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REVIEW OF PRIMARY HEALTH CARE DEVELOPMENT

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REVIEW OF PRIMARY HEALTH CARE DEVELOPMENT

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REVIEW OF DEVELOPMENTS IN PRIMARY HEALTH CARE

INTRODUCTION

The World Health Assembly in 1977 accepted the challenge of "Health for All by the Year 2000" when it decided that the main social goal of governments and of WHO should be the attainment by all peoples of a level of health permitting them to lead socially and economically productive lives. In 1978 an International Conference on Primary Health Care (PHC) in Alma-Ata, USSR, stated that PHC was the key to attaining that target.

While it was acknowledged that many of the principles and practices of PHC had already been in operation in some places, it was the first time that this accumulated wealth of experience had been formally woven into a specific global plan for action.

In 1979 the Health Assembly launched the Global Strategy for Health for All when it endorsed the Alma-Ata Report and Declaration and invited Member States to act individually in formulating national strategies and collectively in formulating regional and global strategies.

The purpose of this review is to learn what 70 WHO Member States (see map) have done, and are doing, with regard to the development of primary health care. The main emphasis of the review is on learning both from positive experiences and from some of the problems and constraints encountered in the process. The review does not attempt to assess the present detailed status of PHC development for individual countries. That can only be done adequately by countries themselves.

What the review does attempt to do is to highlight some of the present trends in the development of PHC and give an overview of the accumulated experiences reported by countries. It also underlines the areas of concern to which countries have applied themselves and brings out common factors which are emerging and the types of country action being taken. The emphasis then is on implementation, not status or effectiveness. The review aims to make available to countries shared experiences which may serve to assist them in their own planning and action for PHC as they strive towards the goals of Health for All by the Year 2000 (HFA/2000).

With these objectives in view the potential audience for the review is necessarily wide. It includes at country level ministries of health and other ministries, departments, institutions, organizations and groups, particularly those concerned with community development, education and agriculture. With regard to the latter, there are, for the purposes of intersectoral cooperation, advantages in having a consolidated document on PHC such as a Review. It also includes organizations at regional and global level, including those within the UN system, and others who are charged with the crucial global task of supporting countries in the diverse activities necessary to the promotion of better health for their peoples.

METHODS USED IN PREPARATION OF THE REVIEW

The review is based on a large body of information provided by countries in the form of national health plans, strategies, reports, evaluations, and reports of meetings and workshops. Another principal source of information is the documentation from the WHO Regions. Other sources include WHO annuals of statistics, the World Health Assembly verbatim reports, documents from other UN agencies including UNICEF, UNDP and the UN Social and Economic Council, the World Bank, and other international and national organizations. Selected articles and reports, published and unpublished, have also been used. A total of approximately 850 documentary sources were used and approximately 16,500 printed pages in English, French and Spanish, have been "processed" in order to extract the material on which this review is based.

In order to process so large a body of information, a nine-page pilot-tested framework based largely on the global indicators was used to extract the information required. (This framework is presented in Annex I.) The resulting approximately 800 pages contained the specific information extracted, which was used in the writing of the review. This has included the use, where possible, of the actual phrases used by countries themselves in documenting their own experiences or progress in PHC development.

Given the diverse sources of information used for the review and the fact that it was assembled with rapidity, it is readily acknowledged that there are of necessity many gaps in the information presented. However, one of the main purposes of the whole exercise was to elicit from readers themselves their opinions concerning the review as a whole, the methods used in its preparation and particularly to obtain from them more complete information.

An obvious problem relating to any information is whether it is true, and "reliable". It is acknowledged that some of the information presented in the review cannot fulfil all the demands of reliability and may not, in some cases, be the latest information available. It is nevertheless considered valid enough to be used for the present purposes.

The review has been completed by the reception and incorporation of comments and 250 pages of additional information from the six WHO Regions, thus increasing its usefulness as a working document. The whole process of review preparation has also been seen as a step towards the development of specific monitoring tools for Health for All at regional and global level and particularly in view of the progress reports being prepared by countries. The process used for the preparation of the review has already served as a useful learning experience for all those involved.

THE COUNTRIES REVIEWED

To review information from all Member States was not considered possible. Originally it had been hoped to select countries on the basis of their annual per capita expenditure on health. However, as the interpretation of this data was not unfortunately uniform for all potential countries, it was decided to select countries on the basis of the figures relating to Gross National Product. Accordingly, 70 countries were chosen in what has been termed the "low income" and "middle income"¹ range². (A list of the countries reviewed is presented in Annex II; see also map in Annex III.) The 70 countries reviewed represent nearly half (44%) of WHO Member States (159 as of September 1982). The 70 countries also contain 64% of the total world population (see Table 1).

THE PRESENTATION AND STRUCTURE OF THE REVIEW

In presenting the country information on developments in PHC, countries have been set within their different WHO regional contexts. Information has also been included which sets countries within a global context, and relates to global programmes, plans and experiences. This has sometimes resulted in the text of the review in an "imbalance" of information on certain topics, especially where country information has been scarce.

Regarding the structure of the review, the latter part of this introduction briefly considers the demographic characteristics, and the socioeconomic, political and cultural contexts of the 70 countries.

The first chapter, "Policies and Plans", looks at policies, plans and legislation regarding PHC, i.e. the kinds of policies and plans that have been formulated; the planning mechanisms used or suggested; the kinds of PHC targets being set and the bases for their selection; the types of legislation introduced or planned.

The second chapter, "Financing the Plan - Resource Allocation", considers some of the financial implications of PHC, including how much appears to be spent on health, and what changes in health expenditure are evident since Alma-Ata.

¹ World Bank Development Report, World Bank, 1981.

² One country in the Region of the Americas (Canada) and one in the European Region (Finland) fall outside of these categories but the inclusion of higher income countries has demonstrated that the same framework for looking at PHC can be used in a variety of countries of differing socio-economic conditions. In addition, it has been widely accepted that the PHC approach is of relevance to all countries in achieving HFA.

The third chapter, "Manpower: The Plan Implementors", looks at a variety of health manpower topics such as development, training, deployment, reorientation, roles, costs and supervision.

The fourth chapter, "Organizing Physical Resources for PHC", considers what is involved in organizing physical resources for PHC and is concerned with types of infrastructures available or planned. Some of the problems and constraints involved are explored, such as for example supply systems. The issues of accessibility, referral, urban PHC requirements and appropriate technology for health are also considered.

Chapter five, "The Role of Community Involvement" considers the type and level of community involvement in decision making for PHC, the kinds of approaches used to obtain community involvement, and its role in PHC development.

Chapter six, "The Core Elements of PHC" considers the eight specific PHC components mentioned in the Alma-Ata Declaration:⁽²⁰⁸⁾ 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 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.

The seventh chapter, "Intersectoral Activities - an Essential Dialogue", is concerned with the interactions between the health sector and other sectors, such as education, community development, agriculture, adult education, and also the nongovernmental sector.

The eighth chapter, "Technical Cooperation Between Countries", considers mechanisms established, plans for action, benefits and constraints to technical and financial cooperation between developing countries, and cooperation with developed countries and collaborative agencies.

The ninth chapter, "Monitoring and Evaluation of PHC", considers the ways in which PHC is being assessed in countries and some of the successes and constraints encountered. It also considers what kinds of indicators for evaluating PHC are being employed or suggested, and how they relate to regional and global indicators.

Chapter ten, "Constraints and Problems" focuses on the main constraints and problems being encountered by the countries reviewed in the process of implementing PHC. It draws together information from previous chapters as a prelude to the conclusions of the review.

THE REGIONAL DEMOGRAPHIC CONTEXTS OF THE COUNTRIES REVIEWED¹

The population of the world increased in the 1970s at an annual rate of 1.9% and exceeded 4000 million in 1977 as against 3600 million in 1970. In 1977, eight countries had a population of between 50 and 100 million, whereas 15 countries had a population of between 25 and 50 million.

Low rates of population growth are associated with high levels of economic development.⁽¹⁴⁾ In 1976, 22% of the world's population was concentrated in countries with low population growth and with high or moderate income levels. On the other hand, most developing countries experience a population growth of more than 2% a year, implying a doubling of their population within 30-35 years. However, the poorest countries among them are not those with the most rapid population increases. This is mainly due to high levels of mortality.

The 30 countries with the highest population growth, that is to say 3% or more, represented 8.2% of the world's population in 1976 (doubling in about 20-23 years). This group is followed by a group of 35 countries (representing 17.6% of the world's population), which had an annual population increase of 2.5-2.9% between 1970 and 1976. This group includes most of the low-income countries, as well as middle-income countries.

¹ The demographic data in this section of the review is taken from WHO Regional documentation (14) (5) (11) (10) EURO (144) and (196).

However, the slowing of the growth rate does not mean a decrease in absolute numbers. In the mid-1970s, the world's population was increasing annually by about 80 million in contrast to 68 million a decade earlier.

The population in 1980 of the African Region was estimated to be in the region of 345 million. If the present annual growth rate¹ is maintained the population of Africa, South of the Sahara, is expected to reach 578 million by the year 2000. In the Region of the Americas the total population in 1980 was estimated to be 615 million or 13.9% of the world's population. In the Eastern Mediterranean Region, the population in 1980 was estimated at 268 million. Great variations exist between countries regarding the size of populations. In fact, five out of the 23 countries in the region contain 74% (203 million) of the total population. By the year 2000 an additional 190 million may have been added to the population, giving a total of 459 million, many of whom will live in urban areas. Density differs widely from one to 323 inhabitants per square kilometre. But averages do not take into account vast uninhabited desert areas. There are in fact much higher densities in certain countries, in particular in overcrowded urban settlements. The total population of the South East Asian Region is approximately one billion, nearly one quarter of the world's population, yet the region occupies only 6% of the earth's habitable land mass. This gives it a fourfold population density when compared, for example, to the developed world. By the year 2000 the total population may have reached 1651 billion. (In 1975 the total population was 946.9 million). The Western Pacific Region contains a total population of 1.3 billion. The 15 individual countries vary considerably in size - from total populations of 6000 to 960 million. By the year 2000 the total population may be 1.6 billion with country populations ranging from 7000 to 1.2 billion.

By the year 2000 the total population may have reached 898 million. At the growth rates estimated in the 1970s, it would take almost 26 years for Latin America's total population to double, but the most densely populated areas are those in which the doubling will occur soonest. The persistence of high population growth rates will be due to high fertility rates expected in all Latin American countries except those in the "Southern Cone" (Argentina, Chile, Uruguay, Paraguay), and in the Caribbean. A drastic shift in this situation would require significant changes from the present fertility rates which are deeply rooted in socio-cultural patterns that are difficult to modify in a short space of time.

RURAL AND URBAN CHARACTERISTICS

Of the 30 countries in the African region considered in this review, approximately 80% of the total population is rural (see Table 2) varying from Rwanda² 96% to the People's Republic of the Congo 55%. The average annual urban growth rate is 5.6 varying from Mauritania 8.6 to Burundi 2.5. In the Region of the Americas the 10 countries included in this review are 49.8% urban. The most rural is Haiti, 72%, the least, Colombia 30%. The average annual urban growth rate is 4.1 varying from Honduras 5.5 to El Salvador 3.3 and Canada 1.7.

In the European Region the three countries included in the review are 49.5% urban. The most rural is Portugal 69%, the least Bulgaria 36%. The average annual urban growth rate is 3.2 varying from Morocco 4.6 to Bulgaria 2.6.

In the Eastern Mediterranean Region 40% of the population live in urban areas. The five countries from that region in this review are 27% urban varying from Egypt with 45% urban to the Yemen Arab Republic, 10% urban. The average annual urban growth rate in these five countries is 5.1 varying from Egypt with 2.8 to Yemen Arab Republic with 7.2.

¹ It should be noted that urban population growth is due not only to migration but also to natural population growth.

² Throughout the Review the 70 countries reviewed are underlined.

In the South-East Asian Region 80% of the total population live in rural areas. Most rural of the countries is Nepal with 96%, and least rural is Mongolia with 46%. Of the 10 countries in the Region considered in this review, 20% of the population are urban¹ with 80% rural. Bhutan is the least urban, 4% and Mongolia the most with 54%. The average annual urban growth rate is 4.0 with a variation which includes Bangladesh 6.8 and Maldives 2.6.

The six countries considered from the Western Pacific Region are 20.4 urban². The most rural country is China 87% and the least the Philippines 64%. The average annual urban growth rate is 4.7 varying from Papua New Guinea 8.7 to China 3.1.

SOME REGIONAL SOCIOECONOMIC, POLITICAL AND CULTURAL CHARACTERISTICS

The countries reviewed were considered within the contexts of their specific regions. Generally it can be said that the last few years have not been altogether favourable ones for world health⁽¹⁴⁾. Droughts and severe winters have reduced harvest yields; wars and civil unrest have destroyed crops, land, and housing; and the proliferation and use of newly synthesized substances has continued without adequate check. In a substantial number of developing countries rapid population growth has become a matter of serious concern, to which close attention has to be paid in the overall task of promoting socioeconomic development. Inflation has raised costs and inhibited the development of trade.

Prior to 1960 the only independent countries in the African Region were Ethiopia, Liberia (1822), Ghana (1957) and Guinea (1958). The majority of the countries became independent between 1960 and 1965 and account for 88% of the population of the region. Four countries won their independence after 1975 through an armed struggle. The African region contains 20 of the 36 countries considered as "low-income".

In the Region of the Americas, while the 1960s was in general a period of economic growth, the world economic slowdown in 1970 adversely affected the rate of that growth. Balance of payment deficits, inflation, unemployment, underemployment and social tension increased in almost all countries. The social effects of inflation have been devastating, and countries face enormous problems expanding and diversifying their energy, agricultural and industrial sectors. Because they assign priority to these problems and need funds to service foreign debts and balance of payment deficits, the budget assigned to health and social services has been reduced at the very time when the countries have made the improvement of health and eradication of extreme poverty and inequality a priority objective.⁽¹¹⁾

The widely differing socio-political conditions of Bulgaria, Finland and Portugal in the European Region make it difficult to give any kind of valid regional generalizations to set them appropriately within their European context.

Despite the variety of situations and of political, demographic and economic factors, the countries of the Eastern Mediterranean Region share some common characteristics. There is generally for example, a national desire and rising community expectations for economic development, expansion of agriculture, the establishment of industries, the provision of basic services such as water and electricity, the upgrading of the communications infrastructure and provision of educational facilities at all levels.⁽¹⁰⁾

In the South-East Asian Region many countries experienced colonial rule for varying periods and achieved independence during the late forties and early fifties. Thus, planned national development efforts in these countries have extended only for a little over three decades. Individual countries, each within their limited resources and irrespective of their diverse political systems have nevertheless attained progress in socioeconomic development.⁽¹¹²⁾

¹ This figure excludes the Republic of the Maldives.

² Excluding Democratic Kampuchea.

In the Western Pacific Region "uncertainty of peace, political instability and social unrest have characterized the beginning of the two decades in the course of which a new International Order is to be achieved".⁽¹⁹⁵⁾ Shifting value systems have given rise to new social relationships and new expectations. The economic systems of many countries are unable to respond adequately to these rising expectations resulting in under and unemployment, low incomes and a period of financial insecurity leading in some cases to social unrest.

It is then within the context of rapid demographic, socioeconomic, political and cultural changes that the 70 countries considered in this review are engaged in the complex task of responding to the health needs of their people.

Table 1 TOTAL POPULATION/RATE OF INCREASE/PROJECTED POPULATION BY THE YEAR 2000

	1979/80 TOTAL pop (million)	Annual Rate of Increase		Pop: by year 2000
		1960-1970	1970-1979	
AFRO				
Chad	4.5	1.8	2.0	7
Ethiopia	32.6	2.4	2.1	53
Mali	6.6	2.4	2.6	12
Burundi	4.5	1.6	2.0	7
Upper Volta	6.9	1.6	1.6	10
Malawi	6.1	2.8	2.8	11
Rwanda	4.7	2.8	2.8	9
Benin	3.5	2.6	2.9	6
Mozambique	10.4	2.2	2.5	20
Sierra Leone	3.4	2.2	2.5	6
Tanzania	17.9	2.7	3.4	35
Zaire	28.2	2.0	2.7	49
Niger	5.3	3.3	2.8	10
Guinea	5.0	2.8	2.9	9
Central African Rep.	2.2	2.2	2.2	3
Madagascar	8.7	2.1	2.5	15
Uganda	13.2	3.7	3.0	24
Mauritania	1.6	2.5	2.7	3
Lesotho	1.3	2.0	2.3	2
Togo	1.3	2.7	2.4	4
Kenya	15.4	3.2	3.4	34
Ghana	11.6	2.4	3.0	21
Senegal	5.6	2.4	2.6	10
Angola	7.0	1.5	2.3	12
Zimbabwe	7.2	3.9	3.3	15
Liberia	1.8	3.1	3.3	4
Zambia	5.6	2.8	3.0	11
Cameroon	8.4	1.8	2.2	14
Congo People's Rep.	1.5	2.1	2.5	3
Nigeria	77.0	2.5	2.5	161
Gambia	0.6	NA	2.8 ⁵	1 (estimate)
Swaziland	0.5	NA	3.0 ^A	1 "
Botswana	0.8	NA	3.0 ^A	1.6 "
TOTAL	310.9			
AMRO				
Haiti	5.8	1.5	1.7	8
Honduras	3.6	3.1	3.3	7
Bolivia	5.5	2.3	2.5	9
Nicaragua	2.7	2.9	3.3	5
El Salvador	4.8	2.9	2.9	8
Peru	17.7	2.8	2.7	55
Dominican Rep.	5.9	2.9	2.9	9
Colombia	26.9	3.0	2.3	40
Guatemala	7.2	2.8	2.9	12
Canada	24.0	1.8	1.1	28
TOTAL	104.1			
EMRO				
Somalia	3.6	2.4	2.3	6
Afghanistan	22.0	2.3	2.6	25
Pakistan	82.4	2.8	3.1	141
Sudan	18.4	2.2	2.6	31
Yemen Arab Rep.	5.9	1.8	1.8	9
Egypt	42.0	2.2	2.0	60
Yemen PDR	1.9	1.9	2.3	3
TOTAL	176.2			

Table 1 (cont.) Total Population/Rate of Increase/Projected Population by the year 2000

	1979/80 <u>TOTAL</u> pop (million)	Annual Rate of Increase		Pop: by year 2000
		1960-1970	1970-1979	
EURO				
Morocco	20.3	2.5	2.9	36
Bulgaria	9.0 ¹	0.8	0.6	10
Finland	4.8 ¹	0.4	0.5	5
Portugal	9.8 ¹	0.2	1.4	11
TOTAL	<u>43.9</u>			
SEARO				
Bhutan	1.3 ¹	2.0	2.1	2
Bangladesh	88.7	2.4	3.0	148
Nepal	14.2	2.0	2.2	21
Burma	35.3	2.2	2.2	50
India	693.9	2.3	2.1	975
Sri Lanka	14.9	2.4	1.7	21
Indonesia	151.9	2.0	2.3	220
Thailand	47.3	2.9	2.4	68
Mongolia	1.6 ¹	2.9	2.9	3
Maldives	0.1 ²	NA	2.6 ²	NA
TOTAL	<u>1049.2</u>			
WPRO				
Kampuchea Dem.	5.0 ³	2.7	3.3 ⁴	NA
Lao PDR	3.3 ¹	2.2	1.4	5
Viet Nam	52.3	3.1	2.9	88
China	964.5	1.9	1.9	1239
Philippines	51.0	3.0	2.6	75
Papua New Guinea	3.1	2.1	2.3	4
TOTAL	<u>1079.2</u>			
TOTAL - ALL REGIONS	<u>2763.5</u>			

Sources of Statistics for Table I.

- A AFRO - Population Statistics. 'The Work of WHO in the African Region' 1979-80. Biennial Report of the Regional Director AFR/RC/31/3. 1 Jan 1981
- B AMRO - "Health for All by the Year 2000 - Strategies". PAHO. WHO 1980 official Document 173.
- C EMRO, EURO, SEARO - International Drinking Water Supply and Sanitation Decade. Present Situation and Prospects. Report of Secretary General to the UN. 18 Sept. 1980.
- 1 1979 World Development Report, World Bank 1981.
- 2 1978 - Country Health Programme - Republic of Maldives. Ministry of Health 1980.
- 3 1976 - Background Notes - Kampuchea. US Dept of State 1977. (WHO World Health Statistics Annual 1980 figure for 1971 population was 6.9 million)
- 4 1978 - Country Fact Sheet on Kampuchea. Licross/Volags Steering Committee for Disasters, Geneva 1978.
- 5 The Gambia PHC Action Plan 1980/81 - 1985/86. Baijul, Ministry of Health Oct/Nov 1979.

Table 2: POPULATION - URBAN/RURAL AND GROWTH RATE

	Urban pop as % Total Pop ¹		Average Annual Growth Rate % ¹		Total population (millions)		Rural % 1980
	1960	1980	Urban		Urban	Rural	
			1960-70	1970-80			
Chad	7	18	6.7	6.5	0.6	3.9	82%
Ethiopia	6	15	6.1	6.6	3.9	28.7	85
Mali	11	20	5.4	5.5	1.1	5.5	80
Burundi	2	2	1.6	2.5	0.2	4.3	98
Upper Volta	5	9	5.3	3.8	0.6	6.3	91
Malawi	4	10	6.6	6.8	1.2	5.0	90
Rwanda	2	4	5.6	5.9	0.2	4.6	96
Benin	10	14	5.3	3.9	0.8	2.7	86
Mozambique	4	9	6.6	6.8	0.7	9.8	91
Sierra Leone	13	25	5.5	5.6	0.7	2.8	75
Tanzania	5	12	6.3	8.7	1.6	16.3	88
Zaire	16	34	5.2	7.2	9.9	19.4	66
Niger	6	13	7.0	6.8	0.5	4.8	87
Guinea	10	18	6.2	5.5	0.8	4.2	82
Central African Rep.	23	41	5.3	5.0	0.8	1.4	59
Madagascar	11	18	5.0	5.2	1.4	7.3	82
Uganda	5	12	7.8	7.0	1.3	11.9	98
Mauritania	3	23	15.8	8.6	0.4	1.2	77
Lesotho	2	5	7.5	7.7	0.1	1.2	95
Togo	10	20	5.6	6.6	0.4	2.3	80
Kenya	7	14	6.4	6.8	2.0	14.4	86
Ghana	23	36	4.6	5.1	3.7	8.0	64
Senegal	23	25	2.9	3.3	1.4	4.3	75
Angola	10	21	5.1	5.7	1.3	5.8	79
Zimbabwe	13	23	6.8	6.4			77
Liberia	21	33	5.6	5.6	0.6	1.3	67
Zambia	23	38	5.4	5.5	1.9	3.7	62
Cameroon	14	35	5.6	7.5	2.3	6.1	65
Congo People's Rep.	30	45	4.7	4.1	0.5	1.0	55
Nigeria	13	20	4.7	4.7	13.9	63.2	80
Gambia	NA	18 ²	NA	3.0 ²		84.0 ²	82
Swaziland	NA	9 ⁵	NA	3.0 ⁵			91
Botswana	NA	20 ³²	NA	3.0 ⁵			80
Haiti	16	28	4.0	4.9	1.5	4.3	72
Honduras	23	36	5.4	5.5	1.3	2.4	64
Bolivia	24	33	3.9	4.1	2.4	3.2	67
Nicaragua	41	53	4.2	4.5	1.2	1.5	47
El Salvador	38	41	3.2	3.3	1.4	3.4	59
Peru	46	67	4.9	4.3	10.7	7.1	33
Dominican Rep.	30	51	5.8	5.3	2.7	3.2	49
Colombia	48	70	5.2	3.9	15.6	11.3	30
Guatemala	33	39	3.6	3.7	2.6	4.7	61
Canada	69	80	2.7	1.7			20
Somalia	17	30	5.3	5.0	1.0	2.6	70
Afghanistan	8	15	5.5	5.9	2.9	19.1	85
Pakistan	22	28	4.0	4.3	23.0	59.4	72
Sudan	10	25	6.9	6.8	3.7	14.7	75
Yemen Arab Rep.	3	10	7.5	7.2	0.4	5.5	90
Egypt	38	45	3.3	2.8	18.5	23.5	55
Yemen PDR	28	37	3.2	3.7	0.6	1.3	63
Morocco	29	41	4.2	4.6	7.5	12.8	59
Bulgaria	39	64	3.8	2.6			36
Finland	38	62	3.2	2.7			38
Portugal	23	31	1.3	2.9			69
Bhutan	3	4	4.1	4.5			96
Bangladesh	5	11	6.3	6.8	8.9	79.8	89
Nepal	3	5	4.3	4.7	0.8	13.4	95
Burma	19	27	3.9	3.9	8.8	26.5	73
India	18	22	3.3	3.3	152.3	541.6	78
Sri Lanka	18	27	4.3	3.6	3.3	11.6	73
Indonesia	15	20	3.6	4.0	26.0	125.9	80
Thailand	13	14	3.5	3.3	10.7	36.6	86
Mongolia	36	51	5.2	4.1			49
Maldives	11 ⁴	NA	NA	2.6 ⁴			88.7 ⁴
Kampuchea Dem.	11.0	NA	3.6	NA			NA
Lao PDR	8	14	4.1	4.8			86
Viet Nam	15	19	5.3	3.3	10.5	41.8	81
China	20 ³	13	NA	3.1			97
Phillipines	30	36	3.8	3.6	16.3	34.7	64
Papua New Guinea	3	20	15.2	8.7	0.4	2.7	80

¹ World Development Report, World Bank 1981² The Gambia PHC Action Plan 1980/81 - 85/86. Banjul Ministry of Health Oct/Nov 1979 (Figures 1979/80)³ 1972 Country Health Information Profile. Peoples Republic of China. WHO/WPRO/HST/HPU Nov 1975⁴ 1967 - Country Health Programming - Republic of Maldives - Ministry of Health March 1980⁵ 1979/80 The Work of WHO in the African Region 1970-80. Biennial Report of the Regional Director AFR RC 31/3 1981⁶ International Drinking Water Supply and Sanitation Decade. Present Situation Prospects. Report of Secretary General. UN 18 Sept 1980.