Glossary of Terms

used in the "Health for All" Series No. 1-8

WORLD HEALTH ORGANIZATION

GENEVA

1984

"HEALTH FOR ALL" SERIES, No. 9

ISBN 92 4 180009 7

PRINTED IN SWITZERLAND

84/6186 — Kundig — 10 000

Contents

Preface

The International Conference on Primary Health Care held in 1978 at Alma-Ata declared that "A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice". The Conference called on all governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors.

WHO subsequently issued guiding principles for formulating national strategies for health for all. It then prepared a Global Strategy, based on the national strategies, which was adopted by the World Health Assembly in 1981. In 1982 the Assembly approved a Plan of Action for implementing that Strategy.

The development and implementation of national strategies require the application of a managerial process. One component of this process is evaluation using appropriate indicators. WHO issued guiding principles for such a managerial process. Subsequently, the Organization developed its Seventh General Programme of Work, which constitutes WHO's support to Member States in attaining the goal of health for all.

The essential documentation for all the above has been published in a special *"Health for All" Series*, which consists at present of the following eight volumes:

No. 1 — *Alma-Ata 1978: Primary Health Care* contains the Declaration of Alma-Ata, the report of the Conference of Alma-Ata, and the joint report of the Director-General of WHO and the Executive Director of UNICEF.

No. 2 — *Formulating Strategies for Health for All by the Year 2000* contains guiding principles and discusses essential issues for strategy formulation.

No. 3 — *Global Strategy for Health for All by the Year 2000* outlines, against the background of world health and related socioeconomic problems and trends, the ingredients of health policies and the development of health systems based on the concept of primary health care. The book also explains how to promote and support the development of such health systems; to generate and mobilize resources for them; to ensure the intercountry cooperation required; to monitor and evaluate health strategies; and how WHO can provide appropriate support.

No. 4 — *Development of Indicators for Monitoring Progress towards Health for All by the Year 2000* lists possible indicators and discusses the information requirements.

No. 5 — *Managerial Process for National Health Development* sets out guiding principles for the application of a managerial process to develop and implement strategies for health for all.

No. 6 — *Health Programme Evaluation* sets out guiding principles for the application of evaluation as part of the managerial process for national health development.

No. 7 — *Plan of Action for Implementing the Global Strategy for Health for All* also contains an index to the first seven volumes.

No. 8 — *Seventh General Programme of Work covering the period 1984-1989* contains the first of the three general programmes of work of the World Health Organization that will cover the period until the target date of the year 2000.

Introduction

In all branches of the sciences and the arts terms are used at any given time with meanings specific to the subject and its context unlike dictionary definitions. In the above publications listed on page 6, certain terms have been used in the specific context of developing and implementing strategies for health for all by the year 2000. Their meaning may therefore not be clear to all readers. The descriptions that follow attempt to clarify them.

The terms have been grouped in a functional manner, so as to illustrate their relationships, rather than in the usual glossary format. They are, however, numbered for purposes of reference in the order of their occurrence in the text and an alphabetical index is provided at the end of the volume (see page 35).

Description of terms[1]

1. Health for All

In 1977 the Thirtieth World Health Assembly decided that the main social goal of governments and WHO in the coming decades should be the attainment by all the people of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. This goal is commonly known as "health for all by the year 2000". "Health for all" is a process leading to progressive improvement in the health of people, not a single, finite target. It will be interpreted differently by each country in the light of its social and economic characteristics, the health status and morbidity patterns of its population, and the state of development of its health system. However, there is a health baseline below which no individuals in any country should find themselves; *all* people in *all* countries should have a level of health that will permit them to work productively and to participate actively in the social life of the community in which they live.

Health for all does not mean that in the year 2000 doctors and nurses will provide medical care for everybody in the world for all their existing ailments and that nobody will be sick or disabled. It does mean that health begins and is fostered or endangered at home, in schools and in factories, where people live and work. People will use better approaches than they do now for preventing disease and alleviating unavoidable illness and disability, and have better ways of growing up, growing old and dying in dignity.

[1] An alphabetical list of the terms explained is given on page 35.

Essential health care will be accessible to all individuals and families, in an acceptable and affordable way, and with their full involvement. There will be an even distribution among the population of whatever resources for health are available and people will realize that they themselves have the power to shape their lives and the lives of their families, free from the avoidable burden of disease, and aware that ill-health is not inevitable.

2. Primary health care

The key to attaining the goal of health for all by the year 2000 is, in the view of the Alma-Ata Conference, primary health care. **Primary health care** is essential health care made accessible at a cost the country and community can afford, with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it. Related sectors should also be involved in it in addition to the health sector. At the very least it should include education of the community on the health problems prevalent and on methods of preventing health problems from arising or of controlling them; the promotion of adequate supplies of food and of proper nutrition; sufficient safe water and basic sanitation; maternal and child health care, including family planning; the prevention and control of locally endemic diseases; immunization against the main infectious diseases; appropriate treatment of common diseases and injuries; and the provision of essential drugs.

Primary health care is the central function and main focus of a country's health system, the principal vehicle for the delivery of health care, the most peripheral level in a health system stretching from the periphery to the centre, and an integral part of the social and economic development of a country. The form it takes will vary according to each country's political, economic, social, cultural and epidemiological patterns. To be successful it needs in-

dividual and community self-reliance and the maximum **community involvement** or participation, that is to say, the active involvement of people living together in some form of social organization and cohesion in the planning, operation and control of primary health care, using local, national, and other resources. The term "involvement" is preferable to "**participation**" because it implies a deeper and more personal identification of members of the community with primary health care. In community involvement individuals and families assume responsibility for their, and the community's, health and welfare and develop the capacity to contribute to their own and the community's development. Part of such responsibility is **self-care**, which implies largely unorganized health activities and health-related decision-making carried out by individuals, families, neighbours, friends and workmates. These include the maintenance of health, prevention of disease, self-diagnosis, self-treatment, including self-medication, and self-applied follow-up care after contact with the health services.

3. Community involvement

4. Community participation

5. Self-care

The term **primary health care approach** is often used. It simply means the establishment of a health system as described in the Alma-Ata report, with primary health care as the central function and main focus supported by the rest of the health system.

6. Primary health care approach

Primary health care should be distinguished from **basic health services**, which consist of a network of institutions run by the government as part of the country's administrative system that provide certain indispensable medical care and preventive services to individuals. The services are rendered by professional and non-professional staff who have been selected without prior consultation with the community they serve, and the community itself is not necessarily involved in the action taken to improve its health. Moreover, basic health services usually start from

7. Basic health services

the centre and extend out to the periphery; they do not necessarily attempt to identify and use appropriate health technology (see 80 below), and they do not concern themselves with the socioeconomic aspects of health and the related intersectoral action (see 19 below).

To achieve the goal of health for all by the year 2000 in a country, it is essential to have an adequate number of properly trained health workers. The provision of health workers sufficiently trained to meet present and future needs for activities in the health and related sectors is known as **health manpower development**. It involves the planning, production and management of health manpower — that is, the estimation of needs and the taking of steps to ensure that the health workers are properly trained, recruited or otherwise employed, adequately paid, and given career prospects that will keep them within the health system (see 12 below). To carry out primary health care **community health workers** are needed, that is to say, trained health workers who live within the community and work with other health and development workers as a team. They provide the first contact between the individual and the health system. The types of community health worker vary between countries and communities according to their needs and the resources available for meeting them. In many societies these workers come from and are chosen by the community in which they work. In some countries they work as volunteers; normally those that work part-time or full-time are rewarded, in cash or in kind, by the community and the formal health services. Community health workers, except general medical practitioners and nurses on the one hand, and practitioners of traditional medicine on the other, may fall within the category of **auxiliary worker**, that is, one who has less than full professional qualifications in a particular field and is supervised by a professional worker. Some auxiliary workers with special training and skills were formerly known

8. Health manpower development

9. Community health worker

10. Auxiliary worker

as paramedical workers, but this term has been abandoned. Health workers of all types and degrees of training at each level of the health system are expected to work together as necessary as a **health team**, which is a group of persons having a common health goal, to the achievement of which each member of the team contributes in accordance with his or her competence and skill and in coordination with the functions of the others.

11. Health team

A **health system** is the complex of interrelated elements that contribute to health in homes, educational institutions, workplaces, public places, and communities, as well as in the physical and psychosocial environment and the health and related sectors. A health system is usually organized at various levels, starting at the most peripheral level, also known as the community level or the primary level of health care, and proceeding through the intermediate (district, regional or provincial) to the central level. The intermediate and central levels deal with those elements of the health system that devolve on them by virtue of the country's administrative organization and they also provide progressively more complex and more specialized care and support. It is not easy to conceive such a multifaceted health system, to maintain its cohesion and to ensure that it functions in compliance with agreed policies. **Social control** implies that individuals and communities are involved in doing just that, at community and other levels, in a manner that is commensurate with the country's political, social, cultural and administrative traditions. A **comprehensive health system** denotes one that includes all the elements required to meet all the health needs of the population.

12. Health system

13. Social control

14. Comprehensive health system

The aim of a health system is **health development** — the process of continuous, progressive improvement of the health status of a population. **Health status** is the general term for the state of health of an individual, group, or population

15. Health development

16. Health status

measured against accepted standards (see also 65 "Indicators" and 66 "Criteria", below). The somewhat similar term "level of health" usually implies quantification of health status. **Health situation** implies more than health status; it also includes measures taken to improve health, the resources being devoted to health, an appreciation of specific health problems that require particular attention, and the degree of people's awareness about their health and ways of improving it. The term **health trends** refers not only to the present health situation but also to what led up to it and to prospects for the future. Health development and socioeconomic development are inseparably linked, progress in health leading to and at the same time depending on socioeconomic progress. Health development implies coordination at all levels between activities in the health sector and activities in other social and economic sectors such as education, agriculture, industry, housing, public works, water supply, and communications. Hence the need for **intersectoral action**, that is, action in which the health sector and other relevant sectors collaborate for the achievement of a common goal, the contributions of the different sectors being closely coordinated. For practical purposes intersectoral action and **multisectoral action** are synonymous terms, the former perhaps emphasizing the element of coordination, the latter the contribution of a number of sectors. There is also a need for coordination within the **health sector**, that is, the sector that includes government ministries and departments, social security and health insurance schemes, voluntary organizations and private individuals and groups, providing health services. **Coordination within the health sector** implies organized collaboration as necessary among those providing the services at the same and different levels of the health system in order to make the most efficient use of resources, as well as within and among the various categories of health workers following agreement on the division of labour.

17. Health situation

18. Health trends

19. Intersectoral action

20. Multisectoral action

21. Health sector

22. Coordination within the health sector

A health system needs **health resources** — all the means available for its operation, including manpower, buildings, equipment, supplies, funds, knowledge and technology. These essential resources, ideally well planned, organized and administered, form the **health system infrastructure**, which includes services, facilities, institutions or establishments, organizations, and those operating them for the delivery of a variety of health programmes. They provide individuals, families and communities with health care that consists of a combination of promotive, protective, preventive, diagnostic, curative and rehabilitative measures. Thus the Seventh General Programme of Work (see 88 below) has a section on health system infrastructure that aims at the establishment, progressive strengthening, organization, and operational management of health system infrastructures, including the related manpower, through the systematic application of a well defined managerial process and related health systems research, the delivery of country-wide health programmes using appropriate technologies, and social control of the health system and the technology used in it.

23. Health resources

24. Health system infrastructure

One of the facilities of the health system is the **health centre**, from which health care is delivered to a defined community or area. In WHO usage a health centre is a centre that carries out promotive, protective, preventive, diagnostic, curative and rehabilitative activities for ambulant people, but has no beds other than perhaps the few needed for emergencies and maternity care. In some countries, however, the term is applied to institutions that have beds and may or may not have physicians on the staff; while in yet others it is applied to institutions that provide specialized care.

25. Health centre

Community health workers who cannot diagnose or treat certain patients by themselves, or who face health or social problems that they cannot solve by themselves, can resort to

26. Referral

referral. That is, they can turn for support or refer patients to an appropriate facility, institution or specialist at the next more central level in the health system, such as a health centre or hospital. They in turn can refer problems and patients to the successive levels in the health system, which have health workers with progressively higher training and can give progressively more specialized care over a wider range and using more advanced technology than can be offered at the peripheral level. Referral also implies a two-way exchange of information and returning patients to those who referred them, for example from the first referral level to the community health worker, furnished with appropriate information about the patient's condition and instructions for follow-up care. In addition, it implies providing guidance to community health workers on ways of dealing with problems referred.

27. Secondary health care

Referral services in the first instance provide **secondary health care**, which is of a more specialized kind than can be offered at the most peripheral level, for example radiographic diagnosis, general surgery, care of women with complications of pregnancy or childbirth, and diagnosis and treatment of uncommon or severe diseases. This kind of care is provided by trained staff in such institutions as district or provincial hospitals. Still more specialized care that requires highly specific facilities and the attention of highly specialized health workers, for example for neurosurgery or heart surgery, is provided by **tertiary health care**.

28. Tertiary health care

Included in the task of creating a health system that will permit the entire population to lead a socially and economically productive life are health promotion and protection and disease prevention, which overlap to a certain extent. **Health promotion** is an evolving concept that encompasses fostering life-styles and other social, economic,

29. Health promotion

environmental and personal factors conducive to health. These include: raising people's awareness about health matters and enabling them to cope with health problems by increasing their knowledge and providing them with valid information; encouraging adequate and appropriate diet and exercise and enough sleep; ensuring education and work in conformity with physical and mental capacity; making available suitable housing and safe water and sanitary facilities; improving the physical, economic, cultural, psychological, and social environment; and social support, for example by local women's groups. Activities to promote health may be decided and carried out by individuals, families, communities, various associations of people, health workers, governments, nongovernmental organizations, or combinations of these. **Health protection** implies guarding against potential dangers to health, such as wearing protective clothing against inclement weather, or taking measures to protect workers against the specific hazards of their work. **Disease prevention** covers measures not only to prevent the occurrence of disease, such as immunization or disease vector control or anti-smoking activities, but also to arrest its progress and reduce its consequences once it is established. **Primary prevention** seeks to prevent the initial occurrence of a disease or other health problems such as low birth weight, through such measures as health education, immunization, improved nutrition, improvement of the environment and appropriate care of women during pregnancy. **Secondary prevention** seeks to arrest or retard existing disease through early detection and appropriate treatment or to reduce the occurrence of relapses and the establishment of chronicity through, for example, rehabilitative measures, corrective surgery and the provision of prostheses.

30. Health protection

31. Disease prevention

32. Primary prevention

33. Secondary prevention

Each government needs for the task of improving the people's health a **national health policy**, that is, a set of

34. National health policy

decisions to pursue courses of action aimed at achieving defined goals for improving the health situation, a **goal** being a general aim towards which to strive, for example to have an environment that is conducive to health or to have primary health care available to everybody. Such a policy, which presupposes a political will to commit the nation's resources to the achievement of these goals, also determines the priorities among the goals, and the main directions for achieving them. A national health policy is usually couched in general terms and is the basis of a **national strategy**, which lays down the broad lines of the action required in all the sectors concerned to give effect to the national health policy and indicates the problems and ways of dealing with them. The strategy usually includes specific **programmes** for delivery by the health system infrastructure, for example a programme of health education, a programme being an organized aggregate of activities directed towards the attainment of defined objectives and targets, which are progressively more specific than the goals to which they contribute. Each health programme should have its specific objectives and targets, whenever possible quantified, that are consistent with those of the national health strategy. The programme should set out clearly the requirements in health workers, physical facilities, technology, equipment and supplies, information and intercommunication, the methods of monitoring and evaluation, the timetable of activities, and the ways of ensuring correlation between its various elements and related programmes. Defining all these requirements is referred to as **programming** (see also 47(2) and (5) below). An **objective** is the end result a programme seeks to achieve; for example, the objective of health education can be defined as ensuring that people will want to be healthy, know how to stay healthy, do what they can individually and collectively to maintain health, and know how to seek help when required. A **target** is an intermediate result towards the objective that a programme seeks to

35. Goal

36. National strategy

37. Programme

38. Programming

39. Objective

40. Target

achieve. It is more specific than an objective and the period within which it is to be attained is usually specified. It also lends itself more readily to being expressed in quantitative terms. Examples are the provision of safe drinking-water and basic sanitation for 60% of the population by 1985 in order to attain 100% coverage by 1990, or the immunization of 70% of children against six major infectious diseases by 1986 with a view to immunizing all of them by 1990.

41. National plan of action

The strategy having been defined, a **national plan of action** is drawn up, that is, a broad intersectoral master plan for implementing the strategy in order to attain the national health goals. It specifies in operational terms the steps to be taken in accordance with the strategy, keeping in mind the various objectives and targets to be attained and the programmes for attaining them. These steps include political, economic, financial, social, legislative, administrative, scientific, technical and managerial measures. The action that has to be taken by the health and other sectors concerned is laid down and a framework for monitoring the implementation of the plan of action and evaluating its impact is established. Plans of action form a continuum with national health policies and strategies, there being no sharp dividing lines. For the national plan of action or for any programme under it the government adopts one or several approaches, an **approach** being a means or method of attaining an objective or target, as, for example, the enactment of suitable legislation or the provision of appropriate training. The approach consisting of identifying and devoting more care to individuals or groups who, for biological, environmental or socioeconomic reasons, are at special risk of having their health impaired, of contracting a specific disease, or of having inadequate attention paid to their health problems, is known as the **risk approach**. It has been summed up as "Something for all, but more for those in need — in proportion to that need".

42. Approach

43. Risk approach

The ultimate goal of a national plan of action is the establishment of a comprehensive health system meeting all the health needs of the population. A most important element of such a system is **disease control**, which involves all the measures designed to prevent or reduce as much as possible the incidence, prevalence, and consequences of disease, such as the control of disease vectors, the removal or reduction of the influence of predisposing factors in the environment, immunization and curative care. An important measure for controlling disease is the provision of **essential drugs**, those therapeutic substances that are indispensable for the rational care of the vast majority of diseases in a given population. A model list of such drugs, including about 250 substances, has been drawn up and is kept under review by a WHO expert committee. It furnishes a basis for countries to establish their own lists in the light of their own priorities and special circumstances. Experience has shown that about 30 to 40 drugs are sufficient for primary health care in many countries, the rest being required for secondary and tertiary health care. Such lists do not mean that no other drugs are useful, but simply that in a given situation those drugs are the most needed for the health care of the majority, and should, therefore, be available at all times in adequate amounts and in the proper dosage forms.

44. Disease control

45. Essential drugs

The establishment of a health system that will deliver primary, secondary, and tertiary health care to the entire population with the object of attaining health for all by the year 2000 is a formidable management task, **management** being taken to mean the sum of the measures taken to plan, organize, operate, and evaluate all the many interrelated elements of the system. Such measures are required to translate policies into strategies and strategies into plans of action for determining the action required to define and operate health programmes and ensure that the health system infrastructure is built up to deliver them efficiently and

46. Management

effectively. WHO advocates for this purpose a **managerial process for national health development**, which is a continuous process of systematic planning and programming carried out in collaboration with other sectors concerned with health. The managerial process for national health development involves :

47. Managerial process for national health development (MPNHD)

(1) formulating policies and defining priorities;

(2) broad programming to translate these policies into a strategy with clearly stated objectives and targets;

(3) programme budgeting to ensure the preferential allocation of resources for the implementation of the strategy;

(4) preparing plans of action in the light of broad programming and programme budgeting, indicating the main lines of action to be taken in the health and other sectors to implement the strategy;

(5) working out detailed programmes ("detailed programming") for each of the programmes in the plan of action;

(6) implementing the programmes through their delivery by the health infrastructure and applying sound day-to-day managerial procedures to this end;

(7) monitoring and evaluating programmes with a view to ensuring that they are proceeding as planned and that the services and institutions concerned are delivering them efficiently and effectively;

(8) preparing revised programmes as necessary with a view to introducing any modification or improvements recommended as a result of monitoring and evaluation;

(9) ensuring the information support required for all the above.

Wherever feasible, it is desirable that the managerial process for national health development be decentralized through delegation of authority and resources to intermediate and local administrative levels. A national plan of action is established for the whole country but also, for example, provincial plans for the provinces and local plans for the local communities. The advantage of such decentralization is that intermediate levels are near enough to the community to respond to its needs and to the central level to put government policies into practice, and communities have greater opportunities for direct involvement.

48. Country health programming

The term **country health programming** has been widely used. It consists in essence of assessing the country's health problems in their socioeconomic context, determining which areas need changing, and formulating programmes to bring about the changes needed. It forms part of the broader managerial process for national health development which has superseded it, corresponding in practice to the aggregate of broad programming, programme budgeting and detailed programming (see 47 above).

49. Country health programme

A **country health programme** simply means all the activities making up the coordinated sum of all the health programmes in a country. This term has become obsolete since the broader concepts of strategies and plans of action have come into use.

The managerial process for national health development also involves budgeting; if the money is not there to pay for programmes, they will fail. The process of making resources available to attain the objectives of programmes is called **programme budgeting** (see also 47(3) above). This differs from ordinary budgeting in that the emphasis is on the results to be achieved rather than on unconnected budgetary items. The objectives and targets of the programmes are defined clearly and in order to attain them the resources required are grouped together, those who will receive them specified, and their sources determined. These

50. Programme budgeting

could include public sources, such as the government through the ministry of health or its equivalent and other ministries, regional and local governments, and state governments in countries with a federal system, as well as compulsory health insurance. They could also include private sources such as voluntary health insurance, voluntary organizations, community contributions, private employers, and individual payment. Moreover, they could derive from external sources such as international organizations, bilateral agencies and philanthropic bodies. **Resource management**, the efficient and effective management of resources, is of vital importance in programme budgeting; the aim is the most rational use of manpower, knowledge, facilities, and funds to achieve the intended purposes with the greatest effect for the least outlay. The rate at which and the extent to which a health system based on primary health care can be instituted in a country depend on the availability of resources and their employment to the best advantage. In resource management a distinction has to be made between capital and recurrent costs. In health systems, **capital expenditure** may be taken to mean expenditure on land, buildings, and initial equipment and supplies to establish or extend health facilities such as health centres, laboratories and hospitals. **Recurrent expenditure**, or current operating expenditure, on the other hand, covers items that recur year after year, such as the remuneration of health workers and other staff; the cost of food and other goods and services; the cost of vaccines, medicines, appliances and other supplies; the replacement of equipment; and the maintenance of buildings and equipment.

51. Resource management

52. Capital expenditure

53. Recurrent expenditure

Throughout the implementation of programmes a watch is needed on the way resources are being used and activities carried out. **Monitoring** is the term used for the continuous follow-up of activities to ensure that they are proceeding according to plan (see also 47(7) above). It keeps track of

54. Monitoring

achievements, staff movements and utilization, supplies and equipment, and the money spent in relation to the resources available, so that if anything goes wrong immediate corrective measures can be taken. The information gained from

55. Evaluation

monitoring is utilized for evaluation. **Evaluation**, another essential part of the managerial process for national health development (see also 47(7) above), is the systematic assessment of the relevance, adequacy, progress, efficiency, effectiveness, and impact of a health programme. A programme

56. Relevance

is **relevant** if it answers the needs and social and health policies and priorities it has been designed to meet. It is

57. Adequacy

adequate if it is proportionate to requirements. It is making

58. Progress

good **progress** if its component activities are being carried

59. Efficiency

out in accordance with the planned schedule. It is **efficient** if the effort expended on it is as good as possible in relation

60. Effectiveness

to the resources devoted to it. It is **effective** if the results obtained are in accordance with the objectives and targets for reducing the dimensions of a problem or improving an

61. Impact

unsatisfactory situation. The **impact** of a programme is its overall effect on health status and socioeconomic development.

Because of countries' need to employ their resources as economically and effectively as possible, evaluation ideally

62. Cost-benefit

includes cost-benefit analysis. **Cost-benefit** is the relationship between the cost of an activity and the benefits that accrue from it, and cost-benefit analysis is a method of determining and comparing the costs and benefits of a programme in which all the costs and benefits are expressed in monetary terms. Cost-benefit is thus rarely easy to assess in relation to health programmes, since the benefit, though often obvious, is difficult to express in those terms. Moreover, the benefits of a programme may extend beyond the achievement of the desired effect; thus a programme designed to reduce the incidence and prevalence of a disease may also increase human wellbeing, raise productivity,

or open up new areas to agriculture. Another related term is **cost-effectiveness**, the relationship between cost and effectiveness, the degree of effectiveness being understood as the extent to which a programme or other activity is contributing to the attainment of the objectives and targets for reducing the dimensions of a problem or improving an unsatisfactory situation. The analysis of cost-effectiveness aims at measuring the relative cost of alternative ways of achieving an objective. Yet another term in use is **cost-efficiency**, which is not concerned with the benefit or effectiveness of a programme but with its efficiency — the extent to which its resources are being used as well as possible, for example, in terms of the amount of adequate services provided in relation to the cost. Thus the cost-efficiency of providing obstetric care from a health centre is arrived at by dividing all the costs by the number of appropriately managed deliveries and comparing the results with that obtained, for example, by dividing all the costs of providing obstetric care at the nearest hospital by the number of such deliveries.

63. Cost-effectiveness

64. Cost-efficiency

Evaluation of the changes in the health situation is helped by the use of **indicators**, which are variables that help to measure such changes directly or indirectly and to assess the extent to which the objectives and targets of a programme are being attained. If the aim of a programme is to train a number of auxiliary workers annually, the number of workers trained each year is a direct — or output — indicator. If the aim is to improve child health, several indicators could be used, such as nutritional status, psychosocial development, the immunization rate, or the morbidity and mortality rates. While efforts are normally made to quantify indicators, this is not always possible. Moreover, evaluations cannot always be made by aggregating numerical values alone. Qualitative indicators are therefore often used, for example to assess people's involvement and their perception of their health status. WHO has

65. Indicators

proposed four categories of indicators: health policy indicators; social and economic indicators; indicators of health care delivery; and indicators of health status, including the quality of life. It should be emphasized that, while indicators help to measure the attainment of targets, they are not in themselves targets. Other aids in evaluation are

66. Criteria

criteria. A criterion is a standard by which something is judged, and may be technical or social. A technical criterion for the safety of drinking-water would be a certain technical standard for water purity; a social criterion for the suitability of drinking-water would be the acceptance of its taste by the people for whom it is intended.

If, on the basis of evaluation, it is found that the programme is not acceptable to the people for whom it is intended, is not proceeding according to plan, or is inefficient,

67. Reprogramming

reprogramming, i.e., revising the programme, may be required (see also 47(8) above). Reprogramming — and indeed each and every other component of the managerial

68. Information support

process for national health development — depends on **information support** (see also 47(9) above), the supply to and from all concerned and the constant use of relevant, sensitive and consistent information required for formulating, programming, budgeting, implementing, monitoring, and evaluating. Reporting to those who supplied information

69. Information feedback

on the use made of it, the results obtained and the action to be taken is known as **information feedback**. Information

70. Health information

support depends on **health information**, which in the strict sense means all information related to health and is therefore highly varied in nature. For example, in epidemiology and health statistics it could mean information on morbidity, mortality, quality of life and their determinants; in health education it could mean information conveyed to the general public or to a particular group of people to promote or protect health; in deciding on appropriate health technology it would include information on research findings; and in

relation to a programme it is the management information that enables those in charge of the programme to plan it, carry it out and decide whether it is proceeding according to plan and is having the desired effect, or whether it has to be modified. The collection and transmission of information presents serious problems in most countries and particularly in those with limited numbers of professional health workers. **Lay reporting** is the collection of information, its use, and its transmission to other levels of the health system by non-professional health workers.

71. Lay reporting

The Declaration of Alma-Ata refers to the **self-reliance** of individuals, communities and national authorities in primary health care. This implies their initiative in assuming responsibility for their own health development, adopting measures that are understood by them and acceptable to them, knowing their own strengths and resources and how to use them, and knowing when and for what purpose to turn to others for support and cooperation. This should be distinguished from **self-sufficiency**, which implies depending solely on one's own strengths and resources.

72. Self-reliance

73. Self-sufficiency

In exercising their self-reliance, governments may set up various mechanisms to help prepare and carry out the health policy, strategy, plan of action and component programmes. It may be appropriate in some countries to create a **national health council** to advise governments on health and related socioeconomic issues for the entire country. The composition of such a council would vary from country to country according to its circumstances, but it should preferably cover the fields of health and related political, economic and social affairs and include members of the public. To help carry out the actual task of working out and applying various parts of the managerial process for national health development, ministries of health could designate suitable departments, universities, institutions and

74. National health council

75. National centres for health development

76. National health development network

organizations as **national centres for health development.** These might also advise on technical matters, disseminate information, and help to ensure coordination of activities with other sectors. Whenever such centres are linked together organizationally they are known as a **national health development network.**

77. Health research

Health research is an essential part of national health development, in the broad sense of research on all aspects of health, the factors affecting it, and ways of promoting, protecting and improving it. It therefore includes medical and biomedical research relating to a wide variety of medical matters and involving various life sciences such as molecular biology and biophysics; clinical research, which is based on the observation and treatment of patients or volunteers; epidemiological research, which is concerned with the study and control of diseases and of situations that are suspected of being harmful to health; and socioeconomic and behavioural research, which investigates the social, economic, psychological and cultural determinants of health and disease with a view to promoting health and preventing disease. Often a multidisciplinary combination of the above kinds of research is needed to solve a health problem.

78. Health systems research

Health systems research focuses on the entire health system (see 12 above) or a part of it, and its object is to ensure that the system is optimally planned and organized and that programmes are carried out by the health system infrastructure efficiently and effectively and with appropriate technology (see 80 below). It is often undertaken as part of the managerial process for national health development.

79. Health services research

Health services research is part of health systems research; as its name implies, it deals with the health services component of the broader health system. Also included is research to establish **appropriate health technology**, that is, methods, procedures, techniques, and equipment that are scientifically valid, adapted to local needs, and acceptable to

80. Appropriate health technology

those who use them and to those for whom they are used, and that can be maintained and utilized with resources the community or the country can afford. Part of WHO's task is to support **technology transfer**, that is, the process of ensuring the wide application of scientific discoveries, and of methods, procedures, techniques and equipment that will promote health and socioeconomic development. The concept includes the export of technology and its exchange among countries. WHO accordingly seeks to provide valid information on all forms of health technology, to discover technologies that are appropriate to the social and economic conditions of the countries concerned, to support developing countries in their efforts to become self-reliant in health research and development, and to promote collaborative research between developed and developing countries in areas of particular concern to the latter, such as tropical diseases, diarrhoeal diseases, and human reproduction.

81. Technology transfer

Since countries do not exist in isolation from one another but are often closely bound together by economic, political, and social ties, the failure of a national health strategy in one country could have adverse effects on the national health strategies of its neighbours and on progress towards the goal of health for all by the year 2000. **Regional strategies**, which vary widely according to the needs of countries in any given region, have therefore been formulated to help countries within the region overcome obstacles to the fulfilment of their national health strategies and to give effect to regional health and related socioeconomic policies. For this purpose the exchange of information and experience is essential. Such exchanges may form part of **technical cooperation among developing countries (TCDC)**, that is, voluntary agreements among governments of developing countries to work together in such fields as the sharing of expertise and training facilities, the joint generation of appropriate technology, and the exchange of information

82. Regional strategies for health for all

83. Technical cooperation among developing countries

and experience that contribute to the improvement of the health situation in the countries. TCDC may be linked to

84. Economic cooperation among developing countries

economic cooperation among developing countries (ECDC), which, as its name implies, is cooperation in the economic field. One example concerning health is in the field of drugs — voluntary agreements among governments of developing countries *inter alia* for trade in drugs, joint bulk purchase and shipment, or production and quality control.

85. Global Strategy for Health for All

Just as regional strategies support national strategies, so the **Global Strategy for Health for All** brings together regional and national strategies into an integrated world strategy fostering the development of regional and national policies, strategies and plans of action, and supporting countries, both in regional groupings and individually, in their preparation and implementation. The Global Strategy was adopted by the World Health Assembly in 1981. It describes the broad lines of action to be taken at policy and operational levels, nationally and internationally, in the health sector and in other social and economic sectors, to attain health for all by the year 2000. The central thrust is the building up in each country of the health system infrastructure, starting with primary health care, for the delivery of programmes that reach the whole population, using appropriate health technology. The Strategy involves specifying measures to be taken by individuals and families in their homes, by communities, by the health services at the most peripheral and referral levels, and by other sectors. It also points to ways of ensuring coordination within the health sector and intersectoral action; enlisting the support of health and related workers and of the general public through the dissemination of appropriate information; setting up a managerial process for national health development; reorienting research as necessary; generating and mobilizing all possible resources; cooperating with other countries in common areas of interest; and bringing about

political commitment and financial support for all the above. Crucial to the Strategy is the social control of the health system through a high degree of community involvement. The Strategy also describes how the international community, and in particular WHO, should support national action.

WHO and other international bodies provide technical and managerial support to national, regional and global efforts. This support includes the production of **guiding principles**, general rules that can be used as a guide by the Member States of WHO, for example to develop and implement policies, to set up a managerial process or to organize primary health care in communities. Because of the great difference among the Member States such guiding principles must be very general; but they can be used by Member States as a basis for preparing **guidelines**, which set out the steps to be taken in performing a task or implementing a policy and the manner of doing so. Guidelines are more specific and more detailed than guiding principles, on which they are based.

86. Guiding principles

87. Guidelines

The WHO **General Programme of Work** constitutes WHO's support for national, regional and global strategies and plans of action for the attainment of health for all by the year 2000. Each Programme covers a period of six years. The Seventh General Programme of Work, for the period 1984-1989 inclusive, contains an analysis of the health situation in the world and defines the objectives, intermediate targets and approaches that will be adopted to support Member States of WHO in attaining the long-term goal for the year 2000. It is subdivided into programmes to support countries in building up health system infrastructures of the type described in the Global Strategy and summarized in 24 and 85 above; programmes of science and technology that deal with the research required to identify and generate

88. WHO General Programme of Work

appropriate health technology, including social and behavioural alternatives to technical measures; programmes of direction, coordination and management that concern themselves with the formulation and advocacy of WHO's policy and with the Organization's general programme; and programme support, which deals with informational, organizational, financial, administrative and material support. **Medium-term programmes** prepared on the basis of the General Programme of Work specify the types of activities to be carried out by WHO for the six years covered in order to attain the objectives and targets of that General Programme. Biennial **programme budgets** provide details of the programme activities in the medium-term programme, together with the related budgets, to be carried out in each of the three two-year periods that make up the period of the General Programme of Work.

89. WHO medium-term programmes

90. WHO programme budgets

INDEX

INDEX

The terms described in the text are reproduced in the margins in heavy print and serially numbered. These terms are listed below with an indication of the page on which they are explained and the serial number in bold type in parentheses, e.g., **Community involvement** *appears on page 11 with the serial number* **3.**

WHO publications may be obtained, direct or through booksellers, from:

ALGERIA	Société Nationale d'Edition et de Diffusion, 3 bd Zirout Youcef, ALGIERS
ARGENTINA	Carlos Hirsch SRL, Florida 165, Galerías Güemes, Escritorio 453/465, BUENOS AIRES
AUSTRALIA	Hunter Publications, 58A Gipps Street, COLLINGWOOD, VIC 3066 — Australian Government Publishing Service *(Mail order sales)*, P.O. Box 84, CANBERRA A.C.T. 2600; *or over the counter from:* Australian Government Publishing Service Bookshops *at:* 70 Alinga Street, CANBERRA CITY A.C.T. 2600; 294 Adelaide Street, BRISBANE, Queensland 4000; 347 Swanston Street, MELBOURNE, VIC 3000; 309 Pitt Street, SYDNEY, N.S.W. 2000; Mt Newman House, 200 St. George's Terrace, PERTH, WA 6000; Industry House, 12 Pirie Street, ADELAIDE, SA 5000; 156–162 Macquarie Street, HOBART, TAS 7000 — R. Hill & Son Ltd., 608 St. Kilda Road, MELBOURNE, VIC 3004; Lawson House, 10–12 Clark Street, CROW'S NEST, NSW 2065
AUSTRIA	Gerold & Co., Graben 31, 1011 VIENNA I
BANGLADESH	The WHO Programme Coordinator, G.P.O. Box 250, DHAKA 5 — The Association of Voluntary Agencies, P.O. Box 5045, DHAKA 5
BELGIUM	*For books:* Office International de Librairie s.a., avenue Marnix 30, 1050 BRUSSELS. *For periodicals and subscriptions:* Office International des Périodiques, avenue Marnix 30, 1050 BRUSSELS — *Subscriptions to World Health only:* Jean de Lannoy, 202 avenue du Roi, 1060 BRUSSELS
BHUTAN	*see* India, WHO Regional Office
BOTSWANA	Botsalo Books (Pty) Ltd., P.O. Box 1532, GABORONE
BRAZIL	Biblioteca Regional de Medicina OMS/OPS, Unidade de Venda de Publicações, Caixa Postal 20.381, Vila Clementino, 04023 SÃO PAULO, S.P.
BURMA	*see* India, WHO Regional Office
CANADA	Canadian Public Health Association, 1335 Carling Avenue, Suite 210, OTTAWA, Ont. K1Z 8N8. *Subscription orders, accompanied by cheque made out to the* Royal Bank of Canada, Ottawa, Account World Health Organization, *may also be sent to the* World Health Organization, PO Box 1800, Postal Station B, OTTAWA, Ont. K1P 5R5
CHINA	China National Publications Import & Export Corporation, P.O. Box 88, BEIJING (PEKING)
CYPRUS	"MAM", P.O. Box 1722, NICOSIA
CZECHO-SLOVAKIA	Artia, Ve Smeckach 30, 111 27 PRAGUE 1
DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA	*see* India, WHO Regional Office
DENMARK	Munksgaard Export and Subscription Service, Nørre Søgade 35, 1370 COPENHAGEN K (Tel: +45 1 12 85 70)
ECUADOR	Libreria Cientifica S.A., P.O. Box 362, Luque 223, GUAYAQUIL
EGYPT	Osiris Office for Books and Reviews, 50 Kasr El Nil Street, CAIRO
FIJI	The WHO Programme Coordinator, P.O. Box 113, SUVA
FINLAND	Akateeminen Kirjakauppa, Keskuskatu 2, 00101 HELSINKI 10
FRANCE	Librairie Arnette, 2 rue Casimir-Delavigne, 75006 PARIS
GABON	Librairie Universitaire du Gabon, B.P. 3881, LIBREVILLE
GERMAN DEMOCRATIC REPUBLIC	Buchhaus Leipzig, Postfach 140, 701 LEIPZIG
GERMANY, FEDERAL REPUBLIC OF	Govi-Verlag GmbH, Ginnheimerstrasse 20, Postfach 5360, 6236 ESCHBORN — W. E. Saarbach, Postfach 101 610, Follerstrasse 2, 5000 COLOGNE 1 — Alex. Horn, Spiegelgasse 9, Postfach 3340, 6200 WIESBADEN
GHANA	Fides Enterprises, P.O. Box 1628, ACCRA
GREECE	G.C. Eleftheroudakis S.A., Librairie internationale, rue Nikis 4, ATHENS (T. 126)
HAITI	Max Bouchereau, Librairie "A la Caravelle", Boîte postale 111-B, PORT-AU-PRINCE
HONG KONG	Hong Kong Government Information Services, Beaconsfield House, 6th Floor, Queen's Road, Central, VICTORIA
HUNGARY	Kultura, P.O.B. 149, BUDAPEST 62 — Akadémiai Könyvesbolt, Váci utca 22, BUDAPEST V
ICELAND	Snaebjørn Jonsson & Co., P.O. Box 1131, Hafnarstraeti 9, REYKJAVIK
INDIA	WHO Regional Office for South-East Asia, World Health House, Indraprastha Estate, Mahatma Gandhi Road, NEW DELHI 110002 — Oxford Book & Stationery Co., Scindia House, NEW DELHI 110001; 17 Park Street, CALCUTTA 700016 *(Sub-agent)*
INDONESIA	P. T. Kalman Media Pusaka, Pusat Perdagangan Senen, Block 1, 4th Floor, P.O. Box 3433/Jkt, JAKARTA
IRAN (ISLAMIC REPUBLIC OF)	Iran University Press, 85 Park Avenue, P.O. Box 54/551, TEHRAN
IRAQ	Ministry of Information, National House for Publishing, Distributing and Advertising, BAGHDAD
IRELAND	TDC Publishers, 12 North Frederick Street, DUBLIN 1 (Tel: 744835–749677)
ISRAEL	Heiliger & Co., 3 Nathan Strauss Street, JERUSALEM 94227
ITALY	Edizioni Minerva Medica, Corso Bramante 83–85, 10126 TURIN; Via Lamarmora 3, 20100 MILAN
JAPAN	Maruzen Co. Ltd., P.O. Box 5050, TOKYO International, 100–31
JORDAN, THE HASHEMITE KINGDOM OF	Jordan Book Centre Co. Ltd., University Street, P.O. Box 301 (Al-Jubeiha), AMMAN
KUWAIT	The Kuwait Bookshops Co. Ltd., Thunayan Al-Ghanem Bldg, P.O. Box 2942, KUWAIT
LAO PEOPLE'S DEMOCRATIC REPUBLIC	The WHO Programme Coordinator, P.O. Box 343, VIENTIANE
LEBANON	The Levant Distributors Co. S.A.R.L., Box 1181, Makdassi Street, Hanna Bldg, BEIRUT
LUXEMBOURG	Librairie du Centre, 49 bd Royal, LUXEMBOURG
MALAWI	Malawi Book Service, P.O. Box 30044, Chichiti, BLANTYRE 3

WHO publications may be obtained, direct or through booksellers, from:

MALAYSIA	The WHO Programme Coordinator, Room 1004, 10th Floor, Wisma Lim Foo Yong (formerly Fitzpatrick's Building), Jalan Raja Chulan, KUALA LUMPUR 05–10; P.O. Box 2550, KUALA LUMPUR 01–02; Parry's Book Center, K. L. Hilton Hotel, Jln. Treacher, P.O. Box 960, KUALA LUMPUR
MALDIVES	*see* India, WHO Regional Office
MEXICO	Librería Internacional, S.A. de C.V., Av. Sonora 206, 06100-MÉXICO, D.F.
MONGOLIA	*see* India, WHO Regional Office
MOROCCO	Editions La Porte, 281 avenue Mohammed V, RABAT
MOZAMBIQUE	INLD, Caixa Postal 4030, MAPUTO
NEPAL	*see* India, WHO Regional Office
NETHERLANDS	Medical Books Europe BV, Noorderwal 38, 7241 BL LOCHEM
NEW ZEALAND	Government Printing Office, Publications Section, Mulgrave Street, Private Bag, WELLINGTON 1; Walter Street, WELLINGTON; World Trade Building, Cubacade, Cuba Street, WELLINGTON. *Government Bookshops at:* Hannaford Burton Building, Rutland Street, Private Bag, AUCKLAND; 159 Hereford Street, Private Bag, CHRISTCHURCH; Alexandra Street, P.O. Box 857, HAMILTON; T & G Building, Princes Street, P.O. Box 1104, DUNEDIN — R. Hill & Son Ltd, Ideal House, Cnr Gillies Avenue & Eden Street, Newmarket, AUCKLAND 1
NIGERIA	University Bookshop Nigeria Ltd, University of Ibadan, IBADAN
NORWAY	J. G. Tanum A/S, P.O. Box 1177 Sentrum, OSLO 1
PAKISTAN	Mirza Book Agency, 65 Shahrah-E-Quaid-E-Azam, P.O. Box 729, LAHORE 3; Sasi Limited, Sasi Centre, G.P.O. Box 779, I.I. Chundrigar Road, KARACHI
PAPUA NEW GUINEA	The WHO Programme Coordinator, P.O. Box 646, KONEDOBU
PHILIPPINES	World Health Organization, Regional Office for the Western Pacific, P.O. Box 2932, MANILA — The Modern Book Company Inc., P.O. Box 632, 922 Rizal Avenue, MANILA 2800
POLAND	Składnica Księgarska, ul Mazowiecka 9, 00052 WARSAW *(except periodicals)* — BKWZ Ruch, ul Wronia 23, 00840 WARSAW *(periodicals only)*
PORTUGAL	Livraria Rodrigues, 186 Rua do Ouro, LISBON 2
REPUBLIC OF KOREA	The WHO Programme Coordinator, Central P.O. Box 540, SEOUL
SIERRA LEONE	Njala University College Bookshop (University of Sierra Leone), Private Mail Bag, FREETOWN
SINGAPORE	The WHO Programme Coordinator, 144 Moulmein Road, SINGAPORE 1130; Newton P.O. Box 31, SINGAPORE 9122 — Select Books (Pte) Ltd, 215 Tanglin Shopping Centre, 2/F, 19 Tanglin Road, SINGAPORE 10
SOUTH AFRICA	Van Schaik's Bookstore (Pty) Ltd, P.O. Box 724, 268 Church Street, PRETORIA 0001
SPAIN	Comercial Atheneum S.A., Consejo de Ciento 130–136, BARCELONA 15; General Moscardó 29, MADRID 20 — Librería Díaz de Santos, Lagasca 95 y Maldonado 6, MADRID 6; Balmes 417 y 419, BARCELONA 22
SRI LANKA	*see* India, WHO Regional Office
SWEDEN	*For books:* Aktiebolaget C.E. Fritzes Kungl. Hovbokhandel, Regeringsgatan 12, 103 27 STOCKHOLM. *For periodicals:* Wennergren-Williams AB, Box 30004, 104 25 STOCKHOLM
SWITZERLAND	Medizinischer Verlag Hans Huber, Länggass Strasse 76, 3012 BERNE 9
THAILAND	*see* India, WHO Regional Office
TUNISIA	Société Tunisienne de Diffusion, 5 avenue de Carthage, TUNIS
TURKEY	Haset Kitapevi, 469 Istiklal Caddesi, Beyoglu, ISTANBUL
UNITED KINGDOM	H.M. Stationery Office: 49 High Holborn, LONDON WC1V 6HB; 13a Castle Street, EDINBURGH EH2 3AR; 80 Chichester Street, BELFAST BT1 4JY; Brazennose Street, MANCHESTER M60 8AS; 258 Broad Street, BIRMINGHAM B1 2HE; Southey House, Wine Street, BRISTOL BS1 2BQ. *All mail orders should be sent to:* HMSO Publications Centre, 51 Nine Elms Lane, LONDON SW8 5DR
UNITED STATES OF AMERICA	*Single and bulk copies of individual publications (not subscriptions):* WHO Publications Centre USA, 49 Sheridan Avenue, ALBANY, NY 12210. *Subscriptions: Subscription orders, accompanied by check made out to the* Chemical Bank, New York, Account World Health Organization, *should be sent to the* World Health Organization, PO Box 5284, Church Street Station, NEW YORK, NY 10249; *Correspondence concerning subscriptions should be addressed to the* World Health Organization, Distribution and Sales, 1211 GENEVA 27, Switzerland. *Publications are also available from the* United Nations Bookshop, NEW YORK, NY 10017 *(retail only)*
URUGUAY	Librería Agropecuaria S. R. L., Casilla de Correo 1755, Alzaibar 1328, MONTEVIDEO
USSR	*For readers in the USSR requiring Russian editions:* Komsomolskij prospekt 18, Medicinskaja Kniga, MOSCOW — *For readers outside the USSR requiring Russian editions:* Kuzneckij most 18, Meždunarodnaja Kniga, MOSCOW G-200
VENEZUELA	Librería del Este, Apartado 60.337, CARACAS 106 — Librería Médica Paris, Apartado 60.681, CARACAS 106
YUGOSLAVIA	Jugoslovenska Knjiga, Terazije 27/II, 11000 BELGRADE
ZAIRE	Librairie universitaire, avenue de la Paix N° 167, B.P. 1682, KINSHASA I

Special terms for developing countries are obtainable on application to the WHO Programme Coordinators or WHO Regional Offices listed above or to the World Health Organization, Distribution and Sales Service, 1211 Geneva 27, Switzerland. Orders from countries where sales agents have not yet been appointed may also be sent to the Geneva address, but must be paid for in pounds sterling, US dollars, or Swiss francs.

Price: Sw. fr. 6.—

Prices are subject to change without notice.