

**The  
World Health  
Report  
1995**  
*Bridging the gaps*

*Executive Summary*



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1995*

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# The World Health Report 1995

## Bridging the gaps

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*For most people in the world today every step of life, from infancy to old age, is taken under the twin shadows of poverty and inequity, and under the double burden of suffering and disease.*

### **The state of world health**

**T**he world's biggest killer and the greatest cause of ill-health and suffering across the globe is listed almost at the end of the International Classification of Diseases. It is given the code Z59.5 – extreme poverty.

Poverty is the main reason why babies are not vaccinated, why clean water and sanitation are not provided, why curative drugs and other treatments are unavailable and why mothers die in childbirth. It is the underlying cause of reduced life expectancy, handicap, disability and starvation. Poverty is a major contributor to mental illness, stress, suicide, family disintegration and substance abuse. Every year in the developing world 12.2 million children under 5 years die, most of them from causes which could be prevented for just a few US cents per child. They die largely because of world indifference, but most of all they die because they are poor.

In the time it takes to read this sentence, somewhere in the world a baby has died in its mother's arms. For that mother, the message that her neighbour's infant will live is no consolation. It does not stem her grief to know that 8 out of 10 children in the world have been vaccinated against the five major killer diseases of childhood, or that globally since 1980 infant mortality has fallen by 25%, while overall life expectancy has increased by more than 4 years, to about 65 years.

Beneath the heartening facts about decreased mortality and increasing life expectancy, and many other undoubted health advances, lie unacceptable disparities in health. The gaps between rich and poor, between one population group and another, between ages and between

the sexes, are widening. For most people in the world today every step of life, from infancy to old age, is taken under the twin shadows of poverty and inequity, and under the double burden of suffering and disease.

For many, the prospect of longer life may seem more like a punishment than a gift. Yet by the end of the century we could be living in a world without poliomyelitis, a world without new cases of leprosy, a world without deaths from neonatal tetanus and measles. But today the money that some developing countries have to spend per person on health care over an entire year is just US \$4 – less than the amount of small change carried in the pockets and purses of many people in developed countries.

A person in one of the least developed countries in the world has a life expectancy of 43 years according to 1993 calculations. A person in one of the most developed countries has a life expectancy of 78 – a difference of more than a third of a century. This means a rich, healthy man can live twice as long as a poor, sick man.

That inequity alone should stir the conscience of the world – but in some of the poorest countries the life expectancy picture is getting worse. In five countries life expectancy at birth is expected to decrease by the year 2000, whereas everywhere else it is increasing. In the richest countries life expectancy in the year 2000 will reach 79 years. In some of the poorest it will go backwards to 42 years. Thus the gap continues to widen between rich and poor, and by the year 2000 at least 45 countries are expected to have a life expectancy at birth of under 60 years.

In the space of a day passengers flying from Japan to Uganda leave the

*The number of children under 5 years who died in 1993 equals the entire populations of Norway and Sweden combined.*

country with the world's highest life expectancy – almost 79 years – and land in one with the world's lowest – barely 42 years. A day away by plane, but half a lifetime's difference on the ground. A flight between France and Côte d'Ivoire takes only a few hours, but it spans almost 26 years of life expectancy. A short air trip between Florida in the USA and Haiti represents a life expectancy gap of over 19 years.

The purpose of the report is to highlight such inequities and to tackle the wider question: what are the global health priorities? It also tries to answer other crucially important questions. Which are the major diseases, the major causes of death, handicap, disability and diminution of the quality of life? Which conditions cause most misery, although they may not be fatal? Which countries, or communities within countries, have the greatest health needs? Where should health resources be targeted?

The report, for the first time, has attempted to examine the burden of ill-health not just by disease, but also by age, as the impact of illness differs across the age spectrum. Where possible, the analysis of health status has been carried out for infants and children, adolescents, adults and the elderly. On the basis of the data available and considered to be reasonably reliable, ten leading causes of death, illness and disability have been identified. There is also an explanation of what WHO is doing to bridge the gaps in health, an attempt to assess health trends in the coming years, and an effort to chart a health future for mankind – a future in which a baby lives, not dies, in its mother's arms.

### **Child health**

The number of children under 5 years who died in 1993 – more than 12.2 million – equals the entire populations of Norway and Sweden combined. Of such deaths in the developing world, the great majority could have been avoided if those countries enjoyed the same health and social conditions as the world's most developed nations. The gap

between the developed and the developing world in terms of infant and child survival is one of the starkest examples of health inequity.

The estimated global figure for mortality among children under 5 years in 1993 was 87 per 1 000 live births, an encouraging fall from rates of 215 during the period 1950-1955 and of 115 in 1980. Yet in parts of the developed world only 6 out of 1 000 liveborns die before reaching age 5, whereas in 16 of the least developed countries the rate is over 200 per 1 000, and in one country it is 320 per 1 000.

Infant mortality – deaths of children under 1 year – varies from 4.8 per 1 000 live births to 161 – a 33-fold difference. The gap in infant mortality between developed and developing world narrowed by 50% during the years 1960-1993, from 113 to 54 per 1 000 live births. But at the same time the gap widened between least developed and developing countries.

Malnutrition contributes substantially to childhood disease and death but often goes unrecognized as such. In 1990 more than 30% of the world's children under 5 years were underweight for their age. As many as 43% of children in the developing world – 230 million – have low height for their age. Micronutrient malnutrition is estimated to affect at least 2 billion people of all ages, but children are particularly vulnerable. As a result of iodine deficiency – a public health problem in 118 countries – at least 30 000 babies are stillborn each year and over 120 000 are born mentally retarded, physically stunted, deaf-mute or paralysed. A quarter of all children under age 5 in developing countries are at risk of vitamin A deficiency.

There have been improvements in child health, and 1993 saw the number of children dying from vaccine-preventable diseases reduced by 1.3 million compared to 1985 – equal to the population of Trinidad and Tobago. Nevertheless, around 2.4 million children under 5 years are still dying every year from such diseases, particularly measles, neonatal tetanus, tuberculosis, pertussis,

poliomyelitis and diphtheria. There are also worrying signs that recent immunization gains are being eroded or even reversed by economic and social conditions.

Every year in the developing world acute respiratory infections, particularly pneumonia, kill more than 4 million children under 5 years – one death every 8 seconds – and are a leading cause of disability. They account for 30-50% of visits by children to health facilities everywhere. Significant reductions in mortality could be achieved by treating the underlying bacterial infections with low-cost antibiotics for a few days.

Diarrhoeal diseases, resulting from unsafe water and poor sanitation coupled with poor food-handling practices, are responsible for a further 3 million deaths a year among children under age 5 in the developing world – one every 10 seconds – and are a graphic example of the deadly synergy of poverty and lack of knowledge. Worldwide there are an estimated 1.8 billion episodes of childhood diarrhoea annually. Many of the deaths from diarrhoea could be prevented by using oral rehydration salts, which cost just US \$0.07 on average.

### **Health of school-age children and adolescents**

Across the world some 2.3 billion people, about 40% of the total population, are aged under 20. Although teenagers and young adults are generally healthy, they are among the most vulnerable in terms of the diseases of society – poverty, exploitation, ignorance and risky behaviour. In squandering the health of its young, the world squanders its tomorrows. The behaviour patterns established in adolescence, highly influenced by the adult world, are of immense importance to an individual's life span and to public health as a whole.

In many countries health services are not meeting adolescent needs, and there are concerns that education, training and jobs for the young are inadequate. Education is a vital, although often unrecognized, contributor to the well-being and sensible fertility practices

of young people, because schooling is closely linked with health status and pregnancy rates. A blackboard and piece of chalk can be as influential as antibiotics and contraceptives in protecting health. Improving the education of adolescents in general, and girls in particular, is one of the most effective ways to promote equity, enhance development and protect health for all.

The desire for sex and a fulfilling relationship are powerful driving forces for most young people, who at the same time are under pressure to engage in sexual relationships too early. Yet many young people are denied even basic knowledge about their own bodies or the means to protect themselves from unwanted pregnancy and sexually transmitted diseases (STDs). These diseases are most frequent in younger sexually active people, and appear to be increasing worldwide. The highest rates for notifiable STDs are generally seen in the 20-24 age group, followed by those aged 15-19 and 25-29. In nearly all parts of the world the peak age of infection is lower in girls than in boys.

At the same time HIV and AIDS are having a devastating effect on young people. In many countries in the developing world, up to two-thirds of all new HIV infections are among people aged 15-24. Overall it is estimated that half the global HIV infections have been in people under 25 years – with 60% of infections of females occurring by the age of 20. Thus the hopes and lives of a generation, the breadwinners, providers and parents of the future, are in jeopardy. Many of the most talented and industrious citizens, who could build a better world and shape the destinies of the countries they live in, face tragically early death as a result of HIV infection.

Other health dangers facing adolescents include tobacco, alcohol and other drug misuse, their exploitation as cheap and often illegal labour, and the worrying growth in the numbers of street children. Recent estimates suggest there may be as many as 100 million street children, at high risk of malnutrition, infectious diseases, STDs including HIV/AIDS, and criminal and sexual

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exploitation. The rise in accidents, violence and suicides involving young people in many parts of the world is a cause for deep concern.

### **Health of adults**

Globally about 51 million people of all ages died in 1993, about three-quarters of them adults. Some 39 million deaths took place in the developing world and about 12 million in the developed. Poor countries had three times more deaths than rich ones.

Communicable diseases such as tuberculosis and respiratory infections as well as maternal, perinatal and neonatal conditions account for about 20 million, or about 40%, of the 51 million global deaths; and 99% of these occur in the developing world.

Noncommunicable diseases such as cancer and heart disease account for about 19 million deaths, or 36% of the global total, divided more or less equally between the developing and the developed world. The great majority of such deaths are among adults.

External causes such as accidents and violence account for about 4 million deaths, or some 8% of the total, again mostly among adults. Developing countries have nearly four times the number of deaths from these causes as the developed world. Other and unknown causes account for the remaining 16% of deaths worldwide.

Maternal complications claim another 508 000 lives a year.

Of the 20 million deaths due to communicable diseases more than 16 million, or about 80%, are due to infectious and parasitic diseases. Tuberculosis kills about 3 million people, malaria around 2 million and hepatitis B possibly 1 million.

Among the major communicable diseases, tuberculosis was responsible for more than 5% of the global total of deaths - over 7 000 a day - and it is estimated that there will be 8.8 million new cases in 1995 - equal to more than 1 000 new cases every hour of every day. Drug treatment, in most cases costing as little as US \$13-30 per person for a six-month course, can cure people; but

providing the drugs to those who need them, and ensuring that patients take them for the required period, is a major public health challenge.

Meanwhile the lethal relationship of tuberculosis with HIV is making the death toll many times worse. During the next 10 years in Asia alone it is estimated that tuberculosis and AIDS together will kill more people than the entire populations of the cities of Singapore, Beijing, Yokohama and Tokyo combined.

Malaria, directly or in association with acute respiratory infections and anaemia, causes around 2 million deaths a year, the vast majority among young children, and some 400 million cases annually. Globally more than 2 billion people are threatened. The estimated direct and indirect cost of the disease in Africa alone is expected to reach US \$1.8 billion by 1995.

Cholera has become endemic in many countries in Africa, Asia and Latin America. In 1993 there were 377 000 new cases reported and only 6 800 deaths. Nevertheless, the number of cases and deaths remain at far higher levels than those reported earlier.

Among the other communicable diseases, dengue and dengue haemorrhagic fever are now the most important and rapidly rising arbovirus infections in the world. There are millions of cases annually, with approximately 500 000 people needing hospital treatment, and thousands of deaths. The ancient scourge of leprosy still causes 600 000 new cases a year. Between 2 and 3 million people are disabled by the disease, including those who have been cured but crippled in some way prior to treatment. Onchocerciasis (river blindness) infects 18 million people in 34 countries, while dracunculiasis (guinea-worm disease) causes terrible suffering and disability among 3 million of the world's most deprived people who have no access to safe water. Chagas disease affects 17 million people in 21 countries in Latin America and causes 45 000 deaths and 400 000 cases of heart and stomach disease annually. African trypanosomiasis (sleeping sickness), kills an estimated 55 000 people a year.

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Schistosomiasis (bilharziasis or snail fever) affects 200 million people in 74 countries in the Americas, Africa and Asia and kills perhaps 200 000 people. Leishmaniasis infects about 13 million people. Visceral leishmaniasis, also known as kala-azar, is the most severe form. Almost always fatal if untreated, it causes some 500 000 cases and more than 80 000 deaths a year. Lymphatic filariasis (elephantiasis) affects around 100 million people, while *Ascariis* causes clinical symptoms in as many as 214 million people, *Trichuris* in 133 million and hookworm in 96 million.

Sexually transmitted diseases impose a huge health burden across the world. Some 236 million people are estimated to have trichomoniasis, with 94 million new cases a year. Chlamydial infections affect some 162 million people, with 97 million new cases annually. An estimated 32 million new cases of genital warts occur each year, and there are some 78 million new cases of gonorrhoea. Genital herpes infects 21 million people a year, and syphilis 19 million. More than 9 million people are infected with chancroid each year.

Many, if not all, STDs could be avoided if condoms were used. Most STDs can be treated effectively and cheaply – the cost of treating genital ulcer disease, for instance being between US \$0.5 and US \$4 per person. But there are problems in the supply and accessibility of services, compounded by fear of stigma on the part of patients and the attitude of some service providers.

HIV and AIDS continue to spread relentlessly. WHO estimates that in 1994 HIV prevalence among adults worldwide was over 13 million. Some 6 000 people are becoming infected each day. In parts of Africa and Asia the virus is advancing rapidly. In southern and south-eastern Asia HIV infections were estimated at 2.5 million – a million more than in 1993.

In 1993, 2 065 cases of human plague (with 191 deaths) recorded in 10 countries in Africa, Asia and the Americas were notified to WHO. That number exceeded the 1992 total and the annual average for the previous 10 years. The outbreak was a stern reminder to

the world that a dreaded disease, often regarded as a scourge of the past, still exists.

Noncommunicable diseases such as those of the circulatory system account for 10 million deaths globally, with more than 5 million due to heart disease and another 4 million due to cerebrovascular conditions (such as stroke). These and other noncommunicable diseases that primarily affect adults are also emerging as a major cause of death in the developing world. Although until recently heart disease and stroke were perceived as problems of the developed countries, about 44% of total deaths from these causes now occur in the developing world. Cancer accounts for 6 million or 12% of deaths globally – with the majority of them, 58%, in the developing world.

Among the other noncommunicable diseases, chronic obstructive pulmonary diseases such as chronic bronchitis and emphysema killed nearly 2.9 million adults in 1993, representing about 6% of total deaths. The number of sufferers in the world from these diseases is put at 600 million. This is the second largest known category of persons with a single disorder recorded by WHO. At the same time there are believed to be 275 million asthma sufferers in the world, although WHO has no data on the number of deaths due to this condition.

Diabetes mellitus is a growing public health problem in both developed and developing countries. A recent WHO expert group estimated that more than 100 million people will suffer from diabetes by the end of this century – 85-90% with the non-insulin dependent form. In Europe the prevalence of diabetes is 2-5% per cent of the adult population. In India a quarter of the population is affected by the age of 60, and 1 in 5 North Americans will acquire the disease by the age of 70. One recent estimate put the cost of diabetes in the USA alone, both direct and indirect, at US \$92 billion a year.

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*Smoking is emerging as the world's largest single preventable cause of illness and death. WHO estimates that there are about 1.1 billion smokers in the world today.*

minimal care there is, even in developed countries. There are disturbing signs that society would sooner have such patients wandering the streets homeless than provide them with the care they need. The stigma of "madness" is still a potent barrier in preventing ill people from receiving help. Some 500 million people are believed to suffer from neurotic, stress-related and somatoform disorders. A further 200 million are affected by mood disorders such as chronic and manic depression. Mental retardation afflicts some 83 million people, epilepsy 30 million, dementia 22 million and schizophrenia 16 million.

Smoking is emerging as the world's largest single preventable cause of illness and death. WHO estimates that there are about 1.1 billion smokers in the world today. About 800 million are in the developing world – nearly three times as many as in developed countries. Smoking already kills an average of 3 million adults a year worldwide. If current trends continue, this figure is expected to reach 10 million by the year 2020.

In the area of women's health and childbirth, the differences in maternal mortality between countries are shocking. In Europe maternal mortality is 50 per 100 000 live births. In some of the least developed countries the rate exceeded 700 maternal deaths per 100 000 births in 1991. In developing countries 1 in 5 deaths of women of reproductive age are due to complications of pregnancy and delivery. Half a million women die every year from conditions which are easily preventable.

### **Health of the elderly**

The increase in the number of old people in the world will be one of the most profound forces affecting health and social services in the next century. Overall, the world's population has been growing at an annual rate of 1.7% during the period 1990-1995 – but the population aged over 65 is increasing by some 2.7% annually. Of a world total of 355 million people over 65 in 1993, more than 200 million are in the developing world, where they make up 4.6% of the population, with more than 150 million in developed countries, where the proportion is 12.6%. Although Europe, Japan and the USA currently have the "oldest" populations, the most rapid changes are being seen in the developing world, with predicted increases in some countries of up to 400% in people aged over 65 during the next 30 years.

Alongside the increase in the number of people over age 65, there will also be a dramatic rise in the numbers of "old old" – people over 80. In 1993 they constituted 22% of those over 65 in developed countries and 12% in the developing world. The world elderly support ratio (the number of people over 65 years compared to those aged 20-64) in 1990 was 12 elderly to every 100 people of working age. It is estimated that the figure will be 12.8 in the year 2000 and 13.2 in 2010. In other words, while population increase during 1990-2000 is estimated to be 17%, the increase in the number of elderly is likely to be 30%.

One of the most difficult questions for health planners and politicians trying to allocate funds, as well as for the community and individuals themselves, is whether increased life expectancy means more health or simply more years of sickness. This is an area that is greatly underresearched, yet the question is assuming ever greater importance.

Two of the most pressing problems in the future will be the provision of care for people with dementia and those needing joint replacements for arthritic diseases. WHO estimates that there are

165 million people in the world with rheumatoid arthritis. The long-term care of the frail elderly is becoming one of the most debated medical and political issues in many developed countries, and the developing world too will soon have to wrestle with it. If people are not to be left destitute and uncared for at the end of their lives, more attention must be given to social mechanisms for the support of the elderly and the means to fund them.

### **General health issues**

Although in the past 10 years there has been a global trend towards the democratization of political systems, the much anticipated "peace dividend" has failed to materialize. Poverty has continued, and will continue, to be a major obstacle to health development. The number of poor people has increased substantially, both in the developing world and among underprivileged groups and communities within developed as well as developing countries. During the second half of the 1980s, the number of people in the world living in extreme poverty increased, and was estimated at over 1.1 billion in 1990 – more than one-fifth of humanity.

The changing demographic picture across the world, together with the rapid shift towards urbanization, will have profound implications for the delivery of health services. The unplanned and often chaotic growth of megacities in the developing world will pose particular challenges, as poor sanitation and housing encourage the spread of infectious diseases.

Against any optimism about the global economy throughout the remainder of this century and beyond should be set a number of major uncertainties. There has been a disproportionate flow of resources from the developing to the developed world – poor countries paying money to rich ones – because of debt servicing and repayment and as a consequence of prices for raw materials that favour the latter at the expense of the former. Structural adjustment policies aimed at improving the economic per-

formance of poor countries have in many cases made the situation worse. The words of Robert McNamara, spoken in 1980 when he was President of the World Bank, still hold true: "The pursuit of growth and financial adjustment without a reasonable concern for equity is ultimately socially destabilizing".

A further worrying global trend is growing unemployment, especially in developing countries without social security arrangements to cushion those out of work. Long-term unemployment is creating a new class of "untouchables" – by excluding a large group of people from the mainstream of development and society. The unemployed are a potent reminder of the dangers of assuming that the general prosperity of a country will trickle down to all its members.

There is also considerable concern about the adverse health effects of continuing environmental degradation, pollution and the uncontrolled dumping of chemical wastes, diminishing natural resources, depletion of the ozone layer and predicted global climate changes.

Social mores are also undergoing profound changes, with a move towards shorter marriages and more divorces in many countries, leading to family breakdowns which have repercussions for individuals and for social services that may be called on to provide help for children and single parents.

Beyond any considerations for improving the health of the world must be the recognition that the growing world population will strain to the limit the ability of social, political, environmental and health infrastructures to cope. Health infrastructure – buildings and equipment, the staff, the drugs, the vehicles – is central to good health care. Services must be integrated, cost-effective and provided as close as possible to the people who need them.

With health resources unlikely to be greatly increased but with ever-growing demands for services, because of expanding populations and the advances of science which make more conditions

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*The unplanned and often chaotic growth of megacities in the developing world will pose particular challenges, as poor sanitation and housing encourage the spread of infectious diseases.*

treatable, the debate about the rationing of health care, with the attendant ethical problems, is likely to become intense. Hard choices will have to be made – and greatly enhanced mechanisms found for listening to the voice of the health consumer.

### **WHO's contributions to world health**

Within the framework of the organization's constitution and the guidance given in the periodic general programmes of work, all WHO activities are geared to respond to the priority problems of the age groups referred to in this summary. The full extent of WHO's work at national, regional and global levels cannot be reflected here, but examples are given of different types of action.

#### **Child and adolescent health**

WHO encourages self-reliance of countries in conducting *immunization* through basic health services. It cooperates with UNICEF in its initiative of supplying vaccines to over 100 countries. Major priorities are to at least sustain the accomplishments of previous years and to continue to strive for achievement of the 1992 World Summit for Children goal of immunization against the six vaccine-preventable diseases (diphtheria, pertussis, tetanus, measles, poliomyelitis, tuberculosis).

In an effort to make the best use of limited resources to eliminate *neonatal tetanus*, WHO has given priority to countries that account for 80% of total cases and have an estimated mortality of 5 or more per 1 000 live births. WHO initiated a series of measures to arrest the spread of *diphtheria* in eastern Europe, including the formulation of a plan of action and the establishment of a European task force. In 1993 progress towards the *poliomyelitis* eradication goal was heartening. Efforts are being made to develop a more heat-stable poliovirus vaccine that can be delivered with a less rigorously maintained cold

chain. Large donations for poliomyelitis eradication were coordinated with different organizations. In 1994 the region of the Americas committed itself to eliminating *measles* by the year 2000, and incidence is now at the lowest level ever. If the momentum is sustained the Americas may well lead the way towards global elimination of this major killer of children.

By the end of 1994 virtually all developing countries had implemented plans of action against *diarrhoeal diseases* in children. Nearly 42% of health staff in the countries had been trained in supervisory skills using materials developed by WHO, and almost 30% of doctors and other health workers had been trained in diarrhoea case management, many of them in the more than 420 diarrhoea training units established in over 90 countries. It is estimated that nearly 85% of the population of the countries had access to oral rehydration salts at the end of 1994.

Particular emphasis is given to training in the management of *acute respiratory infections*. WHO supports courses for workers in first-level health facilities and referral hospitals on standard case management, and distributes training and technical materials. More than 190 000 health managers, doctors, nurses and community health workers in over 60 countries have been trained so far. WHO is involved in numerous studies on acute respiratory infections in Africa, Asia and Latin America.

Activities for better *nutrition* are promoted in 62 countries, mostly in collaboration with FAO and UNICEF. A global database on child growth was established and more than 90 countries are receiving technical and financial support to give effect to the International Code of Marketing of Breast-milk Substitutes. The new WHO/UNICEF "baby-friendly hospital initiative" has proved hugely successful in encouraging proper infant feeding practices, starting at birth. It has already been implemented in two-thirds of African countries. A number of countries have introduced national nutrition policies with WHO support.

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A wide range of WHO programmes focus on the needs of *adolescents* in such fields as nutrition, mental health, sexuality, disease and injury prevention, and substance abuse. A joint UNICEF/WHO/UNFPA policy statement on the reproductive health of adolescents was disseminated. WHO supported the formulation of policies on adolescent health in 20 countries.

### **Health of adults**

WHO activities broadly seek to improve and maintain the economic and social productivity of adults by promoting health and reducing premature morbidity and mortality.

As far as the major communicable diseases are concerned, efforts are being made to mobilize financial support to combat *tuberculosis*, which recently has shown a worrying resurgence. Control programmes were reorganized in several countries, and operational and other studies were supported. The research has produced some important results which may have major implications for policy. A study of rifapentine suggests that it is a promising new drug. A large trial is being organized on the efficacy of sparfloxacin, another new drug, against multidrug-resistant tuberculosis. A study in Uganda on the feasibility of tuberculosis chemoprophylaxis for HIV-infected persons suggests that this intervention is not easily applicable on a large scale in a developing country setting. WHO's global task force on *cholera* control continues to support activities to strengthen national capacity to prepare for and respond to epidemics. Several cholera vaccines are at different stages of development. All 45 countries where *malaria* is endemic received WHO financial support for control activities. National plans of work, based on a revised regional control strategy, were drawn up in a number of African countries. WHO, together with other agencies and NGOs, responded promptly to requests for assistance in combating malaria epidemics in seven countries, including outbreaks among the 500 000 or so Rwandan refugees. In view of the

rapid spread of chloroquine-resistant and multidrug-resistant falciparum malaria, a multicentre research programme has been initiated to study ways of retarding development of drug resistance. The synthetic Colombian malaria vaccine Spf66 has been shown to be safe, to induce antibodies and to reduce the risk of clinical malaria by around 30% among children aged under 5 in the United Republic of Tanzania.

With regard to the other communicable diseases, all countries where *leprosy* is endemic have implemented national strategies and plans for elimination of the disease as a public problem by the year 2000. The *onchocerciasis* control programme in West Africa, executed by WHO with support from UNDP, FAO and the World Bank, has succeeded in eliminating the disease as a public health problem in 11 endemic countries. Remarkable progress has been made in eradication of *dracunculiasis*. National eradication programmes are under way in the 18 endemic countries. A reliable village-based surveillance system has also been implemented, with monthly reporting in operation in all countries. WHO is supporting a campaign to eliminate *Chagas disease* from the Southern Cone of the Americas. Activities include the development of slow-release insecticidal paints which have shown to be nearly twice as effective as traditional sprays in controlling the triatomine vectors and about half as expensive. Seven-day treatments with eflornithine have been shown to be effective against *trypanosomiasis*. As the drug is expensive, WHO has arranged to provide it to four countries on a cost-recovery basis, and is participating in the development of a low-cost synthesis and production method. Support is given for research and training in the epidemiology and control of *schistosomiasis*, and a new candidate vaccine has been identified. Emergency supplies for serological diagnosis and drug treatment of visceral *leishmaniasis* were provided by WHO and UNICEF during a recent epidemic in Sudan. The outbreak of pneumonic *plague* in India in 1994 was

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*WHO's global task force on cholera control continues to support activities to strengthen national capacity to prepare for and respond to epidemics. Several cholera vaccines are at different stages of development.*

a stern reminder that the disease often regarded as a scourge of the past still exists. WHO intervened promptly at the request of the Indian authorities. Travel advice was issued based on the International Health Regulations and an international team of experts was set up to conduct a thorough investigation. The results suggested that the outbreak involved far fewer cases than the number reported. No evidence was found of the plague spreading outside the focus; and no imported, confirmed plague was detected in any other country.

Programmes against HIV/AIDS are under way with WHO support in most Member States, including HIV surveillance activities in some 80 developing countries. Similarly, staff from 80 countries were trained in HIV/AIDS programme management. Agreements were concluded for bulk purchase of HIV test kits, ensuring quality and the best possible price for developing countries. A safety trial of a candidate vaccine against HIV, endorsed by WHO, was conducted for the first time in a developing country. Policy guidance is given in such fields as blood safety, restrictions on HIV-positive travellers and HIV testing. Hundreds of NGOs and networks of organizations work with WHO in the fight against HIV/AIDS.

WHO is developing a network of centres and a database in support of a global programme to monitor and prevent *cardiovascular diseases*, and continues to coordinate the 10-year, 26-country MONICA project which monitors trends and determinants in cardiovascular diseases and measures the effectiveness of interventions. National programmes for the prevention of coronary heart disease were introduced in 41 countries. Sixteen INTERHEALTH demonstration projects have been set up worldwide (9 of them in developing countries) to assess the effectiveness of integrated community-based intervention. The related CINDI programme now covers 21 countries in Europe. WHO supports the implementation of national *cancer* pain relief and palliative care policies in 46 countries, and participates in the development of national cancer registers. A model list

of 24 essential drugs for cancer chemotherapy was updated. Guidelines were produced on ethical issues in human genetics, and on the provision of genetic services for control of *hereditary diseases*. National programmes for control of *diabetes* and *rheumatic diseases* were established in several countries.

Guidelines on mental retardation, epilepsy and suicide and other aspects of *mental health* were issued. Studies are promoted on the long-term course and outcome of schizophrenia and obsessive/compulsive disorders. An international review of mental health legislation was undertaken. As part of efforts to prevent *substance abuse*, recommendations were made on international control of psychoactive substances and support is given to Member States in revising policies and legislation on treatment and rehabilitation of drug and alcohol dependence.

"Africa 2000", a new investment initiative aimed at providing universal coverage of *water supply and sanitation* services, was launched. A broad programme of hygiene education and promotion of low-cost sanitation is being developed in cooperation with UNICEF and other organizations. Training packages and manuals on the proper operation, maintenance and optimization of systems are being prepared, and one on health in water resources development is being tested. The healthy cities initiative now covers over 650 cities worldwide. The global WHO/UNEP networks for monitoring air and water quality are operational in more than 60 countries. Revised WHO guidelines on drinking-water quality were issued. WHO and FAO support the Codex Alimentarius Commission in promoting the adoption of scientifically-based national food legislation. Together with FAO, WHO has established acceptable daily intakes for well over 700 food additives, contaminants and veterinary drug residues in food.

WHO/UNICEF/UNFPA policy statements were issued on promotion of the health of *women*. National safe motherhood action plans were formulated in 10 countries. Databases for monitoring patterns and trends in

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*The outbreak of pneumonic plague in India in 1994 was a stern reminder that the disease often regarded as a scourge of the past still exists. WHO intervened promptly at the request of the Indian authorities.*

maternal health are being disseminated. A total of 87 research projects are funded, many dealing with the causes of maternal death and disability. A project was launched to promote simple methods for early detection of cancer of the cervix and breast in developing countries.

A key objective for WHO is to enable the *elderly* to exercise their full potential as a community resource, and to give them a satisfactory quality of life. Many WHO programmes are involved in this effort, including those concerned with nutrition, cardiovascular diseases, cancer and palliative care. A multinational collaborative study on the predictors of osteoarthritis was launched. In pursuance of the United Nations international plan of action on aging, WHO is setting up an integrated programme on aging and health, which will become fully operational in 1996.

### **General health issues**

A global strategy on *occupational health* was formulated, and country activities supported. Guidelines and monographs were produced on such subjects as the health implications of occupational exposure to organic dust and sensitizing agents as well as selected metals, solvents and pesticides. Since 1976 WHO has evaluated the health risks posed by exposure to some 200 industrial chemicals and other substances. An international collaborative *oral health* research initiative is being set up in collaboration with the International Dental Federation among others. An international action network was established on noma and other mutilating diseases and accidents of the face. Significant progress was made in meeting the *rehabilitation* needs of the 35 million persons with disabilities in Africa, using the community-based district health approach. WHO's global data on *blindness* were updated. Training and research in this field is supported by WHO jointly with NGOs. Quality standards were prepared for small-scale manufacturers of intraocular implants used in cataract surgery.

As a part of activities to promote *healthy lifestyles*, a school health education resource centre and databases were established as well as two regional networks of health promoting schools. The regions for health network in Europe was expanded to include 20 regions. National *tobacco* control programmes are supported. Recent Winter Olympic events have been smoke-free, thanks to collaboration between the International Olympic Committee and WHO.

WHO provides countries with information and guidelines on the organization of *health systems based on primary health care*. Technical guidance is given on the formulation of new health policies and strategies and the reorganization of health care financing systems.

WHO promotes information exchange between countries in relation to the development of *human resources for health*. It has launched an initiative to determine optimum approaches to the training of health personnel under changing socioeconomic conditions. Reviews of public health training and medical education are supported. Fellowships are provided for training in many health and related fields. National, regional and interregional action plans for upgrading nursing and midwifery practice are being drawn up through a network of WHO collaborating centres.

In the field of *pharmaceuticals* guidelines for drug prescribing are being expanded. National systems for drug registration, surveillance and quality assurance are being established in a number of countries with WHO collaboration. The WHO model list of essential drugs is being revised and updated. Working with bilateral agencies, other United Nations bodies and NGOs, WHO collaborates with 55 countries in framing national policies in such areas as drug selection and legislation. Operational research is carried out on the rational use of drugs. Guidelines, tools and training materials have been prepared on many aspects of drug management.

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The WHO Global Commission on Women's Health has drawn up an agenda for action relating to *women, health and development*. Under the auspices of the commission, a scheme to provide credit and banking facilities to the most vulnerable and disadvantaged is being implemented in Africa. At the 1994 International Conference on Population and Development in Cairo, WHO played a key role in helping to reach a consensus and transcend political and religious differences. This was made possible by the Organization's medical and ethical credibility and its inclusive approach to health.

Together with UNDP, WHO promotes recognition of *health and environment* concerns in national plans for sustainable development and has given financial and technical support to six countries for this purpose. WHO has been designated task manager for the "health chapter" of the 1992 United Nations Conference on Environment and Development (UNCED). In collaboration with several United Nations bodies it has prepared a progress report on health, environment and sustainable development, stressing the importance of reform with respect to community development, environmental health, national decision-making and national accounting. Materials produced by WHO included guidelines on the operation of poisons control facilities, 15 health and safety guides, and over 200 international chemical safety cards providing basic information on the diagnosis and treatment of poisonings. Training and research on the broad topic of health and environment are supported.

WHO worked with 26 countries in greatest need in planning and implementing health reforms as part of an overall effort for *strengthening of national managerial capabilities*. A third report on progress towards health for all by the year 2000 was prepared for submission to the WHO governing bodies in 1995. Research on health futures was organized; and assessment of the global

health situation and trends in priority diseases and conditions continued. A total of 184 *nongovernmental organizations* are now in official relations with WHO. The growing awareness among Member States of the need to improve health care delivery systems, and a notable interest on the part of the *World Bank* to promote improvements in the social sector, provided a timely opportunity to forge closer links between WHO, the Bank and governments. Collaboration was also strengthened with the five major regional development banks. The traditional good working relations with UNICEF, UNFPA, FAO, ILO and UNESCO continued.

WHO continues to strengthen national capacity for *emergency preparedness and relief*. Technical expertise and emergency medical supplies were provided to a number of countries including Afghanistan, Angola, Burundi, Iraq, Rwanda, Somalia, Sudan and some new independent states in 1994. WHO cooperated closely with the European Union on assistance for the countries of former Yugoslavia. Ten joint missions were undertaken with WFP for the organization of food aid in support of human resources development.

Handbooks and guidelines in different fields of *health technology* were produced. Progress was made in developing portable laboratory instruments, solar-run equipment and other types of appropriate technologies.

Up-to-date, authoritative *health information* is provided to all Member States through a large number of publications, a series of widely-distributed periodicals, electronic networks and library services. WHO facilitates access by countries to a number of databases containing information on such subjects as communicable diseases and HIV/AIDS. For many health workers in developing countries, WHO materials are often the only source of reliable information on health.

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## Charting the future

By the end of the 20th century we could be living in a world without poliomyelitis, a world without new cases of leprosy, a world without deaths from neonatal tetanus and measles, a world without dracunculiasis. In 1993 measles killed nearly 1.2 million children and infected more than 45 million; poliomyelitis killed 5 500 children and as of that year 10 million people were disabled; leprosy killed 2 400 people and infected 600 000; neonatal tetanus killed 560 000 newborn babies; dracunculiasis infected 2 million people.

By the end of the century maternal mortality could be half what it was in 1993, when more than 500 000 women died in childbirth. Infant mortality rates could be no higher than 50 per 1 000 live births. At least 70 countries had higher rates than this in 1993. By 2000 mortality of children under 5 years could be no more than 70 per 1 000 live births. At least 60 countries had higher rates than this in 1992. We could be living in a world where less than 10% of babies are born weighing under 2.5 kg. In 1990, 17% of babies were born below this weight. For babies born at the beginning of the 21st century life expectancy could be at least 60 years in every country of the world. In 1993, 50 countries were below this target.

In the year 2000 at least 85% of the world's population could be within one hour's distance of medical care. In 1993, about 1 billion people had no access to local health services within a one-hour journey. Deaths from malaria could be cut by a fifth in at least 75% of affected countries; the number of deaths and new infections from tuberculosis could be substantially reduced; the number of new carriers of hepatitis B could fall by 80% as a result of childhood vaccination; deaths from heart disease in people aged under 65 could be reduced by at least 15%; all pregnant women could have proper care.

The year 2000 could see a world where malnutrition among children under 5 years will fall by 50%; where

m micronutrient deficiencies from vitamin A and iodine will be eliminated; where the prevalence of iron deficiency anaemia in women of childbearing age will be reduced by 33%; and where 85% of the population will have access to safe water and 75% to safe sewage disposal.

These are neither utopian goals nor naïve wishes for a perfect world. They are achievable – provided the world cares enough and the necessary resources are made available. WHO sees four main priorities for action in the future.

The **first priority** is to ensure "value for money" by using the available resources as effectively as possible and redirecting them to those who need them most. The aim is to create self-help environments in which men and women can solve their own problems, establishing and sustaining a development process that will ensure a brighter future for their children.

The **second priority** is poverty reduction through better health. Investing in health saves money as well as lives. It must be accepted that expenditure on health is not a drain on national resources but a prerequisite for economic and social progress. Poor health inhibits an individual's ability to work, reduces earning capacity and deepens poverty. Poverty should thus be tackled on two fronts: one to meet people's basic minimum needs including access to health services, housing and education; the other to provide opportunities for people to earn their way out of poverty through better health and increased productivity. In addition to the economic aspect there is another side to poverty which must be corrected – social discrimination and low status for some groups, particularly women.

The **third priority** relates to public health policy, which in the decade of the 1990s has been influenced not only by the health-for-all movement, with its emphasis on equity, but also by political and economic changes in the world at large. At the same time it is recognized that ensuring equal access to health care, a traditional goal of public

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health authorities, will not necessarily reduce gaps in health status insofar as disease is determined by individual behaviour and by the working and living environment. Any genuine improvement in health will thus call for integrated, intersectoral action in addressing all the determinants of ill-health. The training of health professionals will have to be reoriented accordingly.

The *fourth priority* is to strengthen national capabilities for emergency relief and humanitarian assistance in the health sector. The new policy of "emergency management for sustainable development" will provide a bridge between relief work and development proper, the aim being to reduce human suffering and economic loss due to epidemics, complex emergencies and mass population displacements.

The health problems of the future are awesome. Yet much can be done to tackle them with what we know already. In order to succeed the world will have to care more, and try harder, but the situation is not hopeless. Martin Luther King, writing about the civil rights struggle in the United States in the 1960s, said: "We shall have to repent in this generation, not so much for the evil deeds of wicked people, but for the appalling silence of the good people".

Today, as a new generation approaches a new century, it is time for the appalling silence over global health inequities to be broken.

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## **Special chapter** **The evolution of WHO**

The first World Health Assembly, held in June 1948 and attended by 53 delegates from WHO's 55 Member States, approved a programme of work that listed its top priorities as malaria, maternal and child health, tuberculosis, venereal diseases, nutrition and environmental sanitation.

Today, 47 years later, in spite of significant improvements in human health, great burdens of suffering and disease are still with us. Half a century of lessons learned in eradicating and controlling diseases, expanding health care coverage and making the best use of available resources have guided the world community, including WHO, on the way to further progress.

### **The need for a world health organization**

At the end of the second world war the majority of the world's people were still living in extreme poverty and suffering from chronic malnutrition, communicable diseases and parasitic infections to name a few. Many existing health services were severely disrupted and huge segments of the population were excluded from them. The imperative need was therefore recognized for a new world body capable of grouping resources for health, concerting health goals and providing a forum for the exchange of health information. The result was the setting up by the United Nations of a specialized agency to fulfil that need – the World Health Organization.

### **Declaring war on disease**

WHO's first two decades were dominated by mass campaigns to control diseases such as leprosy, malaria, smallpox, syphilis, tuberculosis and yaws. Between 1950 and 1965, for instance, 46 million patients in 49 countries were successfully treated with penicillin against the tropical disease yaws, making it no longer a significant public health prob-

lem in most of the developing world. By 1955 the number of malaria cases worldwide had dropped by at least one-third; but by 1970 eradication of the disease was seen to be impracticable.

The same was not true of smallpox. An eradication campaign that began in 1966, when up to 2 million people a year were dying of smallpox, ended in 1980, when the disease had disappeared from the face of the earth.

These mass campaigns against single diseases gave way to WHO's Expanded Programme on Immunization aimed at protecting by the year 2000 all children against six vaccine-preventable diseases – measles, diphtheria, pertussis, tetanus, poliomyelitis and tuberculosis. Global coverage with the vaccines reached its peak in 1990, when the goal of immunizing 80% of all children by the age of 1 year was achieved. The long-term goal of the multiagency children's vaccine initiative, launched in 1990, is to achieve a world in which all people at risk are protected against vaccine-preventable diseases, if possible by means of a single procedure.

### **Health for all**

In 1979 the World Health Assembly unanimously endorsed the Declaration of Alma-Ata, which stated that primary health care was to be the key to attaining the goal of health for all by the year 2000.

Consequently global targets for health were established and have since been the norms against which all health development efforts have been measured. The strategy of health for all has been endorsed at the highest political level, but a gap remains between what is preached and what is practised.

### **Setting the standards**

The establishment of standards in such fields as vaccines, drugs and laboratory tests has been a permanent part of WHO's work. The WHO Expert Committee on Biological Standardization has met every year since 1951 to formulate standards which are recognized

worldwide. The scientific credibility of WHO provides a guarantee that everyone accepts.

Training physicians, raising the standards of medical schools in developing countries and helping countries organize schools for nurses and midwives has also been a permanent feature of WHO's work. The concept of primary health care has switched much of the emphasis to training directed towards a wide range of health care workers at community level, particularly in developing countries, rather than towards health professionals as such.

### **The way ahead**

WHO's general programmes of work, now covering periods of six years, set out principles and policies for the functioning of the Organization. They also provide a framework for detailed workplans and budgeting. Over the years the programmes have responded to, and often anticipated, the major health concerns of Member countries. The ninth programme (1996-2001) fixes goals and targets for WHO's global health action. It focuses on lessening of inequities in health, control of rising costs, the eradication or elimination of selected infectious diseases, the fight against chronic diseases, and the promotion of healthy behaviour and a healthy environment.

The challenge for the future is to mobilize WHO's Member States to adopt policies and plans that will guarantee the provision of comprehensive integrated health services to each and every member of the community.

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