particular attention to quality of life issues and to the importance of self-determination and self-care. The Committee distributes articles broadly, publishes manuals and schedules workshops and training opportunities on health techniques for nurses. She cited a programme in Asia where the care of older people in the community was the principal issue of the conference.

Ms. Kettlety, representing Help the Aged, Africa offered four observations referring to old people in Africa. She said:

> We should be looking at ways to preserve existing values and attitudes associated with the aged. Special reference can be given to the extended family by encouraging relatives and the community to give support to the elderly.
>
> We must find ways of reaching the isolated elderly. The elderly, sick and handicapped cannot be left behind.
>
> We must encourage the elderly to be self-sufficient and independent. Help The Aged is doing this by supporting self-help projects, income generating projects, etc.

Lastly, improving an exchange of information by those in the field. Help The Aged publishes a regular newsletter AGEWAYS, a practical guide for caring for elderly people.

Ms. V. Ostrander, reporting for the Association of Retired Persons stated:

AARP has met with officials at the Pan American Health Organization (PAHO) to discuss the mutual exchange of information and documents between its online information system and AgeLine, AARP's extensive computerized data retrieval system on aging. AARP agreed to make AgeLine available for PAHO's use either in identifying literature useful to its constituency or sharing abstracted citation of items it wishes to include in its own database. In addition, PAHO is interested in standardizing the terminology it is using for its documentation system with that of AgeLine. AARP provided PAHO with a copy of the current thesaurus governing AgeLine. PAHO, in turn, will share with AARP bibliographies or documents for inclusion in AgeLine.

From the Inter-University European Institute on Social Welfare, a letter was received for inclusion in the report. Signed by the General Director, Serge Mayence, it reads as follows:

Unfortunately, we shall not be able to attend it because we celebrate at that time the 10th anniversary of the first Belgian Third Age University created by our Institute.

However, we would like to inform you that we have actively pursued our activities in the field of social gerontology both at the national and international levels. In this last field, the IEISW has prepared the opening of the first Third Age University in Africa and the Arab world. It will soon be opened in Tunis. Moreover, in tight collaboration with the Tunisian authorities and the Tunisian Organization for Education and Family, a Centre of Documentation on Social Gerontology was created. It already has many references for all those interested in elderly people's problems. This Centre is especially meant for those working at the community level (medical doctors, ancillary medical staff, and social workers).

We would very much appreciate if you could mention our activities to the assembly.

We do apologize for not attending the meeting and thank you in advance for your understanding.

8. REMARKS BY DR. THOMAS MAHONEY

The Chairman introduced Dr. Mahoney, a consultant with the United States House of Representatives.

Dr. Mahoney said that he was "struck by the absence of NGO attention to the underlying ethical and moral aspects of health care issues." He was very critical of the extent to which "economic factors have replaced clinical considerations" in the application of medical knowledge to the care of people. He cited the institution of "diagnostic related groups"

(DRGs) in the States to control health care costs. This development has led to premature and inappropriate release from hospitals for many older people, Dr. Mahoney asserted. He called on NGOs to become involved in the debates about when life support systems should be removed. He expressed concern that some people in need will be denied admission to hospitals if administrators apply only economic factors to the decision.

Dr. Mahoney called for the expansion of research despite the political criticism that surrounds the development and utilization of high-technology science for the care of people. Bio-medical research offers great hope for the future of the old-old, he noted, and urged governments to finance this needed research.

Dr. Mahoney continued with a strong case for the elimination of mandatory retirement. To deny one the opportunity to continue to work when one is physically and mentally able to do so has a profound psychologically destructive effect, he said. He cited studies that show that within three years of forced retirement, people tend to deteriorate. "They lose their sense of independence and their dignity," he stated. When they feel they are becoming a burden to their families, they lose their will to live, he added.

He closed his remarks by urging NGOs to take the lead in seeing beyond political and economic pressures to the urgency of preparing for the future in which the number of older people will continue to increase. He said that older people need the best care scientific research can make possible and the most humane care people can provide.

A discussion of the subject followed with active participation from the participants.

9. RECOMMENDATION OF WRITING COMMITTEE ON "CHANGING ATTITUDES"

While we recognize that a strategy for changing attitudes toward older people is far too ambitious for a day's work, we, nonetheless, offer the following proposal for discussion, development and implementation.

We agree that our goal should be an age-neutral society in which age--as sex, race, religious orientation, or class--should be irrelevant; however, we acknowledge that that goal can only be achieved through the dissemination of information about aging which is accurate, complete and fair.

We agree that older persons are, and must be, their own best advocates and that barriers to full participation in the arenas in which important decisions are reached must be eliminated.

We agree that a strategy to incorporate into the education of people of all ages facts about aging is essential.

We agree that the attitudes about older people must be changed first within older people themselves, and these attitude changes require assertiveness by older people, support and training by NGOs dedicated to the goal of enabling older people to fulfill their potential.

We agree that NGOs can play a key role in combatting age discrimination policies and supporting flexible retirement practices.

We agree that efforts to change attitudes about aging should start with our own organizations' efforts to eradicate age discrimination and to explode myths about aging.

We recommend that a committee comprised of members of the NGO-WHO Collaborative Group be appointed to develop a focused plan on ways NGOs--together at the global level and separately within our nations--may collaborate to to combat misinformation with facts, to empower older people to assert their diverse qualities, and to advocate policies and practices directed toward the goal of an age-neutral society.

We believe that a key role of NGOs is to monitor the implementation of recommendations of the Vienna Plan concerning societies' attitudes, practices and policies which materially affect the well-being of older people.

And, we agree that, NGOs should monitor actions of the United Nations and its component agencies including the World Health Organization.

After discussion, this recommendation was approved.

10. REMARKS BY DR. DAVID MACFADYEN

The chairman asked Dr. Macfadyen to brief the participants on issues in the Technical Discussion relating to the roles of NGOs in working toward the goal of "Health for All by the Year 2000."

Dr. Macfadyen urged the members to take an active part in the discussions held in conjunction with the World Health Assembly scheduled for the next morning. He described how the discussions were organized, identified the working document (see Annex I), and reported that after a general session, the subject would be considered in six group meetings. He said that the record established during these Technical Discussions will determine to a large degree the nature of the working

relationships between the WHO and NGOs and could affect relationships within regions and nations.

(A copy of the Resolution subsequently adopted by the World Health Assembly on "Collaboration with Nongovernmental Organizations in implementing the Global Strategy for Health for All" (WHA38.31) is attached (Annex II).

11. SUGGESTIONS FOR 1986 AGENDA

The Chairman invited participants to suggest items for the 1986 meeting. Among the subjects suggested were the following:

1. The development of a more formal structure between the Collaborative Group on Aging and the WHO.

2. A discussion on collaborative strategies focused on primary health care.

3. A review of the Vienna Plan of Action health-related recommendations, progress made and steps yet to be taken.

4. A discussion on ways to protect those in institutions following from the quality assurance topic on the 1985 agenda.

5. Ethical issues relating to health care.

6. A prevention strategy for those age 40 and older today to avoid burdensome costs later.

7. The media and its impact on attitudes toward older people and further development of the changing attitudes discussion on the 1985 agenda.

8. The special needs in developing countries.

The Group suggested that its leadership consider scheduling a two-day meeting next year in conjunction with the World Health Assembly in May of 1986.

12. ADJOURNMENT

The Chairman and Dr. MacFadyen expressed appreciation to the participants, the translators, and the staff whose work made the meeting a success. Mr. Mayo, Dr. MacFadyen, Ms. Halvorson and Professor Chambers received words of praise from the Group for their leadership.

WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

A38/Technical Discussions/1
15 February 1985

THIRTY-EIGHTH WORLD HEALTH ASSEMBLY

Technical Discussions

COLLABORATION WITH NONGOVERNMENTAL ORGANIZATIONS IN IMPLEMENTING THE GLOBAL STRATEGY FOR HEALTH FOR ALL

Background document for the Technical Discussions at the Thirty-eighth World Health Assembly, 1985

10-11 May 1985

The Technical Discussions on the subject "Collaboration with nongovernmental organizations in implementing the Global Strategy for Health for All" primarily focus on action at the country level. They provide an opportunity to examine the partnership approach - partnership involving people, governments and nongovernmental organizations (NGOs) at local, national, regional and international level. In promoting, fostering and supporting such partnership at each country level the World Health Organization has an important role to play.

This background document for the Technical Discussions is based on the comments received from Member States, nongovernmental organizations, individuals and institutions, in response to an outline document sent to them in July 1984 (document CWO/TD/84.1). Some of the issues relevant to the Technical Discussions relate to the role, responsibility and potential scope of activities of nongovernmental organizations at national and international levels and governmental actions - individual and collective - for facilitating the NGO contribution to implementation of health-for-all strategies. To arrive at concrete conclusions and recommendations for future action through these Discussions, a set of specific questions encompassing these issues have been drawn up.

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I. INTRODUCTION

1. The International Conference on Primary Health Care held at Alma-Ata in 1978, in which high-level delegations from 134 governments as well as a large number of representatives of nongovernmental organizations participated, called on all governments to formulate national policies, strategies and action plans to launch and to sustain primary health care as a key approach for achieving the universal goal of health for all by the year 2000.[1] In 1979, the World Health Assembly endorsed the Alma-Ata Declaration and launched the global strategy towards attainment of this objective. It urged Member States to act individually in formulating national strategies and collectively in formulating regional and global strategies. Already by 1981, the Health Assembly was able to adopt a Global Strategy for Health for All by the year 2000, based on the collective response of Member States to this call. In adopting this Strategy, the Health Assembly recognized that its implementation would require the combined efforts of governments, people and WHO. Consequently, it invited Member States "to enlist the involvement of people in all walks of life, including individuals, families, communities, all categories of health workers, nongovernmental organizations, and other associations of people concerned".[2]

2. The upsurge of development and reconstruction in the post-war era has seen the emergence of a number of social forces. In both the national and international context, the private voluntary sector, or the nongovernmental sector as it is termed in United Nations phraseology, is undoubtedly one such important force. Its contribution to the cause of social development, and in particular to health, has been noteworthy.

3. Collaboration between WHO and nongovernmental organizations dates back to the First World Health Assembly in 1948. The recognition in the 1981 Global Strategy that health for all will be achieved only if governments, people and WHO work together gave this collaboration a new meaning and a new sense of urgency. Nongovernmental groupings, usually formed for a specific purpose within the health or developmental field, already have a well established role in sensing and fulfilling community needs in innovative ways which are relevant to the implementation of primary health care. Traditionally, they have contributed indispensable resources towards this end in the form of publicly-raised finance and skilled or unskilled staff, many giving their services as volunteers. Some governments consciously avail themselves of this asset in carrying out their health policies; many do not. Some nongovernmental groups are conscious of their part in implementing the Strategy for Health for All; many are not.

4. The term "nongovernmental organization" (NGO) in this document necessarily refers very largely to established international and national organizations; but through them, and even independent of them, many less formal groupings of local people abound, such as voluntary health societies, self-help groups, cooperatives, women's organizations (these are particularly important), relevant youth movements, and associations which work at the community level. They may not have come together specifically for the preservation and promotion of health in their communities. Health is a function of total human development involving physical, mental, social and spiritual well-being. Primary health care includes, in the words of the Declaration of Alma-Ata,[3] "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". It also 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". Groups that have come together for better housing, safer water supplies, land tenure reform, higher yielding crops or even purely social purposes can all be relevant to

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[1] Alma-Ata 1978: Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Geneva, World Health Organization, 1978 ("Health for All" Series, No. 1).

[2] Resolution WHA34.36.

[3] Alma-Ata 1978: Primary health care. Op. cit., pp. 2-6.

health for all. The important thing is that the community should be actively involved in its own betterment. Health care cannot successfully be delivered as a gift; communities must adopt it for themselves and sustain it by their own efforts, to accord with their own customs and to meet their own needs. Voluntary action of all kinds is indispensable in achieving primary health care and in this context will thus be within the scope of the Technical Discussions.

5. A great deal is achieved already by WHO/government/NGO consultation and collaboration. But there are constraints, impediments and gaps which need to be examined frankly if there is to be a more rapid advance in the next few years. A main purpose of the Technical Discussions is to explore the mechanisms of closer collaboration, to identify and tackle the impediments and gaps, and to indicate the most fruitful lines of action for the immediate future.

II. THE SCOPE OF THE DISCUSSIONS

The response to an outline document

6. This document is designed to guide and facilitate the Technical Discussions. It has been written in the light of comments received from governments in response to a preliminary document sent out by WHO in August 1984, and from national and international nongovernmental organizations, some very large, some very small, in many parts of the world. The comments dealt with different aspects of the main theme, focusing on the extent to which nongovernmental organizations consciously play their part in implementing the Global Strategy for Health for All and the relationships and mechanisms for ensuring an effective partnership between the governments and nongovernmental elements in attaining that objective. The replies have been very valuable in the preparation of this discussion document.

Involvement of people in strategies for health for all

7. At the Thirty-fifth World Health Assembly in 1982, governments were invited to draw up specific plans of action to implement the Global Strategy for Health for All. A main subject at the Thirty-seventh World Health Assembly (1984) was the monitoring of those plans, in so far as they yet existed. It was reaffirmed that they must necessarily involve "people in all walks of life, including individuals, families, communities, all categories of health workers, nongovernmental organizations, and other associations of people concerned".[1] It is therefore timely that the 1985 Technical Discussions should focus on the extent to which - and the means by which - this very wide range of people is being involved in promoting health for all. In some countries the initiative has already come from governments. They have sought and found effective means of associating community groups in the implementation of a national plan. In several countries, the initiative is now coming from nongovernmental action through the formation of consultative groups which then make a combined approach to governments with a view to collaboration in implementing a national plan of action. Clearly there is universal recognition in both governmental and nongovernmental circles that primary health care requires action not only in the field of health but also in the entire area of community development, as emphasized in the Alma-Ata Declaration. The organizations and self-help groups being mobilized for joint action with government therefore cover a wide developmental field. Health, as already emphasized, is recognized as an integral part of economic as well as social development, requiring, on the government side, high-level interministerial collaboration, especially in areas which include better nutrition, safe and more easily accessible water supply and sanitation, and health education in its broadest sense. These, as well as specific health sector programmes, are spheres of activity in which governments in many countries are finding the cooperation of nongovernmental groups invaluable, indeed indispensable.

Perspective for NGO action

8. Nongovernmental organizations have a long tradition of providing health care. The spirit of compassion and philanthropy still moves many people in many countries to organize themselves in order to raise resources and provide services to meet specific health and developmental needs. The aggregate of their efforts forms a most important asset both

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[1] Resolution WHA34.36.

locally and globally in ensuring health for all. But they themselves may be only partially conscious - or even totally unconscious - of their role in the national and international effort to implement the Global Strategy. Many may react adversely against any suggestion that their endeavours were being harnessed in any way by anyone, but especially by governments. They have a strong spirit of individuality and independence which all too often inhibits their working together in collaboration with each other, let alone with governments. Yet their already great value will be much enhanced if they are willing to recognize that what they are doing is a part of a wider whole and therefore needs to be coordinated with the work of other voluntary agencies and with government's provision for health and development in the community.

III. THE MANY PROFILES OF NONGOVERNMENTAL ORGANIZATIONS

Definition

9. Replies to the questionnaire in document CWO/TD/84.1 of 12 July 1984 emphasized that the Technical Discussions would require a clear definition of the term "nongovernmental organization". The connotation of that term indicates what they are not. This document will seek to define what they are and also their relationship to the Global Strategy for Health for All; these organizations will be referred to specifically as international, national or local, and the generic term NGO will only be used in the general context.

National nongovernmental organizations

10. National nongovernmental organizations are many and diverse. Their scale may be large, medium or small. Their support may come from external sources, from their own fund-raising, from government subventions, or from all these sources at once. Their principal activity may be direct service to those in need in the community, health education, or research, whether in the field or the laboratory; it may include a good deal of advocacy for changes in government policy. Their scene of activity may be confined mainly to urban areas or may deliberately be directed at underserved rural communities. Their attitude to government health policies may be supportive, neutral, occasionally even confrontational. Their concentration may be on establishing and maintaining institutions, or on caring for those suffering from a specific disease or disability and on attacking its causes with a view to prevention. They may have a real concern for the general health of the community but vary in their interpretation of the main priority: specific diseases? pure water supply? sanitation? mother and child care? road safety? nutrition? general health education? Their focus of action may accordingly be mothers, children, environmental planners, the education system, or the community at large. They include full-time professionals and part-time volunteers, some with thorough training, others with none at all. Their motivation may be religious or compassionate. It may even be political or occasionally nothing better than self-promotion.

Local nongovernmental groups

11. But the description in the preceding paragraph relates too narrowly to the traditional "charities", often urban, usually middle-class if not élitist, which are derided sometimes - perhaps unfairly - as deriving their motivation from a desire to help themselves by helping others less fortunate than themselves. Their cooperation is indeed needed as much as ever. But health for all will not be achieved without the full participation of individuals, families and groups within the community, which means all the people the Global Strategy is designed to reach. There must be a shift - there is already a shift - from people seeking to help others as a form of charity to far larger numbers of people seeking to help themselves. There are crucial health actions required for attainment of health for all objectives in such fields as health of the family, particularly mothers and children, including family planning, immunization against preventable diseases, diarrhoeal disease control, and nutrition. Little can be achieved in these vital areas without the understanding and cooperation of the children's mothers through health education. The long-term solution is health education of all, but particularly of women. Meanwhile, every opportunity should be taken by both governmental and nongovernmental organizations to encourage informal groupings of women for social purposes and to motivate them to have their children vaccinated and adopt measures of hygiene and sanitation which will minimize or at least reduce the incidence of diarrhoea. Similarly, the battle against the scourge of malaria will never be won unless communities understand the reasons for spraying and organize themselves to carry it out regularly.

Community involvement in all areas, brought about by active local groups, is most crucial to the promotion of health for all. Many are formed under the influence of primary health care workers and other local manifestations of government. Many are traditional forms of local community development action groups into which a concept of health for all is being introduced. Others come together spontaneously for general developmental purposes, if not specifically in the context of health needs. They are movements within the culture of the people themselves. For this reason, they stand a chance not only of achieving success but also of maintaining it. For all too often success in the local health field has been achieved by outside intervention, only to evaporate when the outside intervention withdraws. If these spontaneous groups within the culture of the local community can be encouraged by various means and then given the opportunity to work together with both governmental and nongovernmental agencies in meeting health needs of which they themselves are conscious, then the Global Strategy will begin to achieve its purposes.

International nongovernmental organizations

12. While many international NGOs have affiliates in several countries, some do not. Others have created or developed relations with country affiliates mainly to give them professional guidance, to maintain or adapt standards, or to offer appropriate training and advice on the use of specialist equipment and materials; some, mainly originating in developed countries, aim at achieving a global objective such as the control of leprosy or tuberculosis, the acceptance of family planning, the prevention of blindness, or the rehabilitation of disabled people. Some are an aggregation of national affiliates for action in times of disaster or for cooperation in specific fields, e.g., nursing and child care; others undertake health work in special fields. Many international nongovernmental organizations exercise an advocacy function particularly in what has come to be known as the North/South dialogue. With their knowledge of health conditions in underserved communities they can influence world opinion and also guide decisions in aid programmes. They can call attention to what they consider to be deleterious activities, inimical to the advance of health for all. They can help to maintain and further promote an awareness within the world's more prosperous communities of what the Declaration of Alma-Ata calls "the existing gross inequality in the health status of the people" in the world which is "politically, socially and economically unacceptable". They can themselves be a channel through which knowledge, funds and materials can flow from the affluent to the underserved peoples of the world. Increasingly, they are coordinating their activities at the international and national level. On the other hand, both national and international NGOs find it difficult to maintain fruitful contact with each other (the link between them is frequently described as "tenuous") because the cost of travel, subsistence and even airmail postage is difficult to meet from membership subscriptions - often their main source of income.

Fund-raising NGOs: Foundations

13. There is yet another category of nongovernmental organizations which are termed "foundations" or "funds", which primarily concern themselves with raising financial resources to support various objectives. These resources represent an important channel of flow of resources from the developed world to the developing countries. In the field of health estimates suggest that the order of magnitude of such resources exceeds several billion United States dollars. Their involvement in the health-for-all movement hence is also of crucial importance to its success.

Various roles of international NGOs

14. These categories are by no means mutually exclusive. Those which are primarily concerned with fund-raising to support work in the field may also engage in research and offer appropriate training. An association that exists primarily to promote professional knowledge among its national and individual membership may undertake a specific field task on its own initiative or at the request of a government or WHO. Their main value to the Global Strategy may lie in its members, whose long experience of research, technology and field work make them valuable members of planning or advisory committees at national or WHO level. WHO, for its part, has developed over the years an expanding base for collaboration.

15. The contribution of international NGOs to the global and national pursuit of health for all is manifold. The international fraternities of professionals, academies, technologists and technicians provide their national affiliates with intellectual stimulus, updating,

opportunities for enhancing qualifications and for exchanging experiences, back-stopping in dealing with professional problems, the promotion of research, advice on equipment, and the means of overcoming a feeling of isolation. Many of these organizations are in official relations with WHO and are therefore a medium for a flow of communication in both directions between professionals and academics at work in the field, the international body, and WHO. Either on their own initiative or with WHO support and participation, they organize conferences or workshops in their field of specialization. They also provide representatives for WHO advisory committees or for ad hoc consultation. They are a ready source of consultants to national governments as well as to WHO on specific problems.

Role at country level

16. Their contact with their membership in many countries - developed and developing - keeps them informed of contemporary world needs. This can be very beneficial if it becomes a means of adapting technology - in its broadest sense - not only to centres of excellence in urban areas in countries of very differing economic development but more importantly to the requirements of primary health care. In countries where government resources for development are limited, a service which they and their affiliates can render is to develop appropriate technology for health, to supplement governmental efforts. A disservice they can render is to induce in their membership a feeling that the appropriate technology they must necessarily use in many countries is "inferior" or "second-best". While technology must constantly be improved, it should at all times remain within the reach of all the people. The best can be the enemy of the good. The test of the good is that the technology is relevant and available to the very large numbers of people who need it, not just to the few who have easy access to it and can afford to pay for it, as has all too often been the situation heretofore.

17. International organizations such as the League of Red Cross and Red Crescent Societies, the Christian Medical Commission, the International Planned Parenthood Federation and the many others concerned with general objectives of primary health care, as well as specific objectives such as the prevention of blindness and the care of the blind, maternal and child health and family health, the relief of famine victims and the development of better nutrition, the prevention of disability and the rehabilitation of disabled persons, cooperate with their national affiliates and help to build up strong local participation. In many developing countries, their inputs of money, materials and skilled staff (provided they are prepared to pass on their skills to local people) make a great deal of difference to the level of health care in the community. In some countries, they cannot operate without specific permission and a considerable measure of control from the government. In others, there is a more laissez faire attitude because the governments readily recognize the value of the external help as a contribution to the national well-being. Either way, negotiations with the external contact provide the national association with an opportunity to coordinate its activities with the government's plans for health care and for general development. These international NGOs provide much more than external finance and supplies of materials. They are valuable sources of encouragement, training and team spirit. As many of them are concerned with the neediest in the community, they and their national affiliates are strong allies in the cause of promoting primary health care. In some of the developed countries a newer trend of NGO work is noteworthy. Several national NGOs in some of these countries, individually or collectively, are directing their activities and resources towards international health development concerns. The Save the Children Fund (United Kingdom) and the National Council for International Health (United States of America) exemplify such cases. Such a trend has opened up new opportunities for international cooperation among NGOs as well as between NGOs and national governments.

Universities

18. "The role of universities in the strategies for health for all" was the subject of the 1984 Technical Discussions. Academic institutions are great reservoirs of talent and of intellectual and technical competence. They have long traditions of education, research and service. While in the past they have focused heavily on their traditional hospital-based, speciality-oriented and disease-oriented activities, with a good deal of academic isolation, they increasingly recognize the need to prepare themselves for multidisciplinary action directly related to primary health care. This will require the breaking down of barriers that exist in most countries between the universities and medical schools on the one hand and the national health services on the other. The 1984 Technical Discussions recommended that ministries of health and other concerned ministries should have more effective collaboration

with the universities; and that the institutions of higher learning and research, for their part, should reorder their academic priorities to accord due recognition to involvement with rural development, environmental and primary care problems, elevating research in these areas to the status hitherto accorded to technically sophisticated aspects. They should constitute a resource centre for government ministries in the development of policy and the planning of strategies for implementing national programmes. It was recognized that this will not be easy, because they are notoriously bound by tradition and resistant to change. Efforts to focus the role of universities on health and development issues thus constitute another dimension of involvement of the "private" or the nongovernment sector in community development.

IV. PARTNERSHIP

19. The quintessence of the Global Strategy for Health for All by the Year 2000 is that its implementation requires the combined efforts of governments, people and WHO. The main theme of partnership is therefore a wider acceptance of this principle and its translation into cooperative action - that is, when governments recognize this, when nongovernmental bodies, for their part, recognize that they have an indispensable part to play in cooperation with government, and when there are effective mechanisms for consultation and for collaboration in the field. There are governments that have already persuaded NGOs to regard their services as an integral part of the total health care provision, but they are relatively few. Conversely, there are countries where an initiative has come from the voluntary bodies which have assembled for the purpose of considering their joint role in achieving health for all and in order to enter into dialogue with governments. They too are still few, although their number is increasing. There is a third category of countries where a dialogue has been in progress for many years; voluntary societies have easy access to officials and ministers and their representatives serve on relevant national committees, but without any formal mechanism for systematic consultation.

Impediments

20. Collaboration has usually turned out to be a matter of personal relationships. But officials get transferred, ministers change, national figures in philanthropic work die; and in any case personal relationships can be very bad as well as good. For the sake of continuity, if for nothing else, collaboration between the government and NGOs needs some degree of institutionalization, albeit without bureaucratization. It will not be achieved if several government agencies have to deal separately with academic bodies, professional associations and a bewildering array of voluntary groups. There are countries where this collaborative process has hardly started. Sometimes, this is because governments have yet to formulate national strategies for health for all. In many others the process of partnership may have been simply held up for want of just the first step to be taken. Sometimes, it is because a government has no modalities for dialogue with nongovernmental bodies at either the policy or implementation level. Voluntary bodies, for their part, are notoriously shy of government interference and resolutely maintain their independence of action. These can all be regarded as impediments to progress in achieving health for all at the national level.

Elements of partnership

21. What, then, are the strong points in favour of bringing about government/NGO collaboration? Where the principle of collaboration has been accepted, governments have recognized that NGOs are indispensable allies because they supplement government resources by publicly-raised money and volunteer staff; they are close to the people, responsive to their needs, and able to act quickly; they are cost-effective because they use their limited funds more for field work and less for staff overheads; they are innovative and flexible, not inhibited by rigid programming; their fund-raising activities call attention to real community needs (they would not survive by public support if this were not so); they are often the channel through which external aid in the form of finance, personnel, materials, equipment and advice reaches the people; whole areas of health care can be entrusted to them in default of, or alongside, the governmental provision; some of them are national affiliates of international specialist associations that feed them with information and keep them abreast of modern technology.

Constraints

22. Objections can be raised to almost every one of these qualities; therein lie the constraints. It is claimed that the "free-lance" activities of NGOs can distort carefully planned and regulated government priorities in the health field; the publicity given to their activities, either in fund-raising or in advocacy, could severely embarrass governments; if the organizations receive funds from external sources, the purposes to which the money is put may not be regarded by governments as first priorities for the limited supply of external aid; some governments consider that they should control all forms of foreign aid; if the organizations receive advanced technological equipment or apparatus from their overseas affiliates, governments may not regard it as appropriate to local needs; and in any case, governments may wish to determine how it is used.

The remedy

23. The remedy, of course, is consultation at every level. Governments will not want to be dictated to and some NGOs will be very wary of government restraint. But these difficulties are being overcome in many countries, by dialogue and by mechanisms of consultation. The elements of partnership are a willingness on the part of governments to work with NGOs on the basis of information about their activities and motivation, which is all too often missing at present; a consciousness on the part of NGOs that their work is a vital element in a national endeavour; a mechanism of consultation which can be set up by government initiative in convening a representative group or, as happens more often, a consortium of NGOs approaching the government; a mutual arrangement (which has long existed in many countries) whereby leaders in NGOs serve on government planning and policy-making councils and ministers or officials are invited to take part in the deliberations and work of NGOs; regular discussions on such matters as tax exemptions in various forms, including duty-free entry for essential materials; areas of possible overlap in activity; division of responsibility for extending health care to underserved communities; training of health care workers and their supervisors; procurement of supplies and distribution of essential drugs; strengthening the chain of responsibility from the centre to the periphery; the allocation of specific areas of activity to NGOs; and the regulation of government subsidies or grants-in-aid. These discussions are most likely to succeed if they are the functions of a standing national body, preferably statutory, specially created to harmonize the government's health-for-all action plan with the work of nongovernmental bodies, on which relevant ministries work together with NGO representatives in both planning and implementation.

V. EXAMPLES OF ACTIVITIES

Country examples

24. There are several countries in which this process of consultation and cooperation at national, provincial and local level is beginning to work well. There have been a number of initiatives, experiments, projects and success stories in different parts of the world which offer valuable pointers to the positive elements of the partnership approach. It is only possible to give some examples in the following paragraphs.

25. In some countries in Asia national NGOs have formed a national association of voluntary organizations to participate as a group, in order to offer advice and support for the implementation of national plans. Individually as well as collectively they undertake primary health care activities, provide managerial support to smaller NGOs, and cooperate with the national ministry of health in various programme areas. The group has been an emphatic advocate of health for all by the year 2000. In another country in Asia a large rural-oriented national organization is cooperating with the government in disease control activities. The ability of this organization to secure community involvement in a malaria control programme has significantly contributed to the success of the programme. In the same country, the priorities of community development programmes at the grass-root level are determined by the weight of the opinion of community NGO groups, which officially constitute the village-level development committee. In yet another country several NGOs, assisted by governmental funds, have established an institution with the specific objective of encouraging the work of smaller community-level NGO groups for the implementation of primary health care. The institution offers managerial training courses, provides information on appropriate technology, and assists project formulation and implementation by NGOs.

26. In a few Latin American countries and the Carribean, NGO work is increasingly recognized as of great relevance to the objectives of health for all. In a few countries NGOs have developed innovative mechanisms such as national federations of NGOs to facilitate collaboration with official programmes.

27. In a European country, a consortium of 11 voluntary societies banded together to campaign for an increase in the uptake of rubella vaccine. One of many intriguing methods was to give a "credit card" to every girl who was found to be immune or received the vaccine. They were soon very much in demand. Just as the campaign started, the consortium found itself backed by the government with significant financial resources over three years for the "eradication" (the government's word) of the rubella syndrome. The consortium became the National Rubella Council, with strong government participation. Effective regional support from both government and voluntary agencies in the country indicates that the campaign has got off to a very good start.

Examples of the work of international NGOs

28. While international NGO work focuses on multifaceted objectives including advocacy, leadership for various causes, the mobilization of expertise in specific areas, a platform for international information exchange and concerted action, and development education, its contribution in programmatic terms at the country level cannot be underestimated. Many examples could be given where international NGO initiatives have furnished major impetus for important national health programmes. To mention only a few:

- Aging and care of the elderly. Following the World Assembly on Aging held in Vienna in 1982, concerted NGO action has facilitated effective launching of national programmes for the care of the elderly in a large number of countries all over the world.

- Population. This is another area where concerted NGO action has played an effective leadership role, in mobilizing resources, harnessing public opinion, and providing technical expertise and advice.

- Prevention of blindness. International NGOs working in the field of blindness prevention spend more than US$ 20 million a year in direct support of a great number of country programmes. The WHO prevention of blindness programme collaborates closely with more than 10 of these NGOs in the development of national programmes for the prevention of blindness. Thus, international NGOs are providing support to the work of national committees for blindness prevention in many countries, to the training of personnel in eye care at various levels, to the conducting of field activities, such as eye camps, and to the general strengthening of eye care in neglected rural areas. In support of the development of national programmes for the prevention of blindness, the common strategy of the NGOs and the WHO programme is based on the provision of eye care as an integral part of primary health care, and on fostering the active involvement of the community in the prevention of avoidable blindness. In major projects, involving several countries, some international NGOs have joined together with WHO in forming a coordinating committee to facilitate the channelling of support from several sources. This approach is being developed particularly in the Caribbean area and in the southern central African subregion, for the provision of eye care services and the training of auxiliary personnel. Several of the international NGOs are also forming, under the auspices of the International Agency for the Prevention of Blindness, a consultative committee to the WHO programme, to further strengthen and facilitate the development of joint activities in support of blindness prevention programmes.

WHO support for government/NGO partnership

29. What is WHO doing to support the partnership concept? In accordance with criteria laid down from time to time by the governing bodies of WHO, over 130 international NGOs are now in official relations with WHO. Relationships with these organizations are reviewed and evaluated periodically. A framework for close collaboration between WHO and NGOs in diverse areas of health development has facilitated increasing mutual cooperation. Collaborative activities have expanded in quantity and improved in quality, especially in recent years. A compendium containing a profile of each NGO and information about collaborative activities has been prepared for participants in WHO's governing bodies, programme managers, regional offices, WHO programme coordinators, and the NGOs themselves. These joint activities relate to all priority programme areas. They range from the dissemination of information through

the NGO networks, data collection in support of a specific activity, the preparation of manuals, and the training of health workers to collaborate in specific health programmes for the control of tuberculosis, leprosy, cancer, blindness, and cardiovascular diseases, etc., as well as programmes of mental health, environmental health, oral health, laboratory and radiological technology, and health education. The activity may be conducted with a single appropriate international NGO; increasingly, however, groups of NGOs come together with WHO for joint collaborative activities in specific areas such as primary health care, infant feeding, maternal and child health, family planning, prevention of blindness, health of the elderly, alcohol and drug abuse, the rehabilitation of disabled children and adults, and accident prevention.

30. Once governments and NGOs have reviewed their state of collaboration and have forged firm links for joint cooperation, within the framework of strategies for health for all, the further supportive role of WHO, at all levels - national, regional and global - will be clearly delineated. Ways and means should be specified by which the support of the technical and other resources of WHO and other international organizations - multilateral, bilateral and others - can be continued and intensified to increase the involvement of NGOs in implementing the Global Strategy. WHO is now reviewing its collaborative procedures and mechanisms to facilitate this process.

Joint activities

31. These joint activities are usually at global level with, of course, implications for national plans for health for all. They are planned and carried out in conjunction with WHO by international NGOs whose national affiliates are associated with them. In addition, regional and national NGOs for which there is no international body, or whose international body is not in official relations with WHO, can nevertheless develop a working relationship informally with WHO. Such contacts have become mutually beneficial in such matters as:

- the use of NGO technical expertise for WHO expert advisory panels;
- collaboration in regional and interregional conferences, seminars or symposia organized or sponsored by WHO or called together by international NGOs with WHO participation;
- the dissemination of technical information and policy statements;
- health systems research, to which NGOs can contribute significantly from their development-oriented work at community level;
- the training of all categories of health workers.

Experimental initiative

32. In 1981 WHO launched an experimental initiative to promote and support effective collaboration between national governments and national NGOs, with support from international NGOs. A three-step action programme was proposed and carried out in a number of countries in different regions. This comprises: (a) systematic collection of information on NGO work at the country level; (b) analysis of such information in reference to the national strategies and plan of action for health for all; (c) development of a continuing dialogue for effective mutual collaboration in priority health programmes and activities. The initiative is in various stages of implementation in different countries, some of which are well ahead in its implementation. This endeavour has yielded valuable experience and has provided useful pointers to possible future action for promotion of the partnership approach for government/NGO collaboration.

An initiative in southern Africa

33. WHO has also supported, with UNICEF, an initiative of an NGO group on primary health care in six countries of southern Africa. This group, representing a number of NGOs in official relations with WHO, prepared a plan in 1982 for promoting collaboration among NGOs, and between NGOs and governments, in Botswana, Lesotho, Malawi, Swaziland, Zambia and Zimbabwe in planning, implementing and reviewing public health care programmes. This NGO

initiative has its coordinating secretariat in the Christian Medical Commission of the World Council of Churches and preliminary reports of successful implementation are becoming available.

Scope for other actions

34. The experimental initiatives to which reference has been made in the preceding paragraphs indicate a promising approach in which more and more countries could become interested, using WHO resources at country, regional and global levels for catalytic support. NGO consultative groups could be established to advise and undertake specific activities for collaboration with the ministry of health. Well-established national NGOs could stimulate and support the work of local NGOs at the community level. Training courses could be organized by the governments to enable management skills to be acquired, especially by the smaller NGOs. International NGOs could mobilize themselves, as indicated previously, to facilitate this process. WHO could collaborate in the entire process to ensure viable development of the partnership approach.

VI. THE TASK AHEAD

35. With only 15 years to go, the goal of health for all by the year 2000 presents a daunting challenge, especially with 82 million additional people a year to feed and to care for. The apparent inadequacy of resources in money and manpower underlines the inescapability of an effective partnership between governments, NGOs, and the people themselves. With imaginative approaches, the goal can be achieved. In the context of this document and the 1985 Technical Discussions, a first requirement is that governments should let it be known that they not only need NGOs but want them as partners. Whether the initiative comes from government or from NGOs, the dialogue needs to be established and maintained. Areas in which NGOs should operate alongside or in lieu of the government need to be identified. Governments' action should include not only public recognition, but the according of practical support, whether in the payment of grants, the provision of supplies, or merely letters of support for everything consistent with national goals.

36. The scope and objective of regular consultation will be varied but focused on bringing NGO work into the mainstream of health development activities, and in this context could extend to the review of rules, regulations, tax and grant codes, NGO registration procedures and the like, followed by action to effect changes in support of NGOs. Governments will need to make it known to external donors that they wish NGOs to be the recipients of money, supplies and staff. They will help NGOs to generate income and supplies, particularly in their relations with the commercial sector, and to improve their managerial capacity, through secondment of staff and training courses. Not only governments but also national NGOs will wish to do everything possible to encourage and build up grass-roots organizations within the communities.

37. In this task ahead, WHO has a vital role of continuing to promote, support and foster such partnership, entirely in the interest of attaining the objectives of health for all in each country.

VII. QUESTIONS FOR DISCUSSION

The questions that arise for representatives of governments and NGOs at the Technical Discussions are:

1. Nongovernmental organizations have an important role to play in the implementation of strategies for health for all at all levels. They represent a precious asset in experience, technical expertise, innovative capability, manpower and other resources for this purpose.

   To what extent are governments willing to recognize nongovernmental bodies as essential partners in strategies for health for all?

   What are the impediments to such recognition?

   How could these be overcome?

2. While the value and potential of the contribution of NGOs to health development is unquestioned, such work must relate and be relevant to the specific objectives of health for all, with primary health care as a key approach. In this context:

   How willing are nongovernmental organizations to regard themselves as a part of a national and global effort to implement the strategies for health for all?

   What are the impediments to this process?

   How could these be overcome?

3. What are the extents and limits of governmental/nongovernmental partnership in implementing health strategies?

   Where governments and NGOs have succeeded in working together, how were the impediments overcome?

   Can their experience be used by countries that have not yet fully tried out such a partnership?

4. To what extent do mechanisms exist for coordination (a) among NGOs and (b) between NGOs and governments?

   How effective are they?

   What form do they best take?

5. What are the most effective means of identifying and encouraging relevant self-help groups, particularly in underserved communities?

   What are the guidelines for governmental support of these groups in the interests of health for all without destroying their spontaneity and their indigenous nature?

   Can national NGOs support these self-help groups without seeking to incorporate them within their formal structure?

6. In the implementation of strategies for health for all at the national level, what is the value and the strength of the link between national nongovernmental organizations and their international umbrella organizations?

7. What should be the role of WHO at the national, regional and global levels in promoting, supporting and strengthening effective partnership between governments and nongovernmental organizations in order to accelerate the implementation of health-for-all strategies?

8. What are the specific recommendations arising out of these Technical Discussions?

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ANNEX II

THIRTY-EIGHTH WORLD HEALTH ASSEMBLY

WHA38.31

Agenda item 22.2

20 May 1985

COLLABORATION WITH NONGOVERNMENTAL ORGANIZATIONS IN IMPLEMENTING THE GLOBAL STRATEGY FOR HEALTH FOR ALL

The Thirty-eighth World Health Assembly,

Recalling resolution WHA34.36, and reaffirming its commitment to the implementation of the Global Strategy for Health for All by the Year 2000 through the solemnly agreed, combined efforts of governments, people and WHO;

Mindful that the attainment of the goal of health for all by the year 2000 is an integral part of international social and economic development as well as a direct contribution to world peace;

Emphasizing the crucial need for a real partnership between governments, nongovernmental organizations and WHO in order to achieve the goal of health for all by the year 2000;

Recognizing the commitment of nongovernmental organizations and the complementarity of the resources which they can mobilize for the achievement of strategies for health for all;

Taking into account the conclusions and recommendations of the Technical Discussions held during the Thirty-eighth World Health Assembly on "Collaboration with nongovernmental organizations in implementing the Global Strategy for Health for All";

1. APPEALS to the global family of nongovernmental organizations to support the strategies for health for all, and calls for their involvement and the increased use of national and international resources towards this end;

2. CALLS on the national nongovernmental organizations:

(1) to commit themselves in practice to the implementation of the strategies for health for all by the year 2000;

(2) to establish close collaboration with governments, in a spirit of partnership, for the implementation of national health for all policies and programmes;

(3) to encourage and support in all ways self-care and self-help groups at the community level for the effective implementation of primary health care;

(4) to establish appropriate national coordinating mechanisms, such as national councils of nongovernmental organizations, to provide a focal point for nongovernmental activities in health and health-related fields;

3. URGES international nongovernmental organizations:

(1) to take appropriate measures to further the collaboration between national nongovernmental organizations and Member States in the implementation of health for all strategies;

(2) to collaborate with WHO and other international organizations in providing support and cooperation in health for all activities;

(3) to coordinate their activities to ensure mutual support and cooperation in health matters;

4. CALLS on Member States:

(1) to promote, foster and support the partnership approach by involving nongovernmental organizations in policy formulation, planning, implementation, and evaluation of the national health for all strategies;

(2) to encourage and support the establishment of self-help and self-care nongovernmental groups at the community level, giving particular emphasis to women's groups, in order to implement primary health care approaches effectively;

(3) to stimulate the active involvement of youth and student organizations, since these represent the generation that will be responsible for the world's health in the year 2000;

(4) to encourage and support the establishment of nongovernmental coordinating or other appropriate mechanisms at the national level to facilitate mutual dialogue and close consultation on health matters;

(5) to utilize the expertise and experience of nongovernmental organizations through consultation, and for this purpose prepare inventories of their resources, skills and collaborative health activities with governments;

(6) to facilitate the mobilization of adequate resources for the work of national nongovernmental organizations for health work;

5. REQUESTS the regional committees to consider ways and means of strengthening the involvement of national and regional nongovernmental organizations in the implementation of regional and national strategies for health for all;

6. REQUESTS the Executive Board to review the existing framework of WHO's collaboration with organizations from the nongovernmental sector, together with the existing rules and procedures, with a view to strengthening it and making in more effective;

7. REQUESTS the Director-General:

(1) to pursue his efforts to promote the involvement of international nongovernmental organizations in the Global Strategy for Health for All;

(2) to promote and support partnership activities of Member States, WHO and nongovernmental organizations for the implementation of strategies for health for all;

(3) to review periodically the progress made in promoting and fostering collaboration between governments and nongovernmental organizations.

Sixteenth plenary meeting, 20 May 1985
A38/VR/16

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