WORLD HEALTH ORGANIZATION

REGIONAL COMMITTEE FOR AFRICA

THIRTY-FIFTH SESSION

Lusaka
11-18 September 1985

REPORT OF THE REGIONAL COMMITTEE

Brazzaville
October 1985

CONTENTS

PART I

PROCEDURAL DECISIONS	Page
1. Composition of the Sub-Committee on Nominations................	1
2. Election of the Chairman, Vice-Chairmen, and Rapporteurs.......	1
3. Composition of the Sub-Committee on Credentials................	2
4. Credentials..	2
5. Joint Coordinating Board.......................................	3
6. Renewal of membership of the Standing Committee on technical cooperation among developing countries.........................	3
7. Choice of subjects for the technical discussions...............	4
8. Subjects to be studied by the TCDC working groups in 1988......	4
9. Nomination of the Chairman and Alternate Chairman of the technical discussions in 1986.................................	5
10. Dates and places of the thirty-sixth and thirty-seventh sessions of the Regional Committee..............................	5
11. Agenda of the seventy-seventh session of the Executive Board and the Thirty-ninth World Health Assembly: regional repercussions..	5
12. Method of work and duration of the World Health Assembly.......	6
13. Technical discussions at the Thirty-ninth World Health Assembly	7

RESOLUTIONS

AFR/RC35/R1	- Regional evaluation report on the implementation of strategies for Health for All by the Year 2000.....	8
AFR/RC35/R2	- Participation by members of the Programme Sub-Committee in meetings of programming interest...	9
AFR/RC35/R3	- Visits by representatives of Member States to other countries of the Region......................	10
AFR/RC35/R4	- Technical cooperation among developing countries...	11
AFR/RC35/R5	- Malaria control..................................	13
AFR/RC35/R6	- Control of diarrhoeal diseases, including cholera..	15
AFR/RC35/R7	- Evaluation of the African experiment of using nationals as WHO Programme Coordinators............	17

Page

AFR/RC35/R8 - Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board.................. 19

AFR/RC35/R9 - Expanded programme on immunization in the African Region: a mid-decade evaluation.................. 19

AFR/RC35/R10 - Meetings of the Regional Committee................ 21

AFR/RC35/R11 - Development and coordination of biomedical and health systems research........................... 22

AFR/RC35/R12 - Regional Director's report........................ 23

AFR/RC35/R13 - Vote of thanks................................... 24

PART II

Paragraphs

OPENING OF THE SESSION 1-11

ORGANIZATION OF WORK 12-15

ADDRESS BY THE DIRECTOR-GENERAL AND THE WORK OF WHO IN THE AFRICAN REGION, 1983-1984: BIENNIAL REPORT OF THE REGIONAL DIRECTOR 16-58

DEVELOPMENT AND COORDINATION OF BIOMEDICAL AND HEALTH SYSTEMS RESEARCH 59-72

REGIONAL PROGRAMME BUDGET POLICY 73-98

EXPANDED PROGRAMME ON IMMUNIZATION (EPI) MID-DECADE EVALUATION 99-127

WAYS AND MEANS OF IMPLEMENTING RESOLUTIONS OF REGIONAL INTEREST ADOPTED BY THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD 128-154

AGENDA OF THE THIRTY-NINTH WORLD HEALTH ASSEMBLY: REGIONAL REPERCUSSIONS 155-158

METHOD OF WORK AND DURATION OF THE WORLD HEALTH ASSEMBLY 159-166

TECHNICAL DISCUSSIONS OF THE THIRTY-NINTH WORLD HEALTH ASSEMBLY (1986): "INTERSECTORAL COOPERATION AND COMMUNITY INVOLVEMENT FOR NATIONAL STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000" 167-179

Paragraphs

EVALUATION OF THE IMPLEMENTATION OF STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000: REGIONAL REPORT 180-213

REPORT ON PARTICIPATION BY MEMBERS OF THE PROGRAMME SUB-COMMITTEE IN MEETINGS OF PROGRAMMING INTEREST 214-221

VISITS BY REPRESENTATIVES OF MEMBER STATES TO OTHER COUNTRIES OF THE REGION 222-234

TECHNICAL COOPERATION AMONG DEVELOPING COUNTRIES (TCDC) 235-252

EVALUATION OF THE AFRICAN EXPERIMENT OF USING NATIONALS AS WHO PROGRAMME COORDINATORS 253-273

REPORT OF THE TECHNICAL DISCUSSIONS: "HEALTH SYSTEMS RESEARCH: AN INSTRUMENT FOR THE PROMOTION AND DEVELOPMENT OF PRIMARY HEALTH CARE" 274-285

NOMINATION OF THE CHAIRMAN AND ALTERNATE CHAIRMAN OF THE TECHNICAL DISCUSSIONS IN 1986 286-287

CHOICE OF SUBJECT FOR THE TECHNICAL DISCUSSIONS IN 1987 288-290

DATES AND PLACES OF THE THIRTY-SIXTH AND THIRTY-SEVENTH SESSIONS OF THE REGIONAL COMMITTEE......................... 291-297

CONCLUSIONS... 298-310

CLOSURE OF THE SESSION.. 311-317

ANNEXES

Page

1. Address by Mr. D. S. Katopola, Minister of Health of the Republic of Malawi, First Vice-Chairman of the thirty-fourth session.......................... 111

2. Address of Dr G. L. Monekosso, Regional Director 115

3. Opening speech delivered by His Excellency Dr K. D. Kaunda, President of the Republic of Zambia... 123

4. Address by Dr H. Mahler, Director-General of the World Health Organization.. 131

5. Agenda... 140

6. Provisional agenda of the thirty-sixth session of the Regional Committee (as at 11 July 1985)................ 142

7. List of participants.................................. 144

8. List of documents..................................... 167

9. Report of the Programme Sub-Committee.................. 169

Page

10. Report of the technical discussions: "Health systems research: an instrument for the promotion and development of primary health care"..................... 207

11. Report of the Programme Sub-Committee held on 18 September 1985 218

12. Closing address by Hon. C. M. Mwananshiku, Minister of Health of the Republic of Zambia 223

13. Official closing address by the Rt. Hon. Kebby S. K. Musokotwane, MCC, Prime Minister of the Republic of Zambia 228

PART I

PROCEDURAL DECISIONS

1. Composition of the Sub-Committee on Nominations

The Sub-Committee on Nominations met on Wednesday, 11 September 1985, and was composed of representatives of the following countries: Angola, Benin, Burkina Faso, Central African Republic, Congo, Ethiopia, Ghana, Malawi, Mauritania, Seychelles, Zambia and Zimbabwe. The Sub-Committee elected Dr J. G. Sambo (Angola) as Chairman.

Second meeting, 11 September 1985

2. Election of the Chairman, Vice-Chairman and Rapporteurs

After considering the report of the Sub-Committee on Nominations, the Regional Committee made the following elections by acclamation:

Chairman : Hon. Mr C. Mwananshiku
Minister of Health (Zambia)

Vice-Chairmen :

- First: Prof. A. Agbetra
Minister of Public Health, Social Affairs and Condition of Women (Togo)

- Second: Dr J. G. Sambo
Vice-Minister of Health (Angola)

Rapporteurs : Dr F. Sequeira
Minister of Health (Sao Tome and Principe)

Dr E. T. Maganu (Botswana)
Dr V. M'Barindi (Central African Republic)

Rapporteurs for technical discussions:

Dr A. N. Kolawole (Nigeria)

Dr (Mrs) R. T. Tshabalala (Swaziland)

Dr M. Saleh (Mauritania)

Third meeting, 11 September 1985

3. Composition of the Sub-Committee on Credentials

The Regional Committee appointed a Sub-Committee on Credentials consisting of representatives of the following 12 Member States: Algeria, Cameroon, Congo, Mauritius, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Swaziland, Zaire and Zimbabwe. The Sub-Committee elected Dr (Mrs) R. T. Tshabalala (Swaziland) as Chairman.

Third meeting, 11 September 1985

4. Credentials

The Regional Committee, acting on the proposal of the Sub-Committee on Credentials recognized the validity of the credentials presented by the representatives of the following Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Equatorial Guinea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, Swaziland, Togo, Uganda, United Republic of Tanzania, Zaire, Zambia and Zimbabwe. The Gambia was not represented in the thirty-fifth session of the Regional Committee; and the Sub-Committee was unable to examine the credentials of Senegal.

Fifth meeting, 12 September 1985

5. Joint Coordinating Board

The Regional Committee noted that in accordance with Procedural Decision 12 of the thirty-third session of the Regional Committee the retiring member of the Joint Coordinating Board (JCB) of the Special Programme for Research and Training in Tropical Diseases (TDR) was Mauritania. It thanked Mauritania for its contribution to the development of research into tropical diseases at the regional and global levels and nominated Niger to replace it for the next three years.

Ninth meeting, 17 September 1985

6. Renewal of membership of the Standing Committee on technical cooperation among developing countries

The Regional Committee noted the expiry of the terms of office of Senegal, Equatorial Guinea and Lesotho. It thanked those countries for their contribution to the promotion and development of TCDC.

It appointed Algeria, Ethiopia and Tanzania to replace them.

Ninth meeting, 17 September 1985

7. Choice of subjects for the technical discussions

The Regional Committee, mindful of the messages contained in the addresses of the Director-General and the Regional Director, inviting the Member States to take action by setting objective targets, and recognizing, furthermore, the high priority of organizing in each country an appropriate support for primary health care at the operational, technical and strategic levels, approves the Regional Director's proposal and decides to establish a three-year plan for the technical discussions:

1987: Operational support for primary health care (peripheral level).

1988: Technical support for primary health care (intermediate level).

1989: Strategic support for primary health care (central level).

Ninth meeting, 17 September 1985

8. Subjects to be studied by the TCDC working groups in 1988

The Regional Committee requests the Regional Director to harmonize the subjects to be studied by the TCDC working groups with those selected for technical discussions of the Regional Committee in 1987, 1988 and 1989 (Procedural Decision No. 7).

Ninth meeting, 17 September 1985

9. Nomination of the Chairman and Alternate Chairman of the technical discussions in 1986

The Regional Committee nominated Dr George Oluwole Sofoluwe and Mr Martial Mboumba as Chairman and alternate Chairman respectively of the technical discussions at the thirty-sixth session, the subject of which will be: "The PHC approach to the promotion and protection of the health of farm workers during the Industrial Development Decade in Africa".

Ninth meeting, 17 September 1985

10. Dates and places of the thirty-sixth and thirty-seventh sessions of the Regional Committee

The Regional Committee decided to hold its thirty-sixth session at the Regional Headquarters in Brazzaville (Congo) in September 1986, and its thirty-seventh session in Bamako (Republic of Mali) in September 1987. During its thirty-fourth session, the Regional Committee took note of the kind invitations extended by the Republic of Niger and the Republic of Burundi. The dates will be determined in accordance with resolution AFR/RC35/R10.

Ninth meeting, 17 September 1985

11. Agenda of the seventy-seventh session of the Executive Board and the Thirty-ninth World Health Assembly: regional repercussions

The Regional Committee approved the provisional agenda of the thirty-sixth session of the Regional Committee proposed by the Regional Director in Annex 4 of document AFR/RC35/6.

It invited the Chairman of the thirty-fifth session and the Regional Director to re-arrange and modify the said provisional agenda in the light of development in the regional programme.

Sixth meeting, 13 September 1985

12. Method of work and duration of the World Health Assembly

President of the World Health Assembly

(1) The candidate for President of the World Health Assembly will be designated at the thirty-seventh session in 1987. The Committee requests the Regional Director to propose criteria for the choice of the President.

Vice-President of the World Health Assembly

(2) The Chairman of the thirty-fifth session of the Regional Committee will be proposed for the office of one of the Vice-Presidents of the Thirty-ninth World Health Assembly in May 1986. If for some reason the Chairman of the Regional Committee is unable to assume that office, one of the Vice-Chairmen of the Committee will replace him, in the order declared after drawing of lots (First and Second Vice-Chairmen). In the event that the Chairman in office of the Committee and the two Vice-Chairmen are unable to assume the office of the Vice-President of the World Health Assembly, the heads of delegations of the countries of origin of the Chairman-in-office of the Regional Committee, the First Vice-Chairman and the Second Vice-Chairman will assume in the declared order of priority, the office of Vice-President of the World Health Assembly.

Main committees of the World Health Assembly

(3) The Director-General, in consultation with the Regional Director will, if necessary, consider before each World Health Assembly, the delegates of Member States of the African Region WHO might serve effectively as:

(i) Chairman of the Main Committees A and B (Rule 34 of the Assembly's Rules of Procedure).

(ii) Vice-Chairmen and Rapporteurs of the Main Committees.

Members entitled to designate persons to serve on the Executive Board

(4) The Member States of the African Region whose terms of office expire at the end of the Thirty-ninth World Health Assembly are Ethiopia and Ghana.

(5) The new members of the Executive Board will be designated by Liberia and Madagascar.

(6) The practice of following English alphabetical order shall be continued.

(7) Members entitled to designate persons to serve on the Executive Board should declare their availability at the latest one month before the World Health Assembly.

Closure of the Thirty-ninth World Health Assembly

(8) The representative of the Republic of Cameroon shall speak on behalf of the Region at the closure of the Thirty-ninth World Health Assembly.

Informal meeting of the Regional Committee

(9) The Regional Director will convene this meeting on Monday, 5 May 1986 at 10 a.m. at the Palais des Nations, Geneva, to confirm or revise the decisions taken by the Regional Committee at its thirty-fifth session.

Sixth meeting, 13 September 1985

13. Technical discussions at the Thirty-ninth World Health Assembly

The Regional Committee requests the Regional Director to transmsit to the Director-General document AFR/RC35/19 and the chapters of his final report entitled: "Intersectoral cooperation and community involvement for national strategies for Health for All by the Year 2000". This will constitute the regional contribution to the technical discussions at the Thirty-ninth World Health Assembly.

Sixth meeting, 13 September 1985

RESOLUTIONS

AFR/RC35/R1 Regional evaluation report on the implementation of strategies for Health for All by the Year 2000

The Regional Committee,

Having considered the evaluation report of the Regional Director on the implementation of strategies for Health for All by the Year 2000;

Noting that the report is the synthesis of the reports on evaluation of national strategies carried out by Member States;

Noting once again the lack of relevant information on the multisectoral aspects of the data to be collected, which are intended for estimating the indicators necessary for evaluating national strategies;

Referring to resolutions WHA35.23 and AFR/RC32/R7, whereby Member States adopted the plan of action for implementing national and regional strategies,

1. INVITES Member States to:

(i) improve intersectoral coordination by finding adequate means of communication at the central level between the health sector and the other relevant sectors;

(ii) determine what is needed for implementing their strategies in order to mobilize national and external financial and material resources;

(iii) strengthen existing health information and epidemiological surveillance systems and, specify indicators, adapted to their conditions, for monitoring and evaluating the implementation of national strategies;

2. REQUESTS the Director-General and the Regional Director to provide Member States with increased support in:

(i) translating their national strategies into specific plans of action;

(ii) carrying out studies on the 12 global indicators, and any others that the Member States may formulate, in order to refine them and make them suitable for monitoring and evaluating national, regional and global strategies;

3. REQUESTS the Regional Director to continue to provide practical training for national and WHO staff in health management and particularly in the information support essential to that process;

4. INVITES the Regional Director to transmit document AFR/RC35/12 to the Director-General as the regional contribution to evaluation of the global strategy for health for all and to the Seventh Report on the World Health Situation.

Ninth meeting, 17 September 1985

AFR/RC35/R2 Participation by members of the Programme Sub-Committee in meetings of programming interest

The Regional Committee,

Bearing in mind Procedural Decision 8 of the twenty-seventh session of the Regional Committee relating to participation of members of the Programme Sub-Committee in meetings of programming interest;

Having studied the reports of the members of the Programme Sub-Committee on:

(i) the seventh session of the African Advisory Committee on Medical Research (AACMR);

(ii) the eighth meeting of the Standing Committee on Technical Cooperation among Developing Countries (TCDC);

(iii) the fifth meeting of the African Advisory Committee for Health Development (AACHD);

Noting outstanding part played by the members of the Programme Sub-Committee in the discussions on subjects of vital interest to the health development of the Region,

1. COMMENDS the members of the Programme Sub-Committee on the brevity and relevance of their report;

2. APPROVES that report;

3. INVITES the members of the Programme Sub-Committee to continue to participate effectively in meetings of programming interest;

4. THANKS the Regional Director for the arrangements made to facilitate participation by members of the Programme Sub-Committee in meetings of programming interest.

<u>Ninth meeting, 17 September 1985</u>

AFR/RC35/R3 <u>Visits by representatives of Member States to other countries of the Region</u>

The Regional Committee,

Considering Decision 9 taken by the Regional Committee at its thirtieth session concerning visits by representatives of Member States to other countries of the Region,

Considering resolution AFR/RC33/R6 of the thirty-third session of the Regional Committee which invites the Regional Director to undertake an overall evaluation of the reports on visits submitted by the representatives of Member States so as to determine the true impact of those visits in terms of the objectives of TCDC,

1. TAKES NOTE of the evaluation report on implementation of the five-year plan of visits;

2. THANKS the Regional Director for the efforts made to promote the exchange of experience in the Region;

3. INVITES the Regional Director to continue the programme of visits by officials of Member States to other countries of the Region with due flexibility and bearing in mind the specific objectives of the programme and the duration of the visits.

Ninth meeting, 17 September 1985

AFR/RC35/R4 Technical cooperation among developing countries

The Regional Committee,

Having examined the report of the Standing Committee on TCDC;[1]

Referring to resolutions AFR/RC29/R16, AFR/RC30/R15, AFR/RC31/R9, AFR/RC32/R5, AFR/RC33/R7 and AFR/RC34/R8;

Recognizing that TCDC is one of the most suitable mechanisms for rational use of the solidarity among developing countries for attaining HFA/2000;

Aware of the need to develop or promote an intersectoral approach to implementing all health activities for attaining HFA/2000,

[1] Document AFR/RC35/R10.

1. APPROVES the report of the Standing Committee on TCDC;

2. INVITES Member States to:

(i) take prompt action to apply the recommendations of the Standing Committee on TCDC;

(ii) promote multidisciplinary and multisectoral action in the design, implementation and evaluation of all health activities for attaining HFA/2000 by introducing and/or strengthening cooperation between the various departments of ministries of health and between the Ministry of Health and the other ministerial departments concerned;

(iii) strengthen the mechanisms for joint agreement and action between the countries of the same Sub-Region and of the Region in order to pool their potential for attaining HFA/2000;

3. REQUESTS the Regional Director to:

(i) facilitate the implementation of the recommendations of the Standing Committee on TCDC;

(ii) continue joint WHO/UNDP preparation and organization of round-table conferences of donor agencies and consultations with the World Bank in order to mobilize and channel more resources into health activities;

4. THANKS the Regional Director for the steps taken to encourage Member States to make systematic use of the TCDC mechanisms for attaining HFA/2000.

Ninth meeting, 17 September 1985

AFR/RC35/R5 Malaria control

The Regional Committee,

Having considered and discussed resolution WHA38.24 of the World Health Assembly;

Noting that malaria control is possible, especially in rural areas of the countries of the Region, by making rational use of antimalaria drugs to reduce mortality and morbidity caused by the disease;

Acknowledging that such malaria control activities require malaria control programmes to be designed as integral components of comprehensive public health services and primary health care system;

Noting that the malaria control programmes of the countries of the African Region are not making satisfactory progress for the following reasons:

(i) shortage of key personnel required for planning, implementation and evaluation of malaria control programmes and for operational research on malaria;

(ii) difficulties arising in the implementation of malaria control activities as components of primary health care system;

(iii) inadequate financial resources for implementation of malaria control programmes;

(iv) inadequate management of malaria control programmes;

Concerned at the serious threat to public health of the emergence and spread in the Region of drug-resistant *Plasmodium falciparum*;

Considering that the epidemiological situation and in particular the emergence and spread of drug resistance make it necessary to examine and review the regional malaria control strategy;

1. INVITES Member States to:

(i) undertake, analyse and evaluate the malaria situation and present strategies in terms of efficacy and efficiency in order to make appropriate changes, placing emphasis on the integration of malaria control activities into national primary health care systems, in pursuance of resolution WHA38.24;

(ii) implement national programmes on the monitoring and evaluation of the effect of standard therapeutic regimens and malaria parasite sensitivity to antimalarials;

(iii) formulate and put into effect policies and measures for the control and use of antimalarials, together with guidelines for the standard treatment of malaria in relation to the degree of malaria parasite sensitivity to antimalarials;

(iv) promote to the greatest possible extent exchange of information and cooperation concerning aspects of malaria control that are relevant to technical cooperation among developing countries;

2. REQUESTS the Regional Director to:

(i) prepare manuals and guidelines for setting up malaria control programmes, with emphasis on their integration into primary health care systems;

(ii) continue building up a network of regional resources for training staff in the field of malaria;

(iii) continue studies in collaboration with Member States on:

(a) integration of malaria control into primary health care systems in different circumstances;

(b) epidemiology of the emergence and spread of drug-resistant Plasmodium falciparum so as to gain a better understanding of this phenomenon and thus become able to devise measures for delaying and containing it;

(iv) increase the technical, logistic and financial support essential to satisfactory implementation of national malaria control programmes by mobilizing and coordinating all available resources;

(v) promote, to the greatest possible extent, research aimed at improving the present control methods and at adapting them to different epidemiological, socioeconomic and ecological conditions;

(vi) submit to the Regional Committee at its thirty-sixth session a revised regional strategy considered in the light of the current epidemiological situation;

(vii) report periodically on the situation to the Regional Committee.

Ninth meeting, 17 September 1985

AFR/RC35/R6 Control of diarrhoeal diseases, including cholera

The Regional Committee,

Having considered and discussed the report[1] of the Standing Committee on Technical Cooperation among Developing Countries (TCDC) concerning the cholera situation in Africa and control methods;

Bearing in mind resolution WHA31.44 adopted by the Thirty-first World Health Assembly urging Member States:

- to identify diarrhoeal diseases as a major priority area for action;

- to apply known effective measures for the management and control of diarrhoeal diseases through appropriate national action plans and in the primary health care context;

[1] Document AFR/RC35/10.

Considering resolution AFR/RC29/R6 adopted by the Regional Committee for Africa at its twenty-ninth session, asking the Regional Director to ensure that epidemiological surveillance and communicable disease control measures are strengthened, with special attention to the control of malaria and diarrhoeal diseases;

Considering the resolution of the Twenty-sixth World Health Assembly terminating the requirement for a certificate of cholera vaccination under the International Health Regulations (Additional Regulations of 1973, resolution WHA26.55);

Considering the disturbing cholera and diarrhoeal disease situation in the Region,

1. INVITES Member States to:

(i) give high priority to the planning, implementation and evaluation of programmes in the control of diarrhoeal diseases focusing on the use of oral rehydration, the improvement of drinking-water supplies and sanitation, and the strengthening of epidemiological surveillance;

(ii) report cases of cholera to the Regional Office of WHO and neighbouring countries as quickly as possible;

(iii) strengthen their collaboration in the spirit of TCDC, especially regarding the exchange of epidemiological and technical information, manpower training, the conduct of surveys to provide basic epidemiological data, and the production and distribution of rehydration salts;

(iv) terminate the requirement that international travellers should carry cholera vaccination certificates;

2. REQUESTS the Regional Director to:

(i) examine, in collaboration with other agencies within the United Nations system, the possibility of setting up subregional stocks of oral rehydration salts to be made immediately available in sufficient quantities to meet the countries' needs in the event of epidemics of diarrhoeal diseases, including cholera;

(ii) collect and disseminate information on Member States' experience of national diarrhoeal disease control programmes;

(iii) inform the Regional Committee at its thirty-sixth session of progress made in implementation of diarrhoeal disease control programmes as part of the primary health care strategy for attaining the social target of Health for All by the Year 2000.

Ninth meeting, 17 September 1985

AFR/RC35/R7 Evaluation of the African experiment of using nationals as WHO Programme Coordinators

The Regional Committee,

Having examined the Regional Director's report on the evaluation of the African experiment of using nationals as WHO Programme Coordinators;

Recalling resolution WHA33.17 on the study of the Organization's structures in the light of its functions;

Recalling resolutions WHA31.27, EB75.R7 and WHA38.11 on regional programme budget policies, which request regional committees in particular to facilitate the rational and optimal use of all national and external resources, and to monitor and evaluate the implementation of these policies;

Considering the guidelines laid down in document DGO/83.1 entitled "Managerial framework for optimal use of WHO's resources in direct support of Member States";

Aware of the gravity of the socioeconomic crisis in Africa and the need to mobilize greater extrabudgetary resources;

Convinced of the usefulness of involving nationals in the management of WHO cooperation programmes;

Recognizing the positive results of the experiment in some countries, notwithstanding the difficulties inherent in this innovation,

1. THANKS the Regional Director for his report;

2. EXPRESSES ITS SATISFACTION that nationals have been given the opportunity to take part in the management of WHO programmes at the country level;

3. TAKES NOTE of the positive and negative aspects of using nationals in certain countries as WHO Programme Coordinators and of the managerial difficulties encountered at the Regional Office;

4. REITERATES the need for stricter aplication of the Organization's directives on the management of WHO programme at the country level;

5. RECOGNIZES the urgent need to mobilize and to improve the management of the extrabudgetary resources essential for implementing national health development programmes;

6. INVITES the Regional Director gradually to bring the experiment to an end and to take all appropriate steps to eliminate any inconvenience which may result from this action for the countries and the Coordinators in question;

7. REQUESTS the Regional Director:

(i) to ensure greater involvement of nationals in the implementation of technical programmes, so as to promote self-sufficiency and self-reliance in countries;

(ii) to transmit this resolution to the Director-General.

<u>Ninth meeting, 17 September 1985</u>

AFR/RC35/R8 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board

The Regional Committee,

Bearing in mind resolutions AFR/RC32/R7, AFR/RC33/R2 and AFR/RC34/R3;

Having examined the Regional Director's proposals concerning ways and means of implementing resolutions of regional interest adopted by the Thirty-eighth World Health Assembly,

1. ENDORSES the Regional Director's proposals;

2. COMMENDS the Regional Director for steps already taken;

3. INVITES Member States and the Regional Director to pursue implementation of the said resolutions;

4. CALLS UPON Member States to strengthen and make greater use of TCDC mechanisms to implement effectively their national strategies for HFA/2000;

5. REQUESTS the Regional Director to continue to report to it concerning steps taken to implement the plan of work to give effect to the said resolutions.

Ninth meeting, 17 September 1985

AFR/RC35/R9 Expanded programme on immunization in the African Region: a mid-decade evaluation

The Regional Committee,

Having examined the report of the Regional Director on the "Expanded programme on immunization in the African Region: a mid-decade evaluation" (document AFR/RC35/21);

Considering resolution AFR/RC31/R14,

1. APPROVES the Regional Director's report that provides a clear picture of the situation in regard to EPI in the African Region;

2. APPRECIATES the substantial support for EPI given by other international, governmental and nongovernmental organizations.

3. INVITES Member States to step up implementation of EPI in compliance with the recommendations set out in the report and ensure that the objectives of the programme are achieved by 1990;

4. DECLARES 1986 African Immunization Year, in the course of which Member States are invited to put into effect the mechanisms required to obtain vaccination coverage of the target populations.

5. REQUESTS the Regional Director to:

(i) strengthen collaboration with Member States to meet the 1990 deadline, giving priority to programme management, logistics and the cold-chain;

(ii) enhance, in collaboration with UNICEF and the other agencies of the United Nations system, the coordination, mobilization and utilization of resources intended for EPI implementation;

(iii) continue to report to the Regional Committee on the progress made by the programme towards attaining the social goal of Health for All by the Year 2000;

(iv) transmit this report as the contribution of the African Region to the Director-General's progress report to the Executive Board and the World Health Assembly;

6. COMMENDS the Regional Director for his efforts to strengthen national immunization programmes.

<u>Ninth meeting, 17 September 1985</u>

AFR/RC35/R10 Meetings of the Regional Committee

The Regional Committee,

Having considered the Regional Director's proposal regarding the Rules in respect of regional committees held away from the Regional Office;[1]

Bearing in mind Article 48 of the Constitution, which provides that regional committees shall meet as often as necessary and shall determine the place of each meeting;

Having regard to resolution AFR/RC18/R10;

Bearing in mind resolutions:

(i) EB75.R7 that seeks to "ensure that optimal use is made of WHO's limited resources at all organizational levels and in particular of the funds allocated in the regional programme budgets for cooperation with Member States";

(ii) WHA38.11 requesting "the Director-General to provide full support to Member States and to the Health Assembly, regional committees and Executive Board, for the preparation, implementation, monitoring and evaluation of programme budget policies";

Taking into account the very high cost of holding regional committees away from the Regional Office,

1. RESOLVES that regional committees shall meet at least once every two years at the Regional Office;

2. REQUESTS the Regional Director to transmit this resolution to the Director-General.

Ninth meeting, 17 September 1985

[1] AFR/RC35/16, paragraph 3.3.

AFR/RC35/R11 Development and coordination of biomedical and health systems research

The Regional Committee,

Recalling resolution AFR/RC33/R1;

Having considered the Regional Director's report[1] on the development and coordination of biomedical and health systems research,

1. COMMENDS the Regional Director for the measures already taken;

2. NOTES WITH SATISFACTION that the Region's health research programmes focus sharply on regional and national strategies;

3. APPRECIATES the efforts made to promote training in health research and the special programmes of control of Diarrhoeal Diseases (CDD), Human Reproduction (HRP), and Tropical Diseases Research (TDR);

4. APPROVES the report of the Regional Director and its recommendations;

5. INVITES Member States to:

(i) continue to strengthen the development of coherent national health research policies based on overall development strategies;

(ii) allocate funds for development of health research capability with a view to undertaking research activities which are relevant to national health development;

(iii) incorporate health systems research as an essential element in the strategy of the national health development centres;

6. REQUESTS the Regional Director to:

(i) continue collaborating with Member States in development and strengthening of national mechanisms for identification and periodic review of national research priorities relevant to HFA strategies;

---

[1] Document AFR/RC35/4.

(ii) promote health-related research on social, economic and behavioural determinants of health and their interaction;

(iii) support national health research councils or similar bodies as an essential element in the formulation of national research policies;

(iv) keep Member States informed periodically of the resources available for health research.

Ninth meeting, 17 September 1985

AFR/RC35/R12 Regional Director's report

The Regional Committee,

Having examined the report of the Regional Director on the work of WHO in the African Region for the period 1983-1984;

Noting that its presentation complies with the guidelines[1] given by the Regional Committee at its twenty-fifth session;

Considering that the report reflects faithfully the work done by WHO in collaboration with the Member States during the biennium under review;

Considering the new structures adopted for the Regional Office to improve decentralization and especially to provide direct support to the countries in order to make better use of WHO's resources,

1. COMMENDS the Regional Director on the clarity of his report and the manner in which the health situation and trends, and the major programmes of WHO, have been described;

2. ADOPTS the biennial report;

3. NOTES WITH SATISFACTION the new structures of the Regional Office and the resulting new trends;

[1] Resolution AFR/RC25/R2.

4. INVITES Member States to continue their dialogue with the Regional Director on the health programme which has just been drawn up and whose activities will be carried out with the support of the subregional health development offices.

Tenth meeting, 18 September 1985

AFR/RC35/R13 Vote of thanks

The Regional Committee,

Considering the enormous effort made by the people and Government of the Republic of Zambia to ensure the complete success of the thirty-fifth session of the Regional Committee for Africa of WHO, held in Lusaka from 11 to 18 September 1985;

Appreciative of the warm and fraternal welcome extended by the Zambian people and Government;

Bearing in mind the political commitment and the determination of the national officials to implement their national strategies for HFA/2000 through primary health care,

1. THANKS His Excellency Dr Kenneth D. Kaunda, President of the Republic of Zambia:

(i) for having opened the thirty-fifth session of the Regional Committee and personally chaired the opening ceremony;

(ii) for his pertinent address on the health problems of southern Africa and of Zambia in particular;

2. EXPRESSES its gratitude to the Government and the people of Zambia for their warmth and hospitality;

3. INVITES the Regional Director to transmit to his Excellency the President of the Republic of Zambia the present vote of thanks.

Tenth meeting, 18 September 1985

PART II

OPENING OF THE SESSION

1. The thirty-fifth session of the Regional Committee for Africa was opened on 11 September 1985 at the Mulungushi Conference Centre, Lusaka (Zambia), by His Excellency Dr Kenneth David Kaunda, President of the Republic of Zambia. This opening meeting, chaired by President Kaunda, was attended by members of the diplomatic corps and representatives of 42 Member States, of National Liberation Movements recognized by OAU, and several international, intergovernmental and nongovernmental organizations.

2. In his address (Annex 1), Mr Katopola, Minister of Health of the Republic of Malawi, First Vice-Chairman of the thirty-fourth session of the Regional Committee, said what a great privilege, honour and pleasure it was for him to welcome His Excellency Dr Kenneth David Kaunda, President of the Republic of Zambia, to the opening ceremony of the thirty-fifth session of the Regional Committee, and to thank him for gracing the occasion with his presence in spite of his many taxing duties and commitments. He expressed the appreciation felt by all the representatives for the authentic African hospitality that has been extended to them since their arrival in the beautiful capital city of Zambia. The Minister went on to say: "I assure Your Excellency that we all look forward to a most enjoyable stay in your beautiful country and among your kind and hospitable people; this atmosphere will undoubtedly lighten the heavy duties that lie before us." Turning to Dr G. L. Monekosso, Regional Director, Mr Katopola said: "Here we are, 20 years after, assembled once again in our sister Republic of Zambia. When the Regional Committee met here the last time in 1965, Lusaka and Zambia were very different. For one thing, Lusaka was a small post-colonial city, and Zambia was a different country. Like many of our countries, Zambia had recently attained her independence and was grappling with problems of adjustment from a colonial system to an independent administration. Today, we find ourselves in a much bigger and vibrant city of Lusaka in a totally confident Zambia." He asked the distinguished delegates to show their customary maturity and thoroughness in giving the new Regional Director and the Secretariat as a whole well-defined directives and making clear-cut decisions.

3. In his address (Annex 2), Dr G. L. Monekosso, Regional Director, thanked the Government and people of the Republic of Zambia for having kindly invited the Regional Committee for Africa to hold its thirty-fifth session in the attractive and congenial city of Lusaka, blossoming with jacarandas and bougainvilleas. The presence of the President of the Republic, he said, was more than a ceremonial ritual: it bore witness to the political will of the Government and people of Zambia and to their total commitment to cooperation with WHO in attaining Health for All by the Year 2000. The Regional Director continued: "I consider it a privilege that the first Regional Committee meeting after my election as Regional Director is being held in Zambia, one of the countries at the forefront of the struggle of our people for freedom and social justice. Mr President, we salute you for sharing with us the same ideals. Your philosophy of humanism has evoked international conscience in favour of human rights and social justice. May the winds of freedom blow from this land to every corner of our continent."

4. Dr Monekosso then paid tribute to Dr Comlan A. A. Quenum who passed away on 15 August 1984 on the eve of the thirty-fourth session of the Regional Committee. "He served as Regional Director for 19 years. He was a great son of Africa who launched Africa into the HFA/2000 programme with creative imagination and skill." The Committee then observed a minute's silence in memory of Dr Quenum.

5. Turning to the representatives, the Regional Director continued: "During these few months in office, I have had the good fortune to meet some of you in your respective countries or in the Regional Office in Brazzaville. We have together surveyed the health scene in Africa, and have discussed many issues such as:

(i) the exponential growth of the population of the African Region, which will rise from 345 million in 1980 to a projection of between 551 and 578 million by the year 2000;

(ii) food production that disproportionately lags behind population growth;

(iii) the slow but seemingly inexorable invasion of the desert, and

(iv) poor health care delivery and coverage at the periphery."

6. The Regional Director reiterated his willingness to continue this dialogue with all health leaders, using all available channels and opportunities. The health sector's contribution to liberating the African Region from the shackles of underdevelopment would have to be augmented.

7. Dr Monekosso then introduced the main theme of his address, namely "Priority in action". The Seventh General Programme of work (1984-1989) clearly defined the entire range of activities calling for political will, administrative organization and managerial skill, mobilization and effective use of resources, and so forth. He went on: "We must build upon the gains of the last two decades, not by continuing business as usual, but by accelerating our health and socioeconomic development. Your World Health Organization has the lead role amongst international agencies to catalyse health development and nowhere is its action more crucial than in the African Region." Health for all the African populations could only be achieved by means of sustained action. In Dr Monekosso's view, the three medium-term objectives adopted in 1980 should be attained by 1990:

(a) to vaccinate all children under one year of age against the six diseases included in the expanded programme on immunization, and to develop mechanisms for ensuring continued implementation of this programme;

(b) to ensure the provision of clean drinking water and the maintenance of environmental sanitation for all communities and to set up, during the decade of the 1980s, mechanisms for maintaining and extending the necessary infrastracture for health care;

(c) to promote and ensure adequatre food and nutrition for the populations of the African Region and in particular for those sectors which are the most vulnerable.

The current African crisis was an eloquent if dramatic reminder of the reality that much remained to be done in five years before the target date. Although the greatest friend of truth was time, such time must be married to action.

8. The Regional Director then undertook to discuss with leaders of Member States a recently elaborated schedule of activities that could be adopted to varying local situations. Those activities would be carried out with the support of the subregional health development offices and were designed to cover the last three years (1986-1989) of the Seventh General Programme of Work of WHO (1984-1989).

9. His Excellency Dr K. D. Kaunda, President of the Republic of Zambia, addressed the representatives of Member States in the following terms (Annex 3): "I am delighted that Zambia has been afforded the rare opportunity to host, yet again, this important conference of the WHO Regional Committee for Africa. You will recall that Zambia had the privilege to host the twentieth session of the WHO Regional Committee for Africa in 1965. At that time we were barely one year old as a free and independent nation. The conference indeed was a great gesture of confidence towards us from this Organization which is so vital to the life of the international community. It is therefore with the greatest pleasure that the people of Zambia, their Party and its Government welcome you, the Director-General of WHO and your staff, all distinguished delegates and conference observers to this thirty-fifth session in Lusaka."

10. Discussing the activities of WHO in Africa in the last two decades, President Kaunda affirmed: "In the last 20 years, our Organization has grown in size and in the scope of its operations. The health activities of WHO are becoming common knowledge to the man in the street and in our villages. African scientists, professionals, administrators and technicians are assuming increasing responsibilities at the various levels of the Organization. This is a very welcome development. The World Health Organization is a major partner in the people of the world's social endeavour. Here on the African continent WHO must continue to forge the unity of action of the peoples of Africa within the Organization of African Unity and to inspire Member States to strive harder towards the stated goal of health for all."

11. The President of the Republic told the Regional Committee that the Party and Government had seriously examined the concept of primary health care, seeing it as an approach that would help to strengthen Zambia's participatory democracy through community participation in health welfare. He went on: "It was to this end that at our last General Conference of the Party we outlined for the country the guidelines for the next development decade 1985-1995. In respect of primary health care, we are stressing its rapid expansion to ensure that the health of our people does not decline below the existing levels. Under this framework, we expect all District Councils to redouble their efforts in promoting primary health care. The success of the health care delivery services will not be allowed to rest on the Ministry of Health alone. We believe community activities such as the provision and proper utilization of pit-latrines can revolutionalize the lives of the people in a profound manner at the grassroots. We want to work to ensure that every household has appropriate, adequate and well-maintained human waste and refuse disposal facilities. The same structures should ensure children receive the required vaccinations at the appropriate time."

ORGANIZATION OF WORK

12. The Regional Committee adopted the agenda contained in Annex 5. The list of participants is given in Annex 7.

13. In accordance with resolution AFR/RC23/R1, and at the suggestion of the Deputy Chairman, the Committee approved the membership of the Sub-Committee on Nominations (Decision 1).

14. The election of officers for the thirty-fifth session of the Regional Committee and the appointment of Rapporteurs for the technical discussions in 1985 are dealt with in Decision 2, which was adopted unanimously.

15. Decisions 3 and 4 concern the membership and work of the Sub-Committee on Credentials.

ADDRESS BY THE DIRECTOR-GENERAL AND THE WORK OF WHO IN THE AFRICAN REGION, 1983-1984: BIENNIAL REPORT OF THE REGIONAL DIRECTOR

16. Dr H. Mahler, in his address (Annex 4) on the topic of "Targeting for health", reminded the Committee that Member States and the Organization had defined a broad general target and established indicators to evaluate progress towards it. Two specific targets had also been set - safe drinking water for all and immunization of all the world's children against the major infectious diseases of childhood by 1990; however, those targets would only be meaningful if they were adopted by each and every Member State. Member States had described their situation and the political, economic, social and cultural uncertainty which was compounded by natural disasters and human inertia. The infant mortality rate was more than 100 per 1000 live births in most countries and more than 200 in some; life expectancy at birth was less than 50 years in almost all countries. The Director-General therefore concluded that the strategy of health for all through primary health care was the only glimmer of hope. He proposed that national action programmes for primary health care should be drawn up and specific targets set. Efforts should then be concentrated on implementing that policy "where it means most - close to the people, in communities and geographical districts". In most countries, such districts were small enough to manage without excessive bureaucracy, and yet large enough to permit the country to be subdivided into limited numbers and therefore avoid overdispersal of skills.

17. Dr Mahler went on to invite leaders in Member States to be as courageously frank in expressing their health situation as they had been in evaluating their strategies for health for all, so as to enable WHO "to act as your intimate partner in health, ensuring that you receive the support you need, not only from WHO's own resources, which are after all limited, but also from the resources of other United Nations organizations and bilateral development agencies".

18. The Director-General went on to say: "Your determination could lead your governments to target for primary health care. Each one of you could do that by incorporating in your action programme for primary health care those elements that are of high priority to you. You could start with a few and set realistic targets for them, adding elements progressively until all are

covered. Strengthening your infrastructure will enable it to deliver more programmes, and sustained delivery of more and more programmes will, in turn strengthen your infrastructure further. We are gaining experience with the kind of research and development required to build up health systems in just that way. You can use that experience in your countries and add to the general pool of knowledge in the process. We understand sufficiently the social fabric of primary health care, and we have adequate experience of the managerial process required to set it up and manage it."

19. Lastly, Dr Mahler confirmed that WHO was fully aware of its responsibilities in the Region and had no illusions about the challenges that were awaiting it. He continued: "Under the leadership of my colleague and friend, Dr Monekosso, your new Regional Director, substantial reorganization of structures in the Region is taking place. It has one aim, and that is to bring WHO's resources as close to you as possible so that you can derive most benefit from them. For I am aware, sadly aware, that the direct support your organization is providing you with in your countries leaves much to be desired. That is where our efforts must now be concentrated. The inertia mentioned in the evaluation of your strategies must become a thing of the past and must give way to a new spirit of dynamic involvement; more than that, to a new spirit of realistic optimism that we will reach our target."

The Regional Director's biennial report 1983-1984 - Presentation

20. Dr G. L. Monekosso, Regional Director, presented the report on the work of WHO in the African Region in 1983-1984. The report describes the efforts made by Member States, the international community and WHO to implement the national strategies for Health for All by the Year 2000.

21. In pursuance of resolution AFR/RC25/R2 adopted by the Regional Committee at its twenty-fifth session, the report on the period 1983-1984 is the fifth of its kind and has been prepared keeping in mind the comments made during consideration of the earlier reports. While having due regard to the structure of the Seventh General Programme of Work, this report is presented in such a way as to enable the Regional Committee to evaluate the follow-up of its guidelines.

22. The African Region has one of the poorest health situations in the world with maternal and child mortality rates that are quite unacceptable: maternal mortality ranges from 1.6 to 11 ‰, i.e. between 20 and 200 times more than rates recorded in industrialized nations, while infant mortality (0-1 year) ranges from 93.7 to 135.2 ‰, making an average of 116.4 ‰, i.e. between 1.8 and 7.2 times higher than the rates in Latin America and Europe. The only Region in the world with comparable figures is southern Asia, with rates from 3 to 10 ‰ and 95.3 to 120.7 ‰ for maternal and infant mortality respectively. Cholera is still found in epidemic proportions in many countries, again with unacceptable case fatality rates. Epidemic bouts of measles still occur here and there, while trypanosomiasis is on the upsurge in many countries.

23. While remaining faithful to the concept of social justice, WHO in the framework of cooperation with Member States and coordination with other organizations, has paid special attention to all activities that might extend national health systems to the most peripheral communities. The project on Women and Health Development is one of WHO's approaches to promoting such social justice.

24. In the framework of the Second International Conference on Refugees in Africa (ICARA II), 23 health projects have been formulated in conjunction with the High Commissioner for Refugees and OAU and submitted to donor countries.

25. The Organization has pursued its efforts to enable Member States to become more familiar with its managerial mechanisms, including the mobilization of extrabudgetary resources. Accordingly, joint workshops have been organized for nationals and WHO personnel; broad discussions have been held in the countries in order to ascertain national authorities' opinions on the new managerial mechanisms which the Organization's Secretariat has proposed so as to make optimal use of WHO's resources for the attainment of HFA/2000. During the 1983-1984 biennium, the catalogue of projects, which is the regional mechanism for circulating information on the countries' needs, was widely distributed to donors.

26. Mechanisms set up in the context of TCDC have enabled exchanges of experience and PHC personnel in the Region to be continued. Study visits by representatives of Member States to other countries of the Region have continued, with due flexibility, under a plan for 1980-1985. In pursuance of resolution AFR/RC34/R7 adopted by the Regional Committee at its thirty-fourth session, the programme of such visits will be evaluated during the thirty-fifth session.

27. WHO and other organizations are continuing to strengthen technical cooperation with National Liberation Movements recognized by the OAU. Some projects financed entirely by the WHO regular budget in support of National Liberation Movements were implemented during the biennium.

28. WHO activities regarding the organization of national health systems based on PHC have been essentially catalytic and promotional in nature, including conferences, educational meetings and consultations, etc.

29. A cooperative programme involving the Christian Medical Commission, WHO and UNICEF was initiated in early February. Under the programme it is proposed to identify NGOs concerned with the health sector so as to coordinate activities under favourable conditions. The countries involved are Lesotho, Malawi and Swaziland.

30. The international conference on "Health for all, 25 years of Cuban experience" organized by the Cuban Government was held in Havana from 3 to 9 July 1983, with the support of the Regional Office; 20 participants from 12 African countries took part: Benin, Burkina Faso, Burundi, Cape Verde, Ethiopia, Guinea-Bissau, Kenya, Malawi, Mali, Mozambique, Zambia and Zimbabwe. Following a review of Cuba's activities to implement the eight components of primary health care, the participants exchanged experiences in order to identify the health problems more clearly and determine ways and means for attaining the social objective of Health for All by the Year 2000.

31. A seminar on primary health care strategies was organized in Washington (United States of America) from 9 to 20 January 1984 by the World Bank. It was attended by some 20 participants, senior officials responsible for health programme policies in 16 countries.

32. During the biennial period under review, WHO activities regarding health manpower development have consisted mainly in: (i) introduction of primary health care modules into the training programmes of several institutes of the Region; (ii) promotion of health development centres; (iii) training and further promotion of health sciences teachers and specialists; (iv) design, production and distribution of teaching materials adapted to training policies and programmes; (v) training of all categories of health manpower in health management and strengthening of the activities of WHO training centres.

33. In 1983-1984, WHO continued to participate in training programmes for all categories of health manpower. This collaboration took the form of workshops for administreators, paramedical trainers, nurses, extension workers and other health technicians such as laboratory and pharmaceutical assistants. Teaching materials were provided to all countries so requesting. The Organization has made major efforts to train all categories of African health personnel. For the biennium 1984-1985, 22% of the Region's regular budget has been allocated to health manpower development. However, it has to be admitted that a large number of trained technicians are not employed in the branch for which they were trained or are not provided with the minimum working conditions to enable them to put their knowledge to work.

34. The Regional Committee has on various occasions drawn Member States' attention to the importance of research programmes as effective tools for health development in the context of TCDC. WHO cooperation in this field takes the form of grants for research and training workshops on research methodology; it is also exercised through collaborating centres, seven of which have been newly designated during the biennium.

35. Interregional exchanges of experience on the subject of traditional medicine have remained very limited and uncoordinated. At the regional level, the four collaborating centres designated in 1981 have continued their activities, while WHO has maintained very close cooperation with the international bodies concerned.

36. The Regional Director's biennial report indicates that there are nine African institutions in the three Sub-Regions that are sufficiently advanced to form part of a "network of national centres for health systems research". However, one should begin by creating in each of the 45 Member States of the Region the necessary skills with which to carry out on-the-spot research on

national health systems. Some measures have already been taken in this respect: courses, seminars and workshops on applied research methodology have been organized in some countries, particularly in collaboration with the Project for Strengthening Public Health Delivery Systems (SHDS) in Central and West Africa. More dynamic steps should be taken in this direction in the years to come, covering all the countries of the Region.

37. Despite efforts made both by the countries and WHO to strengthen food and nutrition surveillance in the Region, the situation remains worrying, especially in the drought-affected countries. Given the socioeconomic crisis, which is growing continually more serious, it would appear to be urgently necessary to seek new types of cooperation with a view to achieving regional self-reliance in food. Even before the famine in Ethiopia, 1000 children were dying every day in Africa. It is generally forgotten that, prior to the outstanding fall in the birth rate in recent years (20% since 1981), food production in Africa was increasing at an impressive pace according to the figures at that time and even today stands comparison with that of industrialized countries. Unfortunately, the increase in production (2% per annum on average) has been seriously out-distanced by demographic growth averaging some 2.7% per annum and surpassing 4% in some countries. What is even more serious is the migration of able-bodied youngsters to the towns: the result is that a physically enfeebled rural population has to produce more in order to support an urban growth rate of between 5 and 10% per annum.

38. WHO is participating, in close collaboration with other agencies of the United Nations system, in emergency aid activities in the 21 countries worst affected by drought and other natural disasters occurring one after the other in the Region. The resources provided for such assistance should be used to set up rehabilitation facilities and ensure long-term development in both the health and socioeconomic fields.

39. The programme of maternal and child health, including family planning, is one of the most important components of primary health care in the African Region. Activities under this programme have concentrated on consultant support services for national programmes, manpower training and research.

Despite the interest displayed by the majority of Member States in questions connected with this programme, the resources devoted to maternal and child health remain somewhat slender. Out of 26 countries in Africa collaborating with WHO in the implementation of their MCH/FP programme, only eight have defined a population policy aimed at reducing the growth rate and, of that number, four - Kenya, Mauritius, Seychelles and Zimbabwe - have signed in 1984 the declaration for the stabilization of their respective populations.

40. WHO's activities regarding drinking water supplies and sanitation during the biennium 1983-1984 were characterized by an improvement in country coverage by the forward posts of intercountry project ICP/CWS/002 set up at Addis Ababa, Bamako, Harare, Lomé, Lusaka and Yaoundé. Thus, seven sanitary engineers and an economist took part in the International Drinking Water Supply and Sanitation Decade (IDWSSD) activities in the countries of the Region. A sanitary engineer assisted in the training of rural public works engineers at the inter-State school in Ouagadougou. The project personnel collaborated with nationals in organizing national IDWSSD workshops in the countries. Twenty-eight such workshops were organized during the period. The regional average of drinking water supply and sanitation (1980 figures) shows that 53.8% of urban communities are properly supplied with drinking water and 43.2% with sanitation services, while corresponding figures for the rural populations are 19.9% and 18.8% respectively. According to data available on 31 March 1985 concerning 16 countries with a total of 218 million rural inhabitants, only 29% of the population have drinking water at home or within 15 miles walk.

41. As regards the programme on essential drugs and vaccines, 16 countries have drawn up their national policy covering the various aspects of the action programme on essential drugs (APED), 23 countries have introduced laws relating to drugs, and 20 now use generic names in the public sector. The Regional Office collaborated closely with countries desirous of improving their system of drug purchase and distribution. WHO sent experts and consultants to help to identify essential drugs, estimate quantities and work out appropriate procedures for purchases at national level. The concept of group bulk purchasing was proposed to the Member States; 12 have accepted the approach while the rest have yet to come to a decision.

42. Under the disease control programme, substantial progress has been made in onchocerciasis control, but other diseases, essentially transmitted by vectors, such as yellow fever, trypanosomiasis, schistosomiasis and malaria, continue to be a cause of great concern. The countries have made praiseworthy efforts but these do not yet reflect the collectively expressed desire to review their present methods of epidemiological surveillance, including information support and exchange.

New Regional Office structures

43. In May 1977, the Thirtieth World Health Assembly decided that the main special target of governments and WHO in the coming decades should be the attainment of all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. One-third of the time allocated for attaining that target has now passed, but it is not at all sure that we have also covered one-third of the distance. The countdown should not be regarded solely in terms of time but also in terms of achievement. Better use should be made of the mechanisms for TCDC and for that reason an inevitable change is being planned, which will enable us to speed up our progress towards the social target of HFA/2000 to which Member States have individually and collectively subscribed.

44. At its twenty-ninth session the Regional Committee considered the implications of resolution WHA33.17 and resolution 34/58 of the United Nations General Assembly, and adopted resolution AFR/RC29/R7 which acknowledged the relevance of the structures of the Regional Office and in operative paragraphs 2 and 3 invited "the Regional Director to take appropriate steps, in conjunction with the Programme Sub-Committee and the Director-General, to ensure that the study of WHO's structures in the light of its functions will enable all Member States to attain the social target of Health for All by the Year 2000" and "to keep the Regional Committee informed, through its periodic reports, concerning development of the structures of the Regional Office in the light of its functions". Furthermore, the plan of action for implementing the provisions of operative paragraphs 6 (2), 6 (3) and 6 (4) of resolution WHA33.17 requests the Regional Director to continue to "decentralize and strengthen self-reliance at both national and regional levels".

45. Accordingly the Regional Director has proceeded to decentralize the Regional Office in order to bring it closer to the countries and enable the Organization to give more practical support by making optimal use of resources. Three subregional health development offices will be set up. Each one will be headed by a director, a highly-qualified international official, assisted by multidisciplinary teams able to respond immediately and effectively to the governments' requests concerning the delivery of community health services. Each office will comprise strategic, logistic and technical support teams.

46. In the countries, the strengthening of the WHO Coordinators' Offices in regard to their administration, finance, technical capacity and personnel will enable Member States to put their national strategies into effect. Similarly, the Coordinators will be given greater responsibility, and will be more carefully selected, so that they can carry out their administrative and managerial functions, advise and supervise and be worthy counterparts of the other representatives of the United Nations system of agencies. The strengthening of the Coordinators' Offices will of course require the utilization of national skills in order to promote and/or develop the countries' self-reliance in regard to health care deliveries to individuals, families and communities.

47. In the Region, this decentralization will improve the orientation of WHO support. All types of logistic and technical support will accordingly be close to the countries, since one of the main objectives is to promote and develop multidisciplinary teams so that better use is made of the Organization's resources. By making rational use of the new structures and pooling national experience in management and health and social deliveries, Africa will be able to meet the deadline of the year 2000.

Discussion

48. The Regional Director's report on the work of WHO in 1983-1984 led to a lively discussion. The representatives of Member States found the report detailed, clear and informative. They exchanged their experience on the various points raised by the report. They asked for clarification on the following points:

(i) level of responsibility of the director of the subregional health development office as compared with that of the WHO Coordinator/Representative in the same country;

(ii) cost of setting up the subregional offices;

(iii) how the offices would operate;

(iv) criteria for selection of host country.

49. The Committee invited the Regional Director to strengthen support to Member States for training health personnel in management and for setting up national health systems based on primary health care.

50. The Regional Director gave clarifications on the following points:

Level of responsibility

51. The subregional health development office was not a hierarchical level but an operational technical liaison between the countries and the Regional Office. The establishment of such offices would enable Member States to receive prompt replies to their requests, thus avoiding bureaucratic procedures prejudicial to the implementation of their national health strategies and obviating communication difficulties. The subregional office was therefore intended to bring the technical back-up closer to the countries. The WHO Coordinator/Representative would represent the Director-General and the Regional Director in the country and would constitute a direct link between the Regional Office and the country. There was therefore no hierarchical link between the Coordinator/Representative and the Director of the Subregional Office.

Cost of establishment

52. The establishment of the subregional offices would not lead to the creation of any additional posts. There would therefore be no increase in staff costs. There would simply be a phased redistribution of the staff currently assigned to intercountry projects and possibly to the Regional Office.

53. However, it would certainly be necessary to provide the offices with logistic support, and especially physical support (office, materials and equipment, etc.), to enable them to function. The additional cost of such facilities would be submitted in accordance with WHO's rules.

Role of the Regional Health Development Centres (RHDCs)

54. The RHDCs in Cotonou, Maputo and Harare were designed to be public health training centres with French, Portuguese and English as the respective language of instruction. Cotonou and Maputo were already functioning as specialized training and research institutions. The RHDCs would provide support for the subregional offices in a series of functions: (i) consultation/advice; (ii) information; (iii) training; (iv) research; (v) technical cooperation with a view to HFA/2000, and (vi) the creation of national health development centres (NHDCs) in the countries.

55. At country level the NHDCs would take responsibility for operational functions (participating in PHC activities) and possibly for technical functions (training, coordination of PHC activities, strengthening of health services infrastructures, imnplementation and evaluation of health programmes), and would provide strategic support for PHC.

Operational mechanisms

56. In order to function, the subregional offices would receive logistic support, in particular a system of communication between the Regional Office and the countries on the one hand, and between the countries themselves on the other hand. Cost studies were currently being undertaken in conjunction with Headquarters. It was intended that advanced data processing facilities would also be made available at all the subregional offices. The current drop in the price of computers would make it possible to solve some communication problems.

57. The present intercountry teams would be regrouped into subregional teams so that their multidisciplinary nature would make them more operational and would serve as an example for the countries themselves. That measure would also meet the wishes of the Regional Committee, which in recent years had been

concerned to provide effective support for intercountry projects in relation to their cost. However, the subregional offices would not simply be a regrouping of existing projects.

Criteria for selection of host country

58. The location of the subregional offices would be decided after a careful study had been made in the countries concerned in accordance with criteria yet to be specified. Factors to be taken into account would include successful experience with primary health care, the level of operation or the possibility of developing a national health development centre, the commitment already demonstrated in transforming primary health care strategy into specific national plans of action, etc.

DEVELOPMENT AND COORDINATION OF BIOMEDICAL AND HEALTH SYSTEMS RESEARCH

Introduction

59. Dr V. M. Eyakuze presented the Regional Director's report on the development and coordination of biomedical and health systems research. The document described the activities of the Regional Research Promotion and Development Programme. It stated the activities of the Special Programmes HRP, TDR and CDD which function in close collaboration with the Regional Office.

60. The introduction explained the necessity of research to tackle the problems of where and how changes can be brought in health systems if the social objective of HFA/2000 is to be achieved.

61. The six main thrusts of the regional strategies were given. They were: contribution to the achievement of the goal of HFA/2000; continuous stimulation and promotion of political commitment and the decision-making processes; understanding community participation; organization and management of health systems; intersectoral activities, and use of appropriate technologies.

62. The report noted that as a result of the systematic evaluation of the regional health research programme in 1983 a regional health research medium-term programme (MTP) for 1984-1989 was prepared. The four specific objectives of the MTP were noted.

63. The implementation of the recommendations of the sixth session of the AACMR and resolution AFR/RC33/R1 and some other programme activities were enumerated. These were: (i) the development of a training manual for health research methodology; (ii) the recommendations of the seventh session of the AACMR held in Madagascar; (iii) the workshops conducted on research methodology and protocol design; (iv) the award of 17 grants to research workers from 11 countries of the Region; (v) the designation of seven new WHO collaborating centres, and (vi) research promotion visit to Member States.

64. The following activities carried out by the Special Programmes in the Region during 1983-1984 were recorded:

- the establishment of the three centres for research and training in diarrhoeal diseases control (Angola, Ethiopia and Senegal);

- TDR's collaboration with 28 African countries in activities of research and development, research training and institution strengthening; it was noted that from January 1983 to March 1985, 143 projects were supported at a cost of US $8.98 million;

- the breakdown of expenditure of HRP during 1983-1984, and the conclusion and recommendations of the second meeting of the African Study Group on Research in Human Reproduction held in Franceville (Gabon).

65. With regard to Health Systems Research the following were noted: (i) the Regional Office in collaboration with SHDS project organized five national courses on methodology of applied research in PHC; (ii) tripartite cooperation in HSR projects similar to that organized in Ethiopia is under consideration by the Botswana Government; (iii) the conclusions and recommendations of the second meeting of the Study Group on HSR held in Brazzaville (Congo) in February 1985.

Discussion

66. The Regional Committee noted with satisfaction the progress that had been made in the development and coordination of biomedical and health systems research. It appreciated the fact that the Region's health research programme focuses sharply on regional and national strategies to attain the goal of HFA/2000 through primary health care.

67. The Committee agreed that the critical issue in health development is the gap between what is known in health sciences and what is actually accessible to the population in terms of knowledge, services and opportunities. The Committee felt that HFA/2000 cannot be achieved if Health Systems Research is neglected, and emphasized the need for this type of research as a priority area for the African Region.

68. The Committee expressed the dire need for health research information, in particular on appropriate health technology, new diagnostic tools, community involvement, resources available to health research and health research results that have been successfully utilized in the Member States' health development process. It was suggested that the Regional Office publish a regional health research journal.

69. The members welcomed the effort made in organizing national and regional workshops in order to enable young research workers to acquire proficiency in research methodology and protocol design. They recommended that the exercise should continue.

70. The Committee agreed that the aims of the activities pursued by the Regional Office were to obtain specific research results that are relevant and applicable to improve health programmes at country level and to strengthen the research capabilities of the countries themselves.

Recommendations of the seventh session of the AACMR

71. The Regional Committee endorsed the recommendations of the seventh session of the AACMR held at Antananarivo (Madagascar) from 15 to 19 April 1985, which were as follows:

(i) That the AACMR should focus its discussions on the central orientation of the policy, strategy and management of research and research training so as to stimulate the creation and/or strengthening of the much needed health research infrastructure in the African Region.

(ii) That the existing WHO collaborating centres be evaluated in terms of their overall contributions to WHO's efforts to achieve the social objectives of HFA/2000 through primary health care.

(iii) That the meetings of the AACMR currently held once every two years should revert to an annual schedule so as to minimize the delay in discussing problems raised by the global ACMR and to sustain the much needed momentum in research in the Region.

(iv) That should the Regional Office realize that a research priority existed which was not being tackled by researchers, it should itself select researchers and commission them to undertake the task.

(v) That the Regional Committee for Africa earmark 5% of the regional programme budget for health research.

(vi) That the Regional Office continue to promote among Member States the creation of health research policy based on overall health development programme.

(vii) That the WHO Coordinators should play a more active role in research promotion.

72. The Regional Committee adopted resolution AFR/RC35/R11.

AFRICAN REGIONAL PROGRAMME BUDGET POLICY

73. The implementation of the regional strategy for HFA as adopted by the Regional Committee at its thirtieth session in September 1980 at Brazzaville, requires that optimal use should be made of WHO resources both at national and regional levels.

74. The Thirty-eighth World Health Assembly urged the regional committees to increase their monitoring, control and evaluation functions so as to ensure that national and regional health policies comply with the resolutions adopted by the governing bodies.

75. The Thirty-eighth World Health Assembly urged the regional committees to formulate a regional programme budget policy that would ensure that optimal use was made of WHO's resources in order to give maximum effect to the Organization's collective regional policy.

76. This regional policy is set in the context of the global guidelines for preparing a regional programme budget policy (document DGO/85.1) which was transmitted to the Member States at the seventy-fifth session of the Executive Board and the Thirty-eighth World Health Assembly.

Main thrusts of the regional programme budget policy

77. The main thrusts of the African regional programme budget policy follow these global guidelines, while being adapted to the specific features of the African Region: (i) support to strategies; (ii) strengthening national capacities; (iii) technical cooperation among developing countries; (iv) optimal use of resources.

78. In the African Region, the Regional Committee, in considering support to national strategies, adopted in the course of its twenty-ninth session (resolution AFR/RC29/R11) the Charter for the Health Development of the African Region, and in 1983, in the course of its thirty-third session, the regional plan of action for implementation of the strategy for HFA (resolution AFR/RC33/R5).

79. The strengthening of capacities has been a constant concern of the Regional Committee since the adoption of the regional strategy. The training of health manpower at all levels is an essential component of the regional strategy and has been accompanied by the development of a regional network of training establishments.

80. The Regional Committee has acknowledged the importance of research and development as a major tool in solving priority health problems, and of drawing up a regional network of health development centres supported by regional centres, which should lead to strengthening national capacities with a view to constituting a critical mass of leaders in action towards HFA.

81. Technical cooperation among developing countries (TCDC) is an essential feature of the regional strategy, having subregional working groups and a Standing Committee. In 1984, the Regional Committee at its thirty-fourth session considered the implementation of the regional strategy for optimal use of WHO's resources in direct support of Member States.

82. WHO cooperation with the countries takes two forms which should be borne in mind during detailed planning of WHO's regular budget: (i) international services, and (ii) direct financial participation.

83. The Regional Committee defined and adopted WHO's policy on fellowships at its thirty-third session (resolution AFR/RC33/R2).

84. The Regional Director had formulated an organizational framework in order to achieve HFA, which contains four main ideas: (i) the WHO Secretariat is first and foremost at the service of Member States; (ii) WHO's policy should be to work closely with the countries; (iii) available resources should consistently be put to better use, and (iv) it is essential to identify and mobilize all resources.

Elements of African programme budget policy

85. The components of African policy may be grouped under four headings: (i) programme budgeting process; (ii) support by the Regional Organization; (iii) role of the Regional Committee, and (iv) monitoring and evaluation.

86. The process of programme budgeting conforms to the principles of programming by objective and budgeting by programme. The process used at country level requires a joint government/WHO study of national programmes to which WHO resources are allocated. Detailed joint government/WHO planning should make possible the implementation, monitoring and evaluation of national programmes in which WHO participates financially or in the form of international services. The setting-up of a joint government/WHO mechanism in which the Coordinator has to participate is a condition for making optimal use of WHO's resources.

87. Regional Organization support should be improved by the new structure of the African Region, based on decentralization of Regional Office activities by opening three subregional offices and strengthening the Coordinators' offices.

88. The role of the Regional Office has been extended further. The new and particularly important feature is the succinct report that each Member State will send to the Regional Office on the use of WHO's resources.

89. Monitoring and evaluation of regional programme budget policy takes place at various stages and at various levels of the Organization.

Regional programme budget structure

90. The proposed programme budget for 1988-1989 will be the first to be prepared in accordance with this policy and its structure will be derived from that. It will emphasize particularly the country statements and the WHO programmes that support national programmes.

91. Following the thirty-fifth session of the Regional Committee the proposed programme budget policy for the countries of the African Region will be prepared with the participation of the WHO Coordinators, the members of the Programme Sub-Committee and national officials, in the course of Regional Programme Meetings (RPM) and meetings of the TCDC working groups. This draft will be examined in June 1986 by the African Advisory Committee for Health Development (AACHD) before its final revision and adoption by the Regional Committee at its thirty-sixth session, in September 1986.

Discussion

92. In the course of its discussions the Regional Committee laid down guidelines for the Regional Secretariat in regard to:

(i) health manpower training in general and the managerial process in particular;

(ii) the use of WHO resources for supplies and equipment;

(iii) the definition of intercountry programmes and activities;

(iv) technical cooperation among developing countries (TCDC);

(v) the respective responsibilities of governments and WHO in the programme-budgeting process.

93. All these guidelines will be taken into consideration when the draft document, to be submitted to it in September 1986, is being prepared. The strengthening of national capacities should take place through development of an operational regional network of training institutes for various categories of personnel in various disciplines, but also, of necessity, through a network of national health development centres supported by regional centres.

94. Since the Member States have collective responsibility for management of WHO's resources, certain limits and certain constraints are set for the use of funds, as recalled by resolution WHA33.17 which requests the Director-General and the Regional Director to respond favourably to government requests only if these are in conformity with the Organization's collectively adopted policies. However, bearing in mind the situation in Africa, the Regional Director has paid special attention to all requests from Member States.

95. The creation of three subregional offices within the new structure of the Region will enable Regional Office activities to be decentralized towards the countries and intercountry programme activities to be redistributed to those subregional offices.

96. The TCDC working groups will consider regional programme budget policy at their meetings in 1986 and will thus be able to determine WHO's role in that field, among other things. WHO's catalytic function will be strengthened by setting up proper TCDC data banks at the WHO Coordinators' Offices.

97. The joint government/WHO study of national programmes to which WHO's resources are allocated does not imply any transgression of Member States' sovereignty. It involves a permanent dialogue with the countries during the various phases of planning and programming of WHO's resources. The purpose of these joint mechanisms is to ensure that WHO's resources are utilized in conformity with WHO's policy and with national health policy.

98. The dialogue concluded with a detailed agreement between the two parties, and the legal documents form the foundations of effective monitoring of the optimal use of WHO's resources.

EXPANDED PROGRAMME ON IMMUNIZATION (EPI): MID-DECADE EVALUATION

Introduction

99. The Regional Director has conducted an evaluation of the expanded programme on immunization in the African Region for the period 1977-1985. Dr D. Barakamfitiye introduced the report of the Regional Director (document AFR/RC35/21) which supplies the Regional Committee with information on progress made and problems encountered during implementation of the programme, and is intended to encourage the Member States of the Region to make a fresh start in order to take the appropriate measures to achieve within the agreed deadlines the objectives and targets that have been set. Evaluation of the programme follows the WHO guiding principles for evaluation of health programmes ("Health for All" Series, No. 6).

100. The African Advisory Committee for Health Development (AACHD) considered the report at its 1985 session and made recommendations. The relevance and importance of EPI have become clear, given the dimensions of the problems to be solved and its compliance with the social target of Health for All by the Year 2000.

Adequacy

101. The formulation of immunization policies is based on a clear definition of problems. The following are noteworthy:

(i) Tetanic infections through the umbilical cord or the circumcision lesion are found mainly among rural populations that have little or no access to health establishments. The results of surveys conducted in Africa to estimate mortality that may be attributed to neonatal tetanus show that the rates imputable to this infection range from 1.0 to 17.0 deaths per 1000 liveborn chidren. Since the number of parturients who have received two doses of tetanus vaccine, that is to say the minimum dose for prevention, is about 10%, it is estimated that in 1985 there will be 170 000 deaths in Africa attributable to neonatal tetanus.

(ii) Pertussis affects 80% of newborn infants and children in Africa. In densely populated urban areas, pertussis is endemic and infects infants during the first year of life, which is an age when case fatality rates are high. In rural areas with a low population density, pertussis is usually an epidemic disease which emerges every two to five years. Apart from the very high mortality rates shown by the foregoing data, anorexia and vomiting caused by pertussis contribute to loss of weight and severe and sometimes fatal malnutrition. Pertussis vaccine given in three doses at one-month intervals is 75-85% effective.

(iii) All African children unprotected by vaccination will be infected by measles, and 80% of them before the age of five. With the possible exception of malaria in certain zones, measles is the number one enemy of African children. It is accompanied by a large number of complications, including encephalitis, xerophthalmia, otisis media, pneumonia, diarrhoea and malnutrition. The immunosupressive reaction induced after measles increases the risk of severe bacterial complications, including tubercular meningitis and shigellosis. The case fatality rates for measles in Africa may be as high as 26%.

(iv) Before the 1970s, poliomyelitis was not fully recognized as an important health problem in tropical Africa. In Ghana, where it was thought that poliomyelitis was not a public problem, studies showed to the great surprise of all concerned, that there was a large number of disabilities caused by poliomyelitis. By applying the WHO standard procedures for conducting surveys on disabilities, it was found that the rates of residual paralysis after poliomyelitis ranged from 1.5 to 8.5 per 1000 children.

102. From the point of view of programme formulation the expanded programme on immunization is an integral part of primary health care programmes at national and regional levels. Regional targets have been set for access to services for all infants aged less than one year by 1990, and for full immunization of at least 75% of infants before the age of 12 months. Targets for the reduction of morbidity and mortality have not yet been set in all the countries.

Progress

103. In 1985, EPI is being implemented in virtually all the countries of the Region. Certain countries are carrying out activities in the capital city and setting up very expensive programmes which they are not in a position to extend throughout the country, given the funds available. Moreover, countries often set up or strengthen independent vertical structures to administer vaccinations, while paying little attention to integration. To date, in 22 countries out of 45, EPI covers the entire country; 39 countries have integrated EPI into either PHC or MCH services. Certain countries are speeding up implementation of the programme by adopting a number of approaches:

- use of mobile teams: in at least 29 countries mobile teams are operational;

- implementation of intensive activities over a short period.

104. An evaluation of these approaches was conducted at the last meeting of the Global Advisory Group on EPI (1984), which commented that any country envisaging an intensive approach should first carry out a meticulous study of its own situation and then consider the probable long-term impact of such a strategy and the country's aptitude for putting that initiative into effect and sustaining it.

105. Progress of EPI is monitored by a series of important indicators prepared at global level and adapted to national and regional needs. Among the vaccines used in EPI, BCG alone is produced by two countries of the Region. Consequently, virtually all vaccines used in the Region are obtained overseas.

106. WHO and UNICEF are the main suppliers of EPI vaccines in Africa and have jointly determined criteria for vaccine quality. Nearly all vaccines used in Africa at present comply with those criteria.

107. Many immunization campaigns in Africa have failed because insufficient attention has been paid to the cold-chain. Efforts by WHO and UNICEF to identify, test and evaluate equipment, organize training courses for the maintenance and repair of equipment and set up routine procedures for operating it, have enabled the cold-chain to function smoothly in many countries of Africa.

108. WHO and its Member countries have made significant progress in upgrading the management skills of health staff. Current training priorities are peripheral level personnel, on-the-job training, continuing education and identification and correction of performance problems. The emphasis is being shifted to the integration of EPI into training curricula for health personnel and to the training of village health workers who interact with the family and are directly involved in activities at community level.

109. Operational research on immunization delivery strategies, epidemiological surveillance of target diseases, cold-chain components and sterilization techniques is given high priority.

Efficiency

110. Immunization coverage measures the efficiency of the delivery system in providing recommended vaccines to target populations. As reporting of immunization of children under the age of one is not yet very common, direct estimates are not often used at this stage. However, it is usually for sample surveys to be carried out to measure coverage in areas served by EPI. In 1983-1984, 30 countries carried out 150 surveys in these areas. It should be noted that only nine countries carried out national surveys, the results of which can be considered valid for the whole country.

111. The results of all these activities in terms of immunization coverage are still rather slight. In spite of the fact that, according to the information available for 1983, 10 countries achieved immunization coverage of the target group ranging from 45% to 87%, the level of coverage for the Region as a whole is barely more than 20%.

Effectiveness

112. Programme effectiveness in terms of reduced morbidity and mortality and of social benefits cannot reasonably be measured at this stage, since immunization coverage has not yet attained the level of 75-80% that is normally required to interrupt transmission of the target diseases. In some countries or areas, however, where there has been satisfactory implementation of the programme and a good system of surveillance, evidence of disease reduction is beginning to appear.

Impact

113. The impact of the programme will be determined by the improvement in the quality of life of the people of the Region. This cannot be brought about by EPI alone. Moreover, the average level of coverage as presently estimated is not yet sufficient to make it possible to point to any striking improvements in the overall health situation.

Recommendations

114. The Regional Director's report contains the following recommendations:

(i) strengthen political commitment at the highest level and foster community involvement;

(ii) ensure further integration of EPI into primary health care structures;

(iii) set targets in terms of reduction of morbidity and mortality from the diseases covered by EPI;

(iv) strengthen the management of national programmes, in particular by organizing meetings of local, intermediate and national level personnel, and continue to hold intercountry meetings of national EPI organizers at the subregional level;

(v) review epidemiological surveillance systems, and in particular simplify systems of data collection and ensure that feedback is available;

(vi) ensure sufficiently early planning of logistic requirements, select cold-chain equipment carefully, and ensure that it is well maintained;

(vii) take advantage of every opportunity to immunize children;

(viii) include EPI in training curricula for health personnel at all levels;

(ix) make the best possible use of available resources and mobilize budget resources;

(x) continue with applied research in the fields of epidemiology and of the cold-chain;

(xi) undertake periodic review and evaluation of the programme.

Discussion

115. Comments on the Regional Director's report were made by 23 delegations. The Regional Committee acknowledged the considerable progress made since 1974, when EPI was first implemented, and felt that if the progress during the last 10 years could be maintained there was reasonable hope of attaining the objective, i.e. providing full vaccination during the first year of life for at least 75% of children by the year 1990.

116. The Committee expressed appreciation of the clarity of the report and the large amount of information contained in it. The Regional Director would be provided with updated information to supplement the report. It particularly emphasized the importance of obtaining valid data in order to manage the programme properly, and requested WHO's support in strengthening national capabilities for the collection and utilization of data, especially at the local level.

117. Many obstacles encountered in implementing national programmes were pointed out. Those obstacles would have to be overcome if the objective for 1990 was to be attained. They included the problems connected with failure to complete a course of vaccinations, training, supervision, supplies, transport, spare parts and maintenance of the cold-chain. Where there were still too few fixed establishments to provide the population with adequate access, the outreach strategy and the use of mobile teams might be necessary. Some countries were thinking of introducing national vaccination days to muster multisectoral political support, increase community participation, and mobilize the financial and human resources for achieving a rapid increase in vaccination coverage.

118. The Committee raised questions concerning the strengthening of facilities for vaccine quality control in the Region, the collection and dissemination of data, the use of solar-powered refrigerators, the choice of the group under one year of age for measuring vaccination coverage, and the revised vaccination timetable given in the report.

119. The problem of obtaining adequate data was not confined to EPI, but applied to practically all health programmes. The Regional Director would give high priority to strengthening national capabilities in that area. The usefulness of a "national vaccination day" and similar campaigns for bringing about a rapid increase in vaccination coverage had been demonstrated; but it was important to ensure that such efforts contributed to strengthening the health infrastructure. It was comparatively easy to increase coverage in the short term, but unless that increase was maintained the long-term effects might be more negative than positive.

120. Two centres in the Region, at Dakar and Nairobi, had been strengthened so as to provide facilities for vaccine quality control. The possibility of strengthening further centres was being studied (Ghana, Ethiopia, Madagascar, Zimbabwe).

121. A recent report on the preliminary results of trials with solar-powered refrigerators would soon be available to Member States. The report indicated that in some areas where no alternative sources of energy were available the relatively high cost of solar refrigerators might be justified. In most cases, however, such refrigerators did not yet offer a satisfactory solution to the problems of the cold-chain. Those problems included the relatively high initial cost, the need for well-trained staff to install and repair equipment, the need for routine cleaning of solar panels, maintenance of batteries, the relatively short life of batteries (about two years), and their high cost which presented problems when they needed to be replaced.

122. The lack of spare parts in insufficient quantities was a widespread problem. Donors should be made aware that the initial purchase of a refrigerator and transport to its place of use accounted for only about one-third of its total cost during its useful life. The other two-thirds were accounted for by fuel, spare parts and maintenance. When donating equipment, donors should supply the spare parts needed during the equipment's lifetime.

123. It was noted that the World Health Assembly had recommended selecting the age-group under one year for the evaluation of vaccination coverage. It was an appropriate decision, for that was the age when vaccination was most effective. In older age-groups, particularly in the developing countries, a higher percentage of children were already immunized by natural infection against the major diseases.

124. The vaccination schedule recommended in the report had the advantage of offering a wider range of possibilities for immunizing the child and encouraged the vaccination of children from early infancy. A dose of oral poliomyelitis vaccine at birth could provide 70% intestinal immunity, and should be administered on the child's first contact with the health services. It could easily be given at the same time as BCG vaccination. Countries which had set up in-service training programmes and provided good supervision could make gradual changes in the timetable without causing any major upheavals in the current programme.

125. The Committee recognized the need to continue operational research to solve the problems regarding failure to complete courses of vaccinations, maintenance of the cold-chain, and other epidemiological problems associated with the expanded programme on immunization. Studies should also be conducted to determine the possibility of vaccinating children against measles before the age of nine months.

126. The Committee noted the value of exchanges of experience between countries, so as to enable national EPI organizers to learn from each other. Such exchanges could be organized within the framework of TCDC, in particular by giving national EPI organizers the opportunity to take part in evaluations of the programme in other countries of the Region and by means of subregional meetings.

127. Following the discussion the Regional Committee adopted resolution AFR/RC35/R9.

WAYS AND MEANS OF IMPLEMENTING RESOLUTIONS OF REGIONAL INTEREST ADOPTED BY THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD

128. Dr A. B. Bella, member of the Executive Board, introduced document AFR/RC35/5 which describes action taken and under way and the prospects for implementation of resolutions of regional interest adopted by the Thirty-eighth World Health Assembly. As in previous years, the report was presented in a form designed to facilitate discussion during the Committee and determination of the guidelines needed for the development of the regional programme, in accordance with operative paragraph 1 of resolution AFR/RC30/R12.

129. Proposals concerning implementation of the resolutions of regional interest adopted by the seventy-third session of the Executive Board and the Thirty-seventh World Health Assembly were presented by major programme, in accordance with the Classified List of Programmes for the period of execution of the Seventh General Programme of Work.

WHA38.11 - Regional programme budget policy

130. The Regional Director has included in the agenda of this session of the Committee an item relating to the study of the document on the regional programme budget policy. He will give his full support to Member States in preparing, implementing and evaluating their programme budget policy.

WHA38.20 - Implementation of the strategies for Health for All by the Year 2000

131. The regional evaluation of the strategy for health for all is based on national evaluations and submitted to the thirty-fifth session of the Regional Committee. This regional consolidation is the Region's contribution to the Seventh Report on the World Health Situation. It describes the principal developments noted in the socioeconomic sector affecting the health of the populations and, in particular, shows that world economic insecurity is giving rise to new types of dependence.

132. A regional report will be prepared on this basis in order to highlight the repercussions of the world economic situation on efforts being made by Member States.

133. The Regional Director, in collaboration with the Director-General and as part of the restructuring of the Regional Office, has set up units as components of the coordination, promotion and information division to be responsible respectively for: (i) mobilization of resources, and (ii) health aspects of management of disasters and refugee relief. The Member States were recently invited by the Regional Director to update information on the health situation resulting from the socioeconomic crisis.

134. The Regional Director has invited WHO Programme Coordinators/ Representatives to work in close collaboration with UNDP, UNICEF, FAO, IFAD, ECA, the World Bank, NGOs and other organizations to implement programmes jointly and exchange experience.

135. The following countries have already finalized their "Country resource utilization review" (CRU): Botswana, Guinea-Bissau, Lesotho, Malawi, Sierra Leone and Zambia. Guinea and Togo are engaged on their review at present.

136. The Director-General will prepare, in close collaboration with Member States, a progress report on the economics of HFA/2000. He will collaborate with the Regional Director on the preparation of the report on effective measures which can support the countries in enhancing their capacities to attract and absorb "significant quantities of new health resources, including the establishment of a special trust health fund to assist them".

WHA38.23 - Technical cooperation among developing countries in support of the goal of health for all

137. The Regional Director continues to provide support to meetings of the subregional TCDC working groups whose terms of reference are to:

(i) develop, within the three Sub-Regions, the framework of technical cooperation among developing countries;

(ii) evolve appropriate methods and mechanisms to promote and strengthen TCDC;

(iii) exchange, share and utilize collective experience and resources for improved national, subregional and regional self-reliance, and

(iv) submit to the Standing Committee on TCDC recommendations for promotion of technical cooperation.

138. The Regional Director will prepare, in even-numbered years, a report on the progress made by the Regional Office in its catalytic and supportive action for TCDC/ECDC in the African Region.

WHA38.28 - Collaboration within the United Nations system: Liberation struggle in southern Africa - Assistance to the front-line States, Lesotho and Swaziland

139. WHO is continuing to collaborate closely with the authorities of the front-line States, Lesotho and Swaziland to assist them in bringing about an improvement in the health status of their populations and of refugees from South Africa and Namibia.

140. WHO will continue its support to the multinational training centre in Morogoro (United Republic of Tanzania).

141. With regard to the implementation of resolution WHA35.21 which urges the Director-General to accelerate the implementation of the plan of action contained in the report of the International Conference on Apartheid and Health, the Regional Director has launched activities aimed at meeting needs for training and study fellowships.

International collaboration

142. WHO Headquarters and the Regional Office for Africa continued to collaborate closely in areas of mutual interest with the countries concerned, the Organization of African Unity (OAU), various agencies and institutions of the United Nations system and other bodies. WHO will also continue to cooperate with UNICEF, UNDP, the Red Cross and other nongovernmental organizations to protect the health of refugee groups.

WHA38.29 - Collaboration within the United Nations system: Emergency health, medical and social assistance to drought, famine and other disaster affected countries in Africa

143. The international community and WHO have responded to appeals from the drought-stricken countries by providing foodstuffs, drugs, vaccines and personnel. Thus, since the initiative taken by the Secretary-General of the United Nations, WHO has pursued and is strengthening its collaborative efforts with the New York-based Office of Emergency Operations in Africa, UNDRO, ECA, HCR, WFP, UNICEF, UNDP and voluntary NGOs.

144. WHO will strengthen its collaboration with UNICEF, the other agencies of the United Nations system, donor governments and nongovernmental aid organizations in order to meet the most pressing needs.

145. In order to enhance the countries' emergency preparedness, the Regional Director, in collaboration with the Director-General, will organize a regional workshop on disaster prevention and management.

146. The Regional Director will keep the Committee informed of the health situation in those countries and of measures taken.

WHA38.31 - Collaboration with nongovernmental organizations in implementing the global strategy for health for all

147. The Regional Director will pursue his efforts to strengthen cooperation with national and regional NGOs involved in implementation of regional and national strategies for health for all. He will envisage the dissemination of WHO's technical data and relevant health literature and strengthen technical support for joint WHO/government/NGO activities. The Regional Director will continue to encourage Member States to provide a description of NGO activities when evaluating their health programme.

WHA38.27 - Collaboration within the United Nations system: Women, health and development

148. The Regional Director will take every opportunity to enhance decision-makers' awareness of the objectives and potential of this project as a PHC entry point. He will contribute to the organization of national seminars in local dialects at village level in order to win the full support of health workers for the activities of the project.

WHA38.18 - Collaboration within the United Nations system: General matters: Prevention of disability and rehabilitation of the disabled

149. Since the expanded programme on immunization (EPI) was started in the African Region in 1977, vaccination has been increasingly adopted as an essential component of primary health care. The Director-General and the Regional Director will continue to support government efforts to prevent disabling diseases, giving priority to achieving the goals of EPI and improving environmental, occupational and other health programmes.

WHA38.22 - Maturity before childbearing and promotion of responsible parenthood

150. The programme of research in human reproduction in the African Region has made considerable progress with the aid of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) and the Division of Family Health at Headquarters.

151. The Regional Director will continue to collaborate with Member States in developing collaborative action-oriented research on biomedical and culturally relevant social factors contributing to the prevention of pregnancy among adolescents. He will strengthen and extend WHO's cooperation with other international agencies and nongovernmental organizations in the field of MCH/FP. For that purpose, a study group on "health-related population issues" will meet in October 1985, bringing together UNFPA, UNICEF, UNDP, the World Bank, the Carnegie Foundation, IPPF, etc., and regional institutions such as the Sahel Institute, the Environment Training Programme (ENDA), and so forth.

WHA38.24 - Malaria control

152. The Regional Director will once again invite Member States to integrate malaria control into national primary health care systems. He will collaborate with all the countries concerned in reviewing and evaluating the malaria situation and the efficacy, effectiveness and prospects of success from the standpoint of the objectives to be attained.

WHA38.30 - Prevention and control of chronic noncommunicable diseases

153. WHO will distribute to all Member States information on these diseases, including the available technologies for their prevention and control. It will strengthen its collaboration with Member States for prevention and control of chronic noncommunicable diseases.

154. The Regional Committee adopted resolution AFR/RC35/R8.

AGENDA OF THE THIRTY-NINTH WORLD HEALTH ASSEMBLY: REGIONAL REPERCUSSIONS

155. The Regional Director's report was introduced by Dr W. K. Koinange, member of the Executive Board. The agenda includes items of regional interest.

156. The provisional agendas of the seventy-seventh session of the Executive Board (January 1986) and of the Thirty-ninth World Health Assembly (May 1986) contain several items which are relevant to the work of the Regional Committee, in particular:

(i) Reports of the Regional Directors on significant regional developments, including regional committee matters. In accordance with resolution WHA33.17, operative subparagraphs 4 (3) and 4 (4), the Executive Board will examine the way the regional committees reflect the World Assembly's policies in their work, and the manner in which the Secretariat provides support to the Member States individually, as well as collectively.

(ii) Evaluation of the African experience of using nationals as WHO Programme Coordinators.

(iii) Global Strategy for Health for All by the Year 2000 - Review of first evaluation report.

(iv) Review of preparation of regional programme budget policies - resolution WHA38.11.

(v) Research promotion and development.

(vi) Expanded programme on immunization - Progress and evaluation report.

(vii) Collaboration within the United Nations system: Liberation struggle in southern Africa: Assistance to the front-line States, Lesotho and Swaziland.

157. The Committee noted that agendas of the governing bodies are reflected in the provisional agenda of the thirty-sixth session of the Regional Committee for Africa (Annex 6).

158. The Committee adopted the provisional agenda of the thirty-sixth session of the Regional Committee. The Committee adopted Decision 11.

METHOD OF WORK AND DURATION OF THE WORLD HEALTH ASSEMBLY

Introductory statement

159. Dr G. L. Monekosso, Regional Director, presented the report on the method of work and duration of the World Health Assembly (document AFR/RC35/18 Rev.1). The document was designed mainly to facilitate the work of the Thirty-ninth World Health Assembly, in compliance with resolution WHA36.16 on the method of work and duration of the World Health Assembly. The document dealt with:

(i) the nomination of the President of the World Health Assembly; the Committee's attention was drawn to the fact that the Regional Committee at its thirty-seventh session would be invited to nominate the future candidate for Presidency;

(ii) the nomination of the Vice-President of the Thirty-ninth World Health Assembly, in May 1986;

(iii) the Main Committees of the Assembly;

(iv) members entitled to designate persons to serve on the Executive Board;

(v) closure of the Thirty-ninth World Health Assembly;

(vi) informal meeting of the Regional Committee.

President of the World Health Assembly

160. The Committee noted that in 1988 the African Region would provide the President of the Forty-first World Health Assembly. It was therefore during its thirty-seventh session in 1987 that the Committee would be called upon to nominate a candidate for the post of President of the Health Assembly. After a very interesting discussion the Committee requested the Regional Director to propose criteria for the choice of the candidate for the President of the World Health Assembly.

Nomination of the Vice-President of the Thirty-ninth World Health Assembly

161. In accordance with the decision taken by the Regional Committee at its thirty-second session, the Chairman of the thirty-fifth session of the Committee will be proposed for the Office of one of the five Vice-Presidents of the Thirty-ninth World Health Assembly in May 1986. The provisions of paragraph 2 of Decision 7 taken by the Committee at its thirty-fourth session will be applied should the incumbent Chairman of the Regional Committee be unable to perform this duty.

Members entitled to designate a person to serve on the Executive Board

162. The Committee noted that the terms of office of Ethiopia and Ghana would expire at the close of the Thirty-ninth World Health Assembly. It congratulated those countries on their contribution to the work of the Executive Board and nominated Liberia and Madagascar as new Members entitled to elect a person to serve on the Executive Board.

163. The Committee invited Members entitled to designate a person to serve on the Executive Board to announce their availability one month before the World Health Assembly at the latest.

Closure of the Thirty-ninth World Health Assembly

164. The Committee decided that the representative of Cameroon should speak on behalf of the Region at the closure of the Thirty-ninth World Health Assembly, in accordance with Decision 7 of the thirty-fourth session of the Regional Committee.

Informal meting of the Regional Committee

165. The Committee agreed that such informal meetings were important and that all members should attend. The decisions taken during a Regional Committee session must, however, be applied; the informal meeting was simply to enable the representatives of Member States to effect the necessary adjustments.

166. The Committee adopted Decision 12.

TECHNICAL DISCUSSIONS OF THE THIRTY-NINTH WORLD HEALTH ASSEMBLY (1986): "INTERSECTORAL COOPERATION AND COMMUNITY INVOLVEMENT FOR NATIONAL STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000"

167. In 1984, the Executive Board chose the subject of "Intersectoral cooperation and community involvement for national strategies for Health for All by the Year 2000" as the topic for the technical discussions to be held during the Thirty-ninth World Health Assembly in 1986. The subject was subsequently thought to be too broad, and an amended version was approved by the Executive Board in May 1985. The new subject is to be "The role of intersectoral cooperation in national strategies for health for all". The attention of the Regional Committee was drawn to this change which came too late for the title of the document to be altered.

168. Document AFR/RC35/19 is a report of the Regional Director and not the document to be discussed at the 1986 technical discussions during the Thirty-ninth World Health Assembly. The recommendations of the Committee would be included in the final document for the technical discussions to be held at the Assembly.

169. The document highlights the important role that can be played by intersectoral cooperation in achieving health goals, by stating that three of the essential elements of primary health care (PHC) namely, health information and education, adequate food supply, safe water and sanitation, lie outside the health sector. It is vital, therefore, for the health sector to seek closer cooperation with these sectors to promote PHC. Major health problems of the Region which are mainly diarrhoea, undernutrition, intestinal parasitic infections, and other infections, are associated with lack of these three essential elements of PHC.

170. The document suggests the countries and WHO take appropriate measures in the following fields:

(i) a clear identification of developmental policies in sectors other than health that are critical in the implementation of PHC in nutrition, water and sanitation, housing, health information and education;

(ii) a clear definition of priorities for intersectoral action, first in relation to the objective of promoting health and strengthening resistance to disease in general, and second in relation to preventing and controlling particular diseases;

(iii) a critical examination of the effectiveness of the mechanisms for intersectoral coordination for health that have been already developed, and suggestions for strengthening them.

171. It is recommended that the following country preparatory activities should be undertaken:

(i) Ministries of health should explain the spirit and the purpose of the technical discussions to colleagues in other sectors so that the right kind of people, i.e. decision-makers, are selected to be part of the delegations to the 1986 technical discussions of the World Health Assembly.

(ii) Each country should undertake preparatory activities such as reviews involving key sectors, conducting studies, workshops and seminars on the subject, identifying breakthroughs either related to policies, to mechanisms involving other sectors or even at the implementation field level where other sectors have produced together a positive impact on people's well-being and health. It is pertinent to report that at least one country is planning to hold such a seminar/workshop in November 1985 probably with WHO support and that the Regional Director intends holding a consultation on the subject co-sponsored by ECA and OAU in the spirit of intersectoral cooperation involving a few countries in December 1985.

172. In order to ensure that follow-up activities are operational rather than conceptual, and as a practical example of intersectoral cooperation, WHO has sought co-sponsorship of the proposed four working groups with the relevant agencies, for example, the possibility of WHO-UNESCO co-sponsorship of the working group on education, culture and life patterns. The same applies to FAO for the working group on agriculture, food and nutrition and similarly UNEP with the working group on environment. It is hoped these agencies will join WHO in sponsorship in all phases of the preparatory activities leading to the technical discussions, as well as participating during the Technical Discussions themselves and follow-up action thereafter.

173. The document ends with five fundamental questions to serve as a checklist for activities at country level and to stimulate the discussions. The outcome of the discussions will be judged by the action they will help to initiate at country level with the support of WHO and other agencies for the accelerated achievement of Health for All by the Year 2000.

Discussion

174. Delegates agreed that intersectoral cooperation for health is very important but did not receive the emphasis it deserved in the national development plans or the OAU Lagos Plan of Action. This in itself was an indication that health still does not receive the political backing it requires. It was therefore up to the health sector to initiate action to win the political and financial backing it deserves.

175. Delegates pointed out that in order to receive cooperation from other sectors, it was important for health implications to be stated at the initial stages of planning development projects. It is the health planners who must give necessary guidance on the health activities required in other sectors. Failure to consider health implications in development projects like irrigation schemes for agriculture often result in health hazards. Examples were given in which lack of involvement of the health sector in the early planning stages of industrial projects resulted in some of these projects not being implemented or being modified to avoid such hazards as pollution to the environment.

176. The Regional Committee recommended that it was necessary to coordinate bilateral and international resources in order to avoid duplication of effort. It was also important to make the best use of the resources offered for maximum benefit to the health sector.

177. It was stated that promotion of intersectoral cooperation could also be effected by inclusion of this aspect in health legislation in Member States.

178. The Regional Director informed the Regional committee that OAU has agreed that the Lagos Plan of Action should contain a strong health component and that the Regional Office for Africa of the World Health Organization should be its executing agency in health matters. OAU and ECA have also agreed to co-sponsor with WHO the consultative meeting to be held in Brazzaville in December 1985. Such cooperation of WHO with sister agencies is vital to demonstrate WHO's commitment to intersectoral cooperation.

179. The Regional Committee was satisfied that the theme of the technical discussions at the Thirty-ninth World Health Assembly in 1986 was chosen because of its relevance to the work being carried out by Member States in primary health care. Its fruitful elaboration therefore would permit countries to make progress towards the achievement of Health for All by the Year 2000.

EVALUATION OF THE IMPLEMENTING OF STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000: REGIONAL REPORT

Introductory statement

180. The Programme Sub-Committee's report on this item was presented by Dr D. G. Makuto, member of the Programme Sub-Committee. The report describes the analysis of the evaluation of the implementation of strategies for Health for All by the Year 2000.

181. In preparation for the evaluation, six subregional workshops were organized in June and October 1984 for high-level national officials, WHO Programme Coordinators, staff from the Regional Office and a number of WHO staff members in the countries. Moreover, nine carefully selected countries presented their experience of the use of this framework at the thirty-fourth session of the Regional Committee in September 1984.

182. By the target date of 31 March 1985, 39 of the 44 Member States had sent their contribution to the Regional Office, which was a considerable improvement on the 32 contributions submitted by the same date the year before for the preparation of the previous report.

The effects of the political, social and economic situation on the health of the peoples of the African Region

183. Health development in Africa is being hampered by the general worldwide climate of insecurity coupled with the Region's own political, economic and social problems: political instability, natural disasters, apartheid, the nuclear threat, etc.

184. Africa's demographic and social characteristics are as follows:

(i) large number of countries with small populations (18 countries have less than two million inhabitants);

(ii) annual growth rate of approximately 3%;

(iii) 45% of the population under 15 years;

(iv) on average 25% of the population live in urban areas;

(v) 75% of the population of Africa live in rural areas, with a subsistence economy;

(vi) food production is becoming inadequate;

(vii) adult literacy rates vary from 10% to 80%.

185. Moreover, there are many obstacles to intersectoral cooperation in the Region, including a shortage of trained personnel and cumbersome bureaucratic procedures.

Health systems development

186. The main developments in regard to health policies and strategies indicate commitment by all countries of the Region to the objective of health for all. Nevertheless, it is difficult to identify the manner in which that commitment has been translated into concrete terms. Efforts are still limited and are subject to material, financial and human constraints.

187. The organization of health systems based on primary health care shows that the PHC concept has been adopted by all countries. It is difficult to assess health coverage in respect of the various PHC components in many countries, for lack of usable data.

188. All the countries are aware of the need to develop a permanent and systematic managerial process for health development, yet few of them are satisfied with the operation of their existing managerial process.

189. All countries acknowledge the need to develop legislative support, particularly in three areas: (i) training of community health workers; (ii) drug legislation, and (iii) regulations governing traditional medicine. However, only five countries have undertaken revision of their health legislation.

190. All countries agree on the need for community involvement in decision-making, but there are as yet few instances of meaningful delegation of responsibility and decentralization of resources.

191. Health personnel: this section emphasizes the fundamental importance of training all health personnel in PHC in order to implement the national strategies for HFA/2000. All the countries have prepared a plan for health manpower development (or intend to do so), but these plans often provide no more than an estimate of future staff training requirements.

192. The mobilization of resources remains one of the main concerns of the countries of the Region, since current resources for health systems are limited. The countries are not easily able to provide national values for global indicators 3, 4 and 6.

193. Health research. Member States will have to make a very great effort to set up the national research and development mechanisms which are part of their strategy, despite funding constraints, shortage of trained manpower and lack of motivation and incentives for this type of activity.

194. Intrasectoral and intersectoral coordinating committees have been set up in some countries, but their suggestions have not been put into effect.

195. Intercountry cooperation is regarded by all the countries as one of the most important means for achieving regional self-reliance.

196. WHO cooperation: all of the countries acknowledge the fact that they have requested and obtained WHO's support in preparing, implementing and evaluating their national strategies.

Health situation: structures and trends

197. The main causes of morbidity are infectious and parasitic diseases, including malaria, measles and intestinal infections; the infant mortality rate is higher than 200 per thousand. Similarly, 37 of the 39 countries give figures of less than 60 years for life expectancy at birth. However, Member States do not at present feel able to make objective measurements of the changes that have taken place in terms of morbidity and mortality.

198. The study of health behaviour patterns shows that (i) breastfeeding is declining; (ii) alcohol and drug abuse is on the increase among adults.

199. The predominant environmental problems are the rapid industrialization taking place in some countries of the Region, and above all, natural disasters, including drought and desertification.

200. All the trends identified above have implications for economic and social policies. Strategies must accordingly focus on four major areas: (i) population and development; (ii) urban development and migration; (iii) women and development, and (iv) morbidity and mortality.

Evaluation of results

201. It is difficult to evaluate effectiveness and impact in view of the lack of sufficient data relating to indicators of community health status and the socioeconomic situation. However, the main achievements reported relate to communicable disease control.

202. The countries in general feel "reasonably satisfied" with the main components of their strategy.

Future prospects

203. The main lines of approach identified by the evaluation mean that country activities may be directed towards: (i) adjustment of strategy and formulation or reformulation of a national plan of action; (ii) development of information support; (iii) planning of overall health manpower development; (iv) improvement of mechanisms for community participation; (v) effective implementation of intra- and intersectoral coordination mechanisms, and (vi) mobilization and rational utilization of resources.

204. The mobilization and rational utilization of resources remains the crucial point. It is essential that the countries: (i) do not delay in calculating the approximate level of funds required to implement their strategy; (ii) identify activities which can be funded from external sources, and (iii) prepare a master plan covering the use of all funding and material resources, including external grants and loans.

Discussion

205. The Committee noted that it is difficult for countries to calculate national expenditure for primary health care in terms of global indicator No. 4, which need to be refined. Moreover, the Committee noted that health manpower planning is inadequate and should not be limited to future projections of training requirements. Countries should take account of the specific needs of their populations so that health personnel can form an integral part of the health infrastructure. The cooperation of the other ministries involved, such as the ministries of labour and education, is needed in order to fulfil the specific requirements of the health system so that the right members of every kind of health personnel required for PHC are available when and where they are needed.

206. The members of the Committee agreed on the importance of technical cooperation among the countries of Africa. They expressed regret that the recommendations remain mere declarations of intent, which do not result in practice in the pooling of development resources.

207. The ensuing discussion enabled Member States to describe the conclusions and lessons they had drawn from the evaluation of strategies in their own countries. They laid special emphasis on the training of health personnel in management and on the assignment of experts by WHO to take part in all activities for implementing their national strategy for HFA/2000. Similarly, better use should be made of the mass media so as to secure improved community participation. The health budget should be reviewed and used more effectively by competent staff. Thus the Regional Committee endorsed the five proposals made by the Programme Sub-Committee.

Translation of national strategies into specific plans of action

208. Member States must have the support of WHO, with emphasis on the legislative, administrative and managerial aspects.

Improvement of intersectoral coordination

209. Countries must find adequate means of communication at the central level between the health sector and the other sectors involved, in order to meet the needs of the operational and functional structures at the peripheral level. The following measures may prove especially effective: (i) the establishment of multidisciplinary teams for development; (ii) decentralization of the planning and implementation of health and health-related programmes; (iii) coordination of international agencies' activities in support of countries.

Assessment of needs for the implementation of strategies

210. The economic recession is exacerbating the shortage of resources in the health sector. Governments should therefore encourage all sectors to participate in PHC activities and should ensure that there is coordination between them. With the support of WHO, they must identify the needs for implementing their strategies so as to mobilize external financial and material resources.

Strengthening of the managerial process for natinal health development

211. There must be continuous training in the management process in countries in order to avoid a brain-drain. To strengthen this process, use should be made of: (i) national experts, and (ii) WHO staff, and there should be better circulation of information to the different levels of the health system.

Refinement of the 12 global indicators

212. Member States must review and/or refine the indicators so as to respond to their countries' needs. They must also identify the indicators best suited to their situation as developing countries, in order to monitor and evaluate the implementation of their national strategies.

213. The Regional Committee adopted resolution AFR/RC35/R1.

REPORT ON PARTICIPATION BY MEMBERS OF THE PROGRAMME SUB-COMMITTEE IN MEETINGS OF PROGRAMMING INTEREST

214. The report on participation by members of the Programme Sub-Committee in meetings of programming interest was introduced by Dr (Mrs) R. T. Tshabalala. Participation by members of the Programme Sub-Comittee in meetings was the subject of Decision 8 taken by the Regional Committee for Africa in September 1980, at its thirtieth session.

215. At its meeting on 19 September 1984 in Brazzaville (People's Republic of the Congo), the Programme Sub-Committee decided to send representatives to three meetings of programming interest: (i) the seventh session of the African Advisory Committee on Medical Research (AACMR); (ii) the eighth meeting of the Standing Committee on Technical Cooperation among Developing Countries (TCDC), and (iii) the fifth meeting of the African Advisory Committee for Health Development (AACHD).

Seventh session of the African Advisory Committee on Medical Research (AACMR)

216. The Regional Committee considered the conclusions and proposals of the seventh session which was held in Antananarivo (Democratic Republic of Madagascar) from 15 to 19 April 1985. The members of the Committee noted with satisfaction: (i) the relevance of the regional research programme; (ii) programme support for priority sectors; (iii) programme support for the development of self-reliance in relation to research.

217. The Committee noted that the major obstacle to the development of this programme in the Region was the lack of national research policy, and felt that national research capabilities should be strengthened through training.

Eighth meeting of the Standing Committee on Technical Cooperation among Developing Countries (TCDC)

218. The Committee endorsed the recommendations of the eighth meeting of the Standing Committee on Technical Cooperation among Developing Countries.

Fifth meeting of the African Advisory Committee for Health Development (AACHD)

219. The representatives of the Member States took an active part in the discussions at the fifth meeting of the African Advisory Committee for Health Development and approved the conclusions and proposals concerning the following topics:

(i) regional evaluation report on implementation of strategies for health for all;

(ii) expanded programme on immunization in the African Region, mid-decade evaluation;

(iii) new structure of the Regional Office and guiding principles for health development centres.

220. The delegates requested the Regional Director to continue to facilitate participation by members of the Programme Sub-Committee in meetings of programming interest.

221. The Committee adopted resolution AFR/RC35/R2.

VISITS BY REPRESENTATIVES OF MEMBER STATES TO OTHER COUNTRIES OF THE REGION

Introductory statement

222. Dr V. Mbarindi introduced the report on visits by representatives of Member States to other countries of the Region. At its thirtieth session in 1980, the Regional Committee adopted, by Decision 9, the principle that two officials from each country of a TCDC Sub-Region should visit two countries in the other Sub-Regions. It also adopted a five-year plan of visits (1980-1985). In 1983, the Committee invited the Regional Director to carry out an evaluation of the results of the implementation of the plan for 1980-1985, and particularly its impact in relation to TCDC. The 1980-1985 plan of visits was carried out with the flexibility recommended by the Regional Committee. By 17 August 1985, 42 of the planned 45 visits had been made, so that the plan had been fulfilled to a level of 93%.

223. The programme of visits was evaluated in respect of: (i) the adequacy of the programme; (ii) efficiency; (iii) effectiveness, and (iv) impact.

(i) The study of adequacy proved that communication problems had made it impossible to organize a rational programme of visits. Furthermore, the reports were not homogeneous in their presentation and most of them were not submitted within the required time limits. Finally, the representatives of the Member States were not always selected from among officials at decision level.

(ii) Efficiency: the cost of implementing the plan of visits was approximately US $3700 per visitor.

(iii) Effectiveness: 85% of the visitors considered that the visits were beneficial to the host countries because they had resulted in useful exchange of experience.

(iv) Impact: there was some modification of the manner in which PHC implementation is viewed in the visitors' home countries.

Discussion

224. The Regional Committee pointed out that the conclusions of the programme evaluation were not altogether clear, particularly in regard to effectiveness. The programme of visits did not appear to be as effective as anticipated; no effects of the visits at country level had been demonstrated, although the participants had expressed interest in and had certainly derived benefit from them.

225. The Committee noted the fairly high cost of each visit, considering the limitations of regular budget funds. They felt that the programme was useful but should be made more efficient.

Recommendations

226. The Regional Committee endorsed the Programme Sub-Committee's proposals that such visits should:

(i) not be a matter of routine;

(ii) take place at the express request of a country and for specific reasons;

(iii) have a specific objective, with an indication of the anticipated results, and

(iv) give rise in every case to a report, as a contribution to subregional development.

227. The Regional Committee was of the view that a full protocol should be drafted for each visit, indicating:

(i) the relevance of the visit, in relation to the overall programme objective as defined by resolution AFR/RC29/R5;

(ii) the problem that the visit to the country concerned might solve;

(iii) the formulation of the specific objective of the visit in relation to the anticipated results;

(iv) the programme of the visit in the host country;

(v) the scheduled duration in terms of the objective and the programme, accompanied by an estimate of its cost and the date of the visit;

(vi) the plan of the report on the visit which must be submitted 15 days after the visit at the latest, and which should be drafted using a common format.

228. The Committee felt that the host country should be given advance information concerning visitors. It was convinced that such visits would help:

(i) to develop more intensive cooperation between countries, thereby strengthening TCDC;

(ii) to foster individual contacts, which would provide opportunities for exchanges of information and bring countries closer to each other.

The Committee was of the view that these visits would help to identify the people able to define health problems in the countries and the Region.

229. Each visit should be followed by a second report at least six months later, indicating its impact in the visitor's country of origin.

230. The Committee felt that the visits should be better prepared and that Member States should identify nationals with knowledge or skills likely to be of benefit to the country visited as well as the country of the visitor;

231. The Committee recommended that the visitors' reports should be detailed and explicit in their description of the problems encountered in the country visited, the steps taken to overcome them and the results achieved.

232. The Regional Director stated that this problem would be very carefully examined by the Secretariat in order to ensure that the visits really fulfilled their purpose and served as a tool for the implementation of TCDC mechanisms. Strict criteria for the selection of visitors and the choice of countries to be visited would be developed.

233. The Deputy Director-General suggested that Heads of State should be alerted to the importance for countries of including technical experts from the Ministry of Health in their delegations when on official missions, so that they would have the opportunity to exchange experience with their counterparts in the country visited.

234. The Committee adopted resolution AFR/RC35/R3.

TECHNICAL COOPERATION AMONG DEVELOPING COUNTRIES (TCDC)

Introduction

235. Mr M. Mboumba introduced the Programme Sub-Committee's report on Technical Cooperation among Developing Countries. The eighth meeting of the Standing Committee on Technical Cooperation among Developing Countries (TCDC) was held in Brazzaville from 17 to 21 June 1985. In accordance with Decision 7 of the Regional Committee at its thirty-third session, confirmed by Decision 9 taken at its thirty-fourth session, the three subregional working groups on TCDC examined eight subjects.

Training of primary health care workers, including traditional birth attendants

236. The Standing Committee on TCDC considered the following aspects: (i) the training of trainers; (ii) the training of Coordinators and leaders of health projects in the private sector; (iii) the training of community health workers, and (iv) the training of traditional birth attendants.

Hygiene in hospitals

237. The members of the Standing Committee on TCDC analysed the situation and highlighted the various factors that may affect hygiene in hospitals. They stressed the importance of intersectoral consultation in designing and siting hospitals. The Committee paid special attention to the problem of maintenance and recommended that this should be entrusted to competent permanent staff so as to ensure the availability of drinking water and power and the efficient operation of systems for the disposal of solid and liquid wastes. It placed special emphasis on: (i) the reception of patients, companions and visitors; (ii) the accommodation, feeding and recreation of hospital patients; (iii) curative care, and (iv) the efficient and effective work of the practitioners.

Health financing and relations between donor agencies and receiving countries

238. By decision EB.67 (5) of the Executive Board and resolution WHA29.32 of the World Health Assembly, the Director-General has been invited to collaborate with the United Nations system of agencies, bilateral donors, nongovernmental organizations (NGOs) and development banks in order to mobilize additional external resources for primary health care services in the least-developed countries (LDCs).

239. The evaluation of the resources required for HFA/2000 has revealed the relatively high cost of primary health care (US $10/inhabitant/year and the impossibility for developing countries of financing the health of their populations on their own. In the overall health budget, moreover, far fewer funds are allocated to primary health care than to other health departments. The financing of a national health system should be studied, planned and implemented in the light of the specific objectives to be achieved in the short, medium and long term. The WHO study on the use of resources for PHC (CRU) should be regarded as a model.

Evaluation of the implementation of primary health care since Alma-Ata

240. The progress achieved by Lesotho in primary health care was examined. Emphasis was placed on the need to coordinate intersectoral cooperation between all services and ministries.

Technical cooperation and malaria control

241. Malaria continues to be a major public health problem in Africa where it is responsible for about 5% mortality among infants and young children under five years. In most countries of the WHO African Region, the antimalaria action that is feasible, especially in the rural areas, is the rational deployment of antimalaria drugs for the reduction of malaria-related mortality and morbidity. Recently chloroquine-resistant malaria parasites have emerged and spread in some areas in the Region. There have been some instances where the phenomenon has necessitated the use of drug combinations. This phenomenon is consequently seen as a serious threat to antimalaria action in the countries of Africa. There are however assurances that chloroquine is still effective in many areas and remains the drug of first choice for treatment.

The Committee agreed that antimalaria action should be developed as part of the public health services in general and as part of primary health care systems in particular, with emphasis on multisectoral collaboration and community participation.

Progress report on care for disabled persons

242. Implementation of the governing bodies' resolutions on the subject of the International Year for Disabled Persons (1981) and the United Nations Decade for Disabled Persons (1983-1992) requires multisectoral and multidisciplinary collaboration involving other agencies in the United Nations system and nongovernmental organizations. Management of programmes for the prevention of disability and physical handicaps is based on support activities in the following areas: legislation, inspection, education and research. The most effective and least costly cooperation mechanisms for the programme on rehabilitation of disabled persons in the framework of TCDC were reviewed.

The cholera situation in Africa and control methods

243. Following the objective analysis of the cholera situation in Africa, efforts should be made to rid cholera of its aura of mystery; it should be regarded as a diarrhoeal disease both by the public and by the authorities. Measures to combat the disease should be integrated into a national programme for diarrhoeal disease control. The programme should concentrate on the use of oral rehydration, the improvement of drinking-water supplies and sanitation and the strengthening of epidemiological surveillance.

Intersectoral cooperation and community involvement for implementing strategies for Health for All by the Year 2000

244. Intersectoral cooperation has always existed in Africa but its improvised nature rendered it ineffective. The expanded programme on immunization is the only component of PHC that can be executed by means of health technology alone. Nonetheless it too requires community involvement and support from other sectors such as transport and so forth. Member States should make efforts to strengthen the links between public health and other sectors of the economy.

Discussion

245. The review of the document gave representatives of Member States an opportunity to share their experience of each of the items discussed. The document gave a true picture of the concerns of Member States. The Committee found that there were too many topics for it to carry out a proper review and make relevant recommendations. It felt that TCDC should take the form of an exchange of services and persons and requested the Regional Director to identify ways and means of achieving this and to propose to a future Regional Committee revised methods of approach for and subjects of discussions by the TCDC subregional working groups.

246. The Committee noted the efforts made in the Region to provide intensive training for PHC workers. Those workers had been selected by the communities themselves, and their training entrusted to health professionals. However, the Committee also noted the difficulties sometimes caused by voluntary personnel, increasing numbers of whom insisted on being paid. It is felt that the populations should participate in the funding of PHC by paying for drugs, even if the payment is only nominal. Research on hygiene in hospitals should be given special attention. Norms and standards should be formulated for maintenance of such hygiene.

247. The Committee hoped that the Regional Office would provide the States with comprehensive data on the malaria situation in the Region and on prospects for control. It noted that cholera control had been integrated into that of diarrhoeal diseases owing to the similarity of epidemiological and therapeutic factors. Epidemiological surveillance of diarrhoeal diseases made it possible, through unfailing vigilance, to identify and rapidly contain epidemics of cholera or of any other diarrhoeal syndrome.

248. The Committee deplored the fact that psychiatric training was not sufficiently developed, considering the importance of this category of manpower in PHC. It proposed that wide coverage be given to the discussions and recommendations of the Standing Committee on TCDC regarding the training of primary health care workers, including traditional birth attendants. Finally, it proposed that war victims in southern Africa should be given rehabilitative care, in view of the appalling physical and mental disabilities they were suffering.

Recommendations

249. The Regional Committee endorsed the Programme Sub-Committee's recommendations:

Training of primary health care workers, including traditional birth attendants

(i) The village health worker and traditional birth attendant must be selected by the community itself and must live and work within the community.

(ii) WHO is invited to collect and disseminate the experience of different countries with the training of village health workers and traditional birth attendants.

(iii) Member States are invited to make use of the TCDC mechanisms for exchanges of training programmes and of trainers.

(iv) The length of training of health workers should be governed by specific objectives and clearly defined tasks which they have to carry out.

(v) Health workers should demonstrate their keen commitment and enjoy the support of the population so that they can implement PHC consistently in the interests of socioeconomic development.

(vi) Member States should as far as possible conform to the profile prepared by WHO for the training of health workers.

Hygiene in hospitals

(i) Member States are urged to provide hospitals not only with sufficient numbers of qualified medical and paramedical staff but also with competent and reliable staff for managerial, administrative, financial and general services, by making systematic use of the TCDC mechanisms.

(ii) Member States should make provision for special budget lines for the financing of all hospital hygiene and safety activities.

(iii) Member States should exchange the texts of regulations on hospital hygiene at the subregional and regional levels, via the Regional Office.

(iv) The dress and behaviour of medical, paramedical and managerial staff should be conducive to good hospital hygiene practice.

(v) Maintenance should be entrusted to competent permanent staff so as to ensure the availability of drinking water and power and the efficient operation of the systems for the disposal of solid and liquid wastes.

(vi) Those involved in the planning and implementation of infrastructure are invited to work together with the users in order to ensure better compliance with all the rules of hygiene and safety, taking into account the layout, organization and operation of the medical services, the managerial services, the catering services and the general services.

(vii) The disposal and treatment of waste should be carried out on a regular basis and the hospital should have an incinerator for the disposal of all infected waste.

(viii) Member States are urged to create awareness and motivation among the central health authorities, the managers of administrative, financial and general services, and unit chiefs regarding the importance of hospital hygiene and their responsibility for providing the best possible conditions for: (a) the reception of patients, companions and visitors; (b) the accommodation, feeding and recreation of hospital patients; (c) curative care, and (d) the efficient and effective work of the practitioners.

(ix) Member States should see that the implementation of hygiene and safety measures is supervised by an official who is qualified in hygiene, epidemiology and sanitary engineering.

(x) The WHO training centres in Togo, Sierra Leone and Zimbabwe should be utilized for training staff capable of repairing and maintaining medical equipment.

(xi) Member States, in close collaboration with WHO, should conduct exhaustive surveys to determine the size of the problem of hospital infections.

Health financing and relations between donor agencies and receiving countries

(i) Member States, in collaboration with WHO, should set up mechanisms for evaluating the impact of foreign aid on health development.

(ii) Member States should consider aid as genuine cooperation, free of any ideological or political implications.

(iii) Member States should identify their priority health needs requiring external funding so as to make maximum use of the funds made available to them.

(iv) Member States should promote or strengthen community participation in order to improve the utilization of resources allocated for health.

(v) The financing of a national health system should be studied, planned and developed in the light of the precise objectives to be achieved in the short, medium and long term. The WHO study on the use of resources for PHC (CRU) should be regarded as a model.

(vi) The use of external bilateral resources or funds from the specialized agencies of the United Nations system (WHO/UNDP/UNICEF/UNFPA) should also be planned as a supplement to national resources. The use of these funds should be specified by the users in projects and operational plans which should have the consent of the countries involved in this cooperation. The Regional Office would collaborate with Member States in setting up mechanisms to improve the countries' ability to absorb the funds made available to them.

(vii) Member States should pay more attention to the point of view of health professionals in formulating and implementing the budget, and more funds should be allocated to the health sector.

(viii) Member States should establish a climate of mutual respect between the countries receiving aid and the donor organizations.

(ix) Member States are urged to give subregional and regional cooperation preference over North-South cooperation.

(x) Member States should submit the necessary information on the flow of external resources mobilized for implementing the HFA/2000 strategy to the Regional Office.

Evaluation of the implementation of primary health care since Alma-Ata

(i) Assisted by the Regional Office, Member States must make every effort to set up health information systems.

(ii) Evaluation must be implemented as part and parcel of primary health care.

(iii) The WHO Regional Office should promote the organization of regional, subregional and national workshops/seminars on planning, management, evaluation and health information systems.

(iv) Member States should draw upon the experience of different countries of the Region in primary health care, particularly through the exchange of information, documentation and specialists.

(v) Member States should upgrade the quality of trainers through periodic workshops and refresher courses.

(vi) Member States are urged to evaluate and redefine PHC programmes periodically.

(vii) Member States should encourage closer collaboration over the production and exchange of teaching materials, which is more necessary than ever because of the cost of importing the materials.

(viii) Governments are urged to define their primary health care policy more clearly, particularly in its multisectoral and multidisciplinary aspects.

(ix) Member States should provide incentives for the village health worker.

Technical cooperation among developing countries and malaria control

Action to be taken at the country level

Member States are urged to:

(i) implement national programmes for the assessment and monitoring of the response to standard treatment regimens as well as the sensitivity of Plasmodium falciparum to antimalaria drugs;

(ii) formulate and pursue policies and measures to control and protect the efficacy of antimalaria drugs, together with guidelines for the treatment of malaria according to the status of the sensitivity of Plasmodium falciparum to antimalaria drugs;

(iii) review and revise their antimalaria strategies in terms of their effectiveness, efficiency and prospects of achieving and maintaining their objectives in the light of the epidemiological situation and the need to develop malaria control as an integral part of national primary health care systems; emphasis should be placed on the multisectoral aspect and community involvement;

(iv) implement vector control measures wherever feasible;

(v) incorporate appropriate courses in the training programmes of all health personnel.

Action to be taken at the subregional level with emphasis on TCDC

Member States are urged to:

(vi) exchange information on all aspects of national malaria control programmes;

(vii) exchange malaria experts and country visits;

(viii) promote training of personnel from countries without training facilities in countries with such facilities;

(ix) collaborate and cooperate in the quality control of antimalaria drugs;

(x) collaborate and cooperate in coordinated antimalaria activities, especially along common frontiers.

Action to be taken at the regional level

WHO is requested to:

(xi) develop a regional network of training resources;

(xii) disseminate information on malaria;

(xiii) develop guidelines, manuals, etc., and promote their use by Member countries;

(xiv) organize meetings for exchange of information, etc.;

(xv) mobilize resources and provide technical and financial support for Member States in collaboration with other international, governmental and nongovernmental agencies;

(xvi) promote and support research activities aimed at improving existing control methods as well as developing new and more effective methods adapted to different epidemiological, socioeconomic and ecological situations;

(xvii) revise the regional antimalaria strategy.

Progress report on care for disabled persons

(i) Countries which already have training facilities for rehabilitation workers and services for disabled persons should open them to countries of the same Sub-Region where such facilities do not exist.

(ii) Member States should facilitate exchange of information on appropriate technologies, e.g. orthopaedic appliances, health education, training manuals, etc., via the Regional Office.

(iii) Member States should promote the prevention and treatment of disabling diseases by increasing community awareness of the plight of disabled persons.

(iv) Member States are urged to encourage activities aimed at integrating the disabled into the community, e.g. by training disabled persons to lead normal lives and training members of their family to assist them; by educating teachers and community leaders to accept the disabled into schools, jobs and other institutions.

(v) Member States should lay special stress on training the staff involved in rehabilitation: rehabilitation workers, physiotherapists, occupational therapists, orthopaedic technicians, nurses and community health workers.

(vi) Member States should encourage the promotion of a multisectoral approach by bringing together government and nongovernment sectors in rehabilitation activities.

(vii) Member States should promote the prevention and treatment of disabling diseases in the community.

(viii) Member States are urged to give priority to activities in regions where nothing has as yet been done for the disabled.

(ix) Member States should ensure that disabled people who are housebound are given rehabilitative treatment.

Diarrhoeal diseases

(i) Health authorities must endeavour to demystify cholera, which should be regarded as a diarrhoeal disease both by the public and by the authorities. Measures to combat the disease should be integrated in a national programme for diarrhoeal disease control. This programme should focus on the use of oral rehydration, the improvement of drinking-water supplies and sanitation, and the strengthening of epidemiological surveillance.

(ii) Member States are urged to make use of the TCDC mechanisms, which have great potential for the control of diarrhoeal diseases, including cholera. Countries should strengthen their collaboration in the exchange of epidemiological and technical data, especially the notification of cholera cases, in staff training, in conducting surveys to provide basic epidemiological data, in formulating messages and preparing materials for health education, and in producing and distributing rehydration salts.

(iii) Countries still requiring cholera vaccination certificates from international travellers are urged to give up this practice as soon as possible, in conformity with the resolution of the Twenty-sixth World Health Assembly withdrawing the cholera vaccination certificate from the requirements of the International Health Regulations (addition to the 1973 Regulations, resolution WHA26.55).

(iv) WHO, in collaboration with other agencies of the United Nations system, is invited to build up subregional stocks of oral rehydration salts, which should be immediately available in adequate quantities to meet countries' needs in the event of epidemics of diarrhoeal diseases, including cholera. WHO is invited to collect and disseminate the experience of different countries with national programmes for diarrhoeal disease control.

Intersectoral cooperation and community involvement for implementing strategies for Health for All by the Year 2000

(i) Member States should endeavour to strengthen existing coordinating mechanisms rather than set up a host of committees.

(ii) Member States should promote multidisciplinary and multisectoral action in the design, organization, and implementation of a national primary health care strategy.

(iii) This strategy should involve integrated activities covering hygiene, prevention, health education and basic curative treatment, carried out by a versatile multidisciplinary team.

(iv) The Ministry of Health, which is the authority for health policy, should cooperate with other ministerial departments and national entities, nongovernmental organizations and the United Nations specialized agencies concerned with health in improving and implementing the operational plans which form part of the strategy.

(v) Since the strategy requires the support and active involvement of the people, it should be backed up by intensive and continuous health education, bearing in mind the community's life-style and its socioeconomic and cultural context.

(vi) Active participation of women should be encouraged in view of their cardinal role in implementing PHC.

(vii) Improvement of the quality of trainers should be encouraged by organizing periodic workshops and refresher courses.

(viii) Governments are urged to put into practice the primary health care policy which they have adopted individually and collectively.

(ix) Member States should introduce and/or improve cooperation between the various departments of ministries of health and set up information systems.

Subjects to be studied by the TCDC working groups in 1988

250. The Regional Committee requests the Regional Director to harmonize the subjects to be studied by the TCDC working groups with those selected for technical discussions of the Regional Committee in 1987, 1988 and 1989.

Replacement of members of the Standing Committee

251. In accordance with operative paragraph 4 of resolution AFR/RC33/R7, the Committee replaced some of its members. Algeria replaces Senegal, Ethiopia replaces Equatorial Guinea, and Tanzania replaces Lesotho. The outgoing countries were replaced by lot on a subregional basis.

252. The Regional Committee adopted Procedural Decisions 6 and 8 and resolutions AFR/RC35/R4, AFR/RC35/R5 and AFR/RC35/R6.

EVALUATION OF THE AFRICAN EXPERIMENT OF USING NATIONALS AS WHO PROGRAMME COORDINATORS

Introductory statement

253. Dr T. Tokon presented the report. The preliminary evaluation of the African experiment of using nationals as WHO Programme Coordinators was submitted to the Regional Committee at its thirty-fourth session in September 1984. The Regional Committee had expressed the view that the experiment had been useful and might be continued. The Director-General had reminded the Regional Committee that the main purpose of the experiment was to develop self-reliance by rational mobilization of human resources in the countries.

254. After thorough consideration, the Regional Committee had: (i) called for "the setting-up of a Programme Sub-Committee working party to review the Special Services Agreement", and (ii) requested the Director-General "to continue the evaluation of this experience".

Report of the Working Party

255. The Working Party met in December 1984 and June 1985. In its final report it expressed the view that:

(i) the nature of the services requested should correspond to the definition contained in document DGO/83.1, whether the Coordinator is nationally or internationally recruited.

(ii) the duration of the agreement should not be less than two years;

(iii) the total remuneration of the national Coordinators paid by WHO and the government should not exceed US $3000 per month in local currency;

(iv) the status of a national Coordinator is that of a civil servant of his own government;

(v) the profile of a national Coordinator is that of a government civil servant with the same qualification as an international Coordinator and selected by the Regional Director from three candidates put forward by the government.

256. The Director-General commented on the report of the Working Party, amended the draft Special Services Agreement and stated that:

(i) the duration of the agreement should be in accordance with the normal practice of the United Nations system and should not exceed 12 months;

(ii) terminal payments should be made only if WHO cancelled the agreement, in which case the indemnity would be calculated in accordance with the provisions of the WHO Staff Rules.

Continuation of evaluation

257. Evaluation of the experiment has continued in accordance with the wishes of the Regional Committee. It has taken the form of:

(i) an administrative evaluation through a comparison of the regularity with which the national and international Coordinators send in their technical and financial reports;

(ii) extension of the sample survey regarding Coordinators to all the national and international Coordinators and to all WHO Regional Office and field staff on the occasion of a special meeting of WHO Coordinators/Representatives;

(iii) transmission of the Working Party report to ministries for comment;

(iv) consultations on the subject on the occasion of official visits by the Regional Director to Member States.

258. The administrative evaluation showed that the regularity with which the technical and financial reports were submitted depended on the Coordinator himself, whether nationally or internationally recruited. In both groups it was always the same Coordinators who were at fault, in fairly equal proportions.

259. Analysis of the questionnaires completed by the Coordinators and other staff members before and after the special meeting of Coordinators/ Representatives held in March 1985 showed that:

(i) all the Coordinators were faced with the same problems, i.e. inadequate staffing, delays in communication with the Regional Office, and inadequate delegation of authority to manage WHO resources;

(ii) the international Coordinators are older, have more experience, have better training in public health and are better prepared for managing WHO programmes;

(iii) the WHO Regional Office and field staff felt that a return to international Coordinators would strengthen the WHO offices in countries.

260. The evaluation shows clearly that the experiment was necessary and that it produced positive results in some countries. However, the experiment encountered the following difficulties:

(i) it seems that the original objective of promoting self-reliance has been lost sight of since the NWCs have not become an integral part of the national health management mechanisms;

(ii) problems of remuneration, supervision of WHO personnel, dual allegiance or inability to provide WHO with essential data have called the experiment into question;

(iii) the new guidelines of the Executive Board on WHO's budget policy at country level stressed the role of the Coordinator as a person authorized to decide on the utilization of WHO resources and to work with the other government departments and international agencies, and therefore favour an international rather than a national Coordinator;

(iv) some countries have asked for a high-ranking international staff member to support the office of the national Coordinator, which confirms that the very concept of the NWC is inadequate, at least at the present time.

261. As directed by the Regional Committee at its thirty-fourth session, only new developments have been taken into consideration in the evaluation of the experiment, and efforts have been made to reach a conclusion concerning its future in spite of an apparent divergence of views. It was recognized:

(i) that it was sometimes difficult for national Coordinators to supply the Regional Office with essential epidemiological data, such as cholera figures; it was easier for the Regional Director to obtain this type of information, which was important for the regional community as a whole, from an international Coordinator; national Coordinators were occasionally put under pressure not to divulge this information, whereas international status was a guarantee of independence of action;

(ii) that paragraph 77 was not sufficiently objective and should be redrafted as follows; "it emerges from these opinions that the experiment of using nationals as WHO Programme Coordinators is confronted by the obstacles inherent in the experiment and foreseen in the Executive Board's organizational study on "WHO's role at the country level, particularly the role of WHO representatives"; in practice nationals are subject to constraints which make it difficult for them to manage WHO's resources to the satisfaction of both WHO and their own countries; accordingly, it is proposed to bring the experiment to an end in the countries where it has been undertaken, gradually, without compromising the interests of any serving staff, or of the country in question, that is, at a time mutually convenient to the country and WHO".

Discussion

262. The Deputy Director-General reminded the Committee of the circumstances under which the experiment had been introduced. The African Region had been the only one that wished to try it. He also recalled the enthusiasm and courage shown by the Director-General and Regional Director in attempting to surmount the difficulties inherent in the innovation. He urged the Committee to consider the matter with an open mind and acknowledge an error if there were one.

263. The representatives who took the floor pointed out the positive aspects of the experiment and the constraints it had encountered. Among the positive aspects all the speakers mentioned: (i) the promotion of national self-reliance in health; (ii) the better integration of the national Coordinators into the health administration, and (iii) the better knowledge of the country and hence of the problems and the possible ways of solving them.

264. Some representatives compared the services of the national Coordinators with those of the international Coordinators used previously; in their view the comparison favoured the nationals. Speakers tended not to draw general conclusions but to analyse specific cases.

265. The constraints mentioned all related to the status, i.e. the dual allegiance of the national Coordinator.

266. Some representatives wondered whether the experiment had from the outset been a basic error of legal procedure on the part of WHO, since staff of this type did not exist elsewhere in the United Nations system. The ways and means required by the Coordinator for carrying out his duties as manager of the resources allocated by WHO should be guaranteed by some measure of independence from the government, which the national Coordinators did not have.

267. The only way to give them that guarantee would be to grant them international status, which was not possible within the framework of the international civil service.

268. The Regional Director suggested that the Regional Committee should consider the views of the three parties involved in the experiment: (i) the countries; (ii) the national Coordinators, and (iii) WHO. Most speakers had mentioned only the favourable aspects of the experiment, but in some cases their views might not correspond with those of all the national authorities.

269. Some Coordinators were themselves not satisfied with their conditions of work; they considered themselves too dependent on the national authorities, and at the mercy of political changes.

270. WHO for its part was not satisfied with the experiment. Some international Coordinators were also out of place, but in the course of his restructuring the Regional Director would be able to take action to optimize the use of WHO resources at country level. The Coordinator was the Regional Director's representative in the country, and should therefore be directly responsible to him, with no possibility of refusing to obey as had occurred in the past.

271. Moreover, thorough knowledge of the country was not in itself sufficient experience. It was necessary to be familiar with other countries and be able to make comparisons. Within the TCDC concept it was necessary to share experiences. Finally, in no other Region had any developing country, even the largest, thought it worthwhile to try the experiment. It was difficult for a national to manage WHO's resources and mobilize those of organizations outside the country, for his dual allegiance could make him suspect to both parties.

Summary

272. The following main points arose out of the discussions:

(i) the national Coordinator cannot be regarded as having the status of an international civil servant;

(ii) that status will invariably be open to dispute and lead to difficulties, since there is no solution to the legal problem;

(iii) WHO, and particularly the African Region, cannot nor ought not to dissociate itself from other United Nations agencies by utilizing a category of manpower whose status is not that of international civil servants;

(iv) the positive aspects of the experiment in some countries (although negative in others) cannot fully compensate for the drawbacks linked to the status of the national Coordinator, which has led to trades-unionist claims on the part of such Coordinators;

(v) there should be no obstacle to communication between the Regional Director and his representative in the country;

(vi) the really negative aspects could only be hinted at, since they might be damaging to individual or national interests;

(vii) the countries can always request the Regional Director to transfer the international Coordinator if the latter does not carry out his role, whereas the Regional Director cannot, should he so desire, request the replacement of a national Coordinator who does not carry out his functions to the satisfaction of WHO;

(viii) the concept of TCDC favours the use of nationals from the countries of the Region as international Coordinators, while it is possible for the countries to place a national counterpart at their side;

(ix) the countries should trust the Regional Director implicitly so that, in the framework of the new structure of the African Region, WHO's cooperation with the countries may be strengthened with a view to making optimal use of the Organization's resources; they should provide the Regional Director with the means to implement his key ideas on behalf of the countries of the Region.

273. The Regional Committee adopted resolution AFR/RC35/R7. The Regional Director thanked the Regional Committee for adopting the resolution unanimously, thus reaffirming the trust it had shown in electing him the previous year.

REPORT OF THE TECHNICAL DISCUSSIONS: "HEALTH SYSTEMS RESEARCH: AN INSTRUMENT FOR THE PROMOTION AND DEVELOPMENT OF PRIMARY HEALTH CARE"

274. Professor D. N. Lantum, Chairman of the technical discussions, presented document AFR/RC35/13 (Annex 10), prepared from the reports of the three working groups - trilingual, English-speaking and French-speaking. As Rapporteurs for the technical discussions the Committee had elected Dr A. D. Kolawole (Nigeria), Dr (Mrs) R. T. Tshabalala (Swaziland) and Dr Mohamed Saleh (Mauritania). The working groups elected as their Chairmen Dr Celestino Mendes da Costa (Guinea-Bissau), Dr G. W. Lungu (Malawi) and Professor Doudou Ba (Senegal). The groups met on 14 September 1985 and studied document AFR/RC35/TD/1 prepared by Professor P. O. Chuke, Professor of Medicine, University of Nigeria, Enugu (Nigeria) and Dr A. C. Nkandawire, Subregional Coordinator, Health Systems Research, Sub-Region III.

275. The discussions of the three working groups dealt with seven basic questions to which the participants were expected to react after studying the working document.

Need for health systems research

276. Health systems research is action research which by use of scientific methods aims to provide information and insight which will:

(i) enable the development of a better understanding of health problems and the role and influence of health sciences;

(ii) assist in more rational health planning;

(iii) lead to more effective and efficient health care which at the same time is better attuned to the cultural and emotional needs of people;

(iv) encourage greater personal, family and community self-reliance in health matters by actively involving people in the study of their own problems.

Research on health systems: places and institutions concerned

277. Health systems research should be a joint multidisciplinary activity of health ministries, university faculties and departments, appropriate research institutions and other ministries and departments. Three types of mechanism for providing effective coordination of research activities were identified:

- establishment within the health ministry of a unit responsible for formulating research policy and identifying research needs; the unit requests assistance from other agencies and assigns research tasks to them wherever necessary;

- establishment of an independent or semi-autonomous commission or similar body with representation of the Ministry of Health to ensure the relevance of all research projects;

- establishment of a department or national committee for research and development in the organization chart of the health services.

278. The main activities selected were as follows:

- collect relevant information for HSR;
- identify priority areas for targeted research;
- receive, screen and recommend research proposals;
- prepare, maintain and update an inventory of research institutions, activities, potentials and personnel;
- provide support and technical advice to investigators, particularly those employed by the health service;
- overview the administrative formalities on resources;
- ensure the respect of safety and ethical considerations.

Steps that national governments should take to make it possible to apply research findings for the attainment of HFA/2000

279. The major obstacles to making use of research findings and results were identified as:

- lack of or ineffective mechanisms for making information available to those who need it;
- absence of people in ministries of health with capabilities for the correct interpretation of research findings and results.

Certain prerequisites, which must be satisfied if research is to be followed by implementation of findings are as follows:

(i) research needs should be identified and ranked in order of priority according to their relevance to national health development policies and strategies;

(ii) there should be effective mechanisms for the review and funding of all research proposals;

(iii) there should be mechanisms for the dissemination of information to ensure that information is available to those who need it;

(iv) there should be mechanisms for follow-up action to ensure utilization of information and implementation.

Traditional medicine and health systems research in primary health care

280. Traditional medicine has much to offer for the development of PHC and its potential should be harnessed to supplement modern medicine. It was agreed that properly selected, trained and supervised traditional healers should be entrusted with specific tasks as front-line workers.

281. The following steps were recommended:

(i) search for appropriate mechanisms for integrating traditional healers into health teams in order to promote their activities, particularly in rural areas;

(ii) strengthening of multidisciplinary research in traditional medicine, including personnel training, documentation, the cultivation of the most useful species of flora and their utilization, whether immediate or as the point of departure for a pharmaceutical industry.

Mobilization of intersectoral components so as to minimize health problems in Africa

282. If intersectoral cooperation is to be realized, the following conditions must be fulfilled:

(i) political will to mobilize effective intersectoral cooperation;

(ii) decentralization of administrative and interrelated development programmes;

(iii) community awareness of their right to participate in matters that affect their socioeconomic development.

Main constraints in health systems research in primary health care

283. The main constraints identified were as follows:

(i) inadequacy of financial resources for research;

(ii) irrelevance of research proposals by donors;

(iii) lack or shortage of trained personnel;

(iv) low perception of HSR.

Scope of health systems research in primary health care

284. HSR is usually concerned with a single culture in a particular setting and hence, although methods may be generally useful, the results have low transferability. HSR helps:

(i) to generate relevant information for action;

(ii) to identify the problem areas for health research;

(iii) to categorize the problem according to priority areas;

(iv) to develop appropriate health technology;

(v) to deliver solutions acceptable to the people;

(vi) to ensure that the objectives are attained.

285. The Regional Committee expressed appreciation for the contents of the technical discussions and thanked Professor Lantum for his presentation.

NOMINATION OF THE CHAIRMAN AND ALTERNATE CHAIRMAN OF THE TECHNICAL DISCUSSIONS IN 1986

286. The Chairman of the thirty-fifth session proposed to the Committee the appointment of Dr George Oluwole Sofoluwe and Mr Martial Mboumba as Chairman and alternate Chairman respectively of the technical discussions in 1986, the subject of which is: "The primary health care approach to the promotion and protection of the health of farm workers during the Industrial Development Decade in Africa".

287. The Committee adopted Decision 9.

CHOICE OF SUBJECT FOR THE TECHNICAL DISCUSSIONS IN 1987

288. The Regional Director made suggestions to the Regional Committee for accelerating the implementation of primary health care in order to achieve the objective of Health for All by the Year 2000. Those suggestions consisted in preparing a plan of work for each country that would specify clearly the activities and support required at the operational (peripheral), technical (intermediate) and strategic (central) levels so as to implement primary health care. In order to focus the Regional Committee's efforts on the Region's top priorities, the Regional Director proposed a three-yearly plan for the technical discussions as from 1987. The following subjects were proposed for the purpose:

1987: Operational support for primary health care (peripheral level);

1988: Technical support for primary health care (intermediate level);

1989: Strategic support for primary health care (central level).

289. The Regional Director will prepare a framework for each subject with certain details that the countries might use in organizing the required support at each level for implementing PHC. The Regional Office and the subregional multidisciplinary teams will be available to each country to support that activity. The experience thus accumulated will be the subject of a document that will be used as a basis for the technical discussions.

290. The Regional Committee considered that the Regional Director's suggestions conformed to the priorities set by the governing bodies. The Regional Committee expressed its approval of the Regional Director's suggestions and adopted Decision 7.

DATES AND PLACES OF THE THIRTY-SIXTH AND THIRTY-SEVENTH SESSIONS OF THE REGIONAL COMMITTEE

291. Mr L. Roy presented document AFR/RC35/16 Rev. 1. He drew the Committee's attention to Decision 13, taken at its thirty-fourth session in September 1984, to hold the thirty-sixth session in Bamako, Republic of Mali, in September 1986. He informed the Committee of the letter dated 20 June 1985, in which the Minister of Health of the Republic of Mali informed the Regional Director that the "Government of Mali has no objection to the holding of the thirty-sixth session of the Regional Committee in Brazzaville in September 1986".

292. The Committee decided to hold its thirty-sixth session in Brazzaville in September 1986.

293. In view of the fact that the thirty-fifth session was held in Lusaka, and that the thirty-sixth session would be held in Brazzaville in 1986, the Committee decided to hold its thirty-seventh session in Bamako in September 1987 at the kind invitation of the Government of the Republic of Mali.

Dates and places of subsequent sessions of the Regional Committee

294. Under the provisions of resolution AFR/RC18/R10 it was customary to hold the Regional Committee at the Regional Headquarters at least one year in three.

295. In the light of the new regional programme budget policy, the Regional Director drew the attention of Member States to the high cost of regional committees organized away from the Regional Office, especially on account of the constantly rising cost of charter aircraft.

296. Accordingly the Regional Committee decided to hold at least one session in two at the Regional Office, and adopted resolution AFR/RC35/R10.

297. During its thirty-fourth session, the Regional Committee took note of the kind invitations extended by the Republic of Niger and the Republic of Burundi. The dates will be determined in accordance with resolution AFR/RC35/R10.

CONCLUSIONS

298. The Thirty-fifth session of the Regional Committee for Africa of the World Health Organization was inaugurated on 11 September 1985 at the Mulungushi Conference Centre in Lusaka (Zambia) by His Excellency Dr Kenneth David Kaunda, President of the Republic of Zambia. Attending the opening ceremony, at which President Kaunda presided, were the Members of the diplomatic corps, representatives of 42 Member States, of Namibia as an Associate Member, the National Liberation Movements recognized by the OAU, and a number of international, intergovernmental and nongovernmental organizations.

299. The report of the Regional Director on the work of WHO in the African Region for the biennium 1983-1984 shows that the health situation in the African Region is among the least favourable in the world, with unacceptable infant mortality rates; the maternal mortality rate ranges between 1.6 and 11 ^{o}/oo, that is to say between 20 and 200 times greater than that of the industrialized countries, while infant (0-1 year of age) mortality ranges between 93.7 ^{o}/oo and 135.2 ^{o}/oo, with an average of 116.4 ^{o}/oo, that is to say 1.8 and 7.2 times greater than the rates recorded in Latin America and Europe. The only region of the world where the figures are comparable is Asia with a rate of 3 to 10 ^{o}/oo and 95.3 to 120.7 ^{o}/oo, respectively, for maternal and infant mortality. Cholera remains rife in epidemic form in many countries and its case-fatality rates are unacceptable.

300. In pursuance of resolution WHA37.13, the Regional Director has proceeded with the decentralization of the Regional Office in order to bring it closer to the countries and thus make the support provided by the Organization more operational, with a view to optimal use of resources. Three subregional health development offices will be set up. Each office will be headed by a director, who will be a very high-level international civil servant, assisted by multidisciplinary teams capable of responding promptly and efficiently to governments' requests in the field of health deliveries to communities. Each office will have strategic, logistic and technical support teams.

301. At country level, strengthening the Coordinator's Office in the administrative, financial and technical areas as well as in manpower will improve the implementation by Member States of their national strategies. Similarly, the Coordinators' responsibilities will be increased and selection procedures will be improved.

302. Regional research in 1983 has been evaluated and a medium-term programme for 1984-1989 prepared. The Regional Committee took note of progress made in research, especially health systems research. Workshops on research methodology were organized in the countries of the Region to improve health programmes at country level and strengthen the countries' research potential.

303. A first draft of the programme budget policy has been proposed, following global guidelines adapted to the specific features of the African Region, in accordance with four main thrusts: (i) support for strategies; (ii) strengthening of national capacities; (iii) technical cooperation among developing countries; (iv) optimal use of resources.

304. The Regional Committee considered the evaluation report on the expanded programme on immunization (EPI) in the African Region, 1977-1985. The relevance and the importance of EPI were obvious, given the dimensions of the problems to be solved. Many immunization campaigns in Africa have failed because insufficient attention has been paid to the cold-chain. Efforts have accordingly been made in this regard both by WHO and UNICEF. Immunization coverage of the Region is estimated at an average of 20%. The effectiveness of programmes in terms of reduced morbidity and mortality cannot be properly measured at the present stage.

305. The Regional Committee gave its agreement to the Regional Director's proposals on ways and means of implementation of resolutions of regional interest adopted by the Thirty-eighth World Health Assembly. A plan of action is to be prepared.

306. The Regional Director submitted his report on the evaluation of the experiment of using African nationals as WHO Programme Coordinators. It emerged from the discussions that: (i) the statute of the national Coordinator cannot be recognized within the framework of the international civil service; (ii) that statute would be a source of continuous litigation and difficulties, since the legal problem is insoluble; (ii) WHO, and in particular the African Region, cannot and should not set itself apart from other United Nations agencies, by making use of a category of personnel that has no statutes within the international civil service; (iv) the positive

aspects of that experiment in certain countries (although negative in others) cannot entirely compensate for the disadvantages linked to the statute of a natinal Coordinator, which has led to trade union type demands from those Coordinators; (v) communications between the Regional Director and his Representatives in the country can allow of no ambiguity.

307. Participation by members of the Programme Sub-Committee in meetings of programming interest facilitated the Committee's work and the Committee adopted all the recommendations of the Sub-Committee's report.

308. The Regional Committee took note of the report of the technical discussions on the subject: "Health systems research: an instrument for the promotion and development of primary health care".

309. In order to concentrate its efforts on the Region's highest priorities, the Regional Committee adopted a three-year plan for the technical discussions, as from 1987, on the following subjects:

1987: Operational support for primary health care (peripheral level).

1988: Technical support for primary health care (intermediate level)

1989: Strategic support for primary health care (central level).

310. The Committee decided to hold its thirty-sixth session at Brazzaville in September 1986 and its thirty-seventh session at Bamako (Mali) in September 1987. It further decided to hold one session in two at the Regional Office.

CLOSURE OF THE SESSION

311. The closing ceremony was chaired by His Excellency Mr Kebby S. K. Musokotwane, Prime Minister, Member of the Central Committee, Member of Parliament.

312. In his welcoming address, the Regional Director, Dr G. L. Monekosso, expressed his gratitude to the Prime Minister for having honoured the closing ceremony of the thirty-fifth session of the Regional Committee with his presence. On behalf of the representatives of Member States, the Secretariat of the Regional Committee and on his own behalf he thanked him for the efforts made by the Government and the people of Zambia towards the brilliant success of the thirty-fifth session of the Region Committee.

313. His Excellency Mr M. C. Mwananshiku, Minister of Health of the Republic of Zambia, Chairman of the thirty-fifth session of the Regional Committee thanked the representatives of the Member States for the cooperation they had extended to him during the exercise of his functions as Chairman. The deliberations had been frank, positive and friendly. He observed how relaxed the delegates and members of the Secretariat had been throughout the conference in spite of the constraints some of them had endured. The spirit of unity and cooperation which had been demonstrated during that meeting had been most encouraging and should prevail for the benefit of the people throughout Africa. After all, the boundaries of our countries are artificial. They had been drawn by the colonialists to safeguard their political and financial interests. "I am confident that given this kind of cooperation the sharing of the resources would be maximized and new areas of cooperation be explored."

314. The Chairman went on to say: "We have individually and collectively examined the strategies necessary to facilitate the implementation of primary health care in the Region. This evaluation has revealed progress made in the programme and many of our weaknesses. As Chairman of this session, I would like to encourage continuous vigilance and hope that the next evaluation will reveal achievement of better health for our peoples".

315. The Committee had an eloquent debate on the issue of National Programme Coordinators which was honest and exhaustive. The Chairman thanked all the delegates for reaching a consensus. He was totally aware that the duties of the Regional Director are onerous and was pleased to note that in the spirit of cooperation their deliberations had strengthened his ability to discharge his duties effectively so that collectively they would be able to achieve their cherished goal of health for all. He however felt it necessary to recall the introductory remarks made by the Regional Director in his 1983-1984 biennial report to the effect that the worldwide socioeconomic crisis had impeded, in a most disquieting manner, the consistent implementation of national strategies for Health for All by the Year 2000 through primary health care.

316. In his closing address, His Excellency Mr Kebby S. K. Musokotwane, the Prime Minister, on behalf of his country, extended gratitude to Dr Mahler, the Director-General, Dr Monekosso, the Regional Director, as well as to their staff for the efforts they had made in ensuring the success of the conference which was followed with great interest. "I am informed that your discussions have been frank, friendly and constructive. The commitment shown by Health Ministers in strengthening strategies intended to facilitate successful implementation of primary health care, gives us tremendous hope that the cherished goal of Health for All by the Year 2000 may indeed be realized. On our part, we shall study your conference resolutions very closely with a view to enhancing the health status of our people."

317. The Prime Minister went on to say: "We have setbacks, we have problems and some of these are of our own making. Unfortunately, some of the problems that we now face are forced on us so that Africa, as a continent, can continue to slumber. The African men and women in politics, in health, in education, in economics and in all areas must now rise and fight for our continent to be what it should be, like any other in the world... I hope that your meeting has added more firm and water-proof bricks in the construction of our continent. We will put this to the test in the next few years by how far we go in improving the quality of health in Africa. We hope we can continue to convince those of our colleagues to determine how much money should go to health and educational services as these are powerful tools which should not be neglected". The Prime Minister closed his address by wishing the delegates a safe return back to their respective countries.

ANNEXES

ANNEX 1

ADDRESS BY MR D. S. KATOPOLA,
MINISTER OF HEALTH OF THE REPUBLIC OF MALAWI,
FIRST VICE-CHAIRMAN OF THE THIRTY-FOURTH SESSION

Your Excellency Mr President of the Republic of Zambia,
The Secretary-General of the Party,
Members of the Central Committee,
Honourable Ministers,
Mr Regional Director,
Members of the Diplomatic Corps,
Distinguished Delegates,
Ladies and Gentlemen,

1. It is a great privilege, honour and pleasure for me to welcome His Excellency Dr Kenneth David Kaunda, President of the Republic of Zambia, to our inaugural meeting and to thank him for gracing the occasion with his presence in spite of his many taxing duties and commitments.

2. Allow me, Sir, on behalf of all Honourable Ministers from sister countries, all the delegates, to extend to you, and through you, to all the people of Zambia, our sincere appreciation of the authentic African hospitality that has been extended to us since our arrival in this beautiful capital city of Zambia - Lusaka.

3. We are heartily pleased to see the progress which is being made in the socioeconomic and health sectors through the widespread development across the beautiful Republic.

4. I assure Your Excellency that we all look forward to a most enjoyable stay in your beautiful country and among your kind and hospitable people; this atmosphere will undoubtedly lighten the heavy duties that lie before us. Your Excellency, Mr Director-General, Mr Regional Director, and fellow delegates here we are, 20 years after, assembled once again in our sister Republic of Zambia. When the Regional Committee met here the last time in 1965, Lusaka and Zambia were very different. For one thing, Lusaka was a small post-colonial city, and Zambia was a different country. Like many of our countries, Zambia had recently attained her independence and was grappling

Annex 1

with problems of adjustment from a colonial system to an independent administration. Our own Organization, the World Health Organization, was also going through a time of adjustment to accommodate its new membership of former colonial countries, which are now sovereign independent States. This was the time of the big eradication and demonstration programmes.

5. Today, we find ourselves in a much bigger and vibrant city of Lusaka, in a totally confident Zambia. Our own Organization, the WHO, is more alive with a clearer goal of Health for All by the Year 2000, and more geared to development of health systems based on primary health care.

6. Your Excellencies, as this is the first occasion that I have had to address the Regional Committee as Chairman, permit me to take this opportunity to express my personal congratulations, as well as the best wishes of my country, to Professor G. L. Monekosso, for his appointment to the distinguished office of Regional Director. Fortunately for me, Dr Monekosso has already been in office for close to one year now and I can, without fear of contradiction, base my complimentary remarks on a track record which he has already ably demonstrated to the continent. We have been highly impressed by his relaxed and informal but serious style, as well as the direct contact and approachable methods which he has introduced as innovations to the Brazzaville Office. We wish you, Sir, success in the challenging tasks of coordinating the immense and varied health programmes of our continent. We will give you all the support that you have already earned through your personal vigour and enthusiasm.

7. Distinguished delegates, ladies and gentlemen, the next few days demand of us our usual sense of maturity and thoroughness in giving our new Regional Director and the whole of the Secretariat clear decisions, directives and resolutions in order for him to serve us better. Glancing through the agenda, there are many important matters, such as the traditional examination of the work of WHO in the African Region.

8. Under this agenda item, you will notice that there is a new item altogether: the Regional Programme Budget Policy.

Annex 1

9. I am personally delighted to see this item on our agenda. I have no doubt that many of you honourable delegates will agree with me that a regional programme budget policy is long overdue.

10. This programme budget policy will help in further focusing our programming and budgeting on our Region's real health priorities. While we have progressed well in developing with the development of General Programmes of Work and Medium-Term Programmes, there lacked the link of a programme budget policy at the regional level which will help focus both programming and budgeting on our Region's priority health problems.

11. The General Programme of Work and its translation into medium-term programmes still remained too global as long as there was no regional programme budget policy. Furthermore, we hope that this innovation will make it easier for Member States and the Secretariat for the accountability in our cooperative effort for optimal utilization.

12. The other matter which I should like to point out as unique on our agenda is the evaluation of the experiment of using nationals as WHO Programme Coordinators (document AFR/RC35/22). While we have had no personal experience in this matter in my country, nevertheless we understand that there have been difficulties in the application of this apparently attractive concept.

13. I am sure that we will examine this matter with "cool" heads and give the Regional Director and the Director-General our honest assessment of this experience. Our view is that our only interest and basis for decision should be the creation of an efficient organization that serves us and our collective interest well.

14. Honourable delegates, distinguished guests, ladies and gentlemen, one last item of our agenda to which I should like to refer is agenda item 8.1 - Evaluation of the implementation of the strategies for Health for All by the Year 2000: regional report (document AFR/RC35/12).

Annex 1

15. Here, I would like to refer to my country's own experience. Reading the regional synthesis of national reports sometimes leaves with one the impression that we are still making general statements that are not out of an experimental context. In some parts, it reads like a desk analysis and not a field experience.

16. In Malawi, our report was preceded by an in-depth field review of our primary health care programme in the country. We intend to carry out these reviews every two years. In the last case, we found that the information we generated in the PHC review served us well to present our evaluation report. We would suggest that as many countries as possible carry out similar reviews of their PHC programmes; after all, have we not all agreed that there cannot be Health for All by the Year 2000 without primary health care?

17. Let me suspend my present remarks by thanking, once again, the Zambian Government for the invitation to host the thirty-fifth session of the Regional Committee. We know how much work goes into the preparations of such meetings. We are conscious of the burden in terms of resources that organizing such a meeting entails. On behalf of all the delegations, I should like to pay homage to Zambia. The hospitality, typically African in character, that we have enjoyed since our arrival makes us feel at home. The interest of the national leadership in this meeting demonstrated by the personal presence of His Excellency the President, Dr Kenneth D. Kaunda, needs no further amplification.

18. Honourable delegates, distinguished guests, ladies and gentlemen, the conditions are right for honest, frank and hard work in the coming week. I wish you well in our labours and have the pleasure and privilege of asking His Excellency Dr Kaunda to officially open the Regional Committee for us.

Thank you.

ANNEX 2

ADDRESS BY DR G. L. MONEKOSSO, REGIONAL DIRECTOR

His Excellency, the President,
His Honour the Secretary-General of the Party,
Right Honourable Prime Minister,
Honourable Members of the Central Committee,
Honourable Ministers,
Excellencies,
Ladies and Gentlemen,

1. Let me begin by thanking the President, Government and people of the Republic of Zambia for having kindly invited the Regional Committee for Africa to hold its thirty-fifth session in this attractive and congenial city of Lusaka, a city that blossoms with sweet jacarandas and bougainvilleas. Your presence, Mr President, today at this meeting is more than a ceremonial ritual; it bears testimony to the political will and commitment of the Government and people of Zambia to cooperation with WHO in the attainment of Health for All by the Year 2000. We gratefully recall that Zambia first hosted the Regional Committee in 1965.

2. I consider it a privilege that the first Regional Committee meeting after my election as Regional Director is being held in Zambia, one of the countries at the forefront of the struggle of our people for freedom and social justice. Mr President, we salute you for sharing with us the same ideals. Your philosophy of humanism has evoked international conscience in favour of human rights and social justice. May the winds of freedom blow from this land to every corner of our continent.

3. May I be permitted to pay tribute to Dr Comlan Alfred Auguste Quenum, who passed away on the eve of the thirty-fourth session of the Regional Committee, on 15 August 1984. He served as Regional Director for 19 years. He was a great son of Africa who launched Africa into the Health for All by the Year

Annex 2

2000 (HFA/2000) programme with creative imagination and skill. We can pay him no greater tribute than to re-dedicate ourselves to the attainment of the health goals which he pursued energetically. May I request you to join me in a solemn tribute and observe one minute of silence in his memory.

Mr President, Excellencies,
Distinguished Delegates,
Ladies and Gentlemen,

4. During these few months in office, I have had the good fortune to meet some of you in your respective countries or in the Regional Office in Brazzaville. We have together surveyed the health scene in Africa, and have discussed many issues such as:

(a) the exponential growth of the population of the African Region, which will rise from 345 million in 1980 to a projection of between 551 and 578 million by the year 2000;

(b) food production that disproportionately lags behind population growth;

(c) the slow but seemingly inexorable invasion of the desert, and

(d) poor health care delivery and coverage at the periphery.

We will continue this dialogue with all our health leaders, using all available channels and opportunities. We must augment the health sector's contribution to liberating the African Region from the shackles of underdevelopment. But rhetoric can hardly replace action, which brings me to the theme of this address, namely: Priority in action.

5. WHO's Seventh General Programme of Work (1984-1989) clearly defines a range of activities requiring political will, administrative organization and managerial capacity, mobilization and effective use of resources, and so on. They challenge our capabilities to translate our policies, strategies and action plans into realistic operational programmes.

Annex 2

6. In 1948, health was defined in the WHO Constitution as a "state of physical, mental and social well-being, and not merely the absence of disease or disability". It is logical therefore that after three decades of trial and error, the World Health Assembly, in 1977, decided that the main social target of Member States, and the World Health Organization should be the attainment by all peoples by the year 2000 of a level of health that will permit them to live socially and economically productive lives. At Alma-Ata, in 1978, it was agreed that the primary health care approach is the key to attaining that goal as part of development in the spirit of social justice. Although countries of the African Region have made some progress in the last two decades, during which the international community was involved in a search for effective ways of ameliorating the health status of people everywhere, the review of progress by WHO in 1982 suggests that more rapid action and sustained progress are indispensable, if we are to overcome the major impediments to the attainment of HFA/2000 through primary health care.

7. Published health and related socioeconomic indicators put many African countries in the unenviable position of being among the least developed in the world. Let us recapitulate:

- infant mortality of 160/1000 compared to 19/1000 in developed countries;

- life expectancy of 45 instead of 72 years;

- adult literacy rate of 28 instead of 98%;

- coverage by safe water supply of 31 instead of 100%;

- gross national product (GNP) per capita of US $170 compared to US $6230 per capita;

- public health expenditure of US $1.7 per capita per annum compared to US $244 in developed countries.

Annex 2

Staggering disparities these are. All this means that as far as primary health care implementation is concerned what is needed is not "rhetoric" but "action". We must build upon the gains of the last two decades, not by continuing business as usual, but accelerating our health and socioeconomic development. Let us mobilize ourselves and brace up for the decisive thrust towards the year 2000. Your World Health Organization has the lead role amongst international agencies to catalyse health development and nowhere is its action more crucial than in the African Region.

8. In order to succeed, we should organize ourselves as relay teams. Each person should proceed as rapidly as he can to the limits of his/her endurance, and pass on the "baton" as soon as he begins "to lose his breath". We cannot afford to lose momentum. Sustained action is of the essence; if we are to achieve health for all in Africa it is to this, that your humble servant hereby pledges his total commitment.

9. When Dr Mahler, the Director-General, proclaimed HFA/2000 in Yaoundé in 1975, we had 25 years. The target year of AD 2000 is now less than 15 years ahead. But we must remind ourselves of our three mid-term objectives set in 1980 to be achieved by the year 1990:

(a) to vaccinate all children under one year of age against the six diseases included in the expanded programme on immunization, and to develop mechanisms for ensuring continued implementation of this programme (resolution WHA31.54);

(b) to ensure the provision of clean drinking water and the maintenance of environmental sanitation for all communities and set up, during the decade (of the 1980s), mechanisms for maintaining and extending the necessary infrastructure for health care (resolution WHA30.33);

(c) to promote and ensure adequate food and nutrition for the populations of the African Region and in particular for those sectors which are the most vulnerable (resolution WHA28.42).

Annex 2

The deadline for attaining these sub-targets is less than five years ahead. We must place emphasis on action because we are clearly behind schedule in our race against 1990 targets. The current African crisis is an eloquent if not dramatic reminder of this reality. Let us remind ourselves that although the greatest friend of truth is time, such time must be married to action.

10. The Lagos Plan of Action adopted in April 1980, by the second extraordinary session of the Conference of Heads of State and Government of the Organization of African Unity (OAU) outlines action programmes necessary for the achievement of national and collective self-reliance in economic and social development in Africa by the year 2000. Primary health care should be seen as part of the operational strategy of the Lagos Plan of Action. We should remember that the estimated additional cost of health coverage by the year 2000 per inhabitant per annum is likely to be US $16.20 by the conventional approach (100% monosectoral) compared to US $2.60 by the PHC approach (100% participatory, multisectoral and multidisciplinary).

11. WHO (AFRO) is willing and ready to play a catalytic role in implementation. In Africa, as indeed everywhere, "health" is a subject on which groups, communities, institutions and countries can usually reach a consensus. Strong family loyalty and deep community spirit, already ingrained in our culture are even stronger when problems of health and social welfare are involved. How health care is financed depends upon socio-political stance. But there is usually agreement on the need to promote health as an integral part of socioeconomic development. Health brings people together. Health action can therefore be an important mechanism for promoting African unity. Let us move forward together - Pamodzi!

12. The World Health Organization, in promoting the implementation of health for all Africans, has an unusual historic opportunity. How that office is organized and how its staff and WHO staff in the field conduct their business would be critical to achieving "Health for all in Africa" and consequently the achievement of political, social and economic goals. Hence the need for reorganization of the Regional Office in the light of these critically vital functions.

Annex 2

13. Within the African Region WHO must work together with several organizations, institutions and departments and individuals if it is to succeed in its mission. The Regional Office and its leadership must be clearly seen by Member States as their most intimate partners in health development. We are decentralizing WHO/AFRO, putting emphasis and the maximum possible resources for action in countries, especially at the community level. The primary health care strategy calls for joint action within communities, districts, provinces, as well as at the national coordinating level. At the regional level, WHO must strengthen its linkages with regional political and economic organizations (like OAU, ADB and ECA) as well as with subregional economic groupings. This should go beyond simple exchange of information or "liaison" but should include joint action over a number of programme areas for the benefit of Member States, especially in mobilizing resources for "health", and promoting economic productivity through ensuring healthy manpower.

14. The Regional Office would also maximize collaboration with other agencies of the UN system in Africa. The close relationship with UNICEF should be palpable at the operational level in countries. WHO and UNICEF should be clearly seen as joint partners in primary health care implementation. There should also be joint programming with other UN agencies on major aspects of "essential health care", like food and nutrition (with FAO), essential drugs (with UNIDO), environmental control (with UNEP), health education/public information (UNESCO), family planning (UNFPA), etc. The "resource gap" in Africa is so large that the UN system must demonstrate their capability under the leadership of UNDP, to work out appropriate vital moves related to achieving the goal of health for all, with WHO acting as the executing agency.

15. WHO must also work closely and maintain good channels of communication with large bilateral agencies and foundations (according to preferred affiliations of Member States). These usually dispose of much larger financial resources than WHO. The possibility of "tripartite" programme implementation (Recipient/Donor/WHO) should be explored, so that WHO would assist these agencies achieve some of their health-related goals. The World Bank should be expected to assist countries in our Region to restore, acquire or expand their primary care infrastructure at favourable lending rates.

Annex 2

16. Finally, collaboration with WHO/HQ, Geneva, and other Regions of the World, would be intensified in keeping with the major objective of "Health for All by the Year 2000". It is hoped to launch a major interregional health development initiative that would deal decisively with Africa's lingering health problems.

17. I crave your indulgence to raise with you again as health leaders the questions that were put before the Regional Committee in 1980 as a prerequisite to our regional health development strategy. These questions are still relevant today:

(a) How will it be possible to encourage reorientation of health systems for the implmentation of policies, strategies and plans of action?

(b) What types of administrative reforms are required to make the health system operational, efficient and effective?

(c) What are the principal reforms to be promoted for the development of human health resources required to implement national strategies?

(d) How can research be reoriented towards solving the priority health problems of African communities?

(e) How can the involvement of communities be stimulated?

(f) What mechanisms should be set up for evaluation?

The approaches and responses to these questions must vary from one country to another depending on the different socio-political, economic and cultural settings. The staff of WHO/AFRO will be discussing with you a recently elaborated schedule of activities, that can be adapted to varying national situations. These activities will be carried out with the support of the subregional health development offices, and are designed to cover the last three years (1986-1989) of the Seventh General Programme of Work of WHO (1984-1989).

Annex 2

18. This session of the Regional Committee will review a report on the "Evaluation of the implementation of the strategies for health for all". This will enable us to audit our primary care activities. Using appropriate indices, we will measure achievements and failures, determine cost-effectiveness, and evaluate our technological options at community level. We would also endeavour to determine the impact of these activities on the health status of populations. When we have done this, the need for accelerated action would be once more evident. Let us go forward together - government - people and WHO - in planning, implementing and evaluating our primary health care strategies.

Mr President,
Honourable Representatives,
Ladies and Gentlemen,

19. It is in this spirit of partnership that we will march forward in our charted journey to Health for All by the Year 2000. As leaders, policy- and decision-makers in Africa, our culture demands of us that we bestow a worthy legacy to our children and the generations yet unborn. Here today we are delicately poised on the threshold of history. Let it be said that ours was a period when the right choices were made: effective action and concrete achievement, technical excellence and political determination to succeed and live up to our solemn pledge at Alma-Ata. There is no other relevant and appropriate approach than primary health care to herald socially satisfying and economically productive lives for our people. Other countries have done it. We also can and must do it with the necessary political will, sustained hard work, and efficient organization and management. It is my hope that those who have taken up the challenge of HFA/2000 will not spare a single ounce of energy to achieve the African Health Revolution in studied and courageous steps. For my part, I am anxious to make my modest contribution, and serve the leaders and peoples of Africa to the best of my ability. Working together and to the best of our abilities, "Health for All Africans by the Year 2000" will be a happy reality.

ANNEX 3

OPENING SPEECH DELIVERED BY HIS EXCELLENCY DR K. D. KAUNDA, PRESIDENT OF THE REPUBLIC OF ZAMBIA

Comrade Chairman,
Comrade Leaders of the Party and its Government,
The Director-General of the World Health Organization,
Distinguished Delegates,
Ladies and Gentlemen,

1. On behalf of the United National Independence Party, the Government, the people of Zambia and indeed on my own behalf, I have pleasure in the name of the Almighty, the Creator of all mankind to declare this the thirty-fifth session of the WHO Regional Committee for Africa officially open.

2. I am delighted that Zambia has been afforded the rare opportunity to host, yet again, this important conference of the World Health Organization Regional Committee for Africa. You will recall that Zambia had the privilege to host the twentieth session of the World Health Organization Regional Committee for Africa in 1965. At that time we were barely one year old as a free and independent nation. The conference indeed was a great gesture of confidence towards us from this Organization which is so vital to the life of the international community.

3. It is therefore with the greatest pleasure that the people of Zambia, their Party and its Government welcome you, the Director-General of WHO and your staff, all distinguished delegates and conference observers to this thirty-fifth session in Lusaka. I want you to feel completely at home among your brothers and sisters in Zambia. Any material shortcomings that you may experience, please, accept them as shortcomings only and nothing more. The hearts of all of us are fully with you.

Annex 3

4. When you held your last session here in Lusaka 20 years ago, our young Parliament was also in session. In our Parliament a hot debate developed about your conference. My then Minister of Health was taken to task by his Parliamentary colleagues about the presence at your meeting of delegations from the then Rhodesia and colonial Portugal. That Parliamentary debate spilt over into your meeting where it almost paralysed the proceedings. Happily your present session finds not only Zimbabwe but Botswana, Lesotho, Swaziland, Mozambique and Angola free, independent and sovereign States in southern Africa. While the battle for freedom rages on in Namibia and apartheid South Africa, freedom is wider in southern Africa today than it was at that time.

5. I mention this incident to illustrate the many qualities of the World Health Organization that endear this international body to the people of Zambia and to southern Africa as a whole. WHO is not a toothless or indifferent organization when it comes to the freedom of man, freedom from oppression. Indeed, this is right and proper. It is as it should be. The domination of one person by another person is as much a disease to the person as the domination of the body of a person by the body of a virus. Oppression like smallpox is a disease to the person. It has to be treated to let the person free. In a large part of southern Africa oppression and political smallpox have been eradicated. I believe the politics of the people is inseparable from the health of the people. Health is politics and politics is health in any given life situation. It is for this reason that we in Zambia have watched with great interest and appreciation the growing political consciousness and understanding on the part of WHO of the forces influencing and shaping total development in the African Region.

6. Since the Lusaka conference, the World Health Organization through the Regional Committee, the Executive Board and the World Health Assembly has paid due attention to the problems afflicting the oppressed peoples of the world. With regard to our Sub-Region in southern Africa, we are aware of the undaunted efforts of the Director-General, and the Regional Director in availing support to the liberation movements. Zambia for her part has on many occasions provided conference, training and health facilities and other services desired by the liberation movements either independently or in collaboration with the World Health Organization.

7. Our commitment to the struggle in southern Africa remains unwavering and we shall continue until political freedom and equal opportunities have been achieved. Therefore, in commending WHO, I must appeal for more support both to the liberation movements and to those countries in our Region which must sacrifice their life in order to assist our brothers and sisters to free themselves from domination, racism and apartheid.

8. Distinguished delegates, ladies and gentlemen, in the last 20 years, our Organization has grown in size and in the scope of its operations. The health activities of WHO are becoming common knowledge to the man in the street and in our villages. African scientists, professionals, administrators and technicians are assuming increasing responsibilities at the various levels of the Organization. This is a very welcome development.

9. I have noted from the provisional agenda that your discussions at this session will include the expanded programme on immunization; ways of implementing resolutions adopted by the World Health Assembly and the Executive Board; evaluation of the implementation of the strategies to achieve Health for All by the Year 2000; and evaluation of the experiment of utilizing African nationals as WHO Programme Coordinators. All these subjects are of very special interest to our Region. The discussion of them by this session will help us in consolidating the efforts of the Region to meet the desired goals.

10. With regard to the experiment of using nationals as Coordinators of WHO Programmes, we in Zambia are of the view that the experiment is very timely. We have welcomed our full participation in the work and administration of WHO at country level through the appointment of a national who is conversant with our aspirations. This arrangement has won the hearts of our people and we look forward to the day when among the experts working at national levels there will be prominent local scientists and professionals.

Annex 3

11. I now wish, Comrade Chairman, to address myself to the resources provided to countries in our Region by WHO. On this matter, I would like to echo the sentiments of our Director-General, Dr Mahler, on the optimal utilization of WHO resources especially at country level. For Zambia, WHO's support remains relatively small in comparison to our national effort and to the support the country receives from friendly countries. However, the Organization's inputs, where strategically applied, produces significant impact on our health programmes.

12. Indeed WHO is one of the organizations whose contributions have helped us to keep our heads above water. This support is even more important today, because of the difficult economic period we are all passing through.

13. In 1965, the WHO Regional Committee for Africa resolved to intensify the struggle against smallpox. Member States were called upon to initiate eradication programmes. With the support of WHO and a great national determination the people of Zambia pursued the eradication programme with vigour. By the year 1978, Zambia was certified a smallpox-free country. We were delighted to be a party to the solemn declaration of the eradication of smallpox from the face of the earth in 1980. The achievement of WHO in eradicating the deadly disease was a great boost to the ability of the Organization to tackle the large health problems on our continent and the world.

14. I would now like to share with you some of the progress in the field of health which Zambia has made since your last meeting here in Lusaka. In 1965, there were a total of 386 health centres and 48 hospitals. Today, there are 730 health centres and 81 hospitals, representing an increase of 155% and 69% respectively. We had only two indigenous doctors at that time; today, there are nearly 300. We had only a handful of nurses and midwives; now we have more than 7000. The variety of training programmes we have initiated have enabled us to Zambianize 98% of the nursing, 99.9% of the environmental, 70% of technical and 30% of medical posts in the government establishment.

Annex 3

15. With regard to financial allocations, in 1965 government appropriation to the health sector was less than one per cent (1%) of the total government expenditure, compared to 7.5% in 1984 and 7.7% estimated for 1985. In absolute terms, the percentages I have referred to represent K11 million in 1965 and K141 million in 1985, an increase of thirteen fold.

16. The abolition of fee-paying hospitals and nursing homes has placed health services at the disposal of the people of Zambia, free of charge and without class distinction. This policy has been influenced by our firm belief that health is a fundamental human right. Therefore, no Zambian citizen should be denied health services because of his inability to pay the cost of being sick.

17. In terms of water supply and sanitation, the progress has been rather slow. We have achieved the provision of safe water to 70% of the urban population and 48% of the rural population. Similarly, only 56% of the urban and 48% of the rural dwellers have access to proper sanitation. It is our sincere hope that the International Drinking Water Supply and Sanitation Decade will accelerate the pace of development in this area.

18. Other notable achievements which have a positive impact on the health status of our people, are the increased rate of literacy to 65% and increased life expectancy from 45 in 1965 to 50 in respect of females and from 41.7 in the case of men. The infant mortality rate has declined from 140 per 1000 live births in 1965 to 105 per 1000 today.

19. One of the principles of our participatory democracy is that of giving power to the people. This implies that in the health sector, the individual person and the community as a whole must participate actively in the formulation and implementation of health development plans. The Ministry of Health is currently busy compiling, coordinating and developing a health programme for the country's Fourth National Development Plan which we hope will go some way in giving health facilities to the people by the year 2000 in keeping with the WHO pledge.

Annex 3

20. Comrade Chairman and Comrades, I wish also to share with you the problems of our country associated with rural-urban migration which have reached alarming proportions and some of the measures we have taken to minimize them.

21. Our urban population is now estimated at 46%. Rural people have moved to towns in the hope of finding jobs in industries. However, the depressed economic conditions have hampered the maximum growth of industries resulting in unemployment and under-employment. The majority of the unemployed have sought refuge with their employed relatives as dependants, thus increasing the size of the family unit and dependence on the urban wage earner. The result has been poor nutrition in some cases, particularly among children and women of child-bearing age.

22. In correcting the trend, the Party and its Government have decided to embark on programmes to make rural areas more attractive. One such measure is the provision of attractive incentives to commercial as well as peasant farmers not only to diversify into the agricultural industry, but also to minimize the flow of the people from the rural to the urban areas.

23. I am, however, acutely aware that we have a long way to go to fully satisfy the aspirations of all our people. It is because of this realization that the Party and its Government have seriously examined the concept of primary health care as an approach which will strengthen our participatory democracy through community participation in health welfare.

24. It was to this end that at our last General Conference of the Party we outlined for the country the guidelines for the next development decade 1985-1995. In respect of primary health care, we are stressing its rapid expansion to ensure that the health of our people does not decline below the existing levels. Under this framework, we expect all District Councils to redouble their efforts in promoting primary health care. The success of the health care delivery services will not be allowed to rest on the Ministry of Health alone. We believe community activities such as the provision and

proper utilization of pit-latrines can revolutionalize the lives of the people in a profound manner at the grassroots. We want to work to ensure that every household has appropriate, adequate and well-maintained human waste and refuse disposal facilities. The same structures should ensure children receive the required vaccinations at the appropriate time.

25. The Party and its Government are committed to the success of the United Nations system, and in particular, to agencies and resolutions promoting the health needs of the people which are applicable to our country. In this regard we have noted that one of the resolutions of the last World Health Assembly in Geneva in May this year, called for maintenance of national health budgets at levels compatible with the attainment of the goal of Health for All by the Year 2000.

26. Here in Zambia we adopted the primary health care approach in 1979 after nationwide consultations and discussions. In 1980, the infrastructures for its implementation were established and managerial teams were appointed at district and provincial levels. From the beginning the need to strengthen managerial processes was felt. To respond to this need, health workers were given the required orientation.

27. The implementation of primary health care in our country has been very much influenced by our great desire to correct the imbalance in the utilization of the health budget which hitherto favoured large hospitals with high technology. These hospitals are placed in urban centres and the health care provided in them is largely curative-oriented.

28. This new organization of primary health care is based on our country's Party and Government structure. The smallest unit being the Section Committee. The Section is the basic unit for community participation. Communities have selected their members who have been trained to support them in identifying health and health-related problems, and determining the necessary interventions to deal with those problems. By the end of 1984, a total of 2340 community health workers had been trained and are supervised by the health centre personnel.

Annex 3

29. At district level, the District Medical Officer, through the district management team, is responsible for development, implementation and management of primary health care in the district. At provincial level, the Provincial Medical Officer, through the provincial management team, is responsible for the implementation of primary health care in the Province. At the central level the Assistant Director of Medical Services, primary health care, is responsible for the development, implementation and evaluation of primary health care in the whole country.

30. A primary health care Secretariat headed by the primary health care specialist has been created to facilitate the coordination of primary health care activities. WHO and UNICEF have supported us in carrying out evaluation to determine the extent of the implementation and the constraints faced in the process.

31. We are mindful, under our philosophy of humanism, that man is not only the cause of but also the most important force for development and that there exists an intrinsic interrelationship between health and development in general. This is the reason for the Party and its Government giving priority attention to health.

32. The World Health Organization is a major partner in the people of the world's social endeavour. Here on the African continent WHO must continue to forge the unity of action of the peoples of Africa within the Organization of African Unity and to inspire Member States to strive harder towards the stated goal of health for all.

33. Once again, I welcome you all and particularly the Algerian delegation which has joined the African Regional Committee following the transfer of Algeria from the European Region. It is my sincere hope that your deliberations will be fruitful and in the interest of the health aspirations of the people of Africa.

34. May the Good Lord bless you all.

ANNEX 4

ADDRESS BY DR H. MAHLER
DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION

Targeting on health for all

Mr Chairman, Excellencies, honourable representatives, ladies and gentlemen, colleagues and friends,

Targeting for health

1. A senior health executive in a North-European country stated recently: "The most novel and exciting idea that Health for All by the Year 2000 inspired in us is that you can target for health". Perhaps we who have been so deeply involved in the health for all movement have taken the very concept of targeting too much for granted. It was at the very basis of our new health policy; have we lost sight of it in practice?

2. I shall be more explicit. To be sure, we have defined the very broad target itself, as well as indicators to help us realize if we are getting there. We have also defined a couple of specific targets - safe drinking water for all and immunization of all the world's children against the major infectious diseases of childhood by the year 1990. We realized full well that these are only meaningful if each and every Member State adopts them as its own. But have national targets been defined for the very vehicle that will make or break the realization of all other targets, and by that I mean primary health care rightfully placed in the health system? I think not. I realize that there may have been good reasons for not doing so in the past, but I believe that there are equally good reasons for starting to do so now.

3. What alternatives are there for the people and countries of Africa? On reading your evaluation of your strategies for health for all, I am afraid I can see none. You have been very courageously frank in your analysis of your situation - political, economic, social and cultural uncertainty compounded by natural disasters and human inertia. Your infant mortality rate is more than

100 per 1000 live births in most countries, and more than 200 in some; your life expectancy at birth is less than 50 in almost all countries. And as your economic resources are weak, it is inevitable that your resources for health should be weak too.

National action programmes for primary health care

4. Under the circumstances the strategy of health for all through primary health care offers the only glimmer of hope. So nothing could be more opportune than intensifying primary health care and widening access to it until all people are covered. At Alma-Ata everyone agreed that primary health care is the key to attaining health for all. That message seems to be getting lost by the wayside. I think the time has come to shout once more the clarion call for national action programmes for primary health care. You can target for that; and you can redouble your efforts to attain your targets. I think we can look back with some satisfaction on the way we have been reshaping health policy at central government level. Now we must concentrate on implementing that policy where it means most - close to people, in communities and in geographical districts. In most countries these are small enough to be managed without becoming submerged in excessive government bureaucracy, and yet large enough to permit the country to be subdivided into limited numbers and therefore avoid overdispersal of skills.

5. What can be done about the reality of limited resources for health? I am afraid a hard look at the money side of health for all is essential if we are to avoid unrealized dreams and discredited promises. First of all, it is necessary to identify clearly what is being spent on health and where it is being spent - information that is sorely lacking in most countries, not only in this Region but throughout the world. Then it is necessary to focus resources more sharply; picking up the slack and putting it to good use could make a tremendous difference in most countries. Health for all is not necessarily a matter of spending more, although I realize that most of you are spending far too little on health, well below the minimum required. Nevertheless, much could be achieved by making sure that existing resources are squeezed to the maximum and used for tomorrow's defined targets, not yesterday's undefined services.

Annex 4

6. In addition, remember that you have the sympathy of the whole world, as recent support for those of you stricken by drought and famine illustrates. You, we, all of us must make sure that the fruits of that sympathy go to seed and lead to the development of your people and not to their dependence on charity. That is why I struck forth at the recent Health Assembly for a restoration of faith in human development. And I was deeply impressed, and had my faith in the developmental nature of our health strategy reinforced, by the words of a Minister of Planning at a recent consultation in Geneva. He said: "For us the strategy for health for all through primary health care is not merely a health matter; it is an exciting new model for human development".

7. Your Organization will be able to cooperate with you effectively in times of immediate crisis and throughout the long-term crisis that Africa is continually facing, if it knows precisely what your problems are. If you hide them or minimize them for whatever reason, no amount of second guessing on WHO's part will help. So I plead with you, when you explain your health problems to your Organization, whether to your WHO Programme Coordinator in the country, to your Regional Director, to your humble servant when I visit you, or to any other staff, when you do that please be as courageously frank in expressing your health situation as you were when you evaluated your strategies for health for all. It is only in that way that your Organization will be able to act as your intimate partner in health, a role that you entrusted to it some years ago. And it is only if your Organization behaves as your intimate partner that it will be able to ensure that you receive the support you need, not only from its own resources, which are after all limited, but also from the resources of other United Nations organizations and bilateral development agencies.

8. Your determination could lead your governments to target for primary health care. Each one of you could do that by incorporating in your action programme for primary health care those elements that are of high priority to you. You could start with a few and set realistic targets for them, adding elements progressively until all are covered. Strengthening your infrastructure will enable it to deliver more programmes, and sustained delivery of more and more programmes will in turn strengthen your infrastructure further. We are gaining experience with the kind of research

Annex 4

and development required to build up health systems in just that way. You can use that experience in your countries and add to the general pool of knowledge in the process. We understand sufficiently the social fabric of primary health care, and we have adequate experience of the managerial process required to set it up and manage it. Add to that the fact that we either have sufficient appropriate technology at our disposal, or could have it by investing energies in intensive research and development, and there is no reason why each and every country should not embark on a primary health care action programme with well-defined targets for its infrastructure and for its content.

9. For what programmes could you define targets within primary health care? I have already mentioned water supply, which includes related sanitation, and I have mentioned immunization. Does appropriate technology exist for these? At the risk of repetition I would remind you that to be appropriate technology has to be not only scientifically sound, but also socially sound - that is acceptable to those on whom it is used and to those who use it. And it has to be economically sound - that is able to be afforded by the community and the country. Wherever water exists, it can be exploited for human use in that kind of appropriate way. Experience has shown that even rural water supply can be made eminently "bankable" - by that I mean that the community itself can repay loans over a reasonable period, in part thanks to the economic gains of having water at hand. In my humble opinion, the best way to motivate people to share the costs of health development is to get them involved in attaining tangible targets that relate to them, to make them so enthusiastic about their health and the health of their children that they will willingly agree even to help solve the financial problems involved.

10. The technology and related managerial know-how are certainly available for programmes of immunization. This applies equally well to diarrhoeal disease control. So it can be targeted for too. The problem of improved maternal and child health is not lack of knowledge, it is lack of application. Proper application can be targeted for. There are no real

mysteries about nutrition, so it too can be targeted for. At the same time, a great deal of social, economic and cultural research and development remains to be done to ensure that people have access to the food they need and actually consume it. We have also demystified the whole issue of drugs and know enough about how to set up and manage essential drugs programmes to make it possible to provide care in the community for common diseases. So medical care and related drug use can also be targeted for.

11. You could target for decentralization too. Each of your governments could make sure that every district reviews what is happening to the national health strategy in its communities; that it identifies priorities for implementation through primary health care; that it targets for them one by one until all are progressively covered; that it builds up its health manpower to carry out first and foremost those priority activities; and that it ensures that its health facilities are geared to the same priorities.

12. Each of your governments could also make sure that every district does its best to take up the slack in the existing health system and to focus resources on targeted priorities. As part of that, the very least you could do, but certainly not the least important in many countries, is to rehabilitate your health institutions. I am referring in particular to the rehabilitation of your health centres and district hospitals so that they become capable functionally and physically of supporting primary health care. To be capable of doing that, they must at least inspire confidence as focal points for health by their appearance and by the way they deal with people; they should certainly not give the impression from their dilapidated state and inefficient management of being focal points for disease. That kind of institutional rehabilitation is certainly eminently suitable for targeted implementation.

13. It goes without saying that manpower rehabilitation is at the very core of institutional rehabilitation. Health personnel can breathe life into bricks and mortar and can convert them into useful health institutions; bricks and mortar alone cannot breathe life into health personnel. They have to be motivated socially so that they want to care for people; and they have

Annex 4

to be provided with the right kind of incentives to work in health centres and district hospitals that are often situated far from their homes, such as bestowing honour on them, providing financial attractions or ensuring adequate educational facilities for their children. All that costs money, so financial rehabilitation of health centres and district hospitals is no less important than physical, managerial and human rehabilitation. In this context I should like to remind you once more of the many untapped resources that could be generated by involving people more deeply in their own health development.

Decisions by governments and people

14. Please note that when I talk of taking decisions I am referring to decisions by governments, by districts, and by people in their communities, not by WHO. It is not for WHO, nor for any external agent for that matter, to decide on behalf of people or governments. It is for them to decide. WHO can help by providing them with the information and generating the skills required to make reasoned decisions, and I think your Organization is now in a very sound position to do that. WHO can cooperate with you in applying that information and using those skills. But it cannot decide for you what your priorities will be. To do that would be United Nations colonialism. Nevertheless, when WHO's Member States have taken collective decisions, as you did with respect to the target of Health for All by the Year 2000 and ways of attaining it - when that has happened you have moral obligations individually and collectively to invest your resources first and foremost in realizing that target. The least you can expect of your Organization is that it should invest its resources in supporting you to do so.

15. I am convinced that we are trying as hard as we can at global and regional levels to do just that. Your Organization in the Region is fully aware of its responsibilities and it has no illusions about the challenges confronting it in trying to support you. Under the leadership of my colleague and friend, Dr Monekosso, your new Regional Director, substantial reorganization of WHO's structures in the Region is taking place. It has one aim, and that is to bring WHO's resources as close to you as possible so that

you can derive most benefit from them. For I am aware, sadly aware, that the direct support your Organization is providing you with in your countries leaves much to be desired. That is where our efforts must now be concentrated. The inertia mentioned in the evaluation of your strategies must become a thing of the past and must give way to a new spirit of dynamic involvement; more than that, to a new spirit of realistic optimism that we will reach our target.

16. We can be an example to all other sectors and can show the way to development through our determination to succeed. In the attempt, do not be afraid to draw on non-Africans if they can be of use to you. You are sufficiently mature now to thwart any form of neocolonialism entering through the back door. I say this as though I was a brother African, because emotionally I feel I am one. I can only repeat what I said to you last year - surely after more than 20 years of progressive decolonization we are sufficiently liberated from historical traumas to work together with others as equal partners, exploiting their experiences to the full. And remember, your Organization stands steadfast with you to make sure that you are not betrayed. We can succeed if we focus all our resources on your defined targets - your national resources, WHO's resources, those of nongovernmental organizations, those of external partners.

Regional programme budget policy

17. That is precisely what the new regional programme budget policy is all about - a policy of targeting resources on health for all. I hope I have been able to get that message across in the guidelines I sent you through your Regional Director. They emphasize investing the Organization's collective resources to trigger off your own resources as well as those of nongovernmental organizations and all external partners in support of your strategies for health for all. If the collective strategy has given rise to national strategies, then surely resources available to the collective strategy should give rise to resources for national strategies. If collective programmes aim at strengthening national ones, then surely the resources of collective programmes should reinforce national programme resources. And if

Annex 4

there are collectively agreed principles for ensuring primary health care that delivers programmes whose technology is appropriate, surely the collective resources for infrastructure development should strengthen national infrastructures based on primary health care. Targeted action programmes for primary health care can concentrate all these resources where they are most needed.

Leadership for health for all

18. Honourable representatives, to set up the kind of primary health care action programmes I have outlined requires leadership and determination. I am not sure which to put first. Leadership can give rise to widespread determination, but widespread determination can also generate leadership. Of one thing I am sure. Leadership is sorely lacking everywhere, not the least in the field of health. I include in leadership the ability to judge wisely, decide firmly and implement vigorously. I started by the need to judge wisely. Otherwise leadership can be dangerous; it can lead in wrong or devious directions. I am convinced that we have provided the world with all the ingredients required to make wise decisions about health development. We are a unique international organization in that respect. These facts alone should excite us to firm decisions and to equally firm resolve to carry them out vigorously despite the obstacles.

19. What are the ingredients I have just mentioned? One is the ethical challenge and philosophy of health for all. Another is the policy and strategy for getting there. Then there is the social contract for health between governments, people and WHO. There is the clear direction of building up infrastructures based on primary health care to deliver programmes that use appropriate technology. And there is the managerial process with its inherent financial planning to create the framework for moulding these ingredients into a variety of coherent national wholes.

20. All that makes WHO the leader in world health. By the same token, by applying all that, each and every one of you in your own country, you will become undisputed health leaders there and you will be able to inspire others to follow in your footsteps. I hope you will pressurize your WHO to help you to develop your leadership qualities for the attainment of health for all.

Annex 4

I hope you will clamour for part of WHO's resources in your country to be devoted to that. I hope that you as a Regional Committee will encourage countries in the Region to devote part of their resources to health-for-all leadership developmnt and that you will make sure that regional resources too are invested in the effort. I shall certainly invest global resources in this initiative.

21. Mr Chairman, honourable representatives, lead your countries towards better health. You can do that by targeting on Health for All by the Year 2000.

ANNEX 5

AGENDA

1. Opening of the thirty-fifth session (document AFR/RC35/1)

2. Adoption of the provisional agenda (document AFR/RC35/11 Rev.1)

3. Constitution of the Sub-Committee on Nominations (resolution AFR/RC23/R1)

4. Election of the Chairman, the Vice-Chairmen and Rapporteurs

5. Appointment of the Sub-Committee on Credentials (resolution AFR/RC25/R17)

6. The work of WHO in the African Region

   6.1 Biennial report of the Regional Director (documents AFR/RC35/3 and AFR/RC35/3 Add.1)

   6.2 Development and coordination of biomedical and health systems research (document AFR/RC35/4)

   6.3 Regional programme budget policy (document AFR/RC35/20)

   6.4 Expanded programme on immunization: mid-Decade evaluation (document AFR/RC35/21)

7. Correlations between the work of the Regional Committee, Executive Board and the World Health Assembly

   7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board: report of the Regional Director (document AFR/RC35/5)

   7.2 Agendas of the seventy-seventh session of the Executive Board and the Thirty-ninth World Health Assembly: regional repercussions (document AFR/RC35/6)

   7.3 Method of work and duration of the World Health Assembly (document AFR/RC35/18)

   7.4 Technical discussions of the Thirty-ninth World Health Assembly (1986): "Intersectoral cooperation and community involvement for national strategies for Health for All by the Year 2000" (document AFR/RC35/19)

8. Report of the Programme Sub-Committee (document AFR/RC35/7)

   8.1 Evaluation of the implementation of the strategies for Health for All by the Year 2000: regional report (document AFR/RC35/12)

Annex 5

8.2 Report on participation by members of the Programme Sub-Committee in meetings of programming interest (document AFR/RC35/8)

8.3 Evaluation of visits by representatives of Member States to other countries of the Region (document AFR/RC35/9)

8.4 Report of the Standing Committee on Technical Cooperation among Developing Countries (document AFR/RC35/10)

8.5 Evaluation of the experiment of using African nationals as WHO Programme Coordinators (document AFR/RC35/22)

9. Technical discussions

9.1 Presentation of the report of the technical discussions: "Health systems research: an instrument for the promotion and development of primary health care" (document AFR/RC35/13)

9.2 Nomination of the Chairman and Alternate Chairman of the technical discussions in 1986 (document AFR/RC35/14)

9.3 Choice of subjects of the technical discussions in 1987 (document AFR/RC35/15)

10. Dates and places of the thirty-sixth and thirty-seventh sessions of the Regional Committee in 1986 and 1987 (document AFR/RC35/16)

11. Adoption of the report of the Regional Committee (document AFR/RC35/17)

12. Closure of the thirty-fifth session.

ANNEX 6

PROVISIONAL AGENDA OF THE THIRTY-SIXTH SESSION OF THE REGIONAL COMMITTEE (as at 11 July 1985)

1. Opening of the thirty-sixth session (document AFR/RC36/1)

2. Adoption of the provisional agenda (document AFR/RC36/11)

3. Constitution of the Sub-Committee on Nominations (resolution AFR/RC23/R1)

4. Election of the Chairman, Vice-Chairmen and the Rapporteurs

5. Appointment of the Sub-Committee on Credentials (resolution AFR/RC25/17)

6. The work of WHO in the African Region

   6.1 Succinct report of the Regional Director (document AFR/RC36/3)

   6.2 Proposed programme budget 1988-1989 (document AFR/RC36/2)

   6.3 Regional programme budget policy (document AFR/RC36/4)

7. Correlations between the work of the Regional Committee, Executive Board and the World Health Assembly

   7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board: report of the Regional Director (document AFR/RC36/5)

   7.2 Agendas of the seventy-ninth session of the Executive Board and the Fortieth session of the World Health Assembly: regional repercussions (document AFR/RC36/6)

   7.3 Method of work and duration of the World Health Assembly (document AFR/RC36/7)

   7.4 Technical discussions at the Fortieth World Health Assembly (1987) (document AFR/RC36/8)

8. Report of the Programme Sub-Committee (document AFR/RC35/9)

   8.1 Eighth General Programme of Work covering the specific period 1990-1995 (document AFR/RC36/10)

   8.2 Report on participation by members of the Programme Sub-Committee in meetings of programming interest (document AFR/RC36/12)

Annex 6

8.3 Evaluation of the visits by representatives of Member States to other countries of the Region (document AFR/RC36/13)

8.4 Report of the Standing Committee on Technical Cooperation among Developing Countries (document AFR/RC36/14)

9. Technical discussions

9.1 Presentation of the report of the technical discussions: "The PHC approach to the promotion and protection of the health of farm workers during the Industrial Development Decade in Africa" (document AFR/RC36/15)

9.2 Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1987 (document AFR/RC36/16)

9.3 Choice of subject of the technical discussions in 1988 (document AFR/RC36/17)

10. Dates and places of the thirty-seventh and thirty-eighth sessions of the Regional Committee in 1986 and 1987 (document AFR/RC36/18)

11. Adoption of the report of the Regional Committee (document AFR/RC36/19)

12. Closure of the thirty-sixth session.

ANNEX/ANNEXE/ANEXO 7

LIST OF PARTICIPANTS
LISTE DES PARTICIPANTS
LISTA DOS PARTICIPANTES

1. REPRESENTATIVES OF MEMBER STATES
REPRESENTANTS DES ETATS MEMBRES
REPRESENTANTES DOS ESTADOS MEMBROS

ALGERIA
ALGERIE
ARGÉLIA

Dr Benadoula Ammar
Ministère de la Santé publique
Chef de délégation

Professeur Mammeri Driss
Ministère de la Santé publique

ANGOLA

Dr Luis Gomes Sambo
Vice Ministro da Saúde
Chefe da delegação

Dr Julio Fernando Leite da Costa
Chefe do Departamento de Higiene e Epidemiologia

Sr Pedro Adão Cahalo
Delegado Provincial de Saúde - Cunene

Sra. Ermelinda Rosário do Nascimento Costa Neto
Chefe do Sector de Cooperação - Ministério da Saúde

Sra. Filomena de Fatima Santana de Sousa
Técnica do Departamento dos Organismos Internacionais

Annex/Annexe/Anexo 7

BENIN
BENIM

M. André Atchadé
Ministre de la Santé publique
Chef de délégation

Dr Lucien Sogansa
Directeur des Etudes et de la Planification

BOTSWANA
BOTSUANA

Hon. P. K. Balopi
Minister of Health
Head of Delegation

Dr J. S. Moeti
Deputy Permanent Secretary/Director of Health Services

Dr E. T. Maganu
Assistant Director Health Services

BURKINA FASO

Dr Ambroise Tiemtore
Chef du Service Entomologie (Surveillance épidémiologique et Vaccinations)

BURUNDI

Dr Paul Mpitabakana
Médecin Inspecteur général de la Santé publique chargé de la
Coordination du Bureau de l'Inspection et de la Planification
Ministère de la Santé publique
Chef de délégation

Dr Cassien Ndikumana
Médecin Directeur général de la Santé publique
Ministère de la Santé publique

M. Anaclet Baza
Pharmacien Inspecteur

Annex/Annexe/Anexo 7

CAMEROON
CAMEROUN
CAMARÕES

Madame Isabelle Bassong
Secrétaire d'Etat à la Santé publique
Chef de délégation

Dr P. C. Mafiamba
Conseiller technique
Ministère de la Santé publique

Dr G. Kesseng Maben
Directeur de la Médecine préventive et de l'Hygiène publique
Ministère de la Santé publique

CAPE VERDE
CAP-VERT
CABO VERDE

Dr João de Deus Lisboa Ramos
Secretário Geral
Ministério da Saúde e dos Assuntos Sociais

CENTRAL AFRICAN REPUBLIC
REPUBLIQUE CENTRAFRICAINE
REPÚBLICA CENTRAFRICANA

M. G. D. Moussa-Labe
Secrétaire général
Ministère de la Santé publique et des Affaires sociales
Chef de délégation

Dr Victor Mbarindi
Directeur général de la Santé publique
Ministère de la Santé publique

Annex/Annexe/Anexo 7

CHAD
TCHAD
CHADE

M. Haroun Gody
Secrétaire d'Etat à la Santé publique
Chef de délégation

Dr M. Mahouri Yankalbe Paboung
Directeur général de la Santé publique

COMOROS
COMORES

Dr M. Velo Marcel
Adjoint technique à la Direction générale de la Santé

CONGO

Prof. C. Bouramoué
Ministre de la Santé publique
Chef de délégation

Dr Alphonse Gando
Directeur général de la Santé publique

Dr E. Mbaloula
Attaché au Cabinet du Chef de l'Etat

Mlle C. Samba-Dehlot
Chef de Service des projets SSP

EQUATORIAL GUINEA
GUINEE EQUATORIALE
GUINE EQUATORIAL

M. Benjamin Mba Ecua Mico
Ministro de Sanidad
Chef de délégation

Annex/Annexe/Anexo 7

ETHIOPIA
ETHIOPIE
ETIÓPIA

Dr T. Tokon
Head, Health Services
Ministry of Health
Head of Delegation

Mr Bona Hora
Head, EPI and General Prophylaxis Division
Ministry of Health

Mr Tena Fikru
Head of Manpower Development Planning
Ministry of Health

GABON
GABÃO

Dr Louis Adandé Menest
Inspecteur général de la Santé publique
Ministère de la Santé publique et de la Population

M. Martial Mboumba
Directeur général de la Santé publique
Ministère de la Santé publique et de la Population

GHANA
GANA

Dr (Mrs) Mary S. Grant
Deputy Secretary
Ministry of Health
Head of delegation

Dr Joseph Dawson Otoo
Director of Medical Services
Ministry of Health

Annex/Annexe/Anexo 7

GUINEA
GUINEE
GUINÉ

Professeur Mamadou Kaba Bah
Ministre de la Santé publique et de la Population
Chef de délégation

Dr Mohamed Sylla
Directeur du CHU de Donka
Ministère de la Santé et de la Population

GUINEA-BISSAU
GUINEE-BISSAU
GUINÉ-BISSAU

Sr. Alexandre Nunes Correia
Ministro da Saúde
Chefe da delegação

Dr Celestino Maria Mendes da Costa
Director Regional da Saúde da Fata

Dr Domingos Fernandes Gomes
Director Clínico do Hospital Nacional de Bissau

Dr José Carlos Gonçalves
Director da Maternidade do "Hospital Nacional Simão Mendes

IVORY COAST
COTE D'IVOIRE
COSTA DO MARFIM

Dr A. B. Bella
Directeur des Relations régionales et internationales
Chef de délégation

Professeur K. G. Guessennd
Directeur de la Santé publique et de la Population

Dr Ibrahim Kone
Directeur de l'Institut d'Hygiène

Annex/Annexe/Anexo 7

KENYA
QUÉNIA

Hon. P. C. J. O. Nyakiamo
Minister for Health
Head of Delegation

His Excellency Mr A. Machayo
High Commissioner of the Republic of Kenya to Zambia
P. O. Box 50298
Lusaka
Zambia

Mr S. Shitemi
Permanent Secretary
Ministry of Health

Dr W. Koinange
Director of Medical Services

Dr J. Otete
Senior Deputy Director of Medical Services

Miss Mary N. Kamau
Nursing Officer in charge Wakuru

Miss Emma Murai
Kenya High Commission
P. O. Box 50298
Lusaka
Zambia

LESOTHO
LESOTO

Mr V. T. Ndobe
Principal Secretary for Health
Head of delegation

Dr (Mrs) A. P. Maruping
Director of Health Services
Ministry of Health

Mrs A. M. Ntholi
Senior Administrative Secretary
Ministry of Health

Annex/Annexe/Anexo 7

LIBERIA

Hon. Martha K. Belleh
Minister of Health
Head of delegation

Dr Andrew Cole
Country Medical Director

Dr A. Hanson
Director, Liberian Institute for Biomedical Research

MADAGASCAR

Professeur E. Andriamampihantona
Secrétaire général
Ministère de la Santé
Chef de délégation

M. Paul André Tsilanizara
Conseiller technique
Ministère de la Santé

MALAWI
MALAUI

Hon. D. S. Katopola
Minister of Health
Head of delegation

Mr A. N. C. Chadzala
Deputy Secretary
Ministry of Health

Dr G. W. Lungu
Deputy Chief Medical Officer
Ministry of Health

Miss L. Kadzamira
Chief Nursing Officer
Ministry of Health

Annex/Annexe/Anexo 7

MALI

Professeur Mamadou Dembele
Ministre de la Santé et des Affaires sociales
Chef de délégation

Dr Gaoussou Traore
Directeur national de la Santé publique
Ministère de la Santé publique

M. Mamadou Konate
Directeur national des Affaires sociales

Dr Cisse Boubacar
Chef de la Division Biologie clinique INRSP

MAURITANIA
MAURITANIE
MAURITÂNIA

M. Hamdi Diop
Ministre de la Santé et des Affaires sociales
Chef de délégation

Dr Mohamed Saleh
Directeur adjoint de la Santé
Ministère de la Santé et des Affaires sociales

MAURITIUS
MAURICE
ILHA MAURÍCIA

Mr D. Ramyead
Permanent Secretary
Ministry of Health
Head of delegation

Annex/Annexe/Anexo 7

MOZAMBIQUE
MOÇAMBIQUE

Dr Pascoal Mucumbi
Ministro da Saúde
Chefe de delegação

Sr Ernesto Vasquez de Lisboa
Chief of the Department of Administration
and Management of Personnel

Sr Alberto Sitoe
Director Provincial de Saúde - Tete

Sr Jorge Fernando Manuel Tomo
Coordinator of the Department of International Cooperation

NIGER

Dr Magagi Daga
Secrétaire général du Ministère de la Santé et des Affaires sociales

NIGERIA

Dr E. A. Smith
Director of Public Health Services
Head of Delegation

Dr A. D. Kolawole
Chief Coordinator - Primary Health Care

Mr B. I. Olinmah
Principal Secretary (State and External Relations)
Federal Ministry of Health

Annex/Annexe/Anexo 7

RWANDA
RUANDA

Dr François Muganza
Ministre de la Santé publique et des Affaires sociales
Chef de délégation

Dr Jean Baptiste Kanyamupira
Directeur général de la Santé publique

Dr Martin Ngabonziza
Directeur de la Région sanitaire de Kibuye

SAO TOME AND PRINCIPE
SAO TOME ET PRINCIPE
SÃO TOME E PRÍNCIPE

Dr Frederico J. H. Sequeira
Ministro da Saúde e Desporto
Chefe da delegação

Dr A. Soares Marques de Lima
Director de Assistência Médica

SENEGAL

M. Mamadou Guèye Lo
Conseiller technique
Ministère de la Santé publique

Professeur Doudou Ba
Directeur de la Recherche, de la Planification et de la Formation

M. C. Fall
Député-Maire, Assemblée nationale

Annex/Annexe/Anexo 7

SEYCHELLES
ILHAS SEYCHELLES

Dr Conrad Shamlaye
Epidemiologist
Ministry of Health
Head of delegation

Mrs Patricia D. Revera
Senior Assistant Secretary
Ministry of Health

SIERRA LEONE
SERRA LEOA

Hon. A. B. Kamara
Minister of Health
Head of Delegation

Mr D. Q. B. Kamara
Permanent Secretary
Ministry of Health

Dr (Mrs) Moira M. Brown
Deputy Chief Medical Officer

SWAZILAND
SOUAZILAND
SUAZILÂNDIA

Mr H. B. Malaza
Acting Principal Secretary
Ministry of Health
Head of Delegation

Dr (Mrs) R. T. Tshabalala
Deputy Director of Health Services
Ministry of Health

Annex/Annexe/Anexo 7

TOGO

Professeur Aissah Agbetra
Ministre de la Santé publique,
des Affaires sociales et de la Condition féminine
Chef de délégation

Dr Bakélé T. Barandao
Directeur général adjoint de la Santé publique

Dr Essosolem Batchassi
Médecin-Chef de la Subdivision sanitaire de Kozah

UGANDA
OUGANDA

Dr S. Etyono
Director of Medical Services
Head of delegation

Dr I. S. Okware
Assistant Director of Medical Services/Public Health
Ministry of Health

Dr J. H. Kyabaggu
Assistant Director of Medical Services
Ministry of Health

Mr M. A. Nyeko
Economist/Health
Ministry of Planning and Economic Development
P. O. Box 7086
Kampala

UNITED REPUBLIC OF TANZANIA
REPUBLIQUE UNIE DE TANZANIE
TANZÂNIA

Hon. M. M. Abdullah
Minister of Health
Head of delegation

Dr A. Y. Mgeni
Director, Preventive Health Division
Ministry of Health

Mr S. S. Said
Ministry of Health Coordinator - Pemba

Annex/Annexe/Anexo 7

ZAIRE

S. E. M. Atenda Mongebe Omwango
Ambassadeur de la République du Zaire à Lusaka
Chef de délégation

Dr Kapata Luvivila
Directeur des Soins de Santé primaires

M. Mwamba Mulunda Munonga
Conseiller principal au Département de la Santé publique

M. Masheda Belesi
Conseiller à l'Ambassade du Zaire à Lusaka

ZAMBIA
ZAMBIE

Hon. C. M. Mwananshiku, MP
Minister of Health
Head of delegation

Hon. P. Chanshi, MP
Minister of State
Deputy Head of delegation

Mr E. H. Himunyanga
Permanent Secretary

Dr E. K. Njelesani
Director of Medical Services

Dr S. L. Nyaywa
Assistant Director of Medical Services (PHC)

Dr G. K. Bolla
Assistant Director of Medical Services (A)

Dr H. B. Himonga
Senior Epidemiologist

Dr P. M. A. Chikusu
Director of Pharmaceutical Services

Mrs H. K. Matanda
Chief Nursing Officer

Annex/Annexe/Anexo 7

Dr K. Mukelabai
Dean, School of Medicine
University of Zambia

Dr M. Mukunyandela
Director, Tropical Diseases Research Centre

Dr R. S. Patel
Primary Health Care Specialist

Dr D. I. Inambao
Malariologist/Epidemiologist

Mr M. Musambo
Health Planner

Dr G. M. Kabwe
Provincial Medical Officer

Dr J. Mbomena
Provincial Medical Officer

Miss J. E. Daka
Registrar, General Nursing Council of Zambia

Dr S. S. Mundia
Chairman, Medical Council of Zambia

Mr P. C. Mphande
Principal, Chainama College of Health Sciences

Dr L. Chiwele
Executive Director
University Teaching Hospital

Dr V. R. Chelemu
Director, Flying Doctor Service

Dr G. M. Mhango
Acting Director, Pneumoconiosis Medical and Research Bureau

Brig. Gen. J. Manuele
Director General of Medical Services
Defence Force

Dr J. Cairns
Chairman, Churches Medical Association of Zambia

Dr D. J. Buchanan
Medical Services Adviser, ZCCM

Annex/Annexe/Anexo 7

ZIMBABWE
ZIMBABUE

Dr S. T. Sekeramayi
Minister of Health
Head of Delegation

Dr D. G. Makuto
Deputy Secretary for Health

2. REPRESENTATIVE OF AN ASSOCIATE MEMBER
REPRESENTANT D'UN MEMBRE ASSOCIE
REPRESENTANTE DE UM MEMBRO ASSOCIADO

NAMIBIA
NAMIBIE

Dr (Mrs) N. Mthoko
SWAPO
P. O. Box 30577
Lusaka
Zambia

3. OBSERVERS INVITED IN ACCORDANCE WITH RESOLUTION WHA27.37
OBSERVATEURS INVITES CONFORMEMENT A LA RESOLUTION WHA27.37
OBSERVADORES CONVIDADOS EM CONFORMIDADE COM A RESOLUCÃO WHA27.37

African National Congress (ANC)
Congrès national africain
Congresso Nacional Africano

Dr Peter L. Mfelang
Secretary for Health
P. O. Box 31791
Lusaka
Zambia

Annex/Annexe/Anexo 7

Pan-Africanist Congress of Azania (PAC)
Congrès panafricain d'Azanie
Congresso Pan-Africano da Azania

Mrs Patricia Moeti
Coordinator of Education and Health
PAC External Headquarters
P. O. Box 2412
Dar es Salaam
United Republic of Tanzania

4. REPRESENTATIVES OF THE UNITED NATIONS AND SPECIALIZED AGENCIES
REPRESENTANTS DES NATIONS UNIES ET DES INSTITUTIONS SPECIALISEES
REPRESENTANTES DAS NAÇÕES UNIDAS E SUAS INSTITUIÇÕES ESPECIALIZADAS

International Labour Organization
Organisation internationale du Travail
Organização Internacional do Trabalho

Dr A. Bakri
Deputy Director
ILO
P. O. Box 32181
Lusaka
Zambia

Food and Agriculture Organization of the United Nations (FAO)
Organisation des Nations Unies pour l'Alimentation et l'Agriculture (FAO)
Organização das Nações Unidas para a Alimentação e a Agricultura (FAO)

Dr E. O. Idusogie
FAO Regional Food Policy and Nutrition Officer
P. O. Box 1628
Accra
Ghana

Annex/Annexe/Anexo 7

United Nations Development Programme (UNDP)
Programme des Nations Unies pour le Développement (PNUD)
Programa das Nações Unidas para a Desenvolvimento (PNUD)

Mr D. Dragic
UNDP Resident Representative
P. O. Box 31966
Lusaka
Zambia

United Nations Children's Fund (UNICEF)
Fonds des Nations Unies pour l'Enfance (FISE)
Fundo das Nações Unidas para a Infância (UNICEF)

Mr H. N. Siulanda
Programme Officer (PHC)
UNICEF
P.O. Box 33610
Lusaka
Zambia

United Nations High Commissioner for Refugees (UNHCR)
Haut-Commissariat des Nations Unies pour les Réfugiés (HCNUR)
Alto Comissariado das Nações Unidas para os Refugiados

Mr A. B. M. Saied
UNHCR Representative
P. O. Box 32542
Lusaka
Zambia

Miss A. Wurie
Social Services Officer
UNHCR
P. O. Box 32542
Lusaka
Zambia

United Nations Industrial Development Organization (UNIDO)
Organisation des Nations Unies pour le Développement industriel (ONUDI)
Organização das Nações Unidas para o Desenvolvimento Industrial (ONUDI)

Mr G. Bekele
Senior Industrial Development Field Adviser
c/o UNDP
P. O. Box 31966
Lusaka
Zambia

Annex/Annexe/Anexo 7

UN Economic Commission for Africa
Commission économique pour l'Afrique
Comissão Económica para a África

Mr J. Babileh
Director
ECA
P. O. Box 30647
Lusaka
Zambia

Mr K. N. Kinsondiza
ECA
P. O. Box 30647
Lusaka
Zambia

5. REPRESENTATIVES OF OTHER INTERGOVERNMENTAL ORGANIZATIONS
REPRESENTANTS D'AUTRES ORGANISATIONS INTERGOUVERNEMENTALES
REPRESENTANTES DE OUTRAS ORGANIZAÇÕES INTERGOVERNAMENTAIS

Organization of African Unity (OAU)
Organisation de l'Unité africaine (OUA)
Organização da Unidade Africana (OUA)

Dr Amin H. Salama
Director, OAU Health Bureau
P. O. Box 3243
Addis Ababa
Ethiopia

Organization for Coordination in the Control of Endemic Disease in Central Africa
Organisation de Coordination pour la Lutte contre les Endémies en Afrique centrale (OCEAC)
Organização de Coordenação para o Combate às Endemias na África Central (OCEAC)

Dr D. Kouka-Bemba
Secrétaire général
OCEAC
B. P. 288
Yaoundé
Cameroun

Annex/Annexe/Anexo 7

African and Malagasy Council on Higher Education
Conseil africain et malgache pour l'Enseignement supérieur (CAMES)
Conselho Africano e Malgaxe para o Ensino Superior (CAMES)

Professeur K. K. E. Nathaniels
Secrétaire général
CAMES
B.P. 134
Ouagadougou
Burkina Faso

Commonwealth Regional Health Secretariat
Secrétariat sanitaire régional du Commonwealth
Secretariado Regional do Commonwealth para a Saúde

Mrs Rosalie M. Kakande
P. O. Box 1009
Arusha
Tanzania

6. REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS
REPRESENTANTS DES ORGANISATIONS NON-GOUVERNEMENTALES
REPRESENTANTES DE ORGANIZAÇÕES NÃO-GOVERNAMENTAIS

International Planned Parenthood Federation (IPPF)
Fédération internationale pour la Planification familiale
Federação Internacional para o Planeamento Familiar (FIPF)

Dr Nimrod A. Mandara
Programme Officer (Medical)
IPPF Field Office
P. O. Box 30234
Nairobi
Kenya

International Committee of Catholic Nurses and Medico-social Assistants
Comité international catholique des Infirmières et Assistantes médico-sociales
Comité Internacional das Enfermeiras e Assistentes Medico-Sociais Católicas

Mrs M. L. Siwale
P. O. Box 31820
Lusaka
Zambia

Annex/Annexe/Anexo 7

World Federation for Mental Health
Fédération mondiale pour la Santé mentale
Federação Mundial de Saúde Mental

Mr I. K. Mwendapole
P. O. Box 50209
Lusaka
Zambia

World Psychiatric Association (WPA)
Association mondiale de Psychiatrie
Associação Mundial de Psiquiatria

Dr (Mrs) B. C. A. Johnson
Medical Director, Chief Consultant i/c
Psychiatric Hospital, Yaba
P. O. Box 726
Lagos
Nigeria

7. OBSERVERS
OBSERVATEURS
OBSERVADORES

International Federation of Pharmaceutical Manufacturers Association (IFPMA)
Fédération internationale de l'Industrie du Médicament (FIIM)
Federação Internacional da Industria Farmacêutica

Mr C. M. Pintaud
Deputy Member of the Board of Management of Sandoz Limited
Leimenstrasse 6
4051 Basle
Switzerland

Pan-African Institute for Development
Institut panafricain de Développement
Instituto Pan-Africano para o Desenvolvimento

Mr A. L. Hagan
Pan-African Institute for Development
P. O. Box 80448
Kabwe
Zambia

Annex/Annexe/Anexo 7

Office de la Recherche scientifique
et technique d'Outre-Mer (ORSTOM)
Instituto Ultramarino de Investigação Científica e Técnica

Dr J. L. Frezil
Directeur de l'ORSTOM au Congo
B.P. 181
Brazzaville
Congo

International Baby Food Action Network (IBFAN)
Réseau d'action international concernant l'Alimentation des nourrissons
Rede de Acção Internacional de Alimentos para Lactentes

Mrs M. I. Kyenkya
IBFAN Regional Representative
P. O. Box 34308
Nairobi
Kenya

Mrs Juliet Manda
Breastfeeding Association of Zambia
c/o Pamodzi Hotel Clinic
P. O. Box 35450
Lusaka
Zambia

Mrs A. P. Phiri
P. O. Box 35450
Lusaka
Zambia

Pan-African News Agency
Agence panafricaine de l'Information
Agência Pan-Africana de Informação

Mr D. K. Afreh
Consultant/Regional Representative
Pan-African News Agency
B.P. 4056
Dakar
Sénégal

International Office of Epizootics
Bureau international d'Epizooties
Agência Internacional de Epizootias

Dr G. C. N. Zyambo
Director of Veterinary Services
P. O. Box 50060
Lusaka
Zambia

Annex/Annexe/Anexo 7

West African Health Community (WAHC)
Communauté sanitaire d'Afrique occidentale
Comunidade Sanitária da África Ocidental

Dr H. K. Menokpor
Deputy Executive Director
West African Health Community
P.M.B. 2023
Yaba
Lagos
Nigeria

ANNEX 8

LIST OF DOCUMENTS

AFR/RC35/1	-	Opening of the thirty-fifth session
AFR/RC35/3	-	Biennial report of the Regional Director
AFR/RC35/3 Add.1	-	New structure of the Regional Office: Organizational charts
AFR/RC35/4	-	Development and coordination of biomedical and health systems research
AFR/RC35/5	-	Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board: report of the Regional Director
AFR/RC35/6	-	Agendas of the seventy-seventh session of the Executive Board and the Thirty-ninth World Health Assembly: regional repercussions
AFR/RC35/7	-	Report of the Programme Sub-Committee
AFR/RC35/8	-	Report on participation by members of the Programme Sub-Committee in meetings of programming interest
AFR/RC35/9	-	Evaluation of visits by representatives of Member States to other countries of the Region
AFR/RC35/10	-	Report of the Standing Committee on Technical Cooperation among Developing Countries
AFR/RC35/11 Rev.1	-	Agenda
AFR/RC35/12	-	Evaluation of the implementation of the strategies for Health for All by the Year 2000: regional report
AFR/RC35/13	-	Report of the technical discussions: "Health systems research: an instrument for the promotion and development of primary health care"
AFR/RC35/14	-	Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1986
AFR/RC35/15	-	Choice of subject of the technical discussions in 1987
AFR/RC35/15 Add.1	-	Choice of subject for the technical discussions in 1987: Suggestions to speed up the implementation of PHC to attain the social goal of health for all in the African Region of WHO
AFR/RC35/16 Rev.1 and corrigendum	-	Dates and places of the thirty-sixth and thirty-seventh sessions of the Regional Committee in 1986 and 1987

Annex 8

AFR/RC35/17	- Report of the Regional Committee
AFR/RC35/18 Rev.1	- Method of work and duration of the World Health Assembly
AFR/RC35/19	- Technical discussions of the Thirty-ninth World Health Assembly (1986): "Intersectoral cooperation and community involvement for national strategies for Health for All by the Year 2000"
AFR/RC35/20	- Regional programme budget policy
AFR/RC35/21	- Expanded programme on immunization: mid-decade evaluation
AFR/RC35/22 & corrigendum	- Evaluation of the experiment of using African nationals as WHO Programme Coordinators
AFR/RC35/23	- Provisional programme of work of the Programme Sub-Committee
AFR/RC35/24	- Distribution by countries of functions during preceding Regional Committees
AFR/RC35/25	- List of participants
AFR/RC35/TD/1	- Technical discussions: "Health systems research: an instrument for the promotion and development of primary health care"
AFR/RC35/TD/2	- Presentation of the document on technical discussions
AFR/RC35/Conf.Doc/1	- Opening address by Mr D. S. Katopola, Minister of Health of the Republic of Malawi
AFR/RC35/Conf.Doc/2	- Address of Dr G. L. Monekosso, Regional Director, at the opening of the thirty-fifth session of the Regional Committee for Africa
AFR/RC35/Conf.Doc/3	- Opening speech delivered by His Excellency the President of the Republic of Zambia, Dr K. D. Kaunda
AFR/RC35/Conf.Doc/4	- Address by Dr H. Mahler, Director-General of the World Health Organization
AFR/RC35/WP/01	- Sub-Committee on Nominations
AFR/RC35/SSC/1	- Sub-Committee on Credentials
AFR/RC35/SSC/2 & 3	- Reports of the Sub-Committee on Credentials

(AFR/RC35/7) ANNEX 9

REPORT OF THE PROGRAMME SUB-COMMITTEE

INTRODUCTION

1. The Programme Sub-Committee met in Lusaka on 9 and 10 September 1985 under the chairmanship of Dr T. Tokon (Ethiopia), who had been elected at the Sub-Committee's meeting on 19 September 1984 in Brazzaville. The list of participants will be found in Appendix 1.

2. In his opening address the Chairman, after welcoming the participants, congratulated Dr G. L. Monekosso on his appointment as WHO Regional Director for Africa. He assured him of the Member States' determination to collaborate closely with him in order to give concrete expression to national and regional strategies for Health for All by the Year 2000 (HFA/2000). He thanked the Government of Zambia for the warm welcome given to the delegates and Secretariat. He went on to emphasize the importance of the Sub-Committee's work in view of the documents submitted for its consideration.

3. The programme of work adopted by the Programme Sub-Committee will be found in Appendix 2.

EVALUATION OF THE IMPLEMENTATION OF STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000: REGIONAL REPORT

Introduction

4. Dr J. C. Alary introduced document AFR/RC35/12: "Evaluation of the implementation of the strategies for Health for All by the Year 2000".

5. In 1982 the Thirty-fifth World Health Assembly approved the plan of action for implementing the strategy for HFA/2000. The plan was adopted the same year by the Regional Committee for Africa[1] at its thirty-second session.

---

[1] Resolution AFR/RC32/R7.

Annex 9

6. In compliance with that plan of action, the first progress report on the monitoring of the implementation of the regional strategy for HFA/2000 was reviewed at the thirty-third session of the Regional Committee in September 1983.

7. The experience of that first stage provided the basis for development of a common framework and format for the preparation of the evaluation report. That framework was studied in depth by the WHO Programme Coordinators/Representatives at the Eighth Regional Programme Meeting (RPM.8) in February 1984, so that they would be able to give the necessary support to their national authorities in the evaluation of their national strategies.

8. Preparations also included the organization of six subregional workshops in June and October 1984 for high-level national officials, WHO Programme Coordinators, staff from the Regional Office and a number of WHO staff members in the countries. Nine carefully selected countries presented their experience of the use of this framework at the thirty-fourth session of the Regional Committee in September 1984.

9. By the target date of 31 March 1985, 39 of the 43 Member States had sent their contribution to the Regional Office, which was a considerable improvement on the 32 contributions submitted by the same date the year before for the preparation of the previous report.

10. The evaluation report follows the format adopted for use by all the Regions so as to facilitate the preparation of the global report by Headquarters.

The effects of the political, social and economic situation on the health of the peoples of the African Region

11. Health development in Africa is being hampered by the worldwide climate of insecurity coupled with the Region's own political, economic and social problems: political instability, natural disasters, apartheid, the nuclear threat, etc.

Annex 9

Population trends

12. The African Region is characterized by: (i) a large number of countries with small populations (only eight countries have more than 10 million inhabitants while 18 have less than two million); (ii) an annual population growth rate of approximately 3%; (iii) a pyramidal age structure with 45% of the population under 15 years, and (iv) on average 26% of the population live in urban areas.

Economic and social trends

13. Some 75% of the population of Africa live in rural areas, with a subsistence economy. Food production is becoming inadequate and international solidarity cannot solve the problem in the long term.

14. Adult literacy rates vary from one country to another, ranging from 10 to 80%, and the food and nutrition situation in the Region continues to cause considerable concern, despite the fact that the joint activities of agencies in the United Nations system are being strengthened.

15. There are many obstacles to intersectoral cooperation in the Region, including a shortage of trained personnel and cumbersome bureaucratic procedures.

Health systems development

16. The main developments in regard to health policies and strategies indicate commitment by all countries of the Region to the objective of health for all. Nevertheless, it is difficult to identify the manner in which that commitment has been translated into concrete terms. Improved benefits to the most deprived groups have been noted, but such efforts on the whole are still limited and are subject to material, financial and human constraints.

Annex 9

17. The organization of health systems based on primary health care shows that PHC concept has been adopted by all countries. It is difficult to assess health coverage in respect of the various PHC components in many countries, due to lack of usable data.

18. All the countries are aware of the need to develop a permanent and systematic managerial process for health development, yet few of them are satisfied with the operation of their existing managerial process.

19. All countries acknowledge the need to develop legislative support, particularly in the following areas: (i) training of community health workers; (ii) drug legislation, and (iii) regulations governing traditional medicine. However, only five countries have undertaken revision of their health legislation.

20. Community involvement: all countries agree on the need for community involvement in decision-making. There are as yet few instances of meaningful delegation of responsibility and decentralization of resources, yet all countries have taken (or intend to take) steps to develop community involvement in health matters.

21. Health personnel: this section emphasizes the fundamental importance of training all health personnel in PHC in order to implement the national strategies for HFA/2000. All the countries have prepared a plan for health manpower development (or intend to do so); but these plans often provide no more than an estimate of future staff training requirements.

22. The mobilization of resources remains one of the main concerns of the countries of the Region, since current resources for health systems are limited. The countries are not easily able to provide national values for global indicators 3, 4 and 6.

Annex 9

23. The development of health care delivery does not provide a quantitative estimate of the efficacy of strategy implementation, although the countries do indicate, in varying degrees, the results obtained.

24. Health research: Member States will have to make a very great effort to set up the national research and development mechanisms which are part of their strategy, despite funding constraints, shortage of trained manpower and lack of motivation and incentives for this type of activity.

25. Coordination within the health sector and with other sectors: intrasectoral and intersectoral coordinating committees have been set up in some countries, but their suggestions have not been put into effect.

26. Intercountry cooperation is regarded by all the countries as one of the most important means for achieving regional self-reliance, yet TCDC is seriously hampered by economic difficulties and uncertainty.

27. WHO cooperation was appreciated during the implementation and evaluation of national strategies. All of the countries acknowledge the fact that they have requested and obtained WHO's support in preparing, implementing and evaluating their national strategies.

Health situation: structures and trends

28. The main causes of morbidity are infectious and parasitic diseases, including malaria, measles and intestinal infections.

29. More than 60% of deaths occur among young people under 15, as against 3% in the industrialized nations. The infant mortality rate is higher than 200 per thousand. Similarly, 37 of the 39 countries give figures of less than 60 years for life expectancy at birth.

Annex 9

30. The Member States do not at present feel able to make objective measurements of the changes that have taken place in terms of morbidity and mortality.

31. The study of health behaviour patterns shows that breastfeeding is declining, while alcohol and drug abuse is on the increase.

32. The predominant environmental problems are the rapid industrialization taking place in some countries of the Region, and above all, natural disasters, including drought, desertification, and so forth.

33. All the trends identified above have implications for economic and social policies. Strategies must accordingly focus on four major areas: (i) population and development; (ii) urban development and migration; (iii) women and development, and (iv) morbidity and mortality.

Evaluation of results

34. It is difficult to evaluate efficacy and impact in view of the lack of sufficient data relating to indicators of community health status and the socioeconomic situation. However, the main achievements reported relate to communicable disease control.

35. Assessment of results attained: the countries in general feel "reasonably satisfied" with the main components of their strategy.

Future prospects

36. The main lines of approach identified by the evaluation mean that country activities may be directed towards: (i) adjustment of strategy and formulation or reformulation of a national plan of action; (ii) development of information support; (iii) planning of overall health manpower development; (iv) improvement of mechanisms for community participation; (v) effective implementation of intra- and intersectoral coordination mechanisms, and (vi) mobilization and rational utilization of resources.

Annex 9

37. The mobilization and rational utilization of resources remains the crucial point. It is essential that the countries: (i) do not delay in calculating the approximate level of funds required to implement their strategy; (ii) identify activities which can be funded from external sources, and (iii) prepare a master plan covering the use of all funding and material resources, including external grants and loans.

Discussion

38. The members of the Sub-Committee expressed their general agreement with the document.

39. The Sub-Committee noted that it was difficult for countries especially those in which all the health system is oriented towards PHC (e.g. Zimbabwe) to calculate national expenditure for primary health care in terms of global indicator No. 4, which needed to be refined.

40. The Sub-Committee noted that health manpower planning was inadequate and should not be limited to future projections of training requirements. Countries should take account of the specific needs of their populations so that health personnel could form an integral part of the health infrastructure. The cooperation of the other ministries involved, such as the ministries of labour and education, is needed in order to fulfil the specific requirements of the health system so that the right members of every kind of health personnel required for PHC are available when and where they are needed.

41. The members of the Sub-Committee agreed on the importance of technical cooperation among the countries of Africa. They expressed regret that the recommendations were merely declarations of intent, which did not result in practice in the pooling of development resources.

42. With regard to mortality rates and birth rates, the members of the Sub-Committee regretted that diarrhoeal diseases were included under the heading of intestinal diseases, in view of their important place among the diseases of the African Region.

Annex 9

43. The Sub-Comittee endorsed the five proposals of the AACHD:

Translation of national strategies into specific plans of action

43.1 Member States must have the support of WHO, with emphasis on the legislative, administrative and managerial aspects.

Improvement of intersectoral coordination

43.2 Countries must find adequate means of communication at the central level between the health sector and the other sectors involved, in order to meet the needs of the operational and functional structures at the peripheral level. The following measures may prove especially effective: (i) the establishment of multidisciplinary teams for development; (ii) decentralization of the planning and implementation of health and health-related programmes; (iii) coordination of international agencies' activities in support of countries.

Assessment of needs for the implementation of strategies

43.3 The economic recession is exacerbating the shortage of resources in the health sector. Governments should therefore encourage all sectors to participate in PHC activities and should ensure that there is coordination between them. With the support of WHO, they must identify the needs for implementing their strategies so as to mobilize external, financial and material resources.

Strengthening of the managerial process for national health development

43.4 There must be continuous training in the management process in countries in order to avoid a brain-drain. To strengthen this process, use should be made of: (i) national experts, and (ii) WHO staff, and there should be better circulation of information to the different levels of the health system.

Annex 9

Refinement of the 12 global indicators

43.5 Member States must review and/or refine the indicators so as to respond to their countries' needs. They must also identify the indicators best suited to their situation as developing countries, in order to monitor and evaluate the implementation of their national strategies.

44. The Programme Sub-Committee proposed to the Regional Committee the adoption of a draft resoslution.

REPORT ON PARTICIPATION BY MEMBERS OF THE PROGRAMME SUB-COMMITTEE IN MEETINGS OF PROGRAMMING INTEREST

45. The report on participation by members of the Programme Sub-Committee in meetings of programming interest (document AFR/RC35/8) was introduced by Dr S. Diop. Participation by members of the Programme Sub-Committee in meetings was the subject of Decision 8 taken by the Regional Committee for Africa in September 1980, at its thirtieth session.

46. At its meeting on 19 September 1984 in Brazzaville (People's Republic of the Congo), the Programme Sub-Committee decided to send representatives to three meetings of programming interest: (i) the seventh session of the African Advisory Committee on Medical Research (AACMR); (ii) the eighth meeting of the Standing Committee on Technical Cooperation among Developing Countries (TCDC), and (iii) the fifth meeting of the African Advisory Committee for Health Development (AACHD).

Seventh session of the African Advisory Committee on Medical Research (AACMR)

47. The Programme Sub-Committee considered the conclusions and proposals of the seventh session which was held in Antananarivo (Democratic Republic of Madagascar) from 15 to 19 April 1985.

48. The members of the Sub-Committee noted with satisfaction:

Annex 9

(i) the relevance of the regional research programme;

(ii) programme support for priority sectors;

(iii) programme support for the devlopment of self-reliance in relation to research.

49. The members of the Sub-Committee also noted that the major obstacle to the development of this programme in the Region was the lack of national research policy, and felt that national research capabilties should be strengthened through training.

Eighth meeting of the Standing Committee on Technical Cooperation among Developing Countries (TCDC)

50. The members of the Programme Sub-Committee endorsed the recommendations of the eighth meeting of the Standing Committee on Technical Cooperation among Developing Countries which appear in document AFR/RC35/10.

Fifth meeting of the African Advisory Committee for Health Development (AACHD)

51. The members of the Programme Sub-Committee took an active part in the discussions at the fifth meeting of the African Advisory Committee for Health Development and approved the conclusions and proposals concerning the following topics:

(i) regional evaluation report on implementation of strategies for health for all;

(ii) expanded programme on immunization in the African Region;

(iii) new structure of the Regional Office and guiding principles for health development centres.

52. The Sub-Committee proposed to the Regional Committee the adoption of a draft resolution.

Annex 9

VISITS BY REPRESENTATIVES OF MEMBER STATES TO OTHER COUNTRIES OF THE REGION

53. Dr S. Diop introduced document AFR/RC35/9.

54. At its thirtieth session in 1980, the Regional Committee adopted, by Decision 9, the principle that two officials from each country of a TCDC Sub-Region should visit two countries in the other Sub-Regions. It also adopted a five-year plan of visits (1980-1985).

55. In 1983 the Committee invited the Regional Director to carry out an evaluation of the results of the implementation of the plan for 1980-1985, and particularly its impact in relation to TCDC.

56. The 1980-1985 plan of visits was carried out with the flexibility recommended by the Regional Committee. By 17 August 1985, 42 of the planned 45 visits had been made, so that the plan had been fulfilled to a level of 93%.

57. The programme of visits was evaluated in respect of: (i) the adequacy of the programme; (ii) efficiency; (iii) efficacy, and (iv) impact.

58. The study of adequacy proved that communication problems had made it impossible to organize a rational programme of visits. Furthermore, the reports were not homogeneous in their presentation and most of them were not submitted within the required time limits. Finally, the representatives of the Member States were not always selected from among officials at decision-making level.

59. Efficiency: the cost of implementing the plan of visits was approximately US $3700 per visitor.

Annex 9

60. Efficacy: 85% of the visitors considered that the visits were beneficial to the host countries because they had resulted in useful exchange of experience.

61. Impact: there was some modification of the manner in which PHC implementation is viewed in the visitors' home countries.

Discussions

62. The Sub-Committee pointed out that the conclusions of the programme evaluation were not altogether clear, particularly in regard to efficiency. The programme of visits does not appear to be as effective as anticipated; no effects of the visits at country level have been demonstrated, although the participants expressed interest in and certainly benefited from them.

63. The members of the Sub-Committee noted the fairly high cost of each visit, considering the limitations of regular budget funds. They felt that the programme was useful but should be made more efficient.

64. The Sub-Committee accordingly proposed that such visits should:

(i) not be a matter of routine;

(ii) take place at the express request of a country and for specific reasons;

(iii) have a specific objective, with an indicator of the anticipated results, and

(iv) give rise in every case to a report, as a contribution to subregional development.

Annex 9

65. The Sub-Committee proposed that a full protocol be drafted for each visit, indicating:

(i) the relevance of the visit, in relation to the overall programme objective as defined by resolution AFR/RC29/R5;

(ii) the problem that the visit to the country concerned might solve;

(iii) the formulation of the specific objective of the visit in relation to the anticipated results;

(iv) the programme of the visit in the host country;

(v) the scheduled duration in terms of the objective and the programme, accompanied by an estimate of its cost and the date of the visit;

(vi) the plan of the report on the visit which must be submitted 15 days after the visit at the latest.

66. The visit must be followed by a second report at least six months later indicating its impact in the visitor's country of origin.

67. The Sub-Committee proposed to the Regional Committee the adoption of a draft resolution.

TECHNICAL COOPERATION AMONG DEVELOPING COUNTRIES (TCDC)

68. The report of the Standing Committee on Technical Cooperation among Developing Countries (document AFR/RC35/10) was introduced by Dr S. Diop.

69. The eighth meeting of the Standing Committee on Technical Cooperation among Developing Countries (TCDC) was held in Brazzaville from 17 to 21 June 1985. In accordance with Decision 7 of the Regional Committee at its thirty-third session, confirmed by Decision 9 taken at its thirty-fourth session, the three subregional working groups on TCDC examined eight subjects.

Annex 9

Training of primary health care workers, including traditional birth attendants

70. The Standing Committee on TCDC considered the following aspects: (i) the training of trainers; (ii) the training of Coordinators and leaders of health projects in the private sector; (iii) the training of community health workers, and (iv) the training of traditional birth attendants.

Hygiene in hospitals

71. The members of the Standing Committee on TCDC analysed the situation and highlighted the various factors that may affect hygiene in hospitals. They stressed the importance of intersectoral consultation in designing and siting hospitals. The Committee paid special attention to the problem of maintenance and recommended that this should be entrusted to competent permanent staff so as to ensure the availability of drinking water and power and the efficient operation of systems for the disposal of sold and liquid wastes. It placed special emphasis on: (i) the reception of patients, companions and visitors; (ii) the accommodation, feeding and recreation of hospital patients; (iii) curative care, and (iv) the efficient and effective work of the practitioners.

Health financing and relations between donor agencies and receiving countries

72. By decision EB/67 (5) of the Executive Board and resolution WHA29.32 of the World Health Assembly, the Director-General has been invited to collaborate with the United Nations system of agencies, bilateral donors, nongovernmental organizations (NGOs) and development banks in order to mobilize additional external resources for primary health care services in the least-developed countries (LDCs).

73. The evaluation of the resources required for HFA/2000 has revealed the relatively high cost of primary health care (US $10/inhabitant/year) and the impossibility for developing countries of financing the health of their populations on their own. In the overall health budget, moreover, far fewer funds are allocated to primary health care than to hospital medicine.

Annex 9

74. The Committee's recommendations were centred on the impact of external aid on development. That aid should be free of any ideological or political implications. The financing of a national health system should be studied, planned and implemented in the light of the specific objectives to be achieved in the short, medium and long term. The Committee considered that the WHO study on the use of resources for PHC (CRU) should be regarded as a model.

Evaluation of the implementation of primary health care since Alma-Ata

75. The members of the Sub-Committee noted the progress achieved by Lesotho in primary health care and exchanged information about their experience. They emphasized the need to coordinate intersectoral cooperation between all services and ministries.

Technical cooperation and malaria control

76. Malaria continues to be a major public health problem in Africa where it is responsible for about 5% mortality among infants and young children under five years. In most countries of the WHO African Region, the antimalaria action that is feasible, especially in the rural areas, is the rational deployment of antimalaria drugs for the reduction of malaria-related mortality and morbidity. Recently chloroquine-resistant malaria parasites have emerged and spread in some areas in the Region. There have been some instances where the phenomenon has necessitated the use of drug combinations. This phenomenon is consequently seen as a serious threat to antimalaria action in the countries of Africa. There are however assurances that chloroquine is still effective in many areas and remains the drug of first choice for treatment. The members of the Sub-Committee agreed that antimalaria action should be developed as part of the public health services in general and as part of primary health care systems in particular, with emphasis on multisectoral collaboration and community participation. The Sub-Committee recommends the adoption by the Regional Committee of the draft resolution on malaria control.

Annex 9

Progress report on care for disabled persons

77. Implementation of the governing bodies' resolutions on the subject of the International Year for Disabled Persons (1981) and the United Nations Decade for Disabled Persons (1983-1992) requires multisectoral and multidisciplinary collaboration involving other agencies in the United Nations system and nongovernmental organizations.

78. Management of programmes for the prevention of disability and physical handicaps is based on support activities in the following areas: legislation, inspection, education and research.

79. The Committee analysed the effective and least-costly cooperation mechanisms for the programme on rehabilitation of disabled persons in the framework of TCDC, and made recommendations.

The cholera situation in Africa and control methods

80. The Standing Committee on TCDC conducted an objective analysis of the cholera situation in Africa. Its members agreed that efforts should be made to rid cholera of its aura of mystery; it should be regarded as a diarrhoeal disease both by the public and by the authorities. Measures to combat the disease should be integrated into a national programme for diarrhoeal disease control. The programme should concentrate on the use of oral rehydration, the improvement of drinking-water supplies and sanitation and the strengthening of epidemiological surveillance.

Intersectoral cooperation and community involvement for implementing strategies for Health for All by the Year 2000

81. The Standing Committee acknowledged that intersectoral cooperation had always existed in Africa but considered it was of an improvised nature that rendered it ineffective. The expanded programme on immunization was the only component of PHC that could be executed through health technology alone. Nonetheless it too required community involvement and support from other sectors such as transport, etc.

Annex 9

82. The Sub-Committee suggested that Member States should make efforts to strengthen the links between public health and other sectors of the economy.

Discussions

83. The document reflects the concerns of the representatives of Member States.

84. However, the number of subjects dealt with would appear to be too great and therefore prejudicial to the effectiveness of the TCDC working groups. The Sub-Committee recommends that the working groups concentrate their discussions on experience gained, whether successful or not.

85. The Sub-Committee suggests that the discussions and recommendations of the Standing Committee on the subject "Training of primary health care workers, including traditional birth attendants", should be given wide circulation among Member States by the Regional Office, in view of the importance of curative medicine in health and social deliveries to the communities.

86. It was proposed that care for disabled persons should cover the victims of the war in southern Africa which is responsible for physical and mental disorders.

87. The members of the Sub-Committee agreed that cholera control should be integrated into diarrhoeal disease control because of the similarity of the epidemiological and therapeutic factors. Epidemiological surveillance of diarrhoeal diseases could be carried out by exercising continual vigilance in the identification and rapid containment of an epidemic of cholera or any other diarrhoeal syndrome.

Recommendations

88. The Sub-Committee endorsed the recommendations of the Standing Committee on TCDC.

Annex 9

Training of primary health care workers, including traditional birth attendants

89. The Committee made the following recommendations:

(i) The village health worker and traditional birth attendant must be selected by the community itself and must live and work within the community.

(ii) WHO is invited to collect and disseminate the experience of different countries with the training of village health workers and traditional birth attendants.

(iii) Member States are invited to make use of the TCDC mechanisms for exchanges of training programmes and of trainers.

(iv) The length of training of health workers should be governed by specific objectives and clearly defined tasks which they have to carry out.

(v) Health workers should demonstrate their keen commitment and enjoy the support of the population so that they can implement PHC consistently in the interests of the socioeconomic development of the community.

(vi) Member States should as far as possible conform to the profile prepared by WHO for the training of health workers.

Hygiene in hospitals

90. The Standing Committee addressed the following recommendations to the Regional Committee:

(i) Member States are urged to provide hospitals not only with sufficient numbers of qualified medical and paramedical staff but also with competent and reliable staff for managerial, administrative, financial and general services, by making systematic use of the TCDC mechanisms.

Annex 9

(ii) Member States should make provision for special budget lines for the financing of all hospital hygiene and safety activities.

(iii) Member States should exchange the texts of regulations on hospital hygiene at the subregional and regional levels, via the Regional Office.

(iv) The dress and behaviour of medical, paramedical and managerial staff should be conducive to good hospital hygiene practice.

(v) Maintenance should be entrusted to competent permanent staff so as to ensure the availability of drinking water and power and the efficient operation of the systems for the disposal of solid and liquid wastes.

(vi) Those involved in the planning and implementation of infrastructure are invited to work together with the users in order to ensure better compliance with all the rules of hygiene and safety, taking into account the layout, organization and operation of the medical services, the managerial services, the catering services and the general services.

(vii) The disposal and treatment of waste should be carried out on a regular basis and the hospital should have an incinerator for the disposal of all infected waste.

(viii) Member States are urged to create awareness and motivation among the central health authorities, the managers of administrative, financial and general services, and unit chiefs regarding the importance of hospital hygiene and their responsibility for providing the best possible conditions for: (a) the reception of patients, companions and visitors; (b) the accommodation, feeding and recreation of hospital patients; (c) curative care, and (d) the efficient and effective work of the practitioners.

Annex 9

(ix) Member States should see that the implementation of hygiene and safety measures is supervised by an official who is qualilfied in hygiene, epidemiology and sanitary engineering.

(x) The WHO training centres in Togo, Sierra Leone and Zimbabwe should be utilized for training staff capable of repairing and maintaining medical equipment.

(xi) Member States, in close collaboration with WHO, should conduct exhaustive surveys to determine the size of the problem of hospital infections.

Health financing and relations between donor agencies and receiving countries

91. The Committee made the following recommendations:

(i) Member States, in collaboration with WHO, should set up mechanisms for evaluating the impact of foreign aid on health development.

(ii) Member States should consider aid as genuine cooperation, free of any ideological or political implications.

(iii) Member States should identify their priority health needs requiring external funding so as to make maximum use of the funds made available to them.

(iv) Member States should promote or strengthen community participation in order to improve the utilization of resources allocated for health.

(v) The financing of a national health system should be studied, planned and developed in the light of the precise objectives to be achieved in the short, medium and long term. The WHO study on the use of resources for PHC (CRU) should be regarded as a model.

(vi) The use of external bilateral resources or funds from the specialized agencies of the United Nations system (WHO/UNDP/UNICEF/UNFPA) should also be planned as a supplement to national resources. The use of these funds should be specified by the users in projects and operational plans which have the consent of the countries involved in this cooperation. The Regional Office would collaborate with Member States in setting up mechanisms to improve the countries' ability to absorb the funds made available to them.

(vii) Member States should pay more attention to the point of view of health professionals in formulating and implementing the budget, and more funds should be allocated to the health sector.

(viii) Member States should establish a climate of mutual respect between the countries receiving aid and the donor organizations.

(ix) Member States are urged to give subregional and regional cooperation preference over North-South cooperation.

(x) Member States should submit the necessary information on the flow of external resources mobilized for implementing the HFA/2000 strategy to the Regional Office.

Evaluation of the implementation of primary health care since Alma-Ata

92. The Committee made the following recommendations:

(i) Assisted by the Regional Office, Member States must make every effort to set up health information systems.

(ii) Evaluation must be implemented as part and parcel of primary health care.

(iii) The WHO Regional Office should promote the organization of regional, subregional and national workshops/seminars on planning, management, evaluation and health information systems.

Annex 9

(iv) Member States should draw upon the experience of different countries of the Region in primary health care, particularly through the exchange of information, documentation and specialists.

(v) Member States should upgrade the quality of trainers through periodic workshops and refresher courses.

(vi) Member States are urged to evaluate and redefine PHC programmes periodically.

(vii) Member States should encourage closer collaboration over the production and exchange of teaching materials, which is more necessary than ever because of the cost of importing the materials.

(viii) Governments are urged to define their primary health care policy more clearly, particularly in its multisectoral and multidisciplinary aspects.

(ix) Member States should provide incentives for the village health worker.

Technical cooperation among developing countries and malaria control

Action to be taken at the country level

93. Member States concerned are urged to:

(i) implement national programmes for the assessment and monitoring of the response to standard treatment regimens as well as the sensitivity of *Plasmodium falciparum* to antimalaria drugs;

(ii) formulate and pursue policies and measures to control and protect the efficacy of antimalaria drugs, together with guidelines for the treatment of malaria according to the status of the sensitivity of *P. falciparum* to antimalaria drugs;

Annex 9

(iii) review and revise their antimalaria strategies in terms of their effectiveness, efficiency and prospects of achieving and maintaining their objectives in the light of the epidemiological situation and the need to develop malaria control as an integral part of national primary health care systems; emphasis should be placed on the multisectoral aspects and community involvement;

(iv) implement vector control measures wherever feasible;

(v) incorporate appropriate courses in the training programmes of all health personnel.

Action to be taken at the subregional level with emphasis on TCDC

94. Member States are urged to:

(vi) exchange information on all aspects of national malaria control programmes;

(vii) exchange malaria experts and country visits;

(viii) promote training of personnel from countries without training facilities in countries with such facilities;

(ix) collaborate and cooperate in the quality control of antimalaria drugs;

(x) collaborate and cooperate in coordinated antimalaria activities, especially along common frontiers.

Action to be taken at the regional level

95. WHO is requested to:

(xi) develop a regional network of training resources;

(xii) disseminate information on malaria;

Annex 9

(xiii) develop guidelines, manuals, etc., and promote their use by Member countries;

(xiv) organize meetings for exchange of information, etc.;

(xv) mobilize resources and provide technical and financial support for Member States in collaboration with other international, governmental and nongovernmental agencies;

(xvi) promote and support research activities aimed at improving existing control methods as well as developing new and more effective methods adapted to different epidemiological, socioeconomic and ecological situations;

(xvii) revise the regional antimalaria strategy.

Progress report on care for disabled persons

96. The Committee made the following recommendations:

(i) Countries which already have training facilities for rehabilitation workers and services for disabled persons should open them to countries of the same Sub-Region where such facilities do not exist.

(ii) Member States should facilitate exchange of information on appropriate technologies, e.g. orthopaedic appliances, health education, training manuals, etc., via the Regional Office.

(iii) Member States should promote the prevention and treatment of disabling diseases by increasing community awareness of the plight of disabled persons.

(iv) Member States are urged to encourage activities aimed at integrating the disabled into the community, e.g. by training members of their family to assist them; by educating teachers and community leaders to accept the disabled into schools, jobs and other institutions.

Annex 9

(v) Member States should lay special stress on training the staff involved in rehabilitation: rehabilitation workers, physiotherapists, occupational therapists, orthopaedic technicians, nurses and community health workers.

(vi) Member States should encourage the promotion of a multisectoral approach by bringing together government and nongovernment sectors in rehabilitation activties.

(vii) Member States should promote the prevention and treatment of disabling diseases in the community.

(viii) Member States are urged to give priority to activities in regions where nothing has as yet been done for the disabled.

(ix) Member States should ensure that disabled people who are housebound are given rehabilitative treatment.

Diarrhoeal diseases -

Recommendations

97. Health authorities must endeavour to demystify cholera, which should be regarded as a diarrhoeal disease both by the public and by the authorities. Measures to combat the disease should be integrated in a national programme for diarrhoeal disease control. This programme should focus on the use of oral rehydration, the improvement of drinking-water supplies and sanitation, and the strengthening of epidemilogical surveillance.

98. Member States are urged to make use of the TCDC mechanisms, which have great potential for the control of diarrhoeal diseases, including cholera. Countries should strengthen their collaboration in the exchange of epidemiological and technical data, especially the notification of cholera cases, in staff training, in conducting surveys to provide basic epidemiological data, in formulating messages and preparing materials for health education, and in producing and distributing rehydration salts.

Annex 9

99. Countries still requiring cholera vaccination certificates from international travellers are urged to give up this practice as soon as possible, in conformity with the resolution of the Twenty-sixth World Health Assembly withdrawing the cholera vaccination certificate from the requirements of the International Health Regulations (addition to the 1973 Regulations, resolution WHA26.55).

100. WHO, in collaboration with other agencies of the United Nations system, is invited to build up subregional stocks of oral rehydration salts, which should be immediately available in adequate quantities to meet countries' needs in the event of epidemics of diarrhoeal diseases, including cholera.

101. WHO is invited to collect and disseminate the experience of different countries with national programmes for diarrhoeal diseases control.

Intersectoral cooperation and community involvement for implementing strategies for Health for All by the Year 2000

102. The Committee made the following recommendations:

(i) Member States should endeavour to strengthen existing coordinating mechanisms rather than set up a host of committees.

(ii) Member States should promote multidisciplinary and multisectoral action in the design, organization, and implementation of a national primary health care strategy.

(iii) This strategy should involve integrated activities covering hygiene, prevention, health education and basic curative treatment, carried out by a versatile multidisciplinary team.

(iv) The Ministry of Health, which is the authority for health policy, should cooperate with other ministerial departments and national entities, nongovernmental organizations and the United Nations specialized agencies concerned with health in improving and implementing the operational plans which form part of the strategy.

Annex 9

(v) Since the strategy requires the support and active involvement of the people, it should be backed up by intensive and continuous health education, bearing in mind the community's life-style and its socioeconomic and cultural context.

(vi) Active participation of women should be encouraged in view of their cardinal role in implementing PHC.

(vii) Improvement of the quality of trainers should be encouraged by organizing periodic workshops and refresher courses.

(viii) Governments are urged to put into practice the primary health care policy which they have adopted individually and collectively.

(ix) Member States should introduce and/or improve cooperation between the various departments of ministries of health and set up information systems.

Subjects for 1988

103. The Regional Committee, by Decision 9 taken at its thirty-fourth session approved the subjects for discussions by the subregional working groups in 1986 and 1987.

104. The Programme Sub-Committee proposes the following subjects to the Regional Committee for discussion by the subregional working groups in 1988:

(i) Africa and family planning (UNFPA).

(ii) Drug abuse and alcohol-related problems in Africa (Nigeria, Kenya, Zaire and Lesotho).

(iii) Possible effects of drought, famine and natural disasters on mental health (Ethiopia, Mali, Niger, Burkina Faso, Chad, Mozambique).

(iv) Promotion of envvironmental sanitation in rural areas (Madagascar).

Annex 9

Replacement of members of the Standing Committee

105. In accordance with operative paragraph 4 of resolution AFR/RC33/R7, the Sub-Committee replaced some of its members. Algeria replaces Senegal, Ethiopia replaces Equatorial Guinea, and Tanzania replaces Lesotho. The outgoing countries were replaced by lot on a subregional basis.

New Regional Office structures

106. The Standing Committee on TCDC had an opportunity to familiarize itself with the new Regional Office structures. The relevant document was prepared in the light of the social objective of attaining HFA/2000 through primary health care strategies. The new structures are primarily aimed at bringing the Regional Office closer to the countries and involve a process of decentralization through subregional offices.

107. The Programme Sub-Committee submitted two draft procedural decisions and three draft resolutions to the Regional Committee for adoption.

EVALUATION OF THE AFRICAN EXPERIMENT OF USING NATIONALS AS WHO PROGRAMME COORDINATORS

108. The document was introduced by Dr V. M. Eyakuze.

109. The preliminary evaluation of the African experiment of using nationals as WHO Programme Coordinators was submitted to the Regional Committee at its thirty-fourth session in September 1984.

110. The Regional Committee had expressed the view that the experiment had been useful and might be continued. The Director-General had reminded the Regional Committee that the main purpose of the experiment was to develop self-reliance by rational mobilization of human resources in the countries.

Annex 9

111. After a thorough study of the document submitted to it, the Regional Committee had:

(i) called for "the setting-up of a Programme Sub-Committee working party to review the Special Services Agreement concluded between the Organization and the national Coordinator", and

(ii) requested the Director-General "to continue the evaluation of this experience and the Regional Director to report to it thereon at its thirty-fifth session".

Report of the Working Party

112. The Working Party met in December 1984 and June 1985. In its final report it expressed the view that:

(i) the nature of the services requested should correspond to the definition contained in document DGO/83.1, whether the Coordinator is nationally or internationally recruited;

(ii) the duration of the agreement should not be less than two years;

(iii) the total remuneration of the national Coordinators paid by WHO and the government should not exceed US $3000 per month in local currency;

(iv) the status of a national Coordinator is that of a civil servant of his own government;

(v) the profile of a national Coordinator is that of a government civil servant with the same qualifications as an international Coordinator and selected by the Regional Director from three candidates put forward by the government.

Annex 9

113. The Regional Director commented on the report of the Working Party, amended the draft Special Services Agreement and stated that:

(i) the duration of the agreement should be in accordance with the normal practice of the United Nations system and should not exceed 12 months;

(ii) terminal payments should be made only if WHO cancelled the agreement, in which case the indemnity would be calculated in accordance with the provisions of the WHO Staff Rules.

Continuation of evaluation

114. Evaluation of the experiment has continued in accordance with the wishes of the Regional Committee. It has taken the form of:

(i) an administrative evaluation through a comparison of the regularity with which the national and international Coordinators send in their technical and financial reports;

(ii) extension of the opinion survey regarding Coordinators to all the national and international Coordinators and to all WHO Regional Office and field staff at a special meeting of WHO Coordinators/ Representatives;

(iii) transmission of the Working Party report to ministries for comment;

(iv) consultations on the subject on the occasion of official visits by the Regional Director to Member States.

115. The administrative evaluation showed that the regularity with which the technical and financial reports were submitted depended on the Coordinator himself, whether nationally or internationally recruited. In both groups it was always the same Coordinators who were at fault, in fairly equal proportions.

Annex 9

116. Analysis of the questionnaires completed by the Coordinators and other staff members before and after the special meeting of Coordinators/ Representatives held in March 1985 showed that:

(i) all the Coordinators were faced with the same problems, i.e. inadequate staffing, delays in communication with the Regional Office, and inadequate delegation of authority to manage WHO resources;

(ii) the international Coordinators are older, have more experience, have better training in public health and are better prepared for managing WHO programmes;

(iii) the WHO Regional Office and field staff felt that a return to international Coordinators would strengthen the WHO offices in countries.

117. The letter to Member States that accompanied the Working Party report stated clearly that failure to reply would be taken as an indication of approval of the report. By March 1985, 20 replies had reached the Regional Office, two-thirds of them from countries with a national Coordinator. It should be noted that five countries with national Coordinators spontaneously stated that they considered the experiment a success and that one country with an international Coordinator stated that in future it would like to use a national Coordinator. The Regional Director has maintained dialogue with Member States on the subject as requested by the Regional Committee.

118. The evaluation shows clearly that the experiment was necessary and that it produced positive results in some countries. However, the experiment encountered the following difficulties:

(i) it seems that the original objective of promoting self-reliance has been lost sight of since the NWCs have not become an integral part of the national health management mechanisms;

Annex 9

(ii) problems of remuneration, supervision of WHO personnel, dual allegiance or inability to provide WHO with essential epidemiological data have called the experiment into question;

(iii) the new guidelines of the Executive Board on WHO's budget policy at country level stressed the role of the Coordinator as a person authorized to decide on the utilization of WHO resources andto work with the other government departments and international agencies, and therefore favour an international rather than a national Coordinator;

(iv) some countries have asked for a high-ranking international staff member to support the office of the national Coordinator, which confirms that the very concept of the NWC is inadequate, at least at the present time.

119. The Director-General will inform the Executive Board in January 1986 of the opinions and conclusions of the Regional Committee, and the Executive Board will make recommendations to the World Health Assembly which will take the final decision. Should the World Health Assembly decide to bring the experiment to an end, the national Coordinators could be appointed as WHO staff members or national programme officers, as is done by UNICEF, and would be given technical responsibility for developing WHO programmes, especially primary health care.

Discussion

120. As directed by the Regional Committee at its thirty-fourth session, the Programme Sub-Committee considered new developments in the evaluation of the experiment, and endeavoured to reach a conclusion concerning its future in spite of an apparent divergence of views.

Annex 9

121. The Programme Sub-Committee noted that paragraph 7 of the cover page should end after the words "... appoint international Coordinators instead". This paragraph would therefore read as follows. "The Regional Committee is invited, after considering the report submitted to it, to give its views on the future of this experiment: whether to continue with it despite its drawbacks, or to end it gradually so as not to damage the interests of serving staff, and appoint international Coordinators instead".

122. The Sub-Committee recognized that it was sometimes difficult for national Coordinators to supply the Regional Office with essential epidemiological data, such as cholera figures. It was easier for the Regional Director to obtain this type of information, which was important for the regional community as a whole, from an international Coordinator. National Coordinators were occasionally put under pressure not to divulge this information, whereas international status was a guarantee of independence of action.

123. The members of the Sub-Committee felt that paragraph 77 was not sufficiently objective. They requested that it be redrafted as follows: "It emerges from these opinions that the experiment of using nationals as WHO Programme Coordinators is confronted by the obstacles inherent in the experiment and foreseen in the Executive Board's organizational study on WHO's role at the country level, particularly the role of WHO representatives. In practice nationals are subject to constraints which make it difficult for them to manage WHO's resources to the satisfaction of both WHO and their own countries. Accordingly, it is proposed to bring the experiment to an end in the countries where it has been undertaken, gradually, without compromising the interests of any serving staff, or of the country in question, that is, at a time mutually convenient to the country and WHO".

124. The Sub-Committee proposed to the Regional Committee a draft resolution for adoption.

Annex 9

CONCLUSIONS

125. The Programme Sub-Committee considered the regional evaluation report on implementing the strategies for Health for All by the Year 2000. It endorsed the proposals of the African Advisory Committee on Health Development regarding: (i) transformation of the national strategies into specific plans of action; (ii) improvement of intersectoral coordination; (iii) assessment of needs for implementing the strategies; (iv) strengthening of managerial processes for national health development, and (v) refinement of the 12 global indicators.

126. The Programme Sub-Committee endorsed the conclusions and recommendations of the meetings in which its members had taken part. In its opinion such participation was particularly important and facilitated its work when considering documents of programming interest. The evaluation of visits by officials of Member States to other countries of the Region showed that the programme was not as effective as anticipated. The Sub-Committee made suggestions for making the programme more efficient and suggested that it should continue, provided that the protocols for the visits were carefully drafted in accordance with the directives given to the Secretariat.

127. The Sub-Committee endorsed the recommendations of the Standing Committee on TCDC concerning: (i) the training of primary health care workers, including traditional birth attendants; (ii) hygiene in hospitals; (iii) health financing and relations between donor agencies and receiving countries; (iv) evaluation of the implementation of primary health care since Alma-Ata; (v) technical cooperation among developing countries and malaria control; (vi) progress report on care for disabled persons; (vii) the cholera situation and control methods in Africa; (viii) intersectoral cooperation and community involvement for implementing strategies for Health for All by the Year 2000.

128. The Sub-Committee noted the new developments in the evaluation of the African experiment of using nationals as WHO Programme Coordinators. It was proposed to bring the experiment to an end, gradually, without damaging the interests either of the staff or of the countries.

APPENDIX 1

Annex 9

LIST OF PARTICIPANTS

ANGOLA

Dr Luis Gomes-Sambo
Vice Ministro da Saude
Luanda

Dr J. F. Leite da Costa
Chefe do Departamento de Hygiene e Epidemiologia
Ministerio de Saude
Luanda

CAMEROON

Dr G. Kesseng Mabem
Directeur de la Médecine préventive et de l'Hygiène publique
Ministère de la Santé publique
Yaoundé

CENTRAL AFRICAN REPUBLIC

Dr V. Mbarindi (Vice-Chairman)
Directeur général de la Santé publique
Ministère de la Santé publique
Bangui

EQUATORIAL GUINEA

Mr B. Mba Ecua Miko
Ministro de Sanidad
Malabo

ETHIOPIA

Dr T. Tokon (Chairman)
Head, Health Services Department
Ministry of Health
Addis Ababa

Annex 9 Appendix 1

GABON

Mr Martial Mboumba
Directeur général de la Santé publique
Ministère de la Santé publique et de la Population
Libreville

SWAZILAND

Dr (Mrs) R. T. Thsabalala
Deputy Director of Health Services
Ministry of Health
P.O. Box 5
Mbabane

TOGO

Dr T. Bakélé Barandao
Directeur général adjoint de la Santé publique
B.P. 336
Lomé

UGANDA

Dr J. H. Kyabaggu
Assistant Director of Medical Services (PHC)
Ministry of Health
P.O. Box 8
Entebbe

ZAIRE

Dr Kapata Luvivila
Directeur de la Direction nationale des SSP
B.P. 1828
Kinshasa I

Appendix 1

Annex 9

ZIMBABWE

Dr D. G. Makuto
Deputy Secretary for Health
Ministry of Health
P.O. Box 8204 - Causeway
Harare

Annex 9

APPENDIX 2

PROGRAMME OF WORK

1. Opening of the meeting

2. Evaluation of the implementation of the strategies for Health for All by the Year 2000: regional report (document AFR/RC35/12)

3. Report on participation by members of the Programme Sub-Committee in meetings of programming interest (document AFR/RC35/8)

4. Evaluation of visits by representatives of Member States to other countries of the Region (document AFR/RC35/9)

5. Report of the Standing Committee on Technical Cooperation among Developing Countries (document AFR/RC35/10)

6. Evaluation of the experiment of using African nationals as WHO Programme Coordinators (document AFR/RC35/22)

7. Adoption of the report of the Programme Sub-Committee (document AFR/RC35/7)

8. Presentation to the Regional Committee of the report of the Programme Sub-Committee: assignment of responsibilities (document AFR/RC35/7)

9. Closure of the meeting.

(AFR/RC35/13) ANNEX 10

REPORT OF THE TECHNICAL DISCUSSIONS

Health systems research: an instrument for the promotion and development of primary health care

INTRODUCTION

1. The technical discussions at the thirty-fifth session of the Regional Committee were held at Lusaka on 14 September 1985 on the subject "Health systems research: an instrument for the promotion and development of primary health care". They were chaired by Professor D. N. Lantum who was elected by the thirty-fourth session of the Regional Committee. The thirty-fifth session of the Regional Committee nominated as Rapporteurs of the technical discussions:

(i) Dr A. D. Kolawole (Nigeria)

(ii) Dr (Mrs) R. T. Tshabalala (Swaziland)

(iii) Dr Mohamed Saleh (Mauritania).

Discussions took place in three working groups: one English-speaking, one French-speaking and one trilingual. The working groups elected their Chairmen as follows:

(i) Dr Celestino Mendes da Costa (Guinea-Bissau)

(ii) Dr G. W. Lungu (Malawi)

(iii) Professor Doudou Ba (Senegal).

Annex 10

PRESENTATION

2. The working paper, document AFR/RC35/TD/1, prepared by Professor P. O. Chuke, Professor of Medicine, University of Nigeria, Enugu, Nigeria, and Dr A. C. Mkandawire, Subregional Coordinator, HSR, Sub-Region III, was introduced by Professor D. N. Lantum, Chairman of the technical discussions. In his presentation in plenary session before the three groups commenced their discussions, he read out the seven basic questions to which the delegates were expected to react after studying the working document.

3. The Chairman emphasized the highlights and the spirit of the working document and developed some relevant fundamental notions in the hope that such a presentation would stimulate the delegates and provoke constructive and productive reactions during discussions. He called the attention of the delegates to the principles of project or health systems monitoring, evaluation and evaluative research. All these actions had the common aims of establishing judgement, drawing conclusions and making some recommendations on how to use the derived knowledge for the improvement of health care systems. These three actions fell within the domain of Applied or Operational Research.

4. The Chairman observed that the working document had assumed that the delegates were used to the practice of at least monitoring the progress of their health care systems. Further, that they had been practising systematic administrative evaluation of their health care systems, as a routine and essential management function. The working paper was now calling on the delegates to add the dimension of scientific health systems research to the process of promotion and development of their health systems.

5. He emphasized that the research process required scientific methodology, adequate training in research theory, rigour, objectivity, depth and thoroughness beyond routine administrative evaluation, quantitative and qualitative data processing for interpretation, conclusion and recommendations. The recommendations should be addressed to the decision- and policy-makers, health care providers, health care consumers and future researchers for their use. Thus operational or health systems research should lay emphasis on relevance to development issues.

Annex 10

6. The primary health care approach to health systems development was highlighted by the Chairman as the special focus of the working document, and he called attention to the characteristics of PHC.

7. The Chairman then described HSR as an instrument for diagnosing problems and situations in the management processes of health care systems; he then recommended appropriate measures for programme amelioration by the optimal utilization of inputs for the maximization of outputs.

8. After a brief analysis of the components of a typical health care system intended as a guide to the better comprehension of the various examples cited in the working document, the Chairman concluded that the key notions of the paper were:

- primary health care systems;
- promotion and development;
- research endeavours and outputs.

DISCUSSIONS

9. The discussions in all groups followed the seven basic questions raised in the working document. The proceedings were enriched by the frequent and highly pertinent interventions of Dr T. Lambo, WHO Deputy Director-General, who participated fully in one group, and the Regional Director who moved from group to group. All major observations and decisions are presented according to the question they address.

Question 1: Do you think that a need exists for health systems research in primary health care?

10. The participants unanimously agreed that the answer to this question is yes. HSR is action research which by use of scientific methods aims to provide information an insight which will:

Annex 10

(i) facilitate the development of a better understanding of health problems and the role and influence of health sciences;

(ii) assist in more rational health planning;

(iii) lead to more effective and efficient health care which at the same time is better attuned to the cultural and emotional needs of people;

(iv) encourage greater personal, family and community self-reliance in health matters by actively involving people in the study of their own problems.

Experience in some countries has clearly demonstrated that the processes of restructuring and reorientation of health systems were not easy. Thus, HSR is urgently needed to find solutions to problems and constraints. One example is how to develop disease control programmes as primary health care systems. Another example is identification of those factors that promote and those that militate against community participation in health activities.

11. Some participants of the groups observed that the whole concept and principles of the primary health care strategy are general and have to be modified and adapted to each local situation. There is therefore the need for HSR to determine the strategy most suited to each local situation. There was also an important observation that as a consequence of behavioural changes in life-styles new health problems were emerging. These problems called for prompt and appropriate intervention measures. The formulation of these measures could only be achieved through HSR.

Question 2: In any country where should such health systems research be done and who should do it?

12. In the examination of this question, a number of views were expressed.

13. One view which was shared by a number of members was that there should be a radical break-away from the old concept that research is a special field of activity that is confined to academics and research scientists in universities and research institutions. In this regard, it was felt that HSR should be a

Annex 10

multidisciplinary and joint collaborative activity between ministries of health, all faculties and departments of universities, relevant research institutions as well as other ministries and government departments. This was necessary because while there were some problems which could be solved by the Ministry of Health alone, there were many problems caused by numerous factors which required inputs from other professionals such as economists, anthropologists, sociologists, agriculturists, etc.

14. Another reason for this collaborative approach was the fact that ministries of health are unlikely in many situations to have adequate capabilities and capacity to undertake HSR on their own. As far as the Ministry of Health was concerned a view which was generally accepted was that personnel at all levels in the health care delivery system should be actively involved in HSR. The expertise required and the degree of complexity and sophistication of the research would vary depending on the nature of the problem.

15. The establishment of an effective mechanism for coordination of HSR activities was regarded as vital but there were some diversities of opinion on the type of mechanism. There was however general agreement on three types of coordinatory mechanisms:

- One mechanism used by one Member State was given as an example. Here the Ministry of Health has established a research unit within the ministry. This unit is responsible for formulation of research policies and identification of research needs. Other agencies are invited and assigned research tasks as and where necessary.

- Another type of mechanism is the establishment of an independent or semi-autonomous commission or similar body with representation of the Ministry of Health to ensure the relevance of all research projects to the health and health-related problems, needs and priorities.

- Yet another option is the establishment of a department or national committee for research and development in the organizational chart of the health services.

Annex 10

16. Whichever option is chosen the main activities will be:

- to collect relevant information for HSR;
- to identify priority areas for targeted research;
- to receive, screen and recommend research proposals;
- prepare, maintain and update an inventory of research institutions, activities, potentials and personnel;
- to provide support and technical advice to investigators, particularly those employed by the health service;
- to supervise the administrative formalities on resources;
- to ensure the respect of safety and ethical considerations.

17. It was noted that multidisciplinary mechanisms for development and coordination of health-related research do exist in many countries. However, many of these for various reasons were inoperational.

18. Training in research methodology with emphasis on the analysis and correct interpretation of research findings and results was also identified as very important.

Question 3: Implementation of findings of HSR is crucial to the attainment of HFA/2000. What steps do you think national governments should take to make this possible?

19. The participants identified two major problems which had hindered and in some countries continue to hinder the utilization of research findings and results:

- It was observed that in many countries an intensive search would reveal volumes of results of research piled up in various places which had not been utilized and were only left to collect dust. This was due to a lack of or ineffective mechanisms for making information available to those who need it.

Annex 10

- The second constraint was attributed to the absence of people in ministries of health with capabilities for the correct interpretation of research findings and results. This handicap invariably made it difficult to apply the results correctly. It was also observed that sometimes misinterpretation of results led to unnecessary public alarm and consternation.

20. The participants strongly recommended action to correct these major deficiencies if the results of research were to be properly utilized to improve programmes and services.

21. Certain prerequisites, which must be satisfied if research is to be followed by implementation of findings, were identified as follows:

(i) research needs should be identified and ranked in order of priority according to their relevance to national health development policies and strategies;

(ii) there should be effective mechanisms for the review and funding of all research proposals;

(iii) there should be mechanisms for the dissemination of information to ensure that information is available to those who need it;

(iv) there should be mechanisms for follow-up action to ensure utilization of information and implementation.

22. With regard to implementation, three levels for action were identified. It was felt that there should be some degree of flexibility to promote the prompt utilization of information. For problems of a complex or general and national character, action should be taken at the national level. This calls for appropriate mechanisms for decision-making and the initiation and follow-up of actions to ensure implementation. For less complex issues especially of local interest there should be mechanisms to allow action to be taken at the intermediate or community level without reference to the central level. These should be done with the involvement of the community concerned.

Annex 10

Question 4: Traditional medicine has been rediscovered as a potential tool in enhancing primary health care. Could health systems research show that this is not a retrogressive step?

23. There was a general consensus that traditional medicine has a lot to offer as a supplement to primary health care. The purely spiritual (religio-magico-social), purely herbal and mixed forms of traditional medicine all have useful contributions to make. Modern and traditional medicine should be complementary with considerable efforts being made to harness the potentialities of traditional medicine. It was agreed that properly selected, trained and supervised, traditional healers should be entrusted with specific tasks as front-line workers although some reservations were expressed about the usefulness of some traditional healers. The members agreed on the following action:

(i) search for appropriate mechanisms for integrating traditional healers into health teams in order to promote their activities, particularly in rural areas;

(ii) strengthening of multidisciplinary research in traditional medicine, including personnel training, documentation, the cultivation of the most useful species of flora and their utilization, whether immediate or as the point of departure for a pharmaceutical industry.

Question 5: Is it true that many health problems in Africa could be minimized by factors outside the health ministry? How could these intersectoral components be best mobilized for effectiveness?

24. The participants agreed that many health problems in Africa could be minimized if intersectoral cooperation were practised. They felt that intersectoral cooperation exists in that Cabinet Ministers, Permanent Secretaries and other officials do meet and discuss national activities and research decisions. However, the decision agreed upon, when transmitted to the lower level where action is required, is so misinterpreted that the expected intersectoral cooperation is not realized. It was felt that for intersectoral cooperation to be realized the following are needed:

Annex 10

(i) political will to mobilize effective intersectoral cooperation;

(ii) decentralization of administrative and interrelated development programmes;

(iii) community awareness of their right to participate in matters that affect their socioeconomic development.

Question 6: Indicate the main constraints in health systems research in primary health care

25. The main constraints identified by the participants may be classified under the following broad categories;

(i) Inadequacy of financial resources for research. Inadequate financial resources were identified as a major constraint in most countries. It was suggested that one possible way of overcoming this constraint could be soliciting of funds from industrial and commercial enterprises as well as philanthropic citizens. It was also reported by the Deputy Director-General that in view of the gravity of the situation in Africa, the Director-General would be willing to provide considerable additional support to health systems research.

(ii) Irrelevance of research proposals by donors. It was observed that not too infrequently donor agencies and sometimes commercial enterprises offer large sums of money, supplies and equipment for research that has no relevance to the health needs and problems of countries. Health authorities often find themselves in difficult positions when such offers are turned down. Some accept the offer in order to avoid the possible future consequences of turning them down.

Annex 10

(iii) Lack or shortage of trained personnel. Lack or shortage of trained personnel was identified as a major constraint. In this connexion, members made a strong recommendation that WHO should collaborate with Member States in the training of key personnel in research methodology as well as in the strengthening of the research capabilities of national research institutions.

(iv) Low perception of HSR. There is a general misconception that HSR is a soft, less scientific brand of research, dealing with administrative matters. Within the university system, greater appreciation and weight is needed for HSR.

Question 7: What is the scope of health systems research in primary health care?

26. The participants appreciated that HSR has wide scope and involves health workers and scientists from many disciplines. Research projects may range in size from major multi-national collaborative studies concerned, for instance, with financing of health services, to small studies involving one or two workers in a village or an urban neighbourhood. HSR is usually concerned with a single culture in a particular setting and hence, although methods may be generally useful, the results have low transferability. HSR helps:

(i) to generate relevant information for action;

(ii) to identify the problem areas for health research;

(iii) to categorize the problem according to priority areas;

(iv) to develop appropriate health technology;

(v) to deliver solutions acceptable to the people;

(vi) to ensure that the objectives are attained.

Annex 10

CONCLUSIONS

27. The participants concluded that HSR is an applied science and not merely research for its own sake. It applies the concepts and methods of other disciplines to analyse and solve problems related to health services delivery. As such, HSR provided with an appropriate infrastructure for its operations, carefully designed and systematically applied to critical problems constitutes a worthwhile area of investment (time, personnel and finance) which can yield substantial benefits to health systems.

28. It was obvious that HSR depends heavily upon a variety of disciplines ranging from social sciences, statistics and management to the biomedical and health sciences proper. The spectrum of areas relating to HSR include epidemiology, health manpower development, appropriate technology, resources mobilization, and community factors relevant to community health development.

29. HSR should be responsive to the needs of the community, policy-makers and administrators and should provide results within a reasonable time frame.

30. HSR is a powerful tool which could change the political desires for primary health care, which already exists in many countries, into the political will and operational know-how needed to provide it. The ultimate success of HSR is measured in terms of improvements in health services and in the health of the population.

ANNEX 11 (AFR/RC35/28)

REPORT OF THE PROGRAMME SUB-COMMITTEE HELD ON 18 SEPTEMBER 1985

INTRODUCTION

1. The Programme Sub-Committee met on 18 September 1985 in Lusaka (Zambia) following the thirty-fifth session of the Regional Committee. The list of participants is found in Appendix 1.

2. It re-elected Dr T. Tokon (Ethiopia) for the second time as Chairman, Dr E. Andriamampihantona (Madagascar) as Vice-Chairman and Dr A. Cole (Liberia), *in absentia*, as Rapporteur.

3. The programme of work was adopted (Appendix 2).

PARTICIPATION BY MEMBERS OF THE PROGRAMME SUB-COMMITTEE IN MEETINGS OF PROGRAMMING INTEREST

4. The Director, Programme Promotion and Coordination, presented document AFR/RC35/27 which contained the list of meetings foreseen during 1985-1986 for which the participation of the Sub-Committee was considered desirable, together with indications as to which members should participate. Annexes 1 to 5 of the report indicated past participation by members of the Programme Sub-Committee in meetings of programming interest since 1980.

5. After examining the document, the Sub-Committee unanimously decided as follows:

Annex 11

MEETINGS OF PROGRAMMING INTEREST TO BE ATTENDED BY
MEMBERS OF PROGRAMME SUB-COMMITTEE - 1985-1986

Name, place and date of meeting	Objective	Language	Participating members
Subregional Programme Meetings (SPM) - Harare, - Bamako, 3 days - Brazzaville successive weeks in February 1986	Consideration of first draft of Programme Budget 1988-1989 Study the terms of reference of the working group vis-à-vis TCDC	E/F/P	Members of the Sub-Committee to attend meeting relating to their Sub-Region
Tenth Regional Programme Meeting Brazzaville, April 1986	Consideration of the Programme Budget 1988-1989	E/F/P	All members of Programme Sub-Committee
African Advisory Committee on Health Development (AACHD) Brazzaville, June 1986	Consideration of regional Programme Budget Policy Chairman, Vice-Chairman Rapporteur	E/F/P	Chairman, Vice-Chairman, Rapporteur
Programme Sub-Committee Meeting Brazzaville, 1986		E/F/P	All members of Programme Sub-Committee

DATE AND PLACE OF THE NEXT MEETING

6. The Chairman reminded members that the next meeting of the Programme Sub-Committee will be held two days preceding the thirty-sixth session of the Regional Committee in Brazzaville (People's Republic of the Congo) in September 1986.

CLOSURE OF THE MEETING

7. The Chairman thanked members of the Programme Sub-Committee for their kind cooperation and help given him in carrying out his duty, and wished them all the best.

Annex 11

APPENDIX 1

LIST OF PARTICIPANTS

BURKINA FASO

Dr A. Tiemtore
Direction de la Surveillance épidémiologique et des Vaccinations
Ouagadougou

BURUNDI

Dr P. Mpitabakana
Inspecteur général de la Santé Publique
Ministère de la Santé publique
Bujumbura

CENTRAL AFRICAN REPUBLIC

Dr V. Mbarindi
Directeur général de la Santé publique
Ministère de la Santé publique
Bangui

EQUATORIAL GUINEA

Mr B. Mba Ecua Miko
Ministre de la Santé
Ministère de la Santé
Malabo

ETHIOPIA

Dr T. Tokon, Head
Department of Health Services
Ministry of Health
Addis Ababa

Annex 11 Appendix 1

GABON

Mr M. Mboumba
Directeur général de la Santé publique
Ministère de la Santé publique et de la Population
Libreville

Dr L. Adandé-Menest
Inspecteur général de la Santé publique
Ministère de la Santé publique
Libreville

MADAGASCAR

Dr E. Andriamampihantona
Secrétaire général
Ministère de la Santé publique
Antananarivo

MALAWI

Dr G. W. Lungu
Deputy Chief Medical Officer
Ministry of Health
Lilongwe-3
Malawi

TANZANIA

Dr A. Y. Mgeni, Director
Preventive Health Division
Ministry of Health
Dar es Salaam

ZIMBABWE

Dr D. G. Makuto
Deputy Secretary for Health
Ministry of Health
P. O. Box 8204, Causeway
Harare

Annex 11

APPENDIX 2

PROGRAMME OF WORK

1. Opening of the meeting
2. Election of Chairman, Vice-Chairman and Rapporteur
3. Participation by members of Programme Sub-Committee in meetings of programming interest (document AFR/RC35/27)
4. Date and place of the next meeting
5. Closure of the meeting.

ANNEX 12

CLOSING ADDRESS BY HON. C. M. MWANANSHIKU, MINISTER OF HEALTH OF THE REPUBLIC OF ZAMBIA, CHAIRMAN OF THE THIRTY-FIFTH SESSION OF THE REGIONAL COMMITTEE

The Right Honourable Prime Minister,
The Secretary of State for Defence and Security,
Honourable Members of the Central Committee,
The Deputy Director-General,
The Regional Director,
Honourable Ministers,
Distinguished Participants,
Ladies and Gentlemen,

1. Sir, I wish to state at the outset how much I have enjoyed chairing the thirty-fifth session of the WHO Regional Committee for Africa and may I thank all members of the bureau for the cooperation they extended to me during the session. The deliberations have been frank, positive and friendly. I have been privileged to observe with humility how relaxed honourable and distinguished delegates and, indeed, members of the Secretariat, have been throughout the conference in spite of the constraints some of them have endured, because of our inability to meet such pressing needs as transport.

2. Sir, the spirit of unity and cooperation which has been demonstrated during this meeting has been most encouraging and should prevail for the benefit of the people throughout Africa. After all, the boundaries of our countries are artificial and were drawn up by the colonialists to safeguard their political and financial interests. I am confident that given this kind of cooperation the sharing of the resources would be maximized and new areas of cooperation be explored.

3. Sir, Honourable Ministers and distinguished delegates have adopted the final report and resolutions of the Committee, thereby giving the Regional Director and his Secretariat guidelines on a number of important issues regarding the work of WHO in the African Region. The Committee has made an

Annex 12

undertaking to implement a number of resolutions which have been adopted. As Chairman of the current Committee it is my understanding that the Committee expects me to cooperate and collaborate with the Regional Director as well as Member States in ensuring that these directives are executed.

4. Sir, I would ask Honourable Ministers, distinguished delegates to allow me to refer to one or two issues we have discussed. I refer firstly to technical cooperation among developing countries (TCDC). It is my view that TCDC within the health sector should be spearheaded in other systems of TCDC. For example, within the Preferential Trade Area (PTA) arrangement and within the Southern African Development Coordinating Conference (SADCC) the health sector is not represented directly. It seems, therefore, that the Ministers of Health should take initiatives to use the broader platforms of cooperation within the African Region.

5. Sir, the ever-increasing role of health services research was discussed at length during the technical discussions and it is my hope that this tool will encourage introspection of our health care systems. I also think that adequate health services research will help us in monitoring and evaluating our strategies.

6. We have individually and collectively examined the strategies necessary to facilitate the implementation of primary health care in the Region. This evaluation has revealed progress made in the programme and many of our weaknesses. As Chairman of this session, I would like to encourage continuous vigilance and hope that the next evaluation will reveal achievement of better health for our peoples.

7. Sir, the Committee had an eloquent debate on the issue of National Programme Coordinators which was honest and exhaustive. I wish to thank them all for helping to reach the consensus. I am aware, distinguished delegates, that the duties of the Regional Director are onerous and I am pleased to note that in the spirit of cooperation our deliberations have strengthened his ability to discharge his duties effectively so that collectively we will be able to achieve our cherished goal of health for all.

Annex 12

8. Honourable Ministers and distinguished delegates, we have discussed many items during this session and one of the general conclusions we have made is the total agreement with the introductory remarks made by the Regional Director in his 1983-1984 biennial report to the effect that the worldwide socioeconomic crisis has impeded, in a most disquieting manner, the consistent implementation of national strategies for Health for All by the Year 2000 through primary health care. The Director-General of WHO, Dr Mahler, has echoed this statement.

9. The Regional Director has also warned that "in spite of commendable efforts by Member States, the international community and above all, WHO, the situation continues to deteriorate". In his view this state of affairs compromises the success of the courageous action taken by governments, governmental organizations and WHO to enable individuals and communities to reach that state of complete physical, mental and social well-being which is not merely the absence of disease.

10. The Regional Director describes the situation in African countries in his report as "frightening" and one which is compounded by disasters of all kinds, such as drought with its unparalleled socioeconomic consequences.

11. As we continue with our various strategies for the implementation of our programmes for Health for All by the Year 2000, we should equally make determined efforts to put across to our people this important message.

12. As the Director-General has pointed out, we need cooperation and understanding of the people for our plans of action to be successful. It is important for the people to understand the basis why governments are taking painful decisions to rehabilitate their economies and thereby avoid political and economic collapse of their countries. But in spite of our economic difficulties we should bear in our minds the theme of the Regional Director's speech of "priority in action".

Annex 12

13. Sir, I wish to report that this session was well attended by all Member countries except the Republic of Gambia who were not able to be with us. I wish to say through you, Mr Regional Director, that we have missed their presence and contributions. I do hope that they will be with us at the next session of the Committee next year.

14. I would like to pay tribute to the Director-General of WHO, Dr H. Mahler, whose presence at the beginning of the conference was highly inspiring. His statement added impetus to our discussions. I would like to draw the attention of Honourable Ministers to the proposal made by the Director-General of the World Health Organization, Dr H. Mahler, that national action programmes for primary health care should be drawn up and that specific targets be established. The speech contains many other valuable suggestions and it is my considered view that Member States would do well to seriously study Dr Mahler's speech for action.

15. I also wish to thank the Deputy Director-General, Dr Lambo, for his presence throughout the meeting and for his timely interventions during our deliberations which have been very fruitful. Dr Lambo is a great son of Africa of great courage who is prepared to call a spade a spade. Those who have read his article entitled "The health of its peoples, strategies for Development" in the journal of "Africa Health" for June/July 1985 will agree with me. I wish to assure Dr Lambo that his advice to the World Health Member States to participate effectively in the deliberations of the World Assembly of WHO has been taken note of by Honourable Ministers and distinguished delegates.

16. I wish to commend the Regional Director, Dr Monekosso, and the entire Secretariat for their hard work and dedication to duty. Conference papers have been prepared efficiently and speedily. I am sure I am speaking for all delegates when I say that the Regional Director has displayed rare and exemplary qualities. His personality and qualities have given us tremendous confidence that he will collaborate with Member States and will offer guidance and support in finding solution to the health problems afflicting the African Region.

Annex 12

17. Sir, I wish to take this opportunity to thank:

(a) observers who were invited in accordance with resolution WHA27.37;

(b) representatives of the United Nations and specialized agencies;

(c) representatives of other intergovernmental organizations;

(d) representatives of nongovernmental organizations and other observers who joined us during this session for their collaboration with WHO and Member countries in furtherance of the objectives of WHO; I pray that this cooperation be continued and strengthened for the benefit of the people of Africa.

18. In conclusion, I wish to pay tribute to the interpreters and translators and other workers who have worked behind the scenes and have contributed so much to the success of our deliberations. I wish you all a safe return to your countries and I pray to the God Almighty that the spirit of "one Africa, one Revolution" will be translated into a practical reality of "One Africa, One Health".

19. It is now my honour and privilege to call upon the Right Honourable Prime Minister to address us.

ANNEX 13

OFFICIAL CLOSING ADDRESS BY THE
RT. HON. KEBBY S. K. MUSOKOTWANE, MCC, MP,
PRIME MINISTER OF THE REPUBLIC OF ZAMBIA

Mr Chairman,
Honourable Members of the Central Committee,
WHO Director-General,
Honourable Ministers,
WHO Regional Director,
Distinguished Delegates,
Ladies and Gentlemen,

1. We have followed with great interest the deliberations of your week-long Conference. I am informed that your discussions have been frank, friendly and constructive. The commitment shown by Health Ministers in strengthening strategies intended to facilitate successful implementation of primary health care, gives us tremendous hope that the cherished goal of Health for All by the Year 2000 may indeed be realized. On our part, we shall study your conference resolutions very closely with a view to enhance the health status of our people.

2. I would like to take this opportunity to extend our gratitude as host country, to Dr Mahler, the Director-General, Dr Monekosso, the Regional Director, and their staff for their excellent efforts in ensuring the success of this conference. It is our sincere hope that all our guests to the conference enjoyed their stay in our capital city.

3. Distinguished delegates, you have been meeting here for a number of days to try and determine how quickly the African continent can take its rightful place as the continent of the future.

4. We have setbacks, we have problems and some of these are of our own making. Unfortunately, some of the problems that we now face are forced on us so that Africa, as a continent, can continue to slumber. The African men and women in politics, in health, in education, in economics and in all areas must now rise and fight for our continent to be what it should be like any other in the world.

Annex 13

5. As it is we will continue for some years to come to go through another kind of slave trade in Africa through the price of our minerals, through the price of our raw materials and through the price of our agricultural products. These will not be determined by us but will be determined by the consumers. The developed world and yet the same developed countries will determine the price for our consumer goods. We will continue to toil for them but we must find a way of overcoming because we have no alternative. This is why during the reception you were kind enough to attend, I said you should be yourselves more as soldiers than health men.

6. I hope that your meeting has added more firm and water-proof bricks in the construction of our continent. We will put this to the test in the next few years by how far we go in improving the quality of health in Africa. We hope we can continue to convince those of our colleagues to determine how much money should go to health and educational services as these are powerful tools which should not be neglected. I plead guilty because when I was Minister of Finance, may be and I am using the word may be I did not allocate adequate resources to these important sectors. I was looking at the problem then from a narrow angle but now as Prime Minister, I know that Africa's future will be determined by the quality of our educational and health standards. Those of the developed countries who want us to be strong partners in the future should in addition to giving us assistance in agriculture also give us adequate assistance in the health and educational sectors.

7. You have been here for many days now and I am sure that you have no appetite for any more speeches. However, can I, on behalf of our President, on behalf of our Central Committee, on behalf of the Government and indeed on behalf of the Zambian people, thank you once again for giving us an honour of hosting this meeting in our country. Can I also thank you for finding time to look at the health problems of Africa as I now declare this important meeting officially closed. I wish each one of you God's blessings as we surrender ourselves to the calls of the African people.

8. God's blessings.