

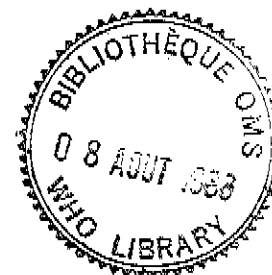
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# ALMA-ATA REAFFIRMED AT RIGA



A Statement of Renewed and Strengthened Commitment  
to Health for All by the Year 2000 and Beyond

adopted at a WHO meeting:

## FROM ALMA-ATA TO THE YEAR 2000:

A midpoint perspective

Riga, USSR  
22-25 March 1988



World Health Organization  
Geneva

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## PREFACE

At the mid-point in time between the historic Alma Ata Conference, in 1978, and the year 2000, a meeting was convened by WHO to review progress and problems experienced in pursuing the goal of health for all and to consider reassessments that might be necessary in order to proceed more effectively towards the goal of health for all by the year 2000, and beyond.

The meeting was held in Riga, USSR, from 22 to 25 March 1988, and brought together experts from all WHO regions as well as representatives of UNICEF, UNDP and nongovernmental organizations.

The participants concluded that the health for all concept has made strong positive contributions to the health and well-being of people in all nations. Nevertheless, they noted that problems remain which call for increased commitment and action to ensure more effective implementation of primary health care.

They strongly reaffirmed the Declaration of Alma Ata and called for the principles and spirit of health for all to be made a permanent goal by all countries.

## INTRODUCTION TO THE ACTIONS AT RIGA

At the International Conference on Primary Health Care held in Alma-Ata in 1978 the nations of the world joined together in expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world.

These concerns, expressed at the World Health Assembly in 1977, were emphasized again in the Declaration of Alma-Ata which stated: that a main social target should be the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life; and that primary health care is the key to attaining this target as part of development in the spirit of social justice. It was also stated that health, peace and development are intimately related to one another, and that each must be pursued and protected in the interests of the well-being of mankind.

The experiences of the Member States in health development over the ten years since the Alma-Ata conference make it clear that the concepts and principles of health for all have provided the world with moral, political, social and technical guidance that has enabled countries to deal forthrightly with the problems of inequity in health care and the ill health of their populations.

This period has also demonstrated the potential importance of political action in contributing to health for all, such as action to decrease military confrontations and reduce defence expenditure, improve trade and economic relations, and the efforts to help resolve the problems of external debt.

Most countries have made considerable gains in increasing the equity and effectiveness of health services and in improving the health and well-being of their populations, thus affirming the validity and strategies of WHO's goal of health for all. Some striking examples can be given of improvements in coverage, effectiveness and quality of programmes:

- immunization rates in most countries of the world have increased from about 5% of children in developing countries in 1970, to more than 50% in the late 1980s.
- decreasing infant, under-five and maternal mortality rates are evidence of remarkable progress in many countries, whose under-five mortality rates have decreased by more than 50% since 1950.
- many countries have based their national health policies on the concepts of health

for all, emphasizing health promotion, including improvements in life-styles, and decentralizing initiative to districts, cities and local communities.

Despite widespread progress, it is evident that the gains have not been uniform, either between countries or within them. All countries recognize the need perpetually to fight against ill health even though the nature of health problems will change. Looking ahead to the turn of the century and beyond, it is clear that maintaining health and ensuring equity must be a permanent goal of all nations.

Moreover, a number of the least developed countries have made only very limited progress: their infant, young child and maternal mortality rates and related morbidities remain unacceptably high. Projections of current trends to the year 2000 indicate that these mortality rates will persist at tragically high levels for many of those countries. For example, in many countries of Africa and Southern Asia mortality rates for children under five will still be well over 100 per thousand in the year 2000.

Health problems are also increasingly serious in large urban populations steeped in poverty.

Thus, health conditions in the least developed countries persist at levels that are so limiting and destructive of human potential and so contrary to the principles and intent of health for all, as to be unacceptable to the global community.

It is urgently necessary to recognize and acknowledge that many of the most serious health problems still remain largely untouched by development efforts. These residual problems, that contribute so heavily to the human burden of death and disability, sound an insistent call for careful assessment and more vigorous application of current approaches, as well as for new approaches - new research, new mechanisms, new partnerships, new resources - in order that these problems may be overcome.

The world is faced with variable progress in pursuit of the goal of health for all, remarkable gains by many countries, modest gains by others, and, for a tragic few, little progress at all. To address the range of persisting problems and to establish preparedness for problems that will emerge in the future, the following action must be undertaken:

## THE PERMANENCE OF HEALTH FOR ALL

### I. Maintaining health for All as a permanent goal of all nations up to and beyond the year 2000

Reaffirm Health for All as a permanent objective of all nations, as stressed in the Alma-Ata Declaration, and establish a process for examining the longer term challenges to Health for All that will extend into the 21st century.

It is clear that the principles and values contained in the Declaration of Alma-Ata that underlie Health for All should be seen as having a permanent place in the responsibilities of nations with respect to the health of their peoples. No nation solves all of its health problems, and new problems continue to emerge in every country. These are biological and social realities of life.

In every nation there will be continuously changing patterns of health and disease, and always there is the national responsibility for dealing with those problems so as to safeguard the health of the people and ensure equity and promote a spirit of self-reliance.

The goal of the year 2000 continues to be a milestone of great significance. Associated with it are imperatives that identified targets be met in every country, but with particular emphasis on mortality and morbidity reduction in vulnerable groups in all countries.

At the same time, it is necessary to look over the horizon, beyond the turn of the century to the problems of that time, some continuing from the present, others emerging as entirely new. The capacity for dealing with those problems will be strengthened further between now and the year 2000. It is likely that a very important long-term contribution of the Health for All movement will be to establish in every country, and in every community, an evolving capacity to deal with the health problems of that place and time.

Thus, the goal of HFA remains unchanged, but targets will shift from those suited to the decade preceding the year 2000 to those relative to future times and places. Key principles will remain - equity, effectiveness, affordability, community participation, intersectoral collaboration. Problems will change, as will the technologies and social and organizational mechanisms to grapple with them.

Here, at the mid-point between Alma-Ata and the year 2000, the goals of all nations should be:

- to identify the critical challenges to be met between now and the turn of the century, and to make headway, even against the problems that have been most difficult to solve;
- to lay the ground for the continuing work that must follow the turn of the century, heralding appropriate changes of strategy necessary to consolidate the pursuit of Health for All beyond the year 2000;
- to continue to recognize and affirm that health, peace and development are intimately related to one another, and that each must be pursued and protected, in the interests of the well-being of mankind.

## **INTENSIFYING SOCIAL AND POLITICAL ACTION FOR THE FUTURE - AGENDA 2000**

### **II. Renewing and strengthening strategies for Health for All**

**Each country should continue to monitor its own health problems and develop its own health strategies in the spirit of Health for All. This will reveal its most pressing health problems and identify the most seriously underserved and vulnerable populations. Programmes should be directed towards those populations in the spirit of equity, inviting their active participation in the development and implementation of the strategies.**

It should be acknowledged and affirmed that the concept of Health for All by the year 2000, formulated at the World Health Assembly in 1977, and further elaborated at Alma-Ata in 1978, has provided the countries of the world with moral, political, social and technical guidelines that have enabled and encouraged them to deal more effectively with the problems of health inequity and ill health of their populations.

In keeping with the goal of Health for All, the majority of nations and regions have made substantial progress in dealing with their problems of inequity and ineffectiveness of health services, and have significantly improved the health of their populations. All nations should continue those efforts, and, in collaboration with each other and with WHO, should pursue further targets of improvement of the health of all their people so as to ensure that every citizen has the opportunity to live a socially and economically productive life. Such improvements should go beyond physical and mental illness to the

quality of life itself. Resources required to meet those targets should be identified and allocated accordingly.

In this spirit, special priority should be given to improving the health conditions of the poor and underserved, in the developed as well as the developing world, and in this way to reduce inequity. Steps should be taken to establish and pursue targets for reducing disparities in both health status and access to health services between disadvantaged population groups and the general population, for example, by reducing the differences from the national mean in under-five mortality rates, infant mortality rates and maternal mortality rates.

It has to be re-emphasized that the concept of Health for All has never included the simplistic notion that the world would ever be free of health problems. The purpose of Health for All is to provide a conceptual framework for thinking about the multiplicity of problems, for guiding decisions about priorities and action with a special concern for equity in health, and for sharing experiences, problems and ideas with other nations in order to promote health and reduce health inequities. It is recognized as well that both international and national policies must be adapted to local settings, where local people can bring about improvements in their own situations.

The procedures for monitoring and reporting on progress towards Health for All are an important example of WHO support for sharing national experiences. They should be further strengthened to ensure that countries will benefit from each other's lessons and be inspired by examples of progress.

### **III. Intensifying social and political action for health**

**Intensify social and political actions necessary to support shifts in policy and allocation of resources required to progress towards Health for All, including the involvement of other sectors, nongovernmental organizations, communities and other interested groups. Seek mechanisms for promoting new partnerships for health among them and with government.**

Social and political action, both national and international, is imperative for progress in health development, not only to support the shifts in policy and support required to have a stronger impact on health, but also to enlist the participation of the wide variety of potentially interested parties - international organizations, nongovernmental organizations, universities, industry, student groups, individual citizens, health workers

and their associations - many of whom are waiting for indications of useful directions in which to apply their resources and energies. These should be true partnerships, with active sharing of ideas, resources and responsibilities. The mass media should be used to inform others about the needs of Health for All, and advocate efforts to meet them.

Political commitment is a prerequisite to progress towards Health for All, but by itself may have limited practical value. Also vital are policies, which embody the commitment to work towards Health for All; budgetary allocations, which are the litmus test of political commitment; structural rearrangements, which may be necessary for policy implementation; and strengthening of management, to progress towards targets and avoid excessive waste. In addition, assignment of strong leadership to key posts, and continuous support for primary health care at the district level can help to ensure that effective services reach the periphery through planned programmes rather than by only trickling down.

There is also an urgent need to challenge current international development philosophies that discount investment in health and other social sectors in favour of economic improvement only. Efforts should be undertaken to enhance the international climate for development support, including policies which focus on social equity rather than economic considerations alone, which recognize the long term nature of social development, and which promote wider understanding and acceptance of the development process including respect for the people who are involved in its implementation. Economic policies should protect those who are most vulnerable and least able to protect themselves from economic penalties, and should recognize the contribution of social development to long term economic progress. It is necessary to acknowledge that health is a fundamental right in addition to being a prerequisite to development.

National and international action is required to mobilize new resources, create new mechanisms and new partnerships for health development, including joint mobilization of resources between health and other sectors. WHO should assume a leadership role in this effort by promoting debate and supporting initiatives on the feasibility of new approaches in favour of the most vulnerable groups.

A special effort should be directed towards enlisting joint efforts by major developed countries towards assisting the least developed countries. Savings achieved through reductions in arms expenditure would serve this purpose well.

#### IV. Developing and mobilizing leadership for Health for All

Give strong emphasis in every country to developing and stimulating the interest and support of current and potential leaders in health and other sectors, at community, district, and national levels, in order to bring creativity, advocacy, commitment and resources to bear on the challenge of health development.

Enlightened leadership for Health for All is in short supply. Is it possible to achieve a major shift, in which those who can assume such leadership positions become more plentiful, rather than occasional, and in the front line, rather than only remote from need?

At its core, Health for All is a value issue. But the problems it addresses are also quantitative - all people, not some. All children are to be monitored, not some. The impact of Health for All must be quantitatively effective. The numbers of people who assume leadership roles for Health for All must be quantitatively significant. Their influence must be pervasive.

But the quality of leadership is also vital. Those in positions where leadership is possible must understand the principles and imperatives of Health for All, have a clear view of what is needed, what might be done to achieve it, how to function in their local situation to progress towards it, and how to mobilize others to join in working towards it.

There is a clear need for leadership in health and in other sectors at every level: in communities, where the need is for self-reliance; in nongovernmental organizations, where their flexibility and creativity can be brought to bear on problems of national interest; in universities, where their capacity for generating and trying new ideas and new programmes can contribute to the effectiveness of health policies and services; in government, where the responsibility resides for reaching the poorest and most deprived, and where effective policies and programmes in pursuit of Health for All must be developed.

Ministries of Health must deal with multiple levels of policy formulation and resource allocation, including the parliament or its equivalent. Those in policy-making roles often need support in the form of policy-related research that will assist them in formulating strategy options. Managerial leadership is required, including the capacity to manage the changes that are vital for progress towards Health for All. Leadership is needed to help redress the current imbalance between social and economic development.

There is a paradox about leadership. Formally trained and experienced leadership is in short supply, and often over-used. At the same time, there are vast numbers with

leadership potential who are untrained and inexperienced. Those already in leadership roles, often too few in number, need support, while at the same time training and experiential opportunities need to be created for others. Incentives need to be developed to help sustain those in leadership roles.

Beyond all else, leadership is to be people-centred.....people leading people in order to benefit people. The ultimate impact is to be at the community level, where the need is the greatest and the opportunity to respond must be extended to those who are on the path towards self-reliance. Leadership formation must be a central theme in the larger scope of health manpower development.

## V. Empowering people

**Empower people by providing information, technical support, and decision-making possibilities, so as to enable them to share in the opportunities and responsibilities for action in the interest of their own health. Give special attention to the role of women in health and development.**

Involvement of communities in primary health care is not an ethical nicety, it is a technical and social necessity. Key advances in health of communities depend on their decisions - about how they live, care for one another and look after their environment. Important promotive, preventive, first aid and rehabilitative actions can be undertaken by people in their own homes and communities. Services that are 'delivered' from the outside will have limited effect unless fully understood, absorbed and taken over by communities.

Health services should fully involve communities: in defining problems, about which communities often have intimate knowledge; in decision-making, in which communities have both a right and a responsibility; in financing, where community resources can be both essential contributions and a lever to ensure that the people's voice is heeded. Health services need to reach the home, family and place of work, through local people trained in or near the community, to provide ready access to health assistance as required. Health personnel must learn how to organize and support community involvement.

The role of women in promoting healthy ways of life is essential. They need to be given opportunities for self-improvement and to contribute to the development and quality of life in their communities, including extending their activities beyond family life to policy-making and implementation. Education alone may not suffice to put women in positions to take effective action - some degree of autonomy or independence is required for them to make decisions and take actions necessary to promote improvements in health

for themselves and their families. Empowering women includes giving them control over their own lives, bodies and family size.

Health is mainly determined in the home and the workplace, where families live and work in healthy or unhealthy ways, where behaviour is influenced by family, neighbours and fellow workers, and where decisions are made that affect every aspect of family health. People must be given information about their health and how it can be improved. For them to lack such knowledge leads to both dependency and ignorance, neither of which has a place in community development. People should participate in determining what kinds of information and education they need for their individual community development. The views of health professionals about community needs may conflict with people's perceptions - differences that require harmonization through better dialogue. Health services must help them to learn how to care for themselves.

The health of the family depends on the health status of all family members; the father and other members of the household should not be overlooked, even though priority is given to the mother and child. Attention to the others, as through assessing their health risks, also serves the interests of the mother and child, and supports the integrity of the family unit. Empowerment should go beyond mothers and fathers to their children, tomorrow's generation, who can be reached through schools and youth groups.

## **VI. Making intersectoral collaboration a force for Health for All**

**Support the creation of sustained intersectoral collaboration for health by incorporating health objectives into sectoral policies and activating potential mechanisms at all levels.**

It is widely recognized that health is not the concern of the health sector alone but is dependent on the actions of many social and economic sectors, both governmental and nongovernmental. Education for literacy, income supplementation, clean water and adequate sanitation, improved housing, ecological sustainability, food and other agricultural products, building of roads - all may have a substantial and synergistic impact on health. Nevertheless, few innovative examples exist of sustained intersectoral collaboration for health.

It is apparent that sectoral priorities and administrative structures usually preclude the sharing of ideas, joint planning and collaborative action. This problem has been exacerbated by poor advocacy and lack of commitment to the idea of intersectoral collaboration by the health sector itself.

At the very time when lack of resources for health is universally proclaimed as a most serious problem, it is neither rational nor defensible to ignore the potential of shared responsibility between sectors. Intersectoral collaboration must be made a force for achieving Health for All.

Many practical possibilities for action exist. Identification of vulnerable groups and cross-sectoral assessment of their needs can provide the basis for collaboration at community level. Involvement in the process by people themselves adds to its effectiveness. Existing intersectoral mechanisms such as district development committees need to be further utilized by the health sector. This will require more effective advocacy on the part of health personnel in relating to other sectors. At national level ways of strengthening sectoral policies need to be found so as to maximize the impact of health enhancing actions whilst eliminating or reducing the impact of those that are harmful. The particular energies and interests of nongovernmental organizations may serve as important catalysts in all of these.

At all levels research jointly pursued by collaborating sectors can be an important tool for identifying ways of making intersectoral collaboration work.

## **ACCELERATING ACTION FOR HEALTH FOR ALL - AGENDA 2000**

### **VII. Strengthening district health systems based on primary health care**

**Strengthen district health systems based on primary health care, as a key action point for focusing national policies, resources and local concerns on the most pressing health needs and underserved people.**

District health systems based on primary health care should be at the centre of the Health for All effort. Acceptance of primary health care is fairly general at policy levels, but implementation that achieves widespread coverage is often absent, especially in the least developed countries. The problem is only partly due to scarcity of resources. There are weaknesses in planning, management, financing and evaluation capacities, and in training and providing effective support for personnel in field settings.

More attention needs to be given to strengthening health infrastructures. Given an effective infrastructure, primary health care programmes can be added or deleted according to local need, targeted at specific problems. Emphasis should be on integrated or comprehensive primary health care, in contrast to selective or vertical structures, which

often lead to over-concentration of limited resources on a few programmes, and disruption of efforts to strengthen health systems based on primary health care as an integral part of community development.

A further deficiency is the inability and even disinterest in monitoring simple indicators of coverage and health status. These deficiencies result in systems that are blind to programme impacts and powerless to correct drift or failure. Here is the heart of Health for All's challenge - equity. Without a system design that can achieve coverage, without simple indicators to identify inequities and measure success or failure in dealing with them, without effective management, including a capacity for self-correction, without involving the community at all levels, equity becomes a lost hope.

Another weakness is the lack of supportive interaction between the district and higher levels of health services on the one hand, and with community level activities on the other. Strongly centralized decision-making discourages initiative at the periphery, while exclusive interest in health facilities and doctor-based services results in little support to community level activities. TCDV - Technical Cooperation among Developing Villages - can be encouraged through district health systems. To facilitate such activities, decentralization to district and community levels is essential.

The district is well suited to overcoming problems of health services in relation to community development including: preparation of health personnel for effective functioning in district programmes; management technologies; interaction with communities; and intersectoral working relationships.

Primary, secondary and tertiary care levels of a health system involve vital interactions that are usually missing in health services, and the district health system is the ideal place to develop them. One of the most difficult linkages to establish among the levels of health services is between the front-line or district hospital and community-based primary health care. Maternity services, based in the community and backed-up by the front-line hospital, are one example of a challenge to primary health care that demands such effective linkages in order to save the lives of women with complications of pregnancy and delivery.

### VIII. Planning, preparing and supporting health personnel for Health for All

Change educational and training programmes for health personnel emphasizing relevance to health services requirements by locating learning experiences in functioning health systems based on primary health care. Provide strong moral and resource support for personnel, particularly those working in remote or difficult circumstances.

The deficiencies are deep and widespread - professionals inadequately trained to motivated to work where the needs are. Three aspects of health manpower development need emphasis:

- Recruitment and training are too often separated entirely from planning and utilization - a reason for WHO's emphasis on integrated health systems and manpower development (HSMD). But the integration must be more than a paper exercise; education and training should relate to and also take place in field settings where operational primary health care programmes embody a large part of the desired manpower competencies. Training and uses of community and auxiliary level personnel need to be closely related to that of other health workers. Health manpower policies should be consistent with national Health for All strategies.
- The preparation of health personnel needs to be strengthened in terms of relevance to health services and to people's health needs and demands, as in competency-based, community-oriented, team-focused learning experiences, and also in terms of educational methodologies, as in community-based, problem-oriented, student-oriented, self-learning experiences. More than academic jargon, these are key ideas in the interactions between education and function.
- Less well appreciated is the severe demoralization of health personnel in many field settings, particularly in more remote locations. The neglect and unresponsiveness of health services in this respect is consistent, widespread and destructive. Neglect often leads to a sense of uselessness and lack of motivation, and, when such despondency occurs, loss of dependability and integrity are not far behind. Better management practices and personnel support systems could incorporate supportive policies, such as: incentives for exemplary work and assignment in hardship settings; amenities to improve the quality of family life; continuing education; and career development opportunities.

Universities and other training institutions have key roles to play in addressing these issues, by linking their educational, research and services programmes directly with national plans for health system and manpower development. Universities should be

involved in community-based primary health care activities where various kinds of students can learn, as team members, how to address health and health system problems in community settings. Early exposure to community-based problems, and to interactions of epidemiology and management can be emphasized. In these settings, students can also learn about the needs of field-based health personnel for support and professional encouragement.

Thus, the concept of health system and manpower development leads the university beyond the more traditional concept of the teaching hospital to a teaching health system. Through association with a functioning health system, the university has the opportunity for ensuring close relevance between educational preparation and national needs, and also for contributing to improvements in the field-based health services research.

#### **IX. Ensuring the development and rational use of science and appropriate technology**

**Emphasize the applications of science and appropriate technology to the critical health problems that threaten populations in all parts of the world, and strengthen research capacities of developing countries, with emphasis on research aimed at improving the health of the most deprived people.**

Science has much to offer Health for All. Some problems call for most advanced scientific insight and methodologies almost on an emergency scale, as in grappling with the AIDS pandemic. There are other calls on science, some less dramatic, but no less important, for example new applications of diagnostic methods that can be used even in remote locations. New vaccines will strengthen health services, and new techniques for the control of tropical diseases will ease the burden of suffering on countless lives.

However, the most serious deficiencies in improving health in developing countries do not relate to a shortage of technology, but to inadequacies of health system infrastructures and the high cost of making technology available to all in need. This fundamental deficiency is often compounded by the indiscriminate transfer of technology to developing countries. The result is the consumption of scarce resources which could be used more effectively in primary health care programmes.

Technology assessment has an important place in assessing costs and impacts of alternative technologies. The costs of the transfer of technology may be more than that of the technology itself. Applying existing knowledge and technology when they are effective is an

imperative first step. The utility of traditional versus modern technologies needs to be kept in view. Good maintenance can reduce overall costs and ensure reliable functioning of technologies. Educational methods are an important consideration in transferring appropriate technology from country to country to country and sector to sector.

Most problems of developing countries cannot be solved by indiscriminate technology transfers. Solutions must be developed on the spot, and capacity building in research is essential, based on a clear view of the range of technological choices involved, and a detailed knowledge of local research capacities. This is an ideal enterprise for North-South collaboration. Emerging needs for enhanced research capacity must be addressed in the context of extreme resource constraints and the search begun, nonetheless, for new resources, new mechanisms, and new partners. Operations research or health services research have great practical utility in dealing with problems at field level.

Attention should also be given to the ethical implications of advances in technology. When the technology is beneficial but costly, questions of equity and autonomy arise: who should benefit and who should be passed by, and what are the roles of individuals and communities in making such decisions?

Thus, a balanced strategy is needed for applying the benefits of science and technology to health worldwide. There should be strong support for the enhancement of scientific research and education in all countries. Continued global efforts should be directed towards strengthening health research capacities of scientists from developing countries and their institutions, so they might collaborate in a global research network.

#### **X. Overcoming problems that continue to resist solution**

**Establish priority programmes aimed at overcoming serious problems where under-development or disturbances of development are major contributing factors and progress has been very limited, such as high infant, child and maternal mortality rates; substance abuse, such as tobacco and alcohol; and the imbalance between population growth and environmental and socioeconomic resources. Develop improved approaches through primary health care emphasizing intersectoral action.**

The most serious problems to be addressed between now and the year 2000 will be those which resist solution largely because of underlying conditions of severe under-development, as in the least developed countries, or under conditions of long established patterns of personal and social behaviour, as in developed countries. It is necessary to be

clear, however, that the people are not the causes of these problems, they are the victims...of under-development or 'development-gone-wrong' ... and solutions must address those development problems at their roots, and not simply blame people for circumstances the world has given them. Examples can be taken from both developed and developing countries:

**Very high maternal and under-five mortality rates.** Sixty-four countries with 40% of the world's population suffer more than 80% of the under-five deaths, and more than 90% of maternal deaths occurring in the world each year. These high death rates are embedded in the problems of under-development - poverty, malnutrition, illiteracy, and contaminated environments - and remain unresolved in a large number of countries despite widespread knowledge of how to deal with the problems.

**Underdevelopment, population growth and environment.** A number of developing countries face serious problems of socioeconomic underdevelopment: ineffective agricultural development, landlessness of populations, migration of rural populations to urban centres, poverty, weakness of health systems, including family planning services based on primary health care, and poor environmental health. These examples show the importance of a multisectoral approach to the solution of health problems on the part of national authorities and international organizations.

**The expanding use of tobacco and its commercial exploitation.** The continued use of tobacco in developed countries, and its expanding use in developing countries, with commercialization pursued in the face of irrefutable scientific evidence of human harm is an example of a global problem that calls for continued aggressive action to combat it at all levels: political, social, scientific and economic.

Other examples can be given of problems embedded in the process of development in both developing and developed countries: alcohol and drug abuse; environmental pollution; enlarging and dependent aging population; unwanted pregnancies and illegal abortion.

Efforts to address these problems must be directed at the underlying problems of development. Primary health care, with its strong emphasis on intersectoral collaboration provides avenues for addressing the problems. However, new approaches are also called for: new ways of analysing the problems, new approaches to field-based research, new forms of interacting with other sectors, and new scales of action.

## **SPECIAL PRIORITY INITIATIVE IN SUPPORT OF THE LEAST DEVELOPED COUNTRIES BY WHO AND THE INTERNATIONAL COMMUNITY**

**Establish a special international effort focused on the tragic circumstances of the least developed countries, especially those with markedly elevated infant, under-five and maternal mortality rates, which will address specific obstacles to progress and will set targets to be reached by the year 2000.**

While most countries have benefited from the Health for All movement, a tragic residue suffering from death and disability is so extreme as to leave no doubt that they are being by-passed by even the barest of opportunities to progress towards some minimal levels of human dignity and wellbeing.

It must be appreciated that these nations are not the cause of these problems of development stagnation; rather they are the victims of it. They have been marginalized by it, and to a large extent they have been abandoned to it. The resources and processes involved in international development have failed these people, and the Health for All effort has thus far failed them as well.

In order to confront this unacceptable situation it is proposed that the World Health Assembly declare its commitment to helping these tragedy-ridden countries fully into the development process. This will require special and urgent priority on the part of WHO to support the poorest countries, particularly those with the highest infant, under-five, and mortality rates. More extensive resources and stronger commitment than heretofore available are urgently needed.

The World Health Assembly should further undertake to monitor the outcome of this effort. The rate of progress should serve as an indicator of the effectiveness of the resolve of Member States in dealing with this most fundamental of challenges - countries which, without effective development assistance and collaboration,, will likely slip further down the spiral of development failure.

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