

Chapter 6

WHO worldwide

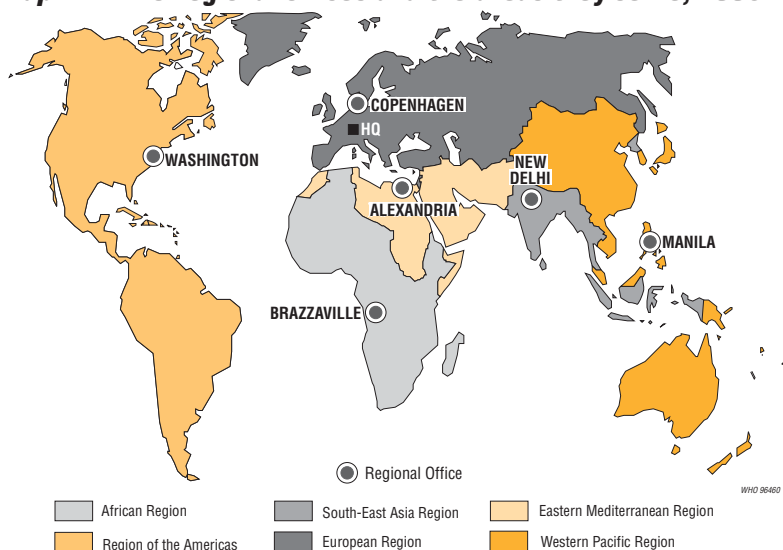
Chapter XI of WHO's Constitution provides that the World Health Assembly may establish a regional organization to meet the special needs of a geographical area. Each regional organization is an integral part of WHO, and consists of a regional committee and a regional office. Regional committees are composed of representatives of the Member States and Associate Members in the region concerned, and their functions include the formulation of policies governing matters of an exclusively regional character, and the supervision of regional office activities. The regional office is the administrative organ of the regional committee, and also carries out within the region the decisions of the World Health Assembly and Executive Board. The head of the regional office is the Regional Director appointed by the Executive Board in agreement with the regional committee.

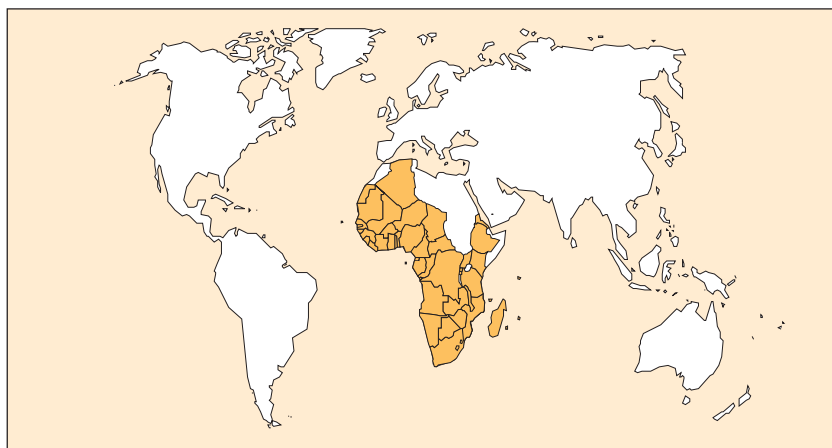
The decentralization of the activities of WHO was one of the most difficult and complex problems facing the First World Health Assembly. How many regions should be created? What groups of countries should they include? How soon should regional organizations be instituted? What would be the financial impact? It was suggested that the following factors should be taken into account: the health level of countries to be included; the possible existence in those countries of a permanent epidemic focus; the extent to which they had managed to overcome the health consequences of war; the efficiency of their health administration; and their capacity to resolve their problems.

Six WHO regions were established: Africa, the Americas, Eastern Mediterranean, Europe, South-East Asia, Western Pacific. The Assembly decision as regards Europe was limited to the setting-up at an early date of a temporary special administrative office to deal with the health rehabilitation of war-devastated countries. In the Eastern Mediterranean area, it was decided to integrate the existing Alexandria Regional Bureau with WHO as soon as possible. An agreement was concluded with the Pan American Sanitary Organization: the Pan American Sanitary Bureau in Washington, DC, would assume, in addition to its former functions, the new role of WHO Regional Office for the Americas.

Map 11 shows the distribution of countries among the six WHO regions and the location of the regional offices.

Map 11. WHO regional offices and the areas they serve, 1998





46 Member States

Population (1997): 612 million

GNP per capita

- Regional average (1995) \$ 564
- min.: Mozambique \$ 80
- max.: Seychelles \$ 6 620
- Annual average growth rate (1985-1995)
- min.: Gabon -8.2 %
- max.: Botswana 6.1 %

Algeria	Lesotho
Angola	Liberia
Benin	Madagascar
Botswana	Malawi
Burkina Faso	Mali
Burundi	Mauritania
Cameroon	Mauritius
Cape Verde	Mozambique
Central African Republic	Namibia
Chad	Niger
Comoros	Nigeria
Congo	Rwanda
Côte d'Ivoire	Sao Tome and Principe
Democratic Republic of the Congo	Senegal
Equatorial Guinea	Seychelles
Eritrea	Sierra Leone
Ethiopia	South Africa
Gabon	Swaziland
Gambia	Togo
Ghana	Uganda
Guinea	United Republic of Tanzania
Guinea-Bissau	Zambia
Kenya	Zimbabwe

Africa

Almost all the countries of the Region were under colonial rule up to the end of the 1950s. The 1960s witnessed a “bumper harvest” of independent African countries. Over 30 countries became independent between 1960 and 1969. The 1970s added six countries. Zimbabwe gained independence in the 1980s, and Eritrea, Namibia and South Africa joined in the 1990s.

Another important determinant during this period was political instability. In some countries this culminated in civil strife and wars: eight countries were affected, at one time or another. In most of such affected countries, hundreds of thousands of people were displaced and the refugee problems compounded the health problems of the day. In some other countries, political instability and the attendant absence of peace destabilized health sector development.

At independence, socioeconomic development was a challenge, and the opportunity of securing favourable trade terms was not missed by some countries. More school and health facilities were built, not only in the urban areas but also in the rural areas. By the end of the 1970s, access to health and education had im-

proved. Literacy rates increased but were still below 20%. The population growth rate was still relatively low at about 2.5%, and there was limited growth in urbanization. Of the 25 countries that were recognized as least developed countries at that time, 13 were in the Region.

The 1980s were the decade of economic reform, following the 1979 oil crisis. The objectives of the reforms, for most countries, were to respond to both internal and external disequilibria created by the worldwide economic crisis. They usually involved the implementation of the IMF/World Bank “packaged” structural adjustment programmes. The 1980s generally witnessed an increase in economic uncertainty, little or no investment, a decrease in food self-reliance and an increase in external debt. The population growth rate increased to 2.8%, and unchecked growth in urbanization created a new class of poor people in the urban areas.

By the 1990s, the negative effects of economic reforms became more vivid. Twenty-one countries had a lower real, as well as nominal, average growth rate in 1991-1995 than they had in 1980-1985.

Health trends

During the immediate post-independence period, health development in the Region called for re-

Tables concerning demography, health indicators and GNP are based on United Nations and World Bank estimates. All other information is from regional sources.

Selected health-for-all (HFA) indicators	1975			1997			2025			HFA targets	No. of Member States which have <i>not</i> met the HFA targets in 1997
	Average	Max.	Min.	Average	Max.	Min.	Average	Max.	Min.		
Life expectancy at birth (years)	46	64	35	53	72	38	65	77	51	> 60	39
Infant mortality rate (per 1000 live births)	125	197	47	89	169	16	47	99	7	< 50	40
Under-5 mortality rate (per 1000 live births)	200	294	51	139	251	16	66	139	6	< 70	40

sponses in four strategic areas: development of human resources for health; promotion of environmental hygiene; epidemiological surveillance and control of communicable diseases; and strengthening of health services.

Many countries made the development of infrastructure the focus of their health policy, to help improve the coverage and management of the health problems of their populations. But the results obtained were uneven because of limited investment capacity. Quite often, achievements could not be maintained except through international cooperation and community initiatives. Infrastructure expansion was noted in some cases but did not measure up to needs.

The deterioration of the economic and financial situation in recent years has been felt particularly in the health sector. Health investment has virtually ceased. The social sectors, including the health sector, have been the hardest hit by the worsening trend of budget deficits. There is still imbalance between expenditure on tertiary care and expenditure for local care, to the detriment of the latter.

The development of **human resources for health** has been a top priority and substantial efforts have been made to provide a generation of trained personnel of all categories, such as physicians, nurses, midwives, laboratory technicians, sanitary engineers, etc. However, in most coun-

tries, the targets in terms of ratio to the population have not been achieved. Qualified specialists were produced but did not always remain in the countries or the public sector because of the brain-drain phenomenon, or because they were lured away by non-national institutions. In some cases, the training provided was not entirely adequate or appropriate.

The reform of medical education has received special attention. Efforts are being made to define the profile and the skills of the 21st century medical practitioner, to improve the functions of nurses and midwives and to redirect them towards primary health care services. Unfortunately, the impact of these reforms has not yet been felt. The low output of health institutions and poor performance of health personnel are still major concerns in a large number of countries. The impoverishment of health personnel is undermining the public sector's capacity to respond.

An increasing number of countries are worried about the general degradation of the **environment** and the inability of their health structures to address the problem. The substantial increase in the volume of industrial and domestic wastes poses a threat, given the inadequacies of waste disposal systems in a large number of countries. The risk of water contamination and soil degradation by chemical pollutants is also a real problem, yet to be solved in many cases.

Death rates: age- and sex-standardized, and age-specific, 1955-2025 estimates (per 100 000 population)

Age group	1955	1975	1995	2025
Age- and sex-standardized	2 670	2 013	1 645	936
0-4	7 243	4 966	3 439	1 431
5-19	1 178	821	612	238
20-64	1 446	1 099	994	544
65+	9 299	8 011	7 159	5 717

A decline in food self-sufficiency, as well as the risk of chronic famine, have been observed in many countries of the Region in recent years. Furthermore, food insecurity and improper dietary habits bring a phenomenon of deficiency malnutrition which particularly affects preschool children and pregnant women.

The number of smokers continues to increase in the Region, particularly among adolescents. Similarly, abuse of alcohol and other toxic substances, including drugs, calls for vigorous action.

Access to **safe water and adequate sanitation** is still far from the set targets, including those of the International Drinking Water Supply and Sanitation Decade. This is particularly true in the rural parts of most countries, where the average proportion of people with access to safe drinking-water is below 60%, while access to appropriate sanitation is less than 50% (as compared to the 90% targeted for the year 2000).

National health systems have been developed and consolidated, with special emphasis on the district health subsystems. Better integration and management of priority programmes such as immunization, control of diarrhoeal diseases, essential drugs and vaccines constitute important achievements, since commendable results have been observed in terms of service coverage and impact on diseases.

Even so, plans were developed without a clear vision and, in some cases, there is no long-term planning culture. Sometimes, lack of political commitment and instability in countries have limited the capacity to respond to needs. Management capacity, including capacity to implement plans, remains weak. Health information systems are still inadequate. Access to health care is generally inequitable, particularly for the rural populations who are underserved. Health for all, but not health for everyone, has been given due consideration, but insufficient emphasis has been given to ensuring access to a minimum package of health care, including curative care.

Public interest in health matters has grown in recent years, partly as a result of the increase in the volume and circulation of **information** provided by the media. More and more newspapers and magazines are devoting special columns and pages to health. This has improved knowledge and stimulated the quest for information.

Economic difficulties and the declining literacy rate in some countries, or among certain population groups, are hampering efforts made in public education. Some countries have therefore explored innovative means of ensuring the adequate production and distribution of information on health. There is increasing recognition of the need for a national policy on health information and education, especially within the context of social mobilization for health.

The countries in the Region have made substantial investment in **maternal and child health**, and integration of activities has been improved, especially immunization services and maternal and child health services. Even so, less than 50% of the countries have a coverage rate of over 50% for antenatal care, and less than

Leading clusters of diseases/conditions, African Region, selected years (indicative list)

Disease category	1960	1980	1997	2025
Infectious and parasitic	1	1	1	1
Perinatal and maternal	2	2	2	2
Malignant neoplasms				
Endocrine and nutritional	4	4	5	5
Mental and behavioural				
Circulatory system	5	5	4	3
Respiratory system	3	3	3	4
All external causes				

40% of mothers have access to assistance from qualified personnel during childbirth.

The strategy of national immunization days has helped to maintain a high level of immunization coverage. Average immunization coverage in the Region is 68% for BCG, 58% for DPT3 and 60% for measles, but the coverage rate in highly populated countries is below 50%. Tetanus toxoid immunization coverage among women of childbearing age is estimated at 38%.

The effective prevention and control of communicable diseases called for effective **epidemiological surveillance** systems. A series of concerted efforts was made during the 1980s in all countries, but the capacity to detect the epidemics that are common is still weak. Consequently, countries in the Region are still experiencing high case-fatality rates and disruption of health services due to outbreaks. The reduction in the morbidity caused by the most prevalent communicable diseases such as malaria, tuberculosis, leprosy and measles is still insufficient. Some diseases that were thought to have been controlled are re-emerging.

Reporting of epidemics is more rapid, and accelerated responses are provided as demonstrated in outbreaks of epidemics of Ebola virus

haemorrhagic fever in the Democratic Republic of the Congo and Gabon, as well as in outbreaks of cholera. Mechanisms for consultation and cooperation have been established among countries affected by epidemics of meningococcal meningitis.

For some time now, countries have been placing increasing emphasis on the prevention of, and preparedness for, all kinds of emergencies. Even so, they still have to establish the structures and mechanisms needed. Relief plans are only rarely decentralized to the district level. Moreover, ministries of health generally play a limited role in the preparation of emergency response plans, except for the control of epidemics.

future prospects

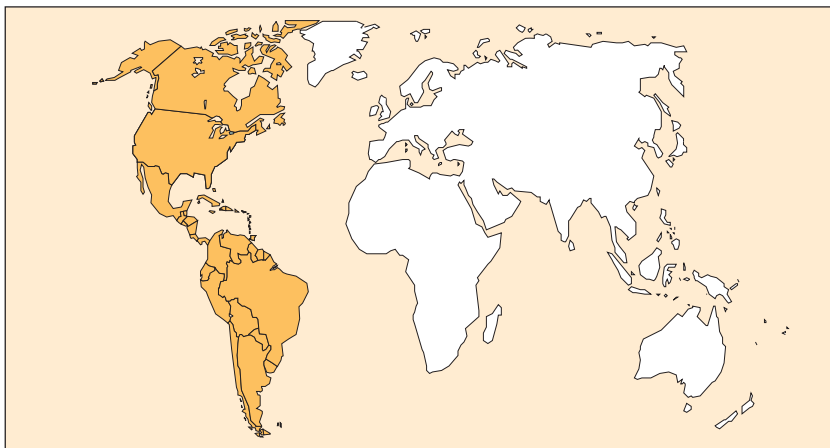
The following opportunities have been identified in order to project future improvements :

- a major aspiration of people is health, which is placed far above education in the order of priorities;
- health sector reform is recognized as an important process;
- the role of the community is increasing in the management, organization and financing of health services, and the community aspires to more decision-making power;

- there is recognition that everyone has the power to do something for her/his own health and for the health of others;
- biotechnology as well as communication and information technologies are developing;
- there is an increasing desire for technical cooperation among developing countries.

Whereas in the past, the multiplicity of scenarios was not properly examined, there are now more complex situations that need to be taken into account. The uncertain factors that could influence future health development in the Region are both external and internal to the health sector. The external factors relate to the combination of political and socioeconomic determinants, particularly political stability and good governance. The internal factors reflect the commitment and priority given to health development within sustainable overall socioeconomic development plans.

Health development in the Region in the past decades has unfortunately been characterized by formidable obstacles and constraints. Therefore, the key questions for the future are: can the tendency be reversed and can the situation be changed by people and governments? These questions and the means of turning round the delayed health development of the Region must be examined in the context of current global changes. To this end, it is crucial to recognize the causes and explain the determinants, to learn lessons from past trends and to elaborate a proper regional policy for long-term health development in the next decades.



35 Member States

1 Associate Member

Population (1997): 792 million

GNP per capita

- Regional average (1995) \$ 12 293
- min.: Haiti \$ 250
- max.: United States \$ 26 980
- Annual average growth rate (1985-1995)
- min.: Nicaragua -5.4 %
- max.: Chile 6.1 %

Antigua and Barbuda	Honduras
Argentina	Jamaica
Bahamas	Mexico
Barbados	Nicaragua
Belize	Panama
Bolivia	Paraguay
Brazil	Peru
Canada	Saint Kitts and Nevis
Chile	Saint Lucia
Colombia	Saint Vincent and the Grenadines
Costa Rica	Suriname
Cuba	Trinidad and Tobago
Dominica	United States of America
Dominican Republic	Uruguay
Ecuador	Venezuela
El Salvador	<i>Associate Member:</i>
Grenada	Puerto Rico
Guatemala	
Guyana	
Haiti	

The Americas

The Region has experienced significant advances in the health of its population, such as increased life expectancy, improvements in communicable disease control, important reductions in infant mortality, the eradication of poliomyelitis, increased immunization coverage, and important reductions in mortality rates and in the incidence of several major diseases. Yet in spite of this progress, the Region also faces the challenges posed by a deteriorating environment, mass urbanization, an ageing population, and the threats of violence and of new and emerging diseases. The general improvements experienced in the health of populations do not hide the differences and gaps which exist between and inside countries and population groups.

Regional trends affecting health

By the mid-1990s, nearly all the countries of the Region had moved towards democratic and participatory models of government. However, serious problems of governance persist. This shift has led to the need to redefine the relationship between government and civil society through the speedy adoption of political and or-

ganizational reforms known as State reform. These reforms cover a broad spectrum, but basically pursue the goals of increased efficiency, responsibility delineation, and participation. Some responsibilities have been transferred to the private sector and some have been devolved to the local level through decentralization. This has resulted in greater participation of local government.

The principal trends that have affected the 1990s have been the ongoing process of economic globalization and the strengthening of subregional trading blocks. **Socioeconomic trends** show that there are currently more poor people in Latin America and the Caribbean than in the early 1980s, with the greatest concentration in urban areas. In absolute terms, the number of people below the poverty line in Latin America grew from 197 million in 1990 to 209 million in 1994, with 65% of this population concentrated in urban areas, although the proportion of poor in the total rural population remained greater than in the cities.

During the present decade, countries have implemented economic policies aimed at recovery of economic growth which have evolved into following models that seek growth while promoting social equity. Even though the average growth rate of the gross domestic product (3%

Tables concerning demography, health indicators and GNP are based on United Nations and World Bank estimates. All other information is from regional sources.

Selected health-for-all (HFA) indicators	1975			1997			2025			HFA targets	No. of Member States which have <i>not</i> met the HFA targets in 1997
	Average	Max.	Min.	Average	Max.	Min.	Average	Max.	Min.		
Life expectancy at birth (years)	67	74	48	73	79	54	77	81	64	> 60	1
Infant mortality rate (per 1000 live births)	60	141	14	28	82	6	15	44	5	< 50	3
Under-5 mortality rate (per 1000 live births)	77	208	18	33	109	7	18	54	7	< 70	3

between 1990 and 1996) reflects improvement when compared to the 1980s, it still has not recovered to levels achieved in decades before that.

Demographic trends in the Region have not changed. The decline in fertility and the ageing and urbanization of the population have persisted and even intensified, as have the inequities and inequalities evidenced in the socioeconomic and demographic situation of the countries. By the mid-1990s, the population of the Americas reached 774 million (from 331 million in 1950), nearly 13% of the current world population, with estimates indicating that it will reach over 1 billion by the year 2025. In terms of population, the relative weight of Latin America has increased over time: in 1950 it accounted for 48.7% of the population of the Hemisphere; in 1995, 61.3%; and, according to current projections, by 2025 it will have 65.1% of the Region's population. The population of North America, in contrast, has fallen from 50.1% in 1950 to 37.7% in 1995, with estimates putting it at 33.9% by 2025.

Total **mortality**, with rare exceptions, continues to present a decreasing trend, with continued increases in life expectancy at birth. These trends are expected to continue into the next millennium. The percentage of deaths in children under 1 year of age has decreased in all countries. However, the most marked reductions (be-

tween one-quarter and one-half of 1960-1964 levels) occurred in the higher-income countries. For the lower-income countries, the reduction has remained at levels between 25% and 38% of 1960-1964 levels. The population aged over 65 years of the countries with the lowest per capita income has seen the most significant increases in mortality.

Between 1960 and 1970, the overall **birth rate** was, on average, over 40 per 1000 population; whereas for 1998, it is estimated to be 19.2 per 1000. Fertility rates have also decreased significantly in all countries. In general, it is predicted that both birth rates and fertility rates will continue to decline, keeping total population growth at a slow pace, despite the reductions in mortality. The population over 65 is expected to continue to grow at an average of 3% per year, accounting for the growing importance of this population group.

The working population constitutes on average 40 - 60% of the general population of the Region. The economically active population was estimated at 357.5 million for 1995 and is projected to grow to 399 million by the year 2000. The changes in the structure and composition of the work force also have an impact on health. The reduction in the real income of families, as well as changes in family structure, place on women and children the major part of the burden of developing subsistence

Death rates: age- and sex-standardized, and age-specific, 1955-2025 estimates (per 100 000 population)

Age group	1955	1975	1995	2025
Age- and sex-standardized	1 173	873	636	462
0-4	2 709	1 690	722	374
5-19	287	160	86	52
20-64	730	544	409	340
65+	6 105	5 650	5 289	4 348

strategies in order to face poverty. These can be most readily seen in the massive incorporation of women into precarious working conditions and in the early insertion of adolescents and minors into the workforce.

Health trends

Mortality indicators have shown improvement in all the countries of the Americas over the last 35 years and, with rare exceptions, in all age groups. However, the favourable evolution in mortality and in the health conditions of the population hides enormous disparities between and within countries. For children under 1 year, the gaps in mortality were stable or decreasing for the countries in the moderate income group, but they were high and tended to increase in countries belonging to the lower income groups.

However, when age-adjusted mortality rates are compared between countries of similar income, reducible gaps in avoidable deaths are significant. The variation of mortality in the Region is notable. However, it is possible to state that in the country with the highest per capita income, 4.7% of mortality in the age group 45-64 could have been avoided, whereas in the country with the lowest income, preventable causes accounted for 62% of mortality in the under-65 age group.

Violence in the Region is responsible for 7-25% of mortality. If cur-

rent trends persist, the problem is likely to increase, reaching epidemic proportions in some countries. In Latin America and the Caribbean, the average mortality and disability attributable to occupational accidents, is calculated to be four times greater than that notified by developed countries, at an estimated 300 daily deaths of workers.

Because one of the major functions of the Organization is to monitor the human condition in order to detect where inequities exist and whether the interventions designed to correct them are effective, methodological advances that allow the analysis of differences among and within countries have been developed. The distribution and spatial dynamics of inequalities in health status and living conditions are being analysed by coupling cartographic information with basic data on health indicators.

Much has been accomplished in the **struggle against disease** in the Americas. The Region remains free of circulating wild poliovirus, and there has been enormous progress towards the elimination of measles and neonatal tetanus. The number of episodes of acute diarrhoeal disease have been markedly reduced, and there have been significant reductions in mortality due to intestinal and acute respiratory infections. Despite these advances, diarrhoeal diseases, acute respiratory infections, and malnutrition continue to be the leading

causes of death in the population under 5 in most of the medium- and low-income countries of the Region. Chronic undernutrition has replaced acute malnutrition in infancy, which, together with micronutrient deficiencies, makes up the nutritional deficiency of the lower-income countries.

The AIDS and HIV epidemic continues, while malaria has expanded its borders and the population at high risk has increased, and dengue continues to be a serious threat. In the case of malaria, morbidity (as measured by the annual parasite infection rate) began a steady increase in the mid-1970s. There was a decrease in 1993 which reversed in 1994 and 1995, reaching rates that are more than twice those registered two decades ago. A similar trend can be observed with the resurgence of dengue. Cholera has become endemic in several areas and countries of the Region, although case-fatality rates have continued to be low.

In order to provide a broader response to the threat posed by **new and emerging diseases**, the Organization will be dealing with foodborne illness and outbreaks through the newly redefined Pan American Institute for Food Protection and Zoonoses in Argentina and with new and emerging zoonoses such as hantavirus, plague and equine encephalitis through the Pan American Foot-and-Mouth Disease Center.

Despite the progress in expanding coverage, there are serious problems related to **water quality and water supply**, as well as to solid waste disposal. As a result of the cholera epidemic, countries have increased investment in water supply and sanitation. The 1995 coverage for the total population with access to water supply through house connections and other acceptable means was 73%. In the field of sanitation, by 1995 the total coverage of wastewater and ex-

Leading clusters of diseases/conditions, Region of the Americas, selected years (indicative list)

Disease category	1960	1980	1997	2025
Infectious and parasitic	1	1	2	4
Perinatal and maternal	2	3	5	5
Malignant neoplasms	5	5	4	3
Endocrine and nutritional				
Mental and behavioural				
Circulatory system	4	4	3	1
Respiratory system				
All external causes	3	2	1	2

creta disposal facilities had increased to 69%. Urban services remained constant at 80%; however, rural services were extended to approximately 40% of the population. One of the most critical sanitary problems in Latin America remains the lack of sewage treatment. A 1995 survey indicated that the percentage of sewage collected that receives treatment is just above 10%.

In response to increasing awareness among Member States that **noncommunicable diseases** account for nearly two-thirds of deaths in the Americas, that these diseases mainly result from risk factors that can be modified, and that increasing the emphasis on prevention could improve health status, the CARMEN programme was developed. It takes an integrated approach that combines clinical prevention for individuals with health promotion directed at the general population. CARMEN projects reach their audience through community, workplace and school settings, as well as through local health services.

The financial constraints in the social sectors over the past decade have increasingly revealed the serious limitations of institutions in terms of resource management, a situation that has worsened due to rising costs in the services. In 1994 the countries of Latin America and the Caribbean

spent over \$1 billion on health, or about \$240 per capita.

future prospects

In contrast to the 1970s, infrastructure development policy in the past 15 years has stagnated and is currently one of the components with the greatest need for state policy support. Infrastructure development is one component that requires strengthening within the health sector reform processes. Another is improving mechanisms to ensure the supply and availability of essential drugs and other supplies.

There have been significant changes in the formulation and implementation of national and health sector policy. Decentralization, social participation, and inter- and intra-sectoral coordination are part of the strategies that have been promoted and that in some places have yielded positive results.

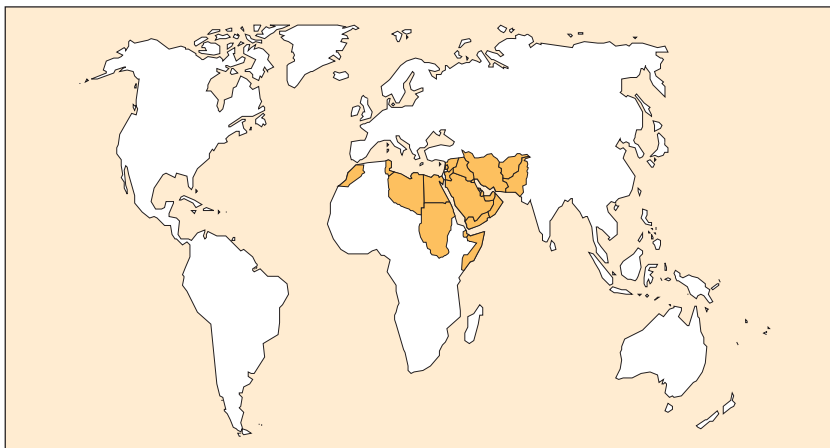
The countries have accorded high priority to the care of children under 5 and women. Action has been geared towards improving coverage. However, the population's need for access persists owing to a variety of constraints. The Organization is responding by promoting the trend towards the delivery of integrated health services to priority population groups.

The need for financing and other resources has been considered a constraint to expanding and maintaining health programmes. In many countries decentralization to the local level and greater community involvement could contribute to the sustainability of activities.

Emphasis will also be given to the crucial importance of actions directed towards safeguarding the planet, particularly in light of events that are affecting natural resources and producing ecological changes. The emergence of new diseases which threaten human existence is linked to these changes. Natural disasters and their effects on drinking-water safety and the availability of food and shelter could have been given more attention, particularly in light of the Region's vulnerability to hurricanes, volcanic activity, earthquakes, and other natural disasters.

The vision of health for all represents a desired future state that is being approached by renewing commitment to the goal and by implementing suitable strategies and concrete actions. This vision may be summarized as a shared understanding of health in which the energies of the Hemisphere respond to the challenges that arise for the achievement of sustainable human development with dignity and equity.

With the new millennium approaching, Member States should renew their commitment to the goal of health for all and its health strategies within the context of the social, economic, political, environmental, and technological trends that are affecting the health of the populations, the environment, and the health services, giving priority to the adoption of policies to resolve their health problems in a sustainable manner and steadily improve the quality of life of their peoples.



22 Member States

Population (1997): 473 million

GNP per capita

- Regional average (1995) \$ 1 385
- min.: Yemen \$ 260
- max.: United Arab Emirates \$ 17 400
- Annual average growth rate (1985-1995)
- min.: Jordan -4.5 %
- max.: Tunisia 1.9 %

Afghanistan
Bahrain
Cyprus
Djibouti
Egypt
Iran (Islamic Republic of)
Iraq
Jordan
Kuwait
Lebanon
Libyan Arab Jamahiriya

Morocco
Oman
Pakistan
Qatar
Saudi Arabia
Somalia
Sudan
Syrian Arab Republic
Tunisia
United Arab Emirates
Yemen

Eastern Mediterranean

Only six nations in what is now the WHO Eastern Mediterranean Region were among those who helped to lay the foundation of WHO. Many of the 22 Member States now constituting the Region had not yet obtained the status of sovereign and independent nations when WHO was established.

During the first 20 years (1949-1969) many Member States experienced difficulties in achieving political freedom and sovereignty, with many changes aimed at building up people's health and happiness. At the same time many countries enjoyed considerable wealth, mainly due to expansion of the oil industry, while others passed through a regression in their economy and lowered income. Those who have made spectacular advances towards better living standards have not neglected health: a relatively high proportion of national income has been devoted to improving health conditions.

The fact that the Region has been plagued with wars and political and military conflicts has meant that expenditure on defence has consumed a large proportion of national resources, including those needed for

health. Some governments passing through economic reform were not able to appreciate fully the significance of health in the promotion of human prosperity and thus did not give priority to health, or reduced their expenditure on health whenever there was shortage of funds. This trend has lately been reversed, particularly after the main players in economic reform have realized the importance of health, and are thus no longer looking at health care as expenditure without return but more as an investment.

During the last 50 years all countries of the Region have moved to the mainstream of modern life at various rates and degrees of change. Modernization has significantly affected the social and cultural values prevailing in the Region. It has affected community ties, and had an impact on issues such as care of the elderly, which is shifting from pure family care to more institutional care. Lifestyles have also been affected negatively by modernization with serious consequences for health. Modernization has also been linked to industrialization with its known problems of occupational risks, pollution of the air, soil and water, mental and psychological diseases due to maladjustment, the development of megacities and nutritional disorders.

Tables concerning demography, health indicators and GNP are based on United Nations and World Bank estimates. All other information is from regional sources.

Selected health-for-all (HFA) indicators	1975			1997			2025			HFA targets	No. of Member States which have <i>not</i> met the HFA targets in 1997
	Average	Max.	Min.	Average	Max.	Min.	Average	Max.	Min.		
Life expectancy at birth (years)	52	73	39	64	78	45	72	80	57	> 60	5
Infant mortality rate (per 1000 live births)	127	188	24	69	154	7	33	105	5	< 50	10
Under-5 mortality rate (per 1000 live births)	185	291	25	94	246	8	41	142	7	< 70	8

WHO response to change

WHO has adjusted its activities to respond to changing patterns of illness. Before 1970, emphasis was placed on the control of infectious and deficiency diseases. Malaria and other parasitic diseases, tuberculosis and other bacterial diseases received priority attention through what became known as vertical programmes. In these programmes (at that time called projects), WHO's contribution included the provision of a suitable expert or a team of experts to provide technical guidance and train national counterparts. Support included the provision of supplies and equipment to ensure the success of the project. Some of these projects were very successful (e.g. the eradication of smallpox and the control of bejel). Success was less evident in malaria control/eradication in some countries.

In the 1970s and early 1980s, the vertical programme approach continued. These projects meant health for some, but in some cases as soon as WHO support came to an end, activities were not maintained by national authorities, so the problem returned. It became clear that the need was rather for collaboration in the development of national health care systems and health manpower development, since many newly independent states in the Region wished to build up their public health infrastructure and respond to the new move away

from health for some to health for all. During this period, many nationals who became responsible for various aspects of public health were trained through WHO fellowships. WHO organized some regional and inter-regional training courses, such as the interregional training course on epidemiological surveillance.

Many countries of the Region were in the vanguard of primary health care, and the spirit of collaboration between Member States was evident. One example was the decision of seven countries (Iran, Iraq, Kuwait, Libya, Qatar, Saudi Arabia and United Arab Emirates) to curtail their own demands on the Organization's budget in favour of expanding activities in the less-favoured countries, in addition to their normal contribution to the WHO budget. There are many other examples of bilateral support directly and through WHO between the well-to-do countries and the less fortunate ones.

The third period started in the early 1980s when available regular budget resources saw no real increase, coinciding with increasing emphasis on chronic noncommunicable disease. This meant globally and regionally significant decreases in the allocation for communicable disease and unfortunately a resurgence of these diseases which was realized rather late in some cases. Many of the achievements of WHO's global programmes reflect those of the Region.

Death rates: age- and sex-standardized, and age-specific, 1955-2025 estimates (per 100 000 population)

Age group	1955	1975	1995	2025
Age- and sex-standardized	2 453	1 698	1 057	630
0-4	7 395	4 523	2 241	874
5-19	898	504	237	91
20-64	1 260	833	486	303
65+	9 002	7 937	6 305	5 008

Programmes which were specifically developed or initiated in the Region are described below.

During the first regional committee held in 1949, the Regional Director indicated that “health is not something which can be done to the people, it must be done for themselves by themselves”. This forward-looking view anticipated the importance of community participation, and became 30 years later one of the pillars of the health-for-all policy through primary health care. Since in the absence of a satisfactory quality of life, primary health care alone cannot maintain and promote health in its full sense, WHO has introduced the basic minimum needs (subsequently called **basic development needs**) approach as a programme of collaboration with Member States of the Region. In introducing this programme in 1987, the Regional Director stated that it would be a mockery to exhort people to lead healthy lives when they do not have sufficient or safe water to drink, enough food, or access to education for their children.

This new concept aimed at achieving a better quality of life. It is a participatory process of integrated socioeconomic development based on self-reliance, and self-management by organized communities supported by coordinated intersectoral action. It is a clear way of involving people in running their own affairs, thus ensuring accountability and transparency.

WHO’s role in this process was mainly of a catalytic nature, such as facilitating political commitment, raising awareness, encouraging training and capacity building in communities, and supporting income-generating schemes, mostly on a loan basis.

In just over 10 years, the basic development needs approach has gained momentum in the Region. New areas have been established in more and more countries. Its success has attracted great interest and inputs from many partners, mainly national authorities and regional and global development agencies. WHO supports the building-up of national capabilities to manage this programme, as well as research to document successes and to find ways of replication and sustainability.

The Member States in the Region no longer regard WHO as an extraneous agency providing technical and financial assistance, but as a full partner, thanks to innovative thinking such as the **joint programme review missions** which were initiated in 1983. These missions are carried out every biennium and are intended to review national achievements for health for all and to identify and plan programmes of collaboration for the coming biennium. This exercise is no longer restricted to reviewing programmes with WHO financial input; it now also involves a process of thinking and introducing structured ap-

proaches in all national programmes. As a result, whenever national programmes are being structured, it is now the practice to formulate objectives, to set measurable targets, to identify approaches to reach these targets, to clearly spell out activities and to develop indicators for measuring achievements.

In most countries of the Region, the **spiritual dimension** plays a considerable role in daily life. It is inseparable from people’s behaviour and beliefs. WHO has initiated activities that help Member States to gain the active support of religious leaders in transmitting health messages to the community. Information and training materials for religious leaders and for dissemination to the public have been planned for many priority health programmes such as control of smoking and drug abuse, prevention of water pollution and control of communicable diseases. Publications such as the six booklets in a series on health education through religion have helped to show that the changes in behaviour required to improve health conform with religious teaching. The spiritual dimension in promoting healthy lifestyles was the subject of a conference held in 1989 in Amman which ended in the Amman Declaration on Health Promotion.

From the outset it was realized that preparing school teachers by providing them with basic facts on the promotion and protection of **health of schoolchildren** is important, and that the participation of educational authorities in this regard is basic. Until 1966, health education was mostly mass-oriented and not focused on the specific needs of various population groups. In 1965, the Regional Committee passed a resolution requesting national authorities to give high priority to preparing teachers for involvement in health education. Scattered efforts were then made for

Leading clusters of diseases/conditions, Eastern Mediterranean Region, selected years (indicative list)

Disease category	1960	1980	1997	2025
Infectious and parasitic	1	2	2	4
Perinatal and maternal	3	5	5	
Malignant neoplasms				5
Endocrine and nutritional				
Mental and behavioural				
Circulatory system	5	1	1	1
Respiratory system	2	3	3	2
All external causes	4	4	4	3

health education in schools, mostly in secondary schools and in the form of special sessions. The impact was not felt to be very great, and it was realized that efforts should be directed at younger age groups, particularly as half of the children at that time did not continue education beyond the primary level. In 1986, following the international consultation on health education for school-age children, WHO in collaboration with UNICEF and UNESCO launched a new initiative to reach and educate children about health through the growing network of primary schools which emphasize action by the pupils themselves in spreading information about health and about healthy behaviour to their families and communities. This project has continued to expand during the last 10 years. In 1996, a guide for evaluation of the programme was developed.

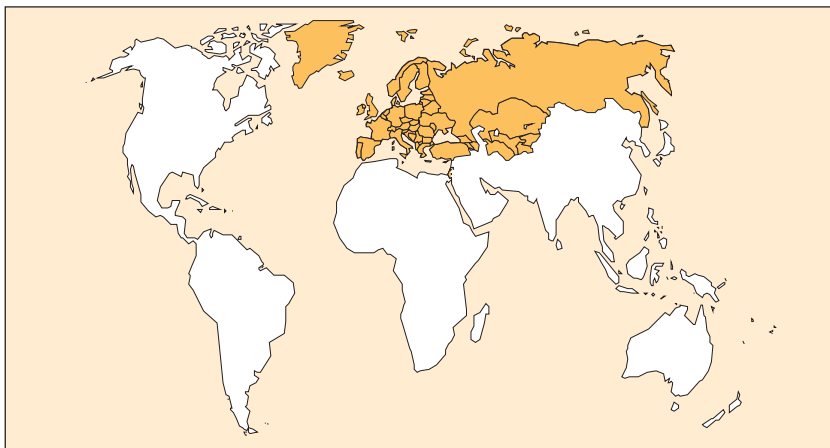
In 1989, another initiative was launched, the **leadership development** training programme, which aims at making individuals in leadership positions (present and future) understand more fully the process involved in developing and implementing the health-for-all strategy, pursuing its values and developing the qualities and abilities required to lead the process.

In the early 1970s more than two-thirds of the population of the world had no access to diagnostic radiology. A new concept for **basic radiological systems** was initiated in 1974 and adopted by WHO in 1978. The Region was proactive in field trials of the system and in the translation of the three manuals prepared with it, to help countries to introduce it and make best use of it.

By 1989 almost all Member States had acquired and installed machines. Unfortunately, interest and enthusiasm has waned considerably during the last few years, partly due to lowered priority given by WHO to this programme in view of the budgetary constraints and due to lack of interest on the part of the major companies producing X-ray equipment. Its price increased to four times that at the time of its initiation (from around \$15 000 to over \$60 000) and so it has lost one of its main comparative advantages. Efforts for local production in one of the countries of the Region in the early days did not meet with the necessary support. This is one of the examples of an applied technology which, though promoted by WHO, could not survive or develop, due to factors beyond WHO's control.

Future prospects

On balance, the health situation and quality of life of the people of the Region has improved during the 1990s. Good progress towards achieving the set targets relating to percentage of gross national product devoted to health, life expectancy and immunization was recorded. Current concerns of the Member States of the Region include appropriate health technology, the elimination and eradication of diseases (especially measles, tuberculosis and poliomyelitis) and health informatics and telematics. In 1997, the Regional Committee urged countries to adopt and implement strategies for the elimination of measles by 2010. Countries with low incidence of tuberculosis were urged to aim at eliminating it by 2010 and countries with intermediate to high incidence of tuberculosis to implement the regional strategy of DOTS as a prerequisite for its elimination. The role of WHO in the Region is to provide technical resources for ministries of health and entities in other, health-related sectors. Collaboration with Member States is mainly directed towards national capacity-building, investing in human resources development and strengthening national health systems.



51 Member States

Population (1997): 869 million

GNP per capita

- Regional average (1995) \$ 11 126
- min.: Tajikistan \$ 340
- max.: Luxembourg \$ 41 210
- Annual average growth rate (1985-1995)
- min.: Georgia -17.0 %
- max.: Ireland 5.2 %

Albania	Monaco
Andorra	Netherlands
Armenia	Norway
Austria	Poland
Azerbaijan	Portugal
Belarus	Republic of Moldova
Belgium	Romania
Bosnia and Herzegovina	Russian Federation
Bulgaria	San Marino
Croatia	Slovakia
Czech Republic	Slovenia
Denmark	Spain
Estonia	Sweden
Finland	Switzerland
France	Tajikistan
Georgia	The Former Yugoslav Republic of Macedonia
Germany	Turkey
Greece	Turkmenistan
Hungary	Ukraine
Iceland	United Kingdom
Ireland	of Great Britain and Northern Ireland
Israel	Ireland
Italy	Uzbekistan
Kazakstan	Uzbooslavia
Kyrgyzstan	
Latvia	
Lithuania	
Luxembourg	
Malta	

Europe

Health trends 1948-1995

Europe has gone through dramatic political and socioeconomic changes during the past 50 years. In the decade immediately after the Second World War, economies and industries, services and infrastructures had to be rebuilt in the war-devastated countries: the main challenges within the health sector were the reconstruction of hospitals and institutions, and combating malnutrition and a number of communicable diseases. Although an economic boom in the early 1950s facilitated work somewhat, difficulties arose from the political differences between the eastern and western parts of the Region, leading to the Cold War which lasted for several decades.

The very first task of the WHO Regional Office for Europe was the reconstruction of health services. Priority was also given to maternal and child health, malaria, tuberculosis, sexually transmitted diseases and environmental health problems such as food hygiene, housing, sanitation and water supply. Attention was given to training and retraining of large numbers of European health personnel and university teachers, and the fel-

lowships programme created tremendous goodwill for WHO in Europe because thousands of former fellows were public health personnel working mainly in national administrations or teaching institutions.

At the First European Conference on Public Health Administration in 1964, the participants noted that health services in industrialized countries were undergoing a number of changes. For example, chronic diseases were growing in importance. The Conference report, published in 1965, became the first detailed post-war report on the organization of health services in countries.

By the end of the 1960s, Europe was an area of fairly uniform and high technical development. Planning and evaluation became accepted as important tools in all health services. Earlier ideological obstacles to national health planning disappeared. WHO also turned its attention to long-term planning. The Regional Office established three long-term programmes on cardiovascular disease, mental health and environmental health which required each programme to work with larger and more varied groups of partners. WHO became the executing agency for many important environmental projects sponsored by UNEP and UNDP.

In 1979, WHO started advocating the application of the principles of Alma-Ata as part of comprehensive

Tables concerning demography, health indicators and GNP are based on United Nations and World Bank estimates. All other information is from regional sources.

Selected health-for-all (HFA) indicators	1975			1997			2025			HFA targets	No. of Member States which have <i>not</i> met the HFA targets in 1997
	Average	Max.	Min.	Average	Max.	Min.	Average	Max.	Min.		
Life expectancy at birth (years)	70	75	59	72	79	64	77	82	72	> 60	0
Infant mortality rate (per 1000 live births)	37	129	9	20	57	5	11	33	5	< 50	2
Under-5 mortality rate (per 1000 live births)	39	133	11	27	75	6	14	42	5	< 70	2

health services. The industrialized countries of the Region took the resolution seriously but believed that it had no relevance to them except that the new approach required them to provide more assistance to developing countries. Many European governments and associations of health professionals mistakenly thought that good primary care was available in the Region. However, this was actually primary medical care, delivered in socialist countries with controlled economies through systematically planned state services, and in countries with free market economies mainly through public and/or private services, supported by sickness insurance.

In 1984, 38 European health-for-all targets were adopted. The report of the 1984 European conference on planning and management for health was a watershed in the development of health planning philosophy in Europe. The point of departure was no longer to be resources or problems, but desired outcomes: improvements in health and the reduction of health hazards. It was acknowledged that health planning had to be multisectoral; was not bound to any specific ideology; could be centred on the national or local levels; and should include both the public and private sectors.

The fundamental changes required to apply the “new” public health in countries could not be made

quickly, but many promising initiatives were under way from the mid-1980s. It was easier to introduce new and exciting projects for health promotion than to reverse long-standing trends. Progress was gradually being made, however, in the areas of quality of care and primary health care, and health promotion initiatives often contributed to it. By 1987, 10 countries had a health policy document related to health for all.

At the end of the 1980s and beginning of the 1990s the communist system collapsed in the countries located in the central and eastern part of the Region, leading to the creation of 21 new countries with democratic constitutions. The process revealed enormous problems in the countries involved, of which health is only a part. Another important event was the reunification of Germany in 1990.

While the advent of these new pluralistic societies brought many positive developments, it also led – at least initially – to a severe economic downturn, an increase in tension (and even to war in 10 countries), as well as to a huge funding crisis and major upheavals in the management of the health sector and other areas. Conflicts and fighting over ethnic and border issues within and among the new democracies brought terrible suffering to millions of people in the Region during the early 1990s.

During the same period, almost all countries in the western part of the

Death rates: age- and sex-standardized, and age-specific, 1955-2025 estimates (per 100 000 population)

Age group	1955	1975	1995	2025
Age- and sex-standardized	949	749	660	473
0-4	1 426	811	561	288
5-19	150	88	73	32
20-64	655	536	499	375
65+	6 523	5 908	5 819	5 112

Region suffered stagnating economic growth, rising unemployment, increasing disparities in income distribution, more extensive migration, a loss of social cohesion and increased violence, all of which have an impact on health. Most countries were under pressure to reduce costs in the health sector, and people became increasingly dissatisfied with the services provided. There was a trend towards the globalization of economic activity, on the one hand, and one towards decentralization, privatization, and an increase in the number of nongovernmental organizations involved in health, on the other. How far this is leading to a weakening of national governments' ability to influence health developments is not clear.

In 1990 the Regional Office created a new programme – EURO-HEALTH – to support the development of health for all in the countries of central and eastern Europe, including the central Asian republics. Helping these countries to close the health gap that lies between them and other Member States of Europe, and to plan for a healthy future, is perhaps the most important health-for-all challenge that will continue into the 21st century.

Life expectancy at birth for the Region as a whole increased during the period 1975-1991 except for a decline in 1983. From 1992 to 1994 it declined again, but this negative trend seems to have been reversed

since 1994. Standardized death rates for infectious and parasitic diseases have been declining between 1975 and 1991, when they started increasing. For circulatory diseases, they were stagnant between 1975-1985, but overall the mortality pattern for major disease categories has changed little during the period 1980 and 1995. Transfrontier environmental pollution and hazardous wastes were more effectively controlled, and the quality of drinking-water improved. However, inequalities in health status between countries had not generally declined and in some cases had increased, particularly between the central and eastern parts of the Region and the rest. Also, tobacco use and alcohol and drug abuse continued to be serious lifestyle problems. Progress in achieving cooperation between different sectors of government and with other sectors, such as private industry, in the interest of health were disappointingly low.

By the mid-1990s, the basic principles of the health-for-all policy had become widely accepted in virtually every country of the Region, and almost all had incorporated at least some parts of them in their national policies. In countries that took this challenge most seriously, major improvements were seen in the way resources for health were mobilized.

There were noticeable improvements in pollution levels in the western part of the Region. In central and

eastern Europe, extensive pollution continued during the 1980s but improved somewhat in the 1990s, largely owing to the economic collapse and closure of big industries that followed the major political and economic upheavals in 1989-1990. In the south-eastern part of the Region, over 100 million people did not have access to sufficient quantities of safe drinking-water in the early 1990s. While many of these problems (establishment of safe drinking-water facilities, industrial pollution control and waste management) could readily be tackled if the necessary economic resources were available, others, such as dealing with the aftermath of the Chernobyl disaster, represent formidable, complex challenges with no easy solutions in sight.

Current situation

There are now 51 Member States in the Region (as opposed to 18 in 1951). The overall population growth rate is very low (under 1%) and in many countries it is close to zero or negative. Throughout the 1990s, birth rates have been decreasing in many countries of eastern and central Europe to levels previously observed only in wartime. Consequently, population ageing has accelerated. The health situation has worsened considerably in the transition economies of central and eastern Europe, where expectations in the early 1990s quickly proved to be over-optimistic.

Although in some countries of western, northern and southern Europe there has been slight progress towards increasing life expectancy, on the whole the trend is now negative. Average life expectancy in the Region decreased from 73.1 years in 1991 to 72.4 in 1994, due almost exclusively to a sharp deterioration in the situation in eastern Europe. If the trend from 1980 to 1994 continues, the

Leading clusters of diseases/conditions, European Region, selected years (indicative list)

Disease category	1960	1980	1997	2025
Infectious and parasitic	5	5		5
Perinatal and maternal				
Malignant neoplasms	2	2	2	2
Endocrine and nutritional				
Mental and behavioural			5	4
Circulatory system	1	1	1	1
Respiratory system	3	4	4	
All external causes	4	3	3	3

Region as a whole will not meet the target of 75 years of life expectancy by 2000.

Countries in the western part of the Region have shown a continuous improvement in most aspects of health status and by the year 2000 will have reached almost all the regional health-for-all targets related to the reduction of mortality rates. As far as disease eradication is concerned, however, these countries are likely to achieve only the eradication of poliomyelitis – not of the other five target diseases (diphtheria, measles, neonatal tetanus, mumps and congenital rubella).

In central and eastern Europe, the decline in health status is now being halted in most countries and replaced by a slight improvement. In the newly independent States, on the other hand, noncommunicable diseases, accidents and infectious diseases have all increased during the 1990s. The upsurge in sexually transmitted diseases and HIV infection is particularly worrying.

The Region is far from reaching its target for smoking (80% non-smokers by the year 2000), although some countries have shown impressive gains. In most western European countries progress is very slow and in the eastern part of the Region a rise in smoking rates among women and

the young has been observed as from the mid-1990s. Alcohol consumption is slowly decreasing in western Europe, while the drug abuse situation is showing little overall improvement. The situation in eastern Europe however is worsening. There are no signs of an effective, Region-wide movement leading to a noticeable change in people's behaviour.

Outlook and challenges for 2025

The European population will grow older. Older people currently represent 13% of the regional population, and this figure will increase to over 15% over the next 30 years. Migration to western Europe from countries outside the Region will continue to grow unless halted by restrictive legislation. If countries take proper steps to help migrants integrate economically and socially, this can create more effective community networks, contributing to better health. Failure to take such steps will increase alienation, social isolation, and violence, and the workload of the health and social sectors.

Imaginative policies are needed to combat the current high levels of unemployment throughout Europe and, in many countries also, the widening income disparities and increasing numbers of people living in poverty.

Otherwise there could be a further rise in health problems such as alcoholism and drug abuse.

Further urbanization is likely throughout the Region. While this trend certainly carries a danger of more social and health problems it can also be turned to advantage by imaginative actions such as “healthy cities”.

There is strong consensus among decision-makers throughout the Region that WHO's long-range regional health-for-all policy is the path not only to lead citizens of central and eastern Europe out of their current predicament in the health sector, but also to bring further improvement in health to western Europe, with forward-looking health policies targeted on equity, improved quality of life, sound ecology and a continually improving quality of care.

The years ahead are likely to see important political, economic, social and technological changes that will provide new opportunities for achieving better health, but also create the need for careful analysis in order to maximize health benefits. Different scenarios can be envisaged for Europe. Whether the outcome will be to enhance or to worsen the health of the 870 million people in the Region depends on the strategic choices that Member States will make.



Bangladesh
Bhutan
Democratic
People's
Republic of
Korea
India

Indonesia
Maldives
Myanmar
Nepal
Sri Lanka
Thailand

South-East Asia

The health situation of the South-East Asia Region today and in the future is determined by many factors including ageing and geographical distribution of the population, poverty and economic progress, education and literacy levels, and infrastructure, functioning and interventions of the health care system.

Along with a slow decline of death rates and gradual increase in life expectancy, the process of epidemiological transition is under way in most countries. Communicable diseases are gradually being replaced by chronic and degenerative conditions (e.g. cardiovascular diseases and cancer) which in some countries are becoming the main causes of death and morbidity. Countries of the Region are thus bearing the double burden of both communicable and noncommunicable diseases.

The infant mortality rate has declined during the last decade in virtually all countries of the Region but still remains high (60-100 per 1000 live births) in some. Under-5 mortality rates show a similar pattern. The maternal mortality ratio has slowly declined overall during the last decade but remains high in most countries, and 235 000 maternal deaths (40% of

10 Member States

Population (1997): 1 457 million

GNP per capita

- Regional average (1995) \$ 532
- min.: Nepal \$ 200
- max.: Thailand \$ 2 740
- Annual average growth rate (1985-1995)
- min.: Bangladesh 2.1 %
- max.: Thailand 8.4 %

the global total) occur in the Region. Only Sri Lanka and Thailand have attained relatively low maternal mortality ratios. Maternal health data show that countries with low maternal mortality have a high proportion of deliveries by trained personnel, a well-established primary health care infrastructure and good referral systems. Management and training programmes in safe motherhood need to focus on midwives and to assign them to the community level.

Health successes

The main change in the morbidity and mortality patterns in the Region during the last 10 years results from a decline of polio, measles, neonatal tetanus and other target diseases of the Expanded Programme on Immunization.

Polio eradication activities have accelerated dramatically, particularly with the implementation of national immunization days in nine countries. Health experts are confident that they will be able to eradicate poliomyelitis through effective universal immunization and adequate epidemiological surveillance. A 70% reduction in the number of reported cases of diphtheria and whooping cough has been achieved as a result of the 90% immunization coverage. The total number of measles deaths in the Region has decreased by about 87% and

Tables concerning demography, health indicators and GNP are based on United Nations and World Bank estimates. All other information is from regional sources.

Selected health-for-all (HFA) indicators	1975			1997			2025			HFA targets	No. of Member States which have <i>not</i> met the HFA targets in 1997
	Average	Max.	Min.	Average	Max.	Min.	Average	Max.	Min.		
Life expectancy at birth (years)	52	66	42	63	73	53	72	78	67	> 60	3
Infant mortality rate (per 1000 live births)	124	171	44	68	104	15	32	41	6	< 50	5
Under-5 mortality rate (per 1000 live births)	177	240	50	85	142	18	38	50	8	< 70	5

the number of reported cases has fallen by about 67% as a result of about 80% immunization coverage. Bhutan, the Democratic People's Republic of Korea, Maldives, Sri Lanka and Thailand have achieved the target of no more than one neonatal tetanus case per 1000 live births.

Another positive epidemiological trend is the fall in the incidence and prevalence of leprosy. Multidrug therapy has proved so successful that it is expected to eliminate leprosy as a public health problem by 2000. There has also been a clear decline in the number of registered cases of guinea-worm disease in India since 1984. If the prevention and control programmes of such diseases are intensified, there is a real chance that they may be eradicated, eliminated or brought to very low levels of incidence and/or prevalence during the next few years.

Unfinished agenda

Despite overall improvements in socioeconomic status and increased life expectancy, **communicable diseases** are still deep-rooted in the Region. Old diseases like cholera and tuberculosis still dominate the disease pattern, while malaria, plague and kala-azar, which were on the verge of eradication, have reappeared. An added cause for concern is the appearance of drug-resistant strains of

tuberculosis, gonococcal infections and malaria. New diseases such as cholera caused by strain O139 and HIV infections have appeared, with HIV/AIDS assuming epidemic proportions and becoming one of the most menacing health problems in some South-East Asian countries. Diseases which were not previously public health concerns are now assuming importance in association with HIV in some countries. In light of these trends, WHO has formulated a strategy to strengthen national and international capacity in the surveillance and control of communicable diseases representing new, emerging and re-emerging public health problems. The underlying factors contributing to the high prevalence of communicable diseases include poverty, malnutrition, ignorance, an insanitary environment and lack of safe drinking-water. Population growth and rapid urbanization with attendant overcrowding, poor housing and environmental deterioration have worsened the situation, and have contributed to the emergence and re-emergence of infectious diseases in the Region.

It is estimated that acute respiratory infections cause about 1.4 million deaths in children aged under 5 annually in the Region. Diarrhoeal diseases continue to be one of the leading causes of childhood death in most South-East Asian countries, accounting for about 25% of under-5

Death rates: age- and sex-standardized, and age-specific, 1955-2025 estimates (per 100 000 population)

Age group	1955	1975	1995	2025
Age- and sex-standardized	2 431	1 655	1081	643
0-4	7 298	4 290	1 992	797
5-19	849	473	254	73
20-64	1 234	865	569	383
65+	8 939	7 657	6 771	5 363

mortality. There are over 1 million under-5 deaths each year from diarrhoea.

Tuberculosis still kills more adults than any other single infectious disease. It is estimated that 3.5 million new cases occurred in the Region during 1995, representing about 40% of the global disease burden. This includes 2.3 million new cases in India, 0.5 million in Indonesia, and 0.4 million in Bangladesh. About 1 million people died from tuberculosis in the Region during 1997, accounting for nearly 40% of global deaths from the disease. HIV-positive persons with a prior tuberculosis infection are especially vulnerable to developing active tuberculosis. For example, 60-80% of people with AIDS in India, Myanmar, Nepal and Thailand develop tuberculosis.

Malaria still dominates the disease pattern in the Region, with 1.2 billion people in eight endemic countries living in malarious areas. The overall malaria situation has been static over the last 12 years, with reported cases ranging from 2.5 to 3.4 million, and reported deaths from 5000 to 8000. During 1996 the reported number of cases and deaths due to malaria were nearly 3.4 million and 8000 respectively. The estimated incidence and number of deaths are much higher. At the country level, the malaria situation is improving in Nepal, Sri Lanka and Thailand, is static in Bhutan, India, Indo-

nesia and Myanmar, and is deteriorating in Bangladesh. The resistance of *P. falciparum* to various drugs constitutes one of the main technical impediments to malaria control in the Region. Drug resistance has been increasing and is now pronounced in all of the malaria-endemic countries. Vector resistance to insecticides and changes in vector behaviour to avoid sprayed surfaces are considered to be some of the factors impeding malaria control efforts. Other administrative and operational constraints include inadequate budgets, shortage of trained personnel at all levels, uncontrolled large-scale population movements, and inadequate intersectoral collaboration and community participation. WHO is assisting Member States in implementing the adapted global malaria control strategy which emphasizes early diagnosis and treatment with effective antimalarial drugs, and selective, cost-effective vector control measures. Emphasis is currently being placed on coordination of malaria control in border areas, upgrading managerial and technical capability and capacity within national programmes, and development of capabilities in applied research methodologies.

The HIV/AIDS pandemic reached the Region relatively late, but has spread rapidly in the last few years. Infection rates have now begun to increase in the general population in addition to those in high-risk behav-

our groups. The epidemic in Asia is still at an early stage and the situation demands urgent control measures that need to be sustained. While the spread of AIDS in various population groups is particularly remarkable in countries such as India, Myanmar and Thailand, the potential for spread within other South-East Asian countries is enormous. It is estimated that by the end of the century, 8-10 million men, women and children are likely to become infected with HIV within the Region, accounting for over 25% of the global cumulative infections.

It is estimated that there were 150 million cases of curable sexually transmitted diseases among adults in the Region in 1995. Syphilis accounts for approximately 5-8 million cases, gonorrhoea for 29 million, chlamydial infections for 40 million, and trichomoniasis for 75 million cases. Although data from countries in the Region on the incidence and prevalence of sexually transmitted diseases are inadequate, recent data from Thailand show a declining trend.

In addition to the current communicable diseases, there are viral infections that have the potential to cause epidemics, including hantaviruses, yellow fever and filoviruses. Hantavirus infection in patients with haemorrhagic fever and kidney involvement have been clinically and serologically documented only in Myanmar to Sri Lanka. In addition, antibodies to hantaviruses have been detected in samples of human and rodent sera from India, Indonesia and Thailand. These findings suggest that there is wide circulation of hantaviruses in both human and rodent populations in the Region. Although Ebola haemorrhagic fever has not occurred in the Region, antibodies to Ebola-related filoviruses have been detected in a species of monkey from Indonesia. Until now, how-

Leading clusters of diseases/conditions, South-East Asia Region, selected years (indicative list)

Disease category	1960	1980	1997	2025
Infectious and parasitic	1	1	1	3
Perinatal and maternal	3	3	3	
Malignant neoplasms				2
Endocrine and nutritional	2	2		5
Mental and behavioural				4
Circulatory system			2	1
Respiratory system				
All external causes				

ever, there has been no report of human illness associated with the Ebola-related virus. Yellow fever also has never been reported in the Region. The recent epidemic of yellow fever in Kenya, however, makes it apparent that the virus could spread to coastal parts of East Africa and from there to Asia. Since the mosquito vector of yellow fever is widely prevalent in the countries of the Region, and since the population has little or no immunity to the disease, there is considerable potential for yellow fever to spread in epidemic proportions.

Challenges for the future

If health authorities vigorously combat infectious diseases such as diarrhoea, acute respiratory infections, malaria and vaccine-preventable diseases, a reduction in infant and overall mortality can be achieved. The countries which are in the early stage of the epidemiological transition are Bangladesh, Bhutan, most of the states in India, Maldives, Myanmar and Nepal.

As transition proceeds, the infective component is gradually replaced by non-infective and noncommunicable conditions such as cardiovascular diseases, cancer and congenital anomalies, endocrine disorders and accidents. This is the situation in the

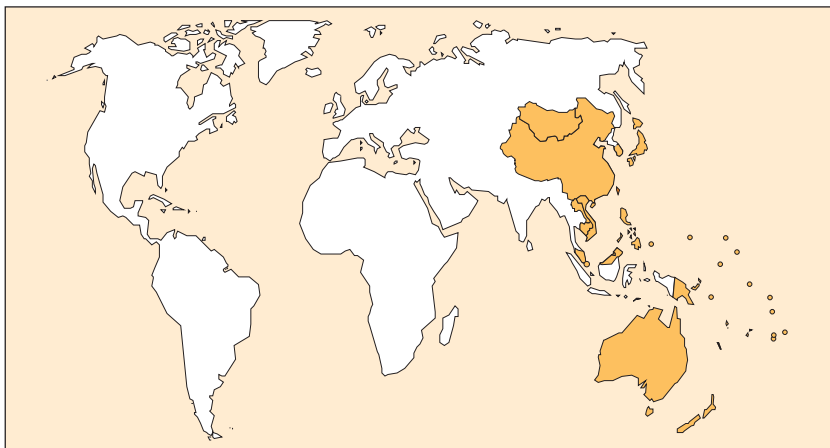
Democratic People's Republic of Korea, Sri Lanka and Thailand, in some states of India, which have achieved high levels of life expectancy, and to some extent in Indonesia, where noncommunicable diseases have more recently become a major public health problem and one of the main causes of death. At present the risk of death from noncommunicable diseases during adulthood is considerably higher in the developing world, including South-East Asia, than in established market economies.

Cardiovascular and cerebrovascular diseases have emerged as major contributors to morbidity and mortality in many countries of the Region. In India it is estimated that every year almost 800 000 people die from coronary heart disease and more than 600 000 from stroke.

The death rate from cancer is rather consistent in some countries in the Region where data are available, at around 37-38 per 100 000 population per year. This is lower than in industrialized countries, mainly because of the different age structure of the populations, but it means that more than 1000 persons die every day of cancer. Due to lack of good palliative care in most instances, they die with unbearable pain and suffering, for patients and families alike.

Another disease that is increasing dramatically with urbanization and changing lifestyles and nutrition habits is diabetes mellitus. Whereas its prevalence has been found recently to be about 2% in rural populations in India, its prevalence in urban areas is about 3% with local peaks as high as 8%. Similar results were found in Thailand in 1991.

Forecasts envisage morbidity and mortality burdens still dominated primarily by re-emerging and emerging infectious diseases with the beginning of a shift towards noncommunicable chronic diseases for Bangladesh, Bhutan, most of the states of India, Maldives, Myanmar and Nepal. Noncommunicable diseases and accidents will affect to a greater extent the more advanced countries of the Region which have achieved higher levels of life expectancy. The HIV/AIDS epidemic will be present throughout the Region, being close to its peak in India, Myanmar and Thailand, and rapidly spreading in some other countries.



27 Member States

1 Associate Member

Population (1997): 1 634 million

GNP per capita

● Regional average (1995) \$ 4 253
 min.: Viet Nam \$ 240
 max.: Japan \$ 39 640

● Annual average growth rate (1985-1995)
 min.: Mongolia -3.8 %
 max.: China 8.3 %

Australia	Nauru
Brunei	New Zealand
Darussalam	Niue
Cambodia	Palau
China	Papua New Guinea
Cook Islands	Philippines
Fiji	Republic of Korea
Japan	Samoa
Kiribati	Singapore
Lao People's Democratic Republic	Solomon Islands
Malaysia	Tonga
Marshall Islands	Tuvalu
Micronesia (Federated States of)	Vanuatu
Mongolia	Viet Nam
	<i>Associate Member:</i>
	Tokelau

Western Pacific

Health trends, 1948-1997

When the Regional Office was established in 1950, most of the countries in the Region were recovering from the devastation of the Second World War. People were getting sick and dying from diseases that were mostly preventable, most of which were of an infectious or nutritional origin. Malaria, tuberculosis, yaws, venereal diseases, filariasis, trachoma, cholera, dysentery and typhoid were rampant. In some countries, 50% of children died before they reached 1 year.

During this period, very few urban communities had water supplies and facilities for the sanitary disposal of human waste. Nutritional deficiencies, particularly lack of proteins and calories, were widespread, aggravating most infectious ailments. The main problems were the paucity of strong public health programmes (health services were mostly concerned with curative medicine and little attention was paid to preventive care); a severe shortage of trained workers of all categories; and incomplete or inaccurate vital and health statistics. The primary purpose of WHO support in this period was to help governments to develop,

strengthen and expand their health services. The 1950s saw the first campaigns aimed at controlling tuberculosis, yaws, malaria, diphtheria and venereal diseases. Field activities were directed towards the eradication of epidemics. Where feasible, WHO promoted the operational integration of health services. Improving environmental sanitation was another priority area of cooperation. Technical support was provided to countries to improve the standard of teaching and training in the health and medical professions. Fellowships were awarded to enable medical schools and training institutions to upgrade their teaching staff, especially in the fields of tuberculosis, maternal and child health, nursing, nutrition, malaria and public health.

In the 1960s, the general policy of strengthening public health administration was maintained. The main emphasis was on the training of all categories of health personnel; control of communicable diseases; development of specific services such as maternal and child health and nursing; and stimulation of environmental sanitation. Considerable progress was made in malaria eradication. WHO supported the establishment of technically strong central administrations capable of building long-term health development plans and carrying out intensified development/

Tables concerning demography, health indicators and GNP are based on United Nations and World Bank estimates. All other information is from regional sources.

Selected health-for-all (HFA) indicators	1975			1997			2025			HFA targets	No. of Member States which have <i>not</i> met the HFA targets in 1997
	Average	Max.	Min.	Average	Max.	Min.	Average	Max.	Min.		
Life expectancy at birth (years)	64	74	36	70	80	53	75	82	67	> 60	3
Infant mortality rate (per 1000 live births)	57	222	10	36	102	4	15	40	4	< 50	5
Under-5 mortality rate (per 1000 live births)	63	317	16	40	140	6	17	46	5	< 70	3

expansion of rural health services. As a result, the integrated approach to public health became more widely accepted and implemented. Long-range plans for comprehensive rural health services were developed, with maternal and child health as an integral component. There was a greater awareness of the necessity to strengthen environmental health involving both public health departments and public works agencies through community water supply programmes. Hospital services were developed in order to enable the relatively small number of existing institutions to fill gaps in curative services. As for the antimalaria programme, the concept of eradication was accepted by most governments. With regard to tuberculosis, chemotherapy on a domiciliary basis had become more widely accepted and there was more understanding of the value of BCG vaccinations. There was a better understanding of the benefits of more community-based and less institutional and segregated treatment of leprosy.

In the 1970s, communicable diseases were still the major causes of morbidity and mortality in developing countries. However, cardiovascular diseases, cancer, accidents and injuries were assuming increasing importance as causes of death. In countries which experienced industrial growth, there was a rise in accidents and pollution. In countries where

there were problems of internal security, services were disrupted. Epidemics of diseases such as malaria broke out. On the other hand, increasing expectations were evident in requests for more health centres, hospitals, health insurance and social security schemes, community water supply and sewerage systems. There was a need for many countries to have more staff flexibility and more coverage of the population by multipurpose health workers. For malaria, attention was given to training personnel and promoting national training centres. For tuberculosis, BCG immunization had achieved remarkable results in both coverage and quality but the problem was one of case-finding. Other communicable diseases such as cholera, typhoid fever, dengue haemorrhagic fever, Japanese encephalitis, plague and venereal infections were causing concern. Programmes to counter these diseases were hampered by lack of trained personnel and the absence of an efficient system of reporting and registration of vital events. The maternal and child health programme however continued to expand basic health services.

In the 1980s, communicable diseases were still major health problems in most of the countries in the Region. WHO paid special attention to the strengthening of national capabilities in all aspects of the managerial process, including policy formulation,

Death rates: age- and sex-standardized, and age-specific, 1955-2025 estimates (per 100 000 population)

Age group	1955	1975	1995	2025
Age- and sex-standardized	2 150	826	725	510
0-4	5 768	1 364	926	343
5-19	681	149	87	31
20-64	1 272	452	371	346
65+	8 695	5 665	6 058	5 298

programming, evaluation and information support. Most activities focused on strengthening or reorienting primary health care through training, operational studies and technical advice. The objective was the integrated delivery of health services, especially in the areas of maternal and child health, immunization, diarrhoeal disease control, water supply and sanitation. However, most countries still had to address inappropriate training and deployment of staff, inadequate patterns of service and low quality of maternal and child health and family planning services.

Malaria prevention and control deteriorated in a number of countries owing to administrative difficulties or lack of resources. Leprosy programmes were integrated into general health services and there was a general improvement in leprosy case-finding. Improved programmes led to a significant decline in mortality and morbidity due to tuberculosis. However, there was a general increase in the incidence of sexually transmitted diseases, especially gonorrhoea. Community participation and health education were key components in the provision of safe drinking-water and adequate sanitation. Pollution and food safety problems were emerging. The Regional Office has provided expertise for industrial waste effluent control, water quality monitoring management and environmental monitoring.

In the 1990s, a stronger emphasis was placed on the six regional priorities – development of human resources for health, eradication or control of selected diseases, health promotion, environmental health, exchange of information and experience and strengthening management. A seventh regional priority – control of emerging and re-emerging communicable diseases – was added in 1996.

Considerable progress was made towards the eradication of selected diseases. Supplementary immunization with the aim of eradicating poliomyelitis began in 1992, and in the period from 1993 to 1997 approximately 100 million children were immunized each year in a series of national and subnational immunization days and high-risk response immunization initiatives.

The annual incidence of tuberculosis did not decline, although the mortality rate fell. The resurgence of malaria continued to pose problems. The control of other diseases such as acute respiratory infections and diarrhoeal diseases made considerable progress. AIDS prevention and control programmes were established in most countries and areas.

Current situation

Since 1991, two primary trends have influenced health policies in the Region: the evolution of new organizational structures in the former centrally-planned economies and initia-

tives in most countries and areas to strengthen individual and community participation in development. Countries in the Region are at different stages of the health transition.

Cambodia, the Lao People's Democratic Republic, Papua New Guinea and some smaller Pacific island countries all have segments of the population at the early stage of the health transition, experiencing infectious diseases, high maternal mortality ratios and infant mortality rates.

Fiji, Malaysia, the Federated States of Micronesia, Mongolia, the Philippines, rural areas of China and Viet Nam include populations in the middle stage of the health transition, who experience a comparatively high incidence of communicable diseases and maternal morbidity, while at the same time suffering strokes and a variety of cancers.

Considerable progress was made towards the eradication of selected diseases. Supplementary immunization with the aim of eradicating poliomyelitis began in 1992, and in the period from 1993 to 1997 approximately 100 million children were immunized each year in a series of national and subnational immunization days and high-risk response immunization initiatives.

As demonstrated by the marked decline in diseases attributable to poor water quality and sanitation, the Region has achieved many collective goals in environmental protection. For the majority of developing countries, efforts focus on the emerging physical hazards associated with chemicals, air pollution and large construction projects. Community sanitation and waste management are high priority concerns in most island states.

Human resources are often concentrated in urban areas where conditions of work are usually better. In some countries, critical nationwide

Leading clusters of diseases/conditions, Western Pacific Region, selected years (indicative list)

Disease category	1960	1980	1997	2025
Infectious and parasitic				
Perinatal and maternal				
Malignant neoplasms	3	2	2	2
Endocrine and nutritional				
Mental and behavioural				
Circulatory system	2	1	1	1
Respiratory system	1	3	3	4
Digestive system ^a	5	5	5	5
All external causes	4	4	4	3

^a Category used by Western Pacific Region only.

public service downsizing measures are being implemented with consequent effects on distribution of the workforce. Shortages of skilled workers continue to be a concern in many island countries.

Some of the most interesting and challenging recent developments relate to the promotion and support of new structures for the delivery of health services (China and New Zealand).

One of the more significant efforts in most countries in the Region is the strengthening and realigning of health promotion programmes to meet the challenges posed by emerging health conditions associated with lifestyle and individual behaviour.

future trends

The primary health care approach as a fundamental value for health policies will remain valid into the 21st century. However, a number of dominant themes are emerging, including the use of more comprehensive frameworks for planning new structures for the delivery of care and the involvement of the community.

Rapid economic growth in the majority of countries in the Region has provided most communities with significant improvements to their quality of life and has reduced the

burden of traditional communicable diseases and other conditions that typically affect young children. However, it is apparent that this new prosperity has also led to many new influences that have the potential to reduce the quality of life.

Individuals and communities will have a greater role, while the influence of governments will be less pervasive.

The epidemiological transition is one long-term trend directly influencing the needs of the health sector. The other is demographic changes, and in particular, the significant rise in the number of people living beyond 65 years.

The health sector in the 21st century will face three major challenges. First, there is a need to ensure that all citizens enjoy equal access to health care. In a market-oriented economy, special attention will be needed to ensure that health care is accessible for those unable to pay. The second major challenge concerns the provision of quality care. The issue of quality also applies to the best and most appropriate care given for acute conditions. The third major challenge is that of costs. The health industry is very labour-intensive, so its costs will typically increase more rapidly than costs in the economy as a whole.

There is no unique solution that will achieve the best results in every situation. Nor is there even any ideal solution that can be foreseen. The renewal of health for all framework is a guide for setting directions and an attempt to highlight the most significant issues.

The next step is to develop implementation plans for the movement from policy to action. The implementation of policies in the 21st century calls for close monitoring, further refinement and development of appropriate, useful and relevant indicators. It also calls for implementation to take place through an appropriate infrastructure, which includes standards, guidelines, workforce development and technical support.