

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA



THIRTY-SIXTH SESSION OF THE
WHO REGIONAL COMMITTEE FOR AFRICA
HELD IN BRAZZAVILLE, PEOPLE'S REPUBLIC OF THE CONGO
FROM 10 TO 17 SEPTEMBER 1986

FINAL REPORT

BRAZZAVILLE
December 1986

PROCEDURAL DECISIONS

1. Composition of the Sub-Committee on Nominations

The Regional Committee appointed a Sub-Committee on Nominations consisting of representatives of the following 12 Member States: Botswana, Equatorial Guinea, Gabon, Guinea, Kenya, Malawi, Mali, Mozambique, Niger, Nigeria, Senegal and Tanzania. The Honourable J. L. T. Mothibamele (Botswana) was elected Chairman.

Second meeting, 10 September 1986

2. Election of Chairman, Vice-Chairmen and Rapporteurs

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

Chairman : Gen. X. S. Yangongo (Central African Republic)
Minister of Health and Social Welfare

Vice-Chairmen :

- First Madam P. D. de MBuamangongo (Equatorial Guinea)
(by ballot) Vice-Minister of Health

- Second Hon. Dr S. Shongwe (Swaziland)
Minister of Health

Rapporteurs : Dr M. Browne (Sierra Leone)

Dr P. Mpitabakana (Burundi)

Dr S. Mohamed (Comoros)

Rapporteurs for the technical discussions:

Dr H. Sanoussi (Benin)

Dr E. K. Njelesani (Zambia)

Dr A. S. Marques de Lima (Sao Tomé and Príncipe)

Third meeting, 11 September 1986

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: Angola, Cape Verde, Comoros, Chad, Guinea, Guinea-Bissau, Kenya, Madagascar, Mauritania, Sierra Leone, Uganda and Zambia. It elected Mr S. Shitemi (Kenya) as Chairman.

Third meeting, 11 September 1986

4. Credentials

The Regional Committee, acting on the proposal of the Sub-Committee on Credentials, recognized the validity of the credentials presented by representatives of the following Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tomé and Príncipe, Senegal, Seychelles, Sierra Leone, Swaziland, Togo, Uganda, Tanzania, Zaire, Zambia and Zimbabwe. The Sub-Committee was unable to examine the credentials of Liberia.

Fourth meeting, 12 September 1986

5. Meeting of the Programme Sub-Committee

The Regional Director will convene a meeting of the Programme Sub-Committee once in every other year in Brazzaville to examine the draft proposed Programme Budget for the next biennium. In the interval years when the Programme Sub-Committee will not meet, the Subregional TCDC meetings and the AACHD meetings will review the main topics of the draft provisional agenda for the next Regional Committee meeting.

Fifth meeting, 15 September 1986

6. Nomination of the Representative of the Region to the Joint Coordinating Board (JCB) of the Special Programme for Research and Training in Tropical Diseases (TDR)

The Regional Committee noted that, in accordance with Decision 12 of the thirty-third session of the Regional Committee, the outgoing member of the Joint Coordinating Board (JCB) is Mauritius. The Committee thanked Mauritius for its contribution to the development of research in tropical diseases at the regional and global levels. It nominated Mozambique as the representative of the Region for the next three years.

Fifth meeting, 15 September 1986

7. Choice of subject for the Technical Discussions in 1987

The Committee chose the following subject for the technical discussions at its thirty-seventh session: "Operational support for primary health care (peripheral level)".

Sixth meeting, 16 September 1986

8. Nomination of the Chairman and Alternate Chairman of the Technical Discussions in 1987

The Regional Committee nominated Dr Dibandala Ngandou-Kabeya and Dr Martin P. Mandara as Chairman and alternate Chairman respectively of the technical discussions at the thirty-seventh session.

Sixth meeting, 16 September 1986

9. Dates and places of the thirty-seventh and thirty-eighth sessions of the Regional Committee

The Regional Committee decided to hold its thirty-seventh session in Bamako (Mali) in September 1987 and its thirty-eighth session in Brazzaville (Congo) in September 1988. 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.

Sixth meeting, 16 September 1986

10. Agendas of the Seventy-ninth session of the Executive Board and the Fortieth World Health Assembly: regional repercussions

The Regional Committee approved the provisional agenda of the thirty-seventh session of the Regional Committee proposed by the Regional Director in Annex 4 of document AFR/RC36/6.

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

Sixth meeting, 16 September 1986

11. 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 in 1988 will be designated at the thirty-seventh session of the Regional Committee in 1987. The countries of Sub-Region II should propose at that session a candidate for the President of the World Health Assembly in 1988. Thereafter, countries of Sub-Region III and Sub-Region I will propose a candidate in turn.

Vice-President of the World Health Assembly

(2) The Chairman of the thirty-sixth session of the Regional Committee will be proposed for the office of one of the Vice-Presidents of the Fortieth World Health Assembly in May 1987. 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 Fortieth World Health Assembly are Equatorial Guinea, Guinea, Côte d'Ivoire and Kenya.

(5) The new members of the Executive Board will be designated by Malawi, Mali, Mauritania and Mauritius.

(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 Fortieth World Health Assembly

(8) The representative of Zaire shall speak on behalf of the Region at the closure of the Fortieth World Health Assembly.

Informal meeting of the Regional Committee

(9) The Regional Director will convene this meeting on Monday, 4 May 1987 at 10 a.m. at the Palais des Nations, Geneva, to confirm the decisions taken by the Regional Committee at its thirty-sixth session.

Sixth meeting, 16 September 1986

RESOLUTIONS

AFR/RC36/R1 The work of WHO in 1985: Succinct report of the Regional Director for 1985

The Regional Committee,

Having examined the succinct report of the Regional Director for 1985;

Noting that its presentation complies with resolution AFR/RC25/R2;

Recognizing the gravity of the current financial situation of the Organization and its adverse effects on programme implementation,

1. APPROVES the report of the Regional Director;
2. CONGRATULATES the Regional Director on measures taken to reorganize the Regional Office and decentralize resources in order to enhance the efficiency and impact of the Organization at the operational level;
3. INVITES the Member States to:
 - (i) take appropriate steps to accelerate the achievement of HFA/2000 by placing emphasis on activities at the local level;
 - (ii) intensify the development of national health systems based on primary health care, using as a frame of reference the three-year plan of action for the period 1986-1988 endorsed by the Committee at its thirty-fifth session;
 - (iii) formulate and implement rational policies on the development and utilization of health manpower;
 - (iv) strengthen the capabilities for planning, implementation, monitoring and evaluation of health programmes;

4. REQUESTS the Regional Director to:

- (i) pursue relentlessly his efforts at intersectoral collaboration and, to this end, to support countries in establishing appropriate structures for intersectoral collaboration, especially at the local level;
- (ii) take appropriate measures to mobilize adequate extrabudgetary funds needed to support primary health care especially at the local level.

Sixth meeting, 16 September 1986

AFR/RC36/R2 Acceleration of the Implementation of Health for All
in the African Region of WHO

The Regional Committee,

Having examined the succinct report of the Regional Director on the work of WHO in 1985;

Having examined the report of the Regional Director on the regional programme budget policy and the Proposed Programme Budget 1988-1989;

Noting that the process for programming and budgeting WHO's resources should make it possible to implement the health policy that has been adopted collectively;

Realizing that the weak point in the provision of support for primary health care is the lack or inadequacy of managerial mechanisms at operational level;

Recalling resolution WHA39.7 urging Member States to lay particular emphasis on district health systems for the delivery of essential elements of primary health care;

Considering that many activities undertaken by government and other agencies at the periphery cannot be sustained because of the lack of managerial capacity and an infrastructure to ensure continuity;

Acknowledging that this managerial shortcoming is the main reason why progress remains elusive in spite of effort and expenditure on vertical programmes,

1. INVITES Member States to earmark at least 5% of the Organization's regular budget funds for improvement of the managerial process at district level to permit the coordination and integration of all primary health care activities at that level, and to derive maximum benefit from all available health resources;

2. REQUESTS the Director-General and the Regional Director to use every means and to take every opportunity to urge potential, national, international, bilateral and nongovernmental funding agencies to mobilize additional financial resources in order to strengthen the implementation of national strategies at district level.

Sixth meeting, 16 September 1986

AFR/RC36/R3 Regional Programme Budget Policy

The Regional Committee,

Noting resolutions EB75.R7 and WHA38.11 requesting the Regional Committee to prepare a regional programme budget policy;

Recognizing the need for Member States to make optimal use of WHO's limited resources for activities that are consistent with health policies adopted collectively by the Member States in WHO for the achievement of HFA/2000;

Having studied thoroughly the report presented by the Programme Sub-Committee,

1. NOTES with satisfaction that the programme budget policy provides a useful synthesis of the existing collective policies of the Organization and outlines a managerial framework for incorporating these policies into national activities to implement the programme budget;
2. OBSERVES that the proposed programme budget policy offers an effective way of improving the partnership between Member States and WHO;
3. RECOMMENDS that the implementation of such policy be monitored and evaluated in order to properly reflect the progress made by the Organization in the Region;
4. INVITES Member States to assume their responsibility in the preparation and implementation of the regional programme budget policy;
5. REQUESTS the Regional Director:
 - (i) to lend his support to Member States in their efforts to develop more effective mechanisms for the preparation, implementation, monitoring and evaluation of the programme budget process;
 - (ii) to ensure that in future, regional programme budget proposals are prepared jointly with all Member States in accordance with such policy.

Sixth meeting, 16 September 1986

AFR/RC36/R4 Proposed Programme Budget 1988-1989

The Regional Committee,

Having studied in detail the report submitted by the Programme Sub-Committee charged with considering the Proposed Programme Budget 1988-1989,

1. NOTES that the Programme Budget has been prepared in accordance with the guidelines laid down by the Thirty-eighth World Health Assembly, and that a zero growth rate in real terms has been the basis for budgeting the Regional Office and regional activities;
2. OBSERVES that participation by members of the Programme Sub-Committee in Regional Programme Meetings, with a view to preparation of the programme budget, facilitates the work and decision of the Regional Committee;
3. COMMENDS the Regional Director and his Secretariat for taking this initiative in order to give concrete expression to the new policy direction in harmony with the new structure of the Regional Office for Africa;
4. APPROVES the report of the Programme Sub-Committee;
5. REQUESTS the Regional Director to transmit the Programme Budget 1988-1989 to the Director-General for examination and inclusion in the Organization's Proposed Programme Budget 1988-1989.

Sixth meeting, 16 September 1986

AFR/RC36/R5 Eighth General Programme of Work covering the period 1990-1995

The Regional Committee,

Having taken note of the approach adopted by the Regional Director in the preparation of the contribution of the African Region to the Eighth General Programme of Work (8GPW);

Noting with satisfaction that the formulation of this programme has been guided by a concern to follow up the Seventh General Programme of Work (7GPW), with appropriate adjustments;

Endorsing the relevant comments and recommendations of the African Advisory Committee for Health Development (AACHD) and the Programme Sub-Committee,

1. APPROVES document AFR/RC36/10 as amended by the Programme Sub-Committee;
2. REQUESTS the Regional Director to transmit document AFR/RC36/10 to the Director-General as the contribution of the African Region to the Eighth General Programme of Work (8GPW).

Sixth meeting, 16 September 1986

AFR/RC36/R6 Regional Antimalaria Strategy

The Regional Committee,

Having studied the Regional Director's report on the antimalaria strategy;

Recognizing that the malaria situation in most African countries is jeopardizing not only the health of their populations but also their overall socioeconomic development and progress towards achievement of the goal of Health for All by the Year 2000;

Considering that most of the recommendations in resolution WHA31.45 adopted by the Thirty-first World Health Assembly when it re-examined the global antimalaria strategy, and in subsequent resolutions of the World Health Assembly and the Regional Committee, have not been implemented,

1. ENDORSES the report of the Regional Director;
2. EMPHASIZES the need for Member States to make a steadfast commitment to combat malaria by releasing adequate resources at national, regional and international levels;
3. URGES Member States to:
 - (i) reorient their malaria control programmes - with the ultimate aim of achieving malaria eradication wherever possible - as an integral part of national health programmes in accordance with the guidelines set out in the Regional Director's report, and
 - (ii) increase their commitment (financial, administrative and technical) to malaria control as part of their national development plans;
4. INVITES funding agencies to provide concrete support for malaria control activities in the countries;
5. REQUESTS the Regional Director:
 - (i) to continue to provide technical guidance and support to national antimalaria activities;
 - (ii) to promote subregional and regional coordination of national antimalaria programmes;
 - (iii) to provide technical support to the countries for integration of malaria control activities into the PHC system, particularly in relation to the training and equipping of community health workers;
 - (iv) to continue to develop a regional network for training community health workers in the field of malaria;

- (v) to promote and strengthen research activities leading to meaningful development of measures for malaria control;
- (vi) to seek the collaboration of the programme of research in tropical diseases (TDR) for the purpose of bringing drug resistance speedily under control in countries of the Region that are facing the problem;
- (vii) to explore every possibility of securing additional extrabudgetary resources for the malaria action programme;
- (viii) to keep the malaria situation and the development of the antimalaria programme under continuous review and to report regularly to the Regional Committee.
- (ix) to initiate a programme aimed at the control of the malaria vector.

Sixth meeting, 16 September 1986

AFR/RC36/R7 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, AFR/RC34/R3, AFR/RC35/R8;

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

1. ENDORSES the Regional Director's proposals;
2. COMMENDS the Regional Director for steps already taken;
3. ADOPTS the proposal made by the Regional Director on a structured working relationship between Member States, WHO/AFRO and nongovernmental organizations (NGOs);

4. CALLS UPON Member States to:

- (i) pursue implementation of the said resolutions;
- (ii) make optimal use of existing resources and mobilize potential ones for implementation of health activities at the peripheral level;
- (iii) promote and sustain intersectoral collaboration where it exists, and introduce and strengthen it where it does not, in order to accelerate the health development process in the attainment of HFA/2000;

5. REQUESTS the Regional Director to continue support to the Member States in the implementation of the said resolutions.

Sixth meeting, 16 September 1986

AFR/RC36/R8 Establishment of "Dr Comlan A. A. Quenum prize for public health"

The Regional Committee,

Considering the discussions during the thirty-sixth session of the Regional Committee for Africa concerning the proposal of the Government of Cameroon to honour the memory of the late Dr Comlan A. A. Quenum by the establishment of a prize for public health bearing his name;

Bearing in mind paragraphs 6.6 and 6.7 of the Financial Regulations of WHO,

1. PAYS TRIBUTE to the memory of Dr Comlan A. A. Quenum;
2. EXPRESSES its gratitude to the Government of Cameroon for its timely and appropriate initiative;

3. INVITES Member States, organizations and persons of goodwill to contribute to the fund that has been opened for the prize;
4. RECOMMENDS to the World Health Assembly the establishment of "Dr Comlan A. A. Quenum Prize for Public Health in Africa".

Sixth meeting, 16 September 1986

AFR/RC36/R9 Control of diarrhoeal diseases

The Regional Committee,

Having considered the report of the Regional Director on the diarrhoeal disease control programme;

Recalling resolution AFR/RC35/R6,

1. NOTES with satisfaction the progress made in the implementation of the diarrhoeal disease control programme in the Region;
2. URGES Member States to intensify diarrhoeal disease control as part of activities related to maternal and child health, especially in view of the expected immediate impact on early childhood mortality;
3. EXPRESSES its gratitude to the United Nations Children's Fund and other international and bilateral agencies that support the programme;
4. REQUESTS the Regional Director to:
 - (i) continue to collaborate with Member States in developing and strengthening national programmes through planning, training and evaluation;
 - (ii) strengthen the Organization's support for operational research, including research on traditional methods for treating and preventing diarrhoeal diseases;

- (iii) continue to collaborate with UNICEF and other agencies taking part in the programme;
- (iv) continue to mobilize extrabudgetary resources for diarrhoeal disease control activities;
- (v) keep the Regional Committee regularly informed of progress made in the implementation of this programme.
- (vi) seek funds for developing a programme of research in the use of traditional methods in the treatment and control of diarrhoeal diseases.

Sixth meeting, 16 September 1986

AFR/RC36/R10 Motion of sympathy to the government of the Republic of Cameroon

The Regional Committee,

Having been informed of the disaster that occurred on 21 August 1986 at Lake Nyos in North-West Cameroon, where an emission of poisonous gas caused considerable losses, particularly in human lives;

Considering that, according to the experts' reports, there is a potential danger that the phenomenon may recur,

1. EXPRESSES its deep sympathy to the people and Government of Cameroon for the incalculable harm done to the stricken communities;
2. COMMENDS the Government of Cameroon on the efficacy with which assistance was provided to the disaster victims;
3. APPRECIATES the rapidity with which the international community and friendly countries responded to the appeal made by the Cameroon authorities;

4. TAKES NOTE with gratification of the measures taken by the Regional Director in support of the efforts of the Government of Cameroon;
5. REQUESTS the Regional Director to:
- (i) keep a close watch on the situation and continue to accord maximum WHO support to the Government of Cameroon;
 - (ii) transmit this resolution to the Government and people of Cameroon.

Sixth meeting, 16 September 1986

AFR/RC36/R11 The primary health care approach to the promotion and protection of the health of farm workers during the industrial development decade in Africa

The Regional Committee,

Having noted the report on the technical discussions (document AFR/RC36/15),

Concerned at the precarious health and social situation of farm workers;

Considering that farm workers constitute from 80 to 90 per cent of the population in most countries of the Region,

1. REQUESTS Member States:

- (a) to accord higher priority to solving the health problems of farm workers within their national health development strategies based on primary health care;
- (b) to frame and strengthen appropriate legislation concerning protection and promotion of the health of farm workers, including legislation on the importation and utilization of chemicals/insecticides in agriculture;

- (c) collaborate with the international and nongovernmental organizations, industries and farm workers in developing activities calculated to raise the living standards of the entire rural population in such spheres as:
 - low cost housing;
 - water supply and sanitation;
 - electrification;
 - mass information and education;
 - nutrition;
- (d) include in the training programmes for the various categories of professional health workers, specific aspects of farm workers' health and social problems;
- (e) promote coordination and collaboration between the various sectors concerned with the health of farm workers, in particular the departments of health, labour, agriculture, education and public works, in order to:
 - (i) plan integrated health and social services for farm workers, etc;
 - (ii) make joint use of the appropriate resources of the various development sectors concerned;

2. REQUESTS the Regional Director;

- (a) to strengthen the regional "Workers' Health" programme so as to pay special attention to farm workers;
- (b) to organize a meeting of experts for the purpose of making a deeper examination of this matter and to make practical recommendations to improve the health and social conditions of farm workers within the framework of the HFA/2000 strategy;
- (c) to give the support required to measures to promote the health of farm workers, particularly at local level;

- (d) to strengthen the collaboration of the Regional Office with the specialized bodies of the United Nations, more especially FAO, ILO, UNIDO, UNEP and UNICEF, the regional bodies such as OAU and ECA in particular, and the nongovernmental bodies concerned, for the integrated planning and implementation of health and social programmes for farm workers;
- (e) to keep the Regional Committee informed of the measures taken and the projects carried out in this field;

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

Sixth meeting, 16 September 1986

PART II

OPENING OF THE SESSION

1. The Thirty-sixth session of the Regional Committee for Africa of the World Health Organization was opened on 10 September 1986 at the WHO Regional Office in Brazzaville, in the presence of His Excellency Colonel Denis Sassou Nguesso, Chairman of the Central Committee of the Congolese Workers' Party, President of the Republic, Head of Government and current Chairman of the Organization of African Unity. The opening ceremony was attended by members of the Political Bureau of the Central Committee of the Congolese Workers' Party and of the Government, representatives of 43 Member States and of the National Liberation Movements recognized by the OAU, the Diplomatic Corps, and representatives of several international and non-governmental organizations.
2. Professor Agbeta, Acting Chairman, opened the thirty-sixth session of the Regional Committee for Africa and called on the Director-General of WHO to address the meeting.
3. The Director-General (see Annex 1 for full address) said that the Thirty-Ninth World Health Assembly in May had been treated by the press as a political jamboree but in reality had been full of health content. The ever-present danger of political explosions had been averted, thanks to the good sense that had prevailed and must continue to prevail if WHO was to survive as the socially relevant international health organization.
4. While there was a high degree of international solidarity regarding health, there had been little or none regarding other sectors. North-South relationships had degenerated into a dialogue of the deaf, and that deafness was threatening to infiltrate international health endeavours. Only exemplary action in the field of health could help to restore confidence. Outstanding leadership would be needed for that, and success with regard to health might even help to restore confidence in other spheres. That leadership, if exerted, would fill an all-too-evident vacuum, for the benefit of the peoples of Africa, to whom all those present were ultimately accountable.
5. The Director-General commended the African Region for its valuable contribution to the world-wide evaluation of the Health for All Strategy at the Health Assembly. It had become clear that evaluation must constitute a normal part of health system management, and that the lessons learned from it

must be promptly applied. The Health Assembly had also recognized that district health systems could provide a good opportunity for people to become genuinely involved in shaping their own health care. However, decentralization must be carried out within a sound national policy framework and in a politically and fiscally responsible manner.

6. He expressed the view that the crisis of confidence facing the Organization could be solved only by demonstrating that WHO was capable of using its resources efficiently and reaching its goal of Health for All by the Year 2000. More countries must show that the strategy was not merely viable, but the only reasonable response in a situation of growing problems and diminishing resources.

7. In his address (Annex 2) the Acting Chairman said that it was a great honour for him to welcome to the opening ceremony His Excellency Colonel Denis Sassou Nguesso, President of the People's Republic of the Congo and current Chairman of the Organization of African Unity. It was the first time that the Regional Committee had welcomed a Chairman of the OAU, whose presence would encourage the Committee in its search for solutions to the various problems on the agenda of the session.

8. Addressing the Director-General, he thanked him for the interest that he had always shown in the African Region; his statement at the Thirty-ninth World Health Assembly had shown that his views on the implementation of primary health care were identical with those held in Africa. He could assure the Director-General that the political will to implement primary health care in Africa really existed. He expressed his confidence that unity would provide the strength needed to overcome the obstacles on the road to Health for All by the Year 2000 in Africa.

9. The main task of the meeting would be to review health activities in the Region during the previous year and the possibilities for further action. In that connection, he congratulated the Regional Director on the speed with which the new Regional Office structure had been established, and in particular the Subregional Offices, the new management system (AFROPOC), and the strengthening of WHO representation in countries. The African

Immunization Year had been favourably received everywhere. All countries had increased their efforts to make their populations aware of the expanded programme on immunization (EPI). That was essential, since it would affect all EPI activities up to 1990, by which time 75% of the target population should have been vaccinated.

10. The Acting Chairman referred to the economic crisis still seriously affecting Africa, which also suffered from fratricidal conflicts and wars inspired by destabilization or apartheid. Natural disasters were also causing grave problems in countries that had only just emerged from a disastrous drought. Yet agriculture and increased productivity were vital in combating malnutrition.

11. Addressing the Committee (Annex 3) the Regional Director said that AFRO had to succeed both to safeguard its Organization and for the sake of Africa. Never before had the United Nations agencies been so disparaged as they were at the present time. The UN agencies, including the most highly specialized such as WHO, were coming under constant scrutiny. Contributions were shrinking, poor results were obtained from resources available and the UN agencies were imperilled. It was therefore essential to adapt to the economic situation and be more realistic in the formulation of projects and the use of appropriate technologies.

12. Only enhanced assistance, good policy and determination to reform could fulfil the promise of profitable investment leading to accelerated growth over the next decade. Therefore, the only way out was to succeed. With the crisis of the industrialized countries constituting a crushing burden and the North-South dialogue long since deadlocked, the time had come to be self-reliant. He recalled that the Regional Committee, at its meeting in Lusaka in 1985, had accepted a three-year strategy for action. A working paper had outlined the ways and means of accelerating the achievement of Health for All by the Year 2000 in Member States of the African Region. It had subsequently been proposed to the countries that they should put its recommendations into practice at district level, which was the most peripheral of all.

13. Administrative structures had also to be adapted to the strategy of decentralization, and the WHO Representative in the country spearheaded the plan of action in the field. His role has been strengthened and he was now responsible for local work at district level. His work would be adapted to the countries' needs and have the full agreement of the Ministry of Health, which was the vehicle of State policy. The three Subregional Offices were the instrument of the policy of decentralization. The Director of each Office would respond to the countries' requests without having to go through the usual bureaucratic channels. Offices which were not yet fully operational were expected to become operational very shortly.

14. Finally the Regional Office itself had been reorganized and a system called AFROPOC installed. The AFROPOC unit stored all the programming planned for the current year and all activities were budgeted. That computerized system was meticulous but not inflexible.

15. The African populations, the WHO Member States and their Regional Office in Africa were already on the march. Action was being undertaken with unrelenting firmness of purpose and, with the total and unfailing cooperation of all, the goal of Health for All by the Year 2000, which should not be regarded merely as a deadline, would be achieved. The Year 2000 should be regarded as a driving force for surpassing one's own achievements and attaining a condition to which every human being was entitled: a decent standard of living for himself and his children.

16. A medal was then presented to the President of the Republic of the Congo to commemorate his joint status as President of the Republic and Chairman of the Organization of African Unity (OAU).

17. In his address (Annex 4) Colonel Denis Sassou Nguesso, President of the Peoples' Republic of the Congo and current Chairman of the Organization of African Unity, said that it was a privilege for the people, the Workers' Party and the Government of the People's Republic of the Congo to host the thirty-sixth Regional Committee for Africa. He commended the Regional

Director and his staff for the skill with which they were continuing the task of seeking ways to achieve the goal of Health for All by the Year 2000, and paid tribute to the memory of Dr Comlan A. A. Quenum, first African Regional Director for Africa.

18. The worsening world economic crisis had been felt particularly acutely in the Third World and had reached dramatic proportions in Africa. That situation, fratricidal wars, internal conflict and natural disasters were hampering the work of WHO and the countries and threatening the fragile achievements that had been made in the health field. Although the People's Republic of the Congo was also a victim of the world economic crisis, it remained determined to consolidate what it had achieved towards Health for All by the Year 2000. Health and social development had been a priority for his country for many years. Primary health care was being implemented and extended to the smaller towns and rural areas. It was hoped to strengthen preventive and curative care, the provision of essential drugs, the expanded programme on immunization, sanitation and nutrition, with community involvement. The support WHO was providing for those efforts was greatly appreciated, especially in the field of health manpower training. The many difficulties confronting Africa made it imperative for the countries of the Region to combine their efforts to solve their health problems.

ORGANIZATION OF WORK

19. The agenda adopted by the Regional Committee is reproduced as Annex 6, the list of participants as Annex 8.

20. In accordance with resolution AFR/RC23/R1 the Committee approved the membership of the Sub-Committee on Nominations (Decision No.1).

21. The election of officers for the thirty-sixth session of the Regional Committee and the appointment of Rapporteurs for the technical discussions are dealt with in Procedural Decision No. 2 (see page 1).

PROCEEDINGS

THE WORK OF WHO IN 1985: SUCCINCT REPORT OF THE REGIONAL DIRECTOR

Introductory statement

22. Introducing his report (Document AFR/RC36/3), the Regional Director said that the document was limited to what had actually occurred in 1985 and did not incorporate material from previous years or projections for future years. It was thus more chronologically realistic. The first section outlined aspects of the reorganization of the Regional Office, while the rest dealt with various activities in eight different programme areas.

23. During 1985 the crisis in Africa continued. Many countries, particularly Ethiopia, had suffered considerably from drought. WHO and its sister agencies of the United Nations system were actively involved under the leadership of the Secretary-General in dealing with a crisis that had caught the world unawares. That was the background to the urgency of WHO's work; the Organization could not allow itself to be seen inactive.

24. The reorganization of the Regional Office that had been dictated by the requirements of efficiency had the following essential features: the creation of subregional health development offices, the strengthening of the offices of the WHO Representatives and the reorganization of the Regional Office structure. The Regional Director had earlier engaged in consultations with the countries, in the course of working visits, and with the Secretariat. The Director-General personally spent a week at the Regional Office to participate in devising the new structure. Finally, WHO auditors and administrative management experts had visited the Regional Office in 1984 and their proposals had also been borne in mind.

25. The Regional Committee was duly informed of the new structure of the Regional Office at its thirty-fifth session in 1985 and took note of it with satisfaction. The most important change was the emphasis on strengthening the WHO Offices in the countries, many of which had a staff of only one or two and were poorly supported. That had been achieved in part, thanks to resolution AFR/RC35/R7 adopted at the thirty-fifth session of the Regional Committee

urging the Regional Director gradually to put an end to the experiment of using nationals as WHO Programme Coordinators. For all practical purposes, that had been completed and international WHO Representatives were either working or had been nominated in nearly all countries. While the process was being completed and strengthened, that in itself was not enough, however, and intensive briefing sessions for WHO Representatives had been held in Geneva, as well as similar meetings at the Regional Office. That process would continue, and the Regional Committee itself would serve as a briefing for WHO Representatives.

26. WHO Representatives should serve as focal points for the monitoring of the Health for All process. They would soon be equipped with microcomputers and provided with administrative assistants in order to enable them to serve effectively as technical advisers to ministries of health, and to coordinate the mobilization and utilization of health resources from other sectors. Many countries also had information and documentation officers, whose main role was to promote public awareness of WHO activities and to provide feed-back to WHO on country activities.

27. As part of the decentralization process initiated by Dr Quenum, three Subregional Health Development Offices had been established in the three Sub-Regions. The emphasis was therefore placed on work in the field and support to PHC at local level. The Subregional Offices were not to become a barrier between the Regional Office and countries; they should not form an intermediate stage in the hierarchy. However, they were very important technical resources, especially in the implementation of primary health care at the local level, and therefore incarnated the new policy emphasis on accelerating the achievement of HFA/2000. That approach should facilitate intersectoral collaboration and coordination. The Regional Director thanked the Governments of Burundi, Mali and Zimbabwe for hosting the Subregional Offices.

28. The Regional Office itself had been restructured on the principle that it represented a back-up for countries. The Regional Office was not a supranational Ministry of Health and the Regional Director was not a supranational Minister of Health. Programme operations were coordinated by the AFROPOC system whereby, before 1 January, consultations should have taken place between WHO and each country on projects for 1987, as far as they could

be foreseen. A document would then be signed by the Ministry of Health on behalf of the Government, and by the Regional Director on behalf of WHO, constituting an agreement on the implementation of WHO country collaborative activities during the year. The WHO Representative only had to implement what had been agreed. The system was flexible.

29. The new Regional Office structure was beginning to function, and he believed it would function well. However, as observed by the Director-General, what was important was not the structure on paper but those who operated it, and he was taking care to recruit the right people for the job. Many changes had already been made, and still more might be made as implementation of the regional programme proceeded. Failure could not be contemplated.

30. The Regional Director said that the need had been felt to consult small groups of experts in areas such as nursing, where weaknesses had been spotted. A consultation had been held on National and Regional Health Development Centres, whose functions were now being reconsidered as a result, and another on intersectoral cooperation in national strategies for Health for All by the Year 2000, involving both Ministers of Health and other Ministers, such as those responsible for water, sanitation and education. Such round-tables would be continued.

31. At its thirty-fifth session in 1985, the Regional Committee had discussed Accelerating the achievement of HFA/2000 through activities at the local level. A scenario had then been adopted whereby health systems at the peripheral level would be covered in 1986, those at intermediate level in 1987, and those at central level in 1988. That did not mean, of course, that countries could ignore the intermediate and central levels in 1986, but only that they should concentrate their efforts on those levels in turn in successive years. Health systems were indivisible, and it was merely convenient to identify the problems at the various levels in that way. In 1987, the Regional Committee would review operational support activities in all the countries of the Region; that would be the subject of the 1987 Technical Discussions. Further discussions would be held in proper sequence. The review would cover not only the infrastructure but also programme activities. In 1986, there was special interest in EPI, since it was also African Immunization Year, in pursuance of resolution AFR/RC35/R9.

32. It was hoped that, by January 1990, all countries would have reviewed their health systems completely and acted to strengthen them. That would put them in a good position to start the race for the year 2000 and it would be a fairly fast race, because the infrastructure had been strengthened. Without that, there would be problems in attaining the goal.

33. The Nairobi Conference marked the end of the United Nations Decade for Women. Activities were being carried out by women in various parts of the Region; they were very important and were taking place in the framework of primary health care. Such activities provided a kind of nucleus around which other primary health care activities could be centred.

34. Many activities in the field of information and education for health were under way and more were planned, especially one initiative at the University of Dakar, where student journalists were being trained in health journalism.

35. He would leave it to delegates to comment on other areas; their questions would be dealt with by the staff members concerned. However, he wished to draw attention to the FAO/WHO/OAU Food and Nutrition Commission for Africa, in which these three organizations had collaborated for some twenty years. A review of the situation had been conducted in 1985, but he had taken the stand that it could not be a purely bureaucratic exercise without field work. He did not want to be party to it if it had no impact on people in the Region. Meetings between WHO and UNICEF had been started and both organizations had invited others to join them in nutrition work in the field.

36. 1985 had been a year in which programmes had to be curtailed because of budgetary constraints; the financial crisis of the United Nations system had seriously affected WHO. That would be discussed under the item dealing with the budget, but he hoped that delegates would ask questions during the first week while Mr Furth, Assistant Director-General for Administration, was present.

Discussion

37. The Regional Committee commended the Regional Director for his succinct report that highlighted the main features of the Organization's work in Africa during 1985. It gave a frank analysis of problems and successes in the conduct of the regional programme during the period under review.

38. The Committee stressed the importance of the restructuring of the Regional Organization.

39. The establishment of Subregional Health Development Offices had already shown some signs of effectiveness. It was of course too early to evaluate their impact. The Office for Subregion III had been operational only since the end of 1985, for Subregion I since January 1986 and for Subregion II since the end of the first quarter of 1986.

40. Each Subregional Office was staffed by: (i) a strategic support team dealing with health systems management, health manpower development, continuing education, and health systems research, placing particular emphasis on district level; (ii) a technical support team mainly responsible for nutrition, epidemiology and disease control, public information and education for health, and drinking-water supply and sanitation, and (iii) an administrative support team that performed the general administrative functions of the Subregional Office and coordinated programme operations by providing the countries of the Subregion with expertise in regard to equipment, administration and financing. The priority objective of the Subregional Offices is to help the countries give support to primary health care at district level.

41. The main body of personnel are members of the former intercountry project posts, merged into the subregional teams. In spite of financial constraints it had been possible to mobilize extrabudgetary funds for technical activities.

42. The Subregional Offices would also be responsible as from 1987 for organizing subregional TCDC meetings geared to the solution of problems specific to the Sub-Region and attuning their discussions to the technical discussions of the Regional Committee in accordance with Decision No. 7 taken at the thirty-fifth session.

43. The establishment of subregional teams should solve the problem of communication between the countries and the Regional Office by bringing technical decisions closer to the country level. The snag of an additional hierarchical and bureaucratic echelon was obviated by clear definition of the roles of the Subregional and Regional Offices.

44. It remained essential for evaluation of the activities of the Subregional Offices to be conducted in terms of achievements in the field in relation to operating costs; such an evaluation would be made regularly and submitted to the Regional Committee.

45. All the countries had appreciated the establishment of the AFROPOC system, which should facilitate continuous monitoring and evaluation of the utilization of WHO's resources in relation to the activities jointly programmed by the countries and the Organization.

46. With regard to the implementation of primary health care at the district level, the countries felt that the outline plan prepared by the Regional Director was a valuable tool for accelerating the achievement of health for all. It remained, however, to overcome certain obstacles pertaining to: (i) clear understanding by the medical and nursing professions of the concept of PHC; and (ii) effective decentralization of national health systems. It was imperative that the training curricula for doctors and other health personnel be reoriented so that they could master the concept of PHC and appreciate the need for intersectoral action in solving health problems.

47. Resistance to decentralization must be overcome if intersectoral activities at the district level were to be organized, coordinated and evaluated by the communities themselves. Such decentralization of the managerial process was basic to the success of PHC.

48. The Regional Committee stressed the need to assign high priority to the expanded programme on immunization, control of diarrhoeal diseases, and the essential drugs programme, while avoiding a vertical approach.

49. The need was mentioned for local drug production whenever feasible as a means of reducing drug costs and promoting self-reliance.

50. Progress had been made in the field of community water supply and sanitation, although funds needed were not always available.

DIARRHOEAL DISEASES CONTROL PROGRAMME

Introductory statement

51. Pursuant to resolution AFR/RC35/R6, the Regional Director had conducted an evaluation of the diarrhoeal diseases control programme (CDD) in the African Region for the period 1978-1985.

52. Dr D. Buriot introduced the report of the Regional Director (document AFR/RC36/20) which provided the Regional Committee with information on progress made and problems encountered during implementation of the programme, and was intended to encourage the Member States of the Region to take appropriate measures to achieve the objectives and targets that had been set.

53. Evaluation of the programme followed the WHO guiding principles for evaluation of health programmes (Health for All series, No.6).

54. The relevance and importance of CDD had become evident, given the dimensions of the problems to be solved. The programme was in compliance with the overall target of Health for All by the Year 2000.

55. The formulation of diarrhoeal diseases control strategies was based on a clear definition of problems.

56. In Africa, from 200 to 300 million episodes of diarrhoea occurring in some 75 million children under five are responsible for:

- (i) the death of one million children;
- (ii) the aggravation of the nutritional status of several million other children;
- (iii) thirty percent of hospital admissions;
- v) several million dollars expenditure on treatment, mostly borne by national budgets.

57. The diarrhoeal diseases control programme was an integral part of primary health care activities at national and regional levels.

58. Regional targets had been set for 1989; these consisted in providing 50% of children under the age of five with access to oral rehydration salts (ORS) and the use of oral rehydration therapy (ORT) for 35% of children under five. The programme should prevent the deaths of 300 000 children under five annually in the Region.

59. By the end of 1985, 35 countries out of a total of 45 had prepared their plan of operation. However, only 17 countries had a national programme implemented in accordance with their written plan of operations and were supplied regularly with ORS sachets either from national production or from UNICEF, WHO, or bilateral agencies. Progress of the programmes was monitored by a series of important global indicators adapted to national needs.

60. Local production of sachets of oral rehydration salts had been implemented in seven countries. UNICEF was the main external supplier of ORS in Africa and WHO and UNICEF had jointly determined criteria for quality. Nearly all ORS packets produced in the Region at present complied with those criteria.

61. WHO and its Member countries had made significant progress in upgrading the management skills of health staff. Current training priorities were training of district level personnel, "hands on" clinical training, and continuing education of physicians and nurses. Emphasis was being placed on the integration of CDD into training curricula for health personnel and the training of village health workers who interact with the family and are directly involved in activities at community level.

62. Three subregional diarrhoea training centres were already operating and three more were being established. By the end of 1985, 32 countries had undertaken activities in the field of social mobilization for the programme, ranging from the production of health education material for mothers and health workers to large-scale information campaigns including the use of radio and television.

63. Fourteen countries had undertaken at least one complete programme evaluation to ascertain success and constraints and to take the necessary corrective measures.

64. Operational research to improve the delivery of programme strategies and studies on the behaviour and practices of families and the community in regard to diarrhoeal diseases was given high priority.

65. Programme efficiency could be estimated by evaluating access to ORS and the use of ORT by the most vulnerable population groups, namely children under the age of five.

66. There had been a marked increase in the percentage of the population with access to ORS from less than one percent in 1982 to 13% in 1984.

67. This was the result of an increased supply of ORS in the countries concerned, thanks to local production and to imports, to their more active distribution, availability of trained personnel and improved data collection.

68. The minimum estimated rate of use of ORT (the proportion of diarrhoeal episodes in children under five treated with ORS or salt/sugar solution or other effective solutions prepared at home) had risen from one percent in 1983 to seven percent in 1984.

69. The increase in the use made of ORT was an outcome of the extension and strengthening of training activities and of a more intensive use of the mass media.

70. Although the countries had made praiseworthy efforts to implement their national programmes, execution of most programmes had been under way for less than three years and their effectiveness in controlling diarrhoeal diseases could only be estimated at this stage.

71. Between 1981 and 1985, 34 surveys on diarrhoea-related mortality and morbidity and on the rate of use of ORT had been carried out in 15 countries of the Region.

72. The surveys showed that mortality and morbidity rates associated with diarrhoeal diseases were higher in countries where the health and social situations were more critical.

73. An effective CDD programme had a potential impact on health by diminishing the severity of diarrhoeal episodes, reducing the number of diarrhoea-related deaths and improving nutritional status. Furthermore, using ORT reduced the number of children who had to be hospitalized and thus reduced the costs of treatment.

74. Surveys in various countries based on hospital data had shown that using ORT reduced diarrhoeal disease-related mortality by two thirds, and led to a significant decrease in overall mortality. Thus, it was estimated that the practice resulted in 37 500 deaths in children under five being avoided in 1984.

75. The reduction of morbidity and mortality related to implementation of other strategies (improvement in nutritional status, use of safe drinking water, promotion of good physical and household hygiene) could not be calculated at present because data available at national and regional levels were insufficient.

Discussion

76. The Regional Committee expressed appreciation of the clarity of the report and the considerable quantity of pertinent information it contained. It emphasized the importance of obtaining exact data in order to ensure that the programme was followed up properly, and asked WHO to give support to strengthening national capabilities in data collection and analysis, especially at the peripheral level.

77. The Committee recognized that considerable progress had been made since 1978. Many obstacles found in the execution of national programmes were mentioned, and it was observed that they would have to be overcome if the programme objectives for 1989 were to be achieved. They concerned training, supervision, equipment and transport. The problem of the inadequacy of resources at national level for assumption of full national responsibility for the programmes was also raised.

78. It was acknowledged that the programme strategies were adapted to the regional situation and the Committee expressed the wish that special attention be paid to strategies for improving nutritional status, the utilization of safe drinking-water and the promotion of good personal and domestic hygiene.

79. The Committee stressed that it was necessary to identify solutions that could be prepared at home and kept available at all times, and that were at the same time culturally acceptable, safe and reliable in the prevention of dehydration, and asked the Regional Director to circulate information available on that subject to the countries.

80. Careful note was taken of the continuing resurgence of cholera epidemics in several countries of the Region and WHO was requested to pursue and increase its aid to the countries in order to contain the scourge.

81. Several countries announced that they intended to strengthen diarrhoeal disease control activities and to diversify those within the programme area by strengthening prevention and paying special attention to work at the peripheral level. They hoped that the Regional Office would be able to support them in such work.

82. After examining the Regional Director's report, the Regional Committee made the following recommendations:

- (i) strengthen political commitment at the highest level and foster community involvement;
- (ii) ensure integration of CDD into primary health care structures;
- (iii) formulate national strategies for utilisation of ORT;
- (iv) pay special attention to the distribution of ORS;
- (v) limit the promotion and use of certain anti-diarrhoeal drugs and antibiotics;
- (vi) assess the appropriateness of marketing ORS and adapt this practice to local conditions;

- (vii) give special attention to health manpower training which must include practical exercises;
- (viii) include CDD in training curricula for health personnel at all levels;
- (ix) give due attention to prevention strategies;
- (x) ensure regular monitoring of programme activities and allocate appropriate budgets for them;
- (xi) undertake periodic review and evaluation of the programme;
- (xii) encourage operational research aimed at solving practical problems;
- (xiii) make the best use of available resources and mobilize extrabudgetary resources.

83. Resolution AFR/RC36/R9 was adopted.

ESTABLISHMENT OF DR COMLAN A. A. QUENUM PRIZE FOR PUBLIC HEALTH IN AFRICA

Introductory statement

84. The Cameroon delegation introduced this agenda item by stating that the late Regional Director for Africa of the World Health Organization, Dr Comlan A. A. Quenum, was the first Black African to hold that prestigious post. He held office for nearly 20 years and as a great Pan-Africanist worked tirelessly to raise the level of health throughout the African continent, despite the fact that Africa contained a very large number of the world's least developed countries.

85. While the World Health Assembly awards a number of prizes for distinguished work in the field of health, until May 1986 none was won by a national from Black Africa, although the level of health education on the continent was rising fast.

86. In recognition of this fact, the Government of Cameroon, both in commemoration of the late Dr Quenum and to encourage health workers of the future, proposed to make a donation with a view to initiating a fund for Dr Comlan A. A. Quenum Prize for Public Health in Africa.

Discussion

87. The Committee unanimously agreed with this proposal and adopted resolution AFR/RC36/R8.

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

Introductory statement

88. Documents AFR/RC36/5 and AFR/RC36/5 Add.1 on the above subject were introduced by Dr B. A. Bella (Côte d'Ivoire), a member of the Executive Board. He pointed out that, as in previous years, the documents were designed to facilitate discussion during the Regional 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. The operative paragraphs of the resolutions with proposals for action were presented. The following 13 WHA resolutions were discussed:

- WHA39.7 Evaluation of the strategy for HFA/2000:
Seventh report on the World Health Situation
- WHA39.15 Global strategy for HFA/2000: Repercussions of the World
Economic Situation
- WHA39.18 Collaboration within the United Nations system - General
matters: Implementation requirements of the Nairobi
Forward-Looking Strategies for the advancement of women in
the health sector
- WHA39.22 Intersectoral cooperation in national strategies for health
- WHA39.24 Collaboration within the United Nations system: Liberation
struggle in southern Africa - Assistance to the front-line
States, Lesotho and Swaziland

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- WHA39.31 Prevention and control of iodine deficiency disorders
 - WHA39.28 Infant and young child feeding
 - WHA39.14 Tobacco or health
 - WHA39.26 Abuse of narcotic and psychotropic substances
 - WHA39.27 The rational use of drugs
 - WHA39.20 International drinking water supply and sanitation decade
 - WHA39.21 Elimination of dracunculiasis
 - WHA39.29 Acquired immunodeficiency syndrome.

89. The Committee's decision would be synthesized into a plan of work for implementation of the resolutions and decisions of the thirty-sixth session of the Regional Committee in order to facilitate monitoring of programme execution.

90. Proposals concerning implementation of the resolutions of regional interest were presented by major programme in accordance with the classified list of programmes for the period of execution covered by the Seventh General Programme of Work.

91. In document AFR/RC36/5 Add.1, the current guidelines concerning WHO relations with nongovernmental organizations (NGOs) were reviewed. The Regional Committee was requested to focus on regional and national NGOs, not affiliated to international NGOs, and the regional or national NGOs affiliated to international NGOs not in official relations with WHO. The Regional Committee was also requested to consider the Regional Director's proposal for a structured working relationship between Member States, WHO/AFRO and NGOs.

92. The Committee was invited to extend and deepen its analysis of the interregional, regional and national implications and lay down guidelines for development of the regional programme. In conclusion, the attention of the Regional Committee was drawn to the draft resolution presented for consideration.

Discussion

93. The following points were raised:

WHA39.7 - Evaluation of the strategy for Health for All by the Year 2000: seventh report on the World Health situation

94. The follow-up action proposed was accepted. It was however mentioned that a number of the indicators that had been selected were more suitable for the developed countries. WHO/AFRO was therefore requested to examine the possibility of modifying some indicators in order to make them more suitable and adaptable to African countries.

WHA39.22 - Intersectoral cooperation in national strategies for health

95. Reference was made to some problems encountered in the promotion of intersectoral cooperation. An appeal was therefore made for WHO/AFRO to identify the problems, to provide suitable solutions and to assist Member countries in applying them as appropriate.

WHA39.24 - Collaboration within the United Nations system. Liberation struggle in southern Africa: Assistance to front-line States, Lesotho and Swaziland.

96. Reference was made to the magnitude and cost of the damage caused to the health care delivery systems in Mozambique as an outcome of the destabilizing activities provoked by South Africa. The support already being given by WHO was highly appreciated. There was however an appeal to WHO to make greater efforts to mobilize additional support for the development of the health systems in the front-line States.

WHA39.28 - Infant and young child feeding

97. Concern was expressed about the failure of some African countries to comply with the International Code of Marketing of Breastmilk Substitutes.

98. It was mentioned that, contrary to belief, studies had shown a decline in breast-feeding in developing countries. There was consequently a fear that there might be a further decline as a result of industrialization and urbanization.

99. Governments were therefore urged to give serious attention to the Code in order to reverse the trend.

WHA39.26 - Abuse of narcotic and psychotropic drugs

100. The magnitude and complexity of the public health and social problems caused by alcohol, drug abuse and tobacco were highlighted.

101. It was suggested that the member countries and WHO should accord the highest priority to the problems of drug abuse, alcohol and tobacco.

102. In this regard, a request was made for the Regional Office to prepare a model legislation and guidelines for prevention and control which could be adapted by member countries.

WHA39.27 - Rational use of drugs

103. The proposed workshops on the promotion of national drug policies in English and French-speaking countries were described as most timely and useful.

104. It was proposed that consideration be given to the organization of a similar workshop in Portuguese.

105. The Regional Office was also requested to promote activities aimed at strengthening the managerial capabilities of pharmacists and those who handle drugs as a means of ensuring optimal use of available resources for the procurement and effective distribution of drugs.

106. Considering the question of indicators the Committee noted that work was in progress on relevant indicators within the framework of resolution WHA39.7 (see para 94), in such sectors as water supply, maternal and child health, immunization and nutrition, and also on indicators which could be used at village level to enable local people to monitor their own progress.

107. In respect of intersectoral cooperation, three meetings were to be held in November 1986 in Bamako (French-speaking), Harare (English-speaking) and Brazzaville (trilingual) pursuant to resolution WHA39.22 (see para 95). It was hoped that African Ministers of Health would also attend the forthcoming OAU meeting in Cairo.

108. There was now general agreement that activities involving women should form the nucleus of village-level activities, and that "pre-packed" projects should be phased out. Women should be allowed to choose which activities to undertake.

109. With regard to the promotion of national drug policies, it was mentioned that the English-speaking and French-speaking workshops referred to in paragraph 103 above would not be financed from AFRO funds, but from extrabudgetary resources. In respect of subregional quality control laboratories, the list presented to the Committee covered only the new subregional laboratories. The Secretariat would welcome details of the new laboratory in Mozambique for inclusion in its TCDC information.

AGENDAS OF THE SEVENTY-NINTH SESSION OF THE EXECUTIVE BOARD
AND THE FORTIETH WORLD HEALTH ASSEMBLY: REGIONAL REPERCUSSIONS

Introductory statement

110. Document AFR/RC36/6 was introduced by Dr A. P. Maruping (Lesotho), member of the Executive Board. The document presented the draft agendas of the forthcoming sessions of the governing bodies of WHO. The draft provisional agenda for the seventy-ninth session of the Executive Board (EB79), the Fortieth World Health Assembly (WHA40), the short provisional agenda drawn up for the Programme Committee of the Executive Board and the provisional agenda for the thirty-seventh session of the Regional Committee for Africa, contained relevant items of regional interest, in particular:

- (i) the report of the Regional Director on significant regional developments, including Regional Committee matters;
- (ii) the Proposed Programme Budget for the financial period 1988-1989:
 - (a) general policy review;
 - (b) programme review;
- (iii) eighth General Programme of Work (finalization of draft programme);

- (iv) collaboration within the United Nations System;
- (v) liberation struggle in southern Africa with special reference to assistance to the front-line States, Lesotho and Swaziland;
- (vi) working principles governing the admission of nongovernmental organizations in official relations with WHO.

Discussion

111. The Committee took note of the agendas of the governing bodies.

METHOD OF WORK AND DURATION OF THE WORLD HEALTH ASSEMBLY

Introductory statement

112. This item was introduced by Dr A. Tekle, member of the Secretariat. He pointed out that the document on this subject had been prepared in order to facilitate the work of the Fortieth World Health Assembly, in compliance with resolution WHA36.16 on the method of work and duration of the World Health Assembly.

113. The document dealt with:

- (i) the nomination of the President of the World Health Assembly; the Regional Committee at its thirty-seventh session, will be invited to nominate the future candidate for Presidency; the Committee was reminded that in September 1985, during the thirty-fifth session of the Regional Committee in Lusaka, the Member States requested the Regional Director to prepare criteria for the choice of the African President of the World Health Assembly in 1988; the document presented three alternative approaches in order to facilitate the choice of the African President for the World Health Assembly in 1988;
- (ii) as in the past the nomination of the Vice-President of the Fortieth World Health Assembly in May 1987 was also discussed;

- (iii) the functions of the two main Committees of the Assembly, namely Committee A and Committee B, were noted;
- (iv) similarly the question of members entitled to designate a person to serve on the Executive Board, the closure of the Fortieth World Health Assembly and the arrangements for the informal meeting of the Regional Committee were discussed.

Discussion

114. The Committee noted that of the five past Presidents of the World Health Assembly from the African Region, four had come from countries in Subregion I and one from Subregion III. Consequently it was agreed that the President for the World Health Assembly in 1988 should come from Subregion II.

115. The countries of Subregion II were therefore to present a candidate to the Regional Committee in 1987. It was agreed that subsequent Presidents of the World Health Assembly to be nominated by the African Region should come from Subregion II and Subregion I in that order.

ECONOMIC SUPPORT FOR NATIONAL HEALTH FOR ALL STRATEGIES

Introductory statement

116. Document AFR/RC36/8 on Technical Discussions at the Fortieth World Health Assembly was presented by Mrs M. Kenneally. The world economic situation had deteriorated over the last decade, and the health budgets of many countries had been severely reduced at a time when additional resources were required to build and sustain national health systems based on primary health care to meet the priority needs of all people, especially the underserved.

117. The discussions would seek to identify means of action to clarify issues and identify options for the mobilization and optimal utilization of resources when developing or reshaping health systems, to ensure social equity.

118. The discussions would specifically focus on:

- (i) review of the long-term economic implications of various options for shaping and adjusting policies and strategies;
- (ii) ways of mobilizing the required resources at community, national and international levels;
- (iii) the use of existing resources, realistic planning, costing and budgeting of health strategies;
- (iv) improvements in the management of health resources with emphasis on social relevance, equity, efficiency and effectiveness.

119. In conclusion the Regional Committee was informed that a background document for the technical discussions was in preparation. To enrich this document, the Regional Office needed information on country experiences which would illustrate issues of economic support for national Health for All Strategies.

Discussion

120. The Committee took note of the information and requested the Regional Director to coordinate the country inputs for the preparation of the regional contribution to the document for the technical discussions at the Fortieth World Health Assembly.

REGIONAL PROGRAMME BUDGET POLICY

Introductory statement

121. Document AFR/RC36/4, Regional Programme Budget Policy, was introduced by Dr V. M. Raharijaona (Madagascar). He underlined the joint efforts of Member States and WHO to make optimal use of health development resources, particularly in the implementation of national HFA policies and strategies.

122. Such joint efforts were governed by the regional programme budget policy, geared to:

- (i) adoption of techniques for precise definition of the most relevant development issues related to the achievement of HFA objectives;
- (ii) selection of priority development areas for resource allocation during the biennial period;
- (iii) identification of the forms of WHO collaboration most appropriate to the programme objectives;
- (iv) institution of a programming, monitoring and evaluation system.

123. The regional programme budget policy additionally emphasized the need for sound programme budgeting mechanisms at national and regional levels, designed to support effectively the accelerated attainment of HFA/2000. At the operational level, specific activities and programmes were identified during the detailed programming process. Programme budget implementation was subject to the full range of managerial control procedures, in particular a monitoring and evaluation system.

Discussion

124. The discussions on the regional budget policy and that of the programme budget were held simultaneously.

125. The Committee noted that the regional budget policy provided a set of guidelines for implementing existing WHO technical cooperation policies through a managerial process for programming, monitoring and evaluating the use of the Organization's resources.

126. The regional programme budget policy would enable countries to make the best possible use of WHO's resources in furthering health development and, in particular, in implementing national Health for All policies and strategies.

PROPOSED PROGRAMME BUDGET 1988-1989

Introductory statement

127. Dr Hailu Meche (Ethiopia), Chairman of the Programme Sub-Committee, introduced the Proposed Programme Budget for 1988-1989 (document AFR/RC36/2) to the Committee. The Sub-Committee noted the change in the presentation which showed the country statements immediately after the introduction. The Sub-Committee also took note of the improved presentation of the explanatory notes.

128. As was the case for the 1986-1987 Programme Budget, the proposed Programme Budget 1988-1989 was based on a zero growth rate in real terms, but nevertheless supported the components of the strategy for Health for All by the Year 2000 in spite of the budgetary constraints.

129. The overall allocation of the Regional Budget for the biennium 1988-1989 was set at US \$114 828 100 which was an increase of 16.1% over and above the Programme Budget 1986-1987. This increase was composed of a cost increase of 12.5% and a currency adjustment of 3.6%.

130. The Sub-Committee further took note of the fact that the budgetary rate of exchange used for the preparation of the Proposed Programme Budget 1988-1989 was set at CFA350 to US \$1. The Sub-Committee expressed the hope that the "casual income facility" available in 1986-1987 would continue into 1988-1989.

131. The country allocation continued to increase its proportion of the overall allocation and was now 56.5% of the total. However, it was noted that this figure was tentative and awaited final approval at the Fortieth World Health Assembly. The individual country planning figures were not the property of the countries and might always be subject to change.

132. The Sub-Committee took note of the fact that the country statements in future would be prepared at country level as a joint contribution by the WHO Representative and the Ministry of Health.

133. As to the overall distribution of funds between the various programmes, the Sub-Committee was assured that this was not arbitrary but was based on the priorities indicated by the countries.

134. It was noted that certain programmes had suffered a decrease but member countries and the Regional Office were urged to increase their efforts to obtain more extrabudgetary resources.

Discussion

135. The Committee adopted the Proposed Programme Budget 1988-1989 by resolution AFR/RC34/R4.

EIGHTH GENERAL PROGRAMME OF WORK COVERING THE PERIOD 1990-1995 (8GPW)

Introductory statement

136. Dr G. W. Lungu (Malawi) introduced document AFR/RC36/10 on the regional contribution to chapter 7 of the global 8GPW. The Committee was reminded that, in accordance with the Constitution, the Executive Board would submit the global 8GPW, covering the period 1990-1995, to the World Health Assembly in May 1987. It was the second of the three programmes within the period covered by the strategy for Health for All by the Year 2000.

137. In accordance with the Organization's guidelines, the main principles and overall structure of the Eighth General Programme of Work followed those of the Seventh, now in process of execution (1984-1989).

138. Certain minor adjustments should however be noted; they highlighted some important entries in the classified list of programmes for the period of execution of 8GPW.

139. The General Programme would become the basis, in close consultation with Member States, for preparation of the medium-term programmes and the biennial budgets reflecting the national and regional variations during the period under review.

140. Finally, emphasis had been placed on the interrelationships between 8GPW, the new decentralized structure of the Regional Office, and the managerial mechanisms for health development that had been set up at the national, subregional, regional and global levels to ensure implementation of the strategies for Health for All by the Year 2000.

141. Document AFR/RC36/10 had been given prior study by the African Advisory Committee for Health Development (AACHD) from 14 to 16 July 1986. The AACHD had made recommendations bearing mainly on improving the approaches that the Organization had proposed with a view to strengthening national capabilities in a spirit of self-reliance. The AACHD had also emphasized the need to pursue the Organization's efforts in regard to training all categories of manpower in health planning and management.

142. The Committee was then invited to consider document AFR/RC36/13, the report of the sixth meeting of the AACHD, together with document AFR/RC36/10, setting out 8GPW.

Discussion

143. Several delegates referred to the new structure of the Organization, especially the Subregional Health Development Offices. They noted that the Subregional Offices had their own budget but, owing to current financial constraints, they did not have all the resources they needed. The Committee heard explanations to the effect that the Subregional Directors were not expected to make formal visits to countries and that countries should request support according to needs. The main features of the new structure of the Regional Office were also explained, and the Committee's attention drawn to the three distinct divisions headed respectively by the Director of Programme Management, the Director of Programme Coordination and Promotion, and the Director of the Support Programme.

144. The Committee noted that health aspects of emergencies were the responsibility of the Director for Programme Coordination, Promotion and Information (DCP). The Committee was informed that a proposal was under consideration for the establishment of a regional centre for relief operations in Addis Ababa.

145. The AFROPOC system had become operational in January 1986, but was still in an early stage of development. The system was under constant review and would be strengthened and improved as necessary. This mechanism was designed to upgrade the efficiency of WHO's support to the Member States.

REVISED REGIONAL ANTIMALARIA STRATEGY

146. Mr M. Mboumba (Gabon) introduced document AFR/RC36/22, "Revised regional antimalaria strategy". The Regional Committee had adopted an earlier antimalaria strategy by resolution AFR/RC31/11, at its thirty-first session. Since that time, certain developments, including the emergence of chloroquine resistance, had made its revision necessary. The revision of the regional strategy was requested in resolution AFR/RC35/R5, adopted by the Regional Committee in 1985 at its thirty-fifth session. The regional officer then introduced the seven chapters of the document.

147. The analysis of the epidemiological situation and the classification of the malarious areas, according to the operational goals of antimalaria activities, highlighted five areas:

- (i) areas where malaria had never existed or had disappeared and where there was no risk of infection, and which were not receptive;
- (ii) areas where malaria eradication had been achieved but which were receptive. Two contrasting countries were Reunion, where there was no re-establishment of transmission, and Mauritius, where transmission had been re-established;
- (iii) areas where transmission had been reduced to a low level, as a result of a long period of organized vector control;
- (iv) areas where transmission was seasonal, with endemicity levels ranging from hypo- to meso-endemic, and epidemic potential;

(v) areas where malaria was stable, with endemicity levels ranging from hyper- to holo-endemic; in these areas, the situation had not changed significantly for generations and there were no organized antimalaria activities; that group comprised most countries of the Region.

148. He described the main characteristics of the principal vectors, Anopheles gambiae and Anopheles funestus, that made them the most efficient and difficult to control vectors in the world.

149. After underlining the public health and socioeconomic implications of the disease, he drew the Sub-Committee's attention to what he considered to be two important issues. The first concerned the implications of continuing the single dose chloroquine treatment regimen, adopted by the Regional Committee at its thirty-first session with the current regional antimalaria strategy; the second related to implications of the emergence and spread of the phenomenon of resistance of P. falciparum to chloroquine in the Region.

150. That situation required a change in the standard treatment regimen.

151. Chapters 2, 3 and 4 respectively listed the main objectives of the revised antimalaria strategy which had remained unchanged, briefly outlined a malaria control strategy, and described the four tactical variants for malaria control. The Thirty-first World Health Assembly had adopted resolution WHA31.45 to that effect in 1978.

152. Chapter 5 outlined the basic conditions for implementing and maintaining an antimalaria programme. Special attention was given to three of those conditions:

- recognition of malaria as a problem and firm commitment at all levels to taking action against the disease;
- ability to maintain a programme after implementation;
- development of antimalaria action as part of primary health care.

153. Chapter 6 touched on the criteria for selection of appropriate control technologies, while Chapter 7 defined the role of WHO and suggested the kind of support and collaboration that Member States might expect from the Organization.

Discussion

154. The Committee expressed concern about the slow-down of progress towards malaria control and consequent deterioration of the epidemiological situation in some areas in spite of general acknowledgement of the harmful public health and socioeconomic effects of malaria.

155. The Committee observed that enough attention was not being given to vector control measures which should be the backbone of any malaria control programme.

156. The Committee therefore urged the Regional Office to promote actively malaria control programmes through the application of integrated vector control measures to the largest extent possible.

157. In this regard WHO was requested to promote and intensify research aimed at improving existing tools and the development of new, safer and more effective vector control approaches.

158. The Committee also expressed some alarm at the threat posed by the emergence and spread of drug resistance. It requested WHO to give priority to research on the epidemiology of this phenomenon with a view to the development of appropriate measures for preventing or delaying the emergence and spread of drug resistance for as long as possible.

159. A call was made for a regional meeting of experts on malaria in Africa, and questions raised about progress in the development of antimalaria vaccines.

160. On vector control, a brief description was given of the essential steps to be taken in the assessment of the epidemiological situation, epidemiological stratification, definition of objectives, selection of control measures, etc.

161. Attention was drawn to the organizational and cost implications of vector control, and especially to the ability to sustain operations on a permanent or long-term basis before embarking on any large-scale vector control programme. The emphasis given by the Regional Office to the training of nationals in basic malariology and malaria control as a means of improving national malaria control programmes was mentioned.

162. The Committee considered drug resistance to be a serious problem. It urged that action be taken to obtain a better understanding of the phenomenon with a view to the development of appropriate preventive and control measures and adequate management of the problem, especially at the community level.

163. On antimalaria vaccine, information was given on the current status of the development of two antisporezoite vaccines and the preparation being made for field trials in Africa, to assess their safety, efficacy and impact and, more important, the place and role of antimalaria vaccines in malaria control.

REPORT ON SUBREGIONAL PROGRAMME MEETINGS

Introductory statement

164. Dr P. Mpitabakana (Burundi) introduced the report on the Subregional Programme Meetings, held from 3 to 7 March 1986 in Brazzaville, in pursuance of decision No.7 of the Regional Committee at its thirty-fifth session to harmonize the subjects to be studied by the TCDC working groups with those of the technical discussions of the Regional Committee in 1987, 1988 and 1989.

165. In 1986 the three subregional meetings had been held, exceptionally, at the WHO Regional Office for Africa. As from 1987 the Subregional Health Development Offices would take responsibility for organizing them.

166. The meetings considered five items: (i) African immunization year; (ii) the AFROPOC system; (iii) the first draft of the Proposed Programme Budget 1988-1989; (iv) accelerating the achievement of Health for All by the Year 2000 in Member States of the African Region, and (v) AIDS.

African Immunization Year

167. The Regional Committee in 1985 adopted resolution AFR/RC35/R9, declaring 1986 African Immunization Year, in order to set up a mechanism designed to provide immunization coverage for the target population by 1990.

168. Judging from the available data, a 75% immunization coverage would demand a sustained effort from many countries for four to five years, with emphasis on the year 1986 - African Immunization Year.

169. The participants in the subregional meetings reported the difficulties encountered and indicated that the countries were expecting assistance from WHO and other international agencies.

170. Those difficulties were mainly of a financial nature, but should not prevent the countries from envisaging procurement of vaccines or their manufacture locally rather than relying too heavily on the generosity of donors, who had hitherto supplied nearly two-thirds of vaccines free of charge.

AFROPOC System

171. The Regional Director had set up the Programme Operations Coordination Unit (POC) to improve operational efficiency of the regional programme.

172. The POC system should make it possible:

(i) when programming:

- to support joint WHO/Government mechanisms;
- to verify that planned activities comply with the policies adopted collectively by the Member States;

(ii) when implementing:

- to respond promptly to all requests from Member States;
- to ensure that the utilization of resources complies with detailed planning;

- to record systematically all necessary financial/accounting and programming data;

(iii) to evaluate WHO's cooperation with Member States.

173. The participants considered three main subjects: (i) learning the new system; (ii) flexibility of use; (iii) monitoring and evaluation.

174. 1986 was a year of testing both at country and Regional Office levels. That would accordingly be a year of training and exchange of experience at all levels so as to make POC operational.

175. The system was flexible: the countries, in consultation with WHO, might at any moment reprogramme the resources needed for national programmes.

176. The participants perceived the advantages of the system in monitoring WHO's cooperation activities. The essential aim of the three-monthly report was to monitor the implementation of detailed plans and make appropriate corrections.

Accelerating the achievement of HFA/2000 through activities at the local level

177. Participants considered the flexible framework that had been prepared by the Regional Director to accelerate achievement of HFA/2000.

178. Most of the countries had made adjustments to their health systems in order to implement the strategies for HFA/2000. Their will and their political commitment were accomplished facts; however, the motivation of communities had not yet attained the level required to enlist their participation.

179. The weak point in the establishment of support for PHC at the operational level was the absence of a managerial mechanism at local level and the paucity of financial and material resources in the African Region.

180. Despite the efforts that WHO had deployed to define the health team concept and to train health development workers, training institutions in the countries did not yet have programmes that were adapted to the role that health workers should perform at technical level.

181. The lack of intersectoral coordination at central and intermediate levels had repercussions on the operational level in the form of overlapping activities.

182. The use of community health workers posed many problems in regard to their selection, remuneration and supervision and to their relationships with the official health services.

AIDS

183. The problem of AIDS was raised in the course of the subregional meetings. AIDS was not a priority for many African countries since other diseases were causing far more fatalities. The question of discussing the clinical aspects of AIDS did not arise.

184. However, AIDS did constitute a serious public health threat. Vigilance should be exercised at national and international levels.

185. An AIDS control strategy began with the creation of a national committee on AIDS, or of a special group; the strategy comprised:

- (i) initial evaluation;
- (ii) strengthening of the health infrastructure, including manpower training;
- (iii) clinical and epidemiological diagnosis of the disease;
- (iv) education and information of the public and at-risk groups.

Discussion

186. The Committee adopted the report of the Subregional Programme Meetings.

REPORT OF THE SIXTH MEETING OF THE AFRICAN ADVISORY
COMMITTEE FOR HEALTH DEVELOPMENT (AACHD)

Introductory statement

187. Introducing this item, Mrs R. A. De Almeida (the Gambia) drew the attention of the Committee to the two documents concerned, namely the report of the sixth meeting of the AACHD (document AFR/RC36/13) and paragraphs 119-140 of the report of the Programme Sub-Committee (document AFR/RC36/9). She pointed out that the the Programme Sub-Committee reviewed the document in the light of the three-year scenario adopted by the Regional Committee at its thirty-fifth session in Lusaka, in September 1985, and of the subsequent restructuring of the Organization.

188. The report of the AACHD consisted of six main parts, namely an introduction, review of the terms of reference of AACHD, indicators for monitoring and evaluation of HFA/2000 at operational level, WHO fellowship policy and national health manpower development, the Eighth General Programme of Work, and the conclusions. The Programme Sub-Committee reviewed the document and endorsed the recommendations made by AACHD.

189. The terms of reference of AACHD were reviewed in the light of the new structure of the Organization and the three-year scenario. The Sub-Committee emphasized the need to broaden further the membership of AACHD in order to strengthen its multisectoral character.

190. The Sub-Committee had examined the section of the report dealing with indicators for monitoring and evaluation in the light of the regional programme for accelerating the implementation of strategies. It noted that the criteria included both the producers and the users of health information.

191. The WHO fellowship programme was discussed in detail in the light of national needs and priorities in the area of health manpower. The Sub-Committee adopted the report of the AACHD.

Discussion

192. Commending the Sub-Committee's work in this regard, the Committee observed that the multisectoral base of the AACHD could not be overemphasized, and endorsed the Sub-Committee's view that its membership should be expanded to reflect this aspect. The Regional Director thanked the Committee for accepting the report.

193. Reflecting on the term "health development", it was stated that it emphasized the link between "health" and "development", and that the membership of AACHD should therefore take account of that fact. It was explained that the Regional Office was currently reviewing the relationship of AACHD to other similar committees. The Committee on health research and development, for example, could be seen as contributing an important research component to health development. The sub-regional TCDC committees and the Council on health sciences education also needed to be linked to AACHD. Obviously, the membership of AACHD should reflect all those interests and serve to stimulate intersectoral action for health development.

194. It was, however, observed that the membership of AACHD had to be within manageable scope. The Regional Office was therefore preparing a plan to set up Sub-Committees on various topics such as food and nutrition, environmental health, water supply etc., following the lead from the technical discussions at the World Health Assembly.

195. The Regional Director would endeavour to make AACHD an influential body with a key person, a minister for example, as its chairman.

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

196. The technical discussions at the thirty-sixth session of the Regional Committee were held in Brazzaville on 13 September 1986 on the subject "The PHC approach to the promotion and protection of the health of farm workers during the Industrial Development Decade in Africa". They were chaired by

Professor George Oluwole Sofoluwe, Professor of Community and Occupational Health, University of Benin, Nigeria, who was nominated by the thirty-fifth session of the Regional Committee. The Committee nominated the following as rapporteurs of the technical discussions:

- (i) Dr Antonio Soares Marques Lima (Sao Tome and Principe)
- (ii) Dr E. K. Njelesani (Zambia)
- (iii) Dr H. Sanoussi (Benin)

197. Discussions were held in three working groups, one multilingual, one English-speaking and one French-speaking. The working groups elected the following as chairmen:

- (i) Dr J. Maneno (Kenya)
- (ii) Dr D. G. Makuto (Zimbabwe)
- (iii) Dr Azara Bamba (Burkina Faso)

198. The working paper, document AFR/RC36/TD/1, prepared by Dr A. Abaglo, Chief Medical Officer, Togolese Phosphate Agency, and Professor Bernard Obiang Ossoubita, Head of the Department of Public and Occupational Health, University Centre for Health Sciences, Libreville, was introduced by Dr G. Oluwole Sofoluwe. He stressed the opportunity facing African countries during the present industrial development decade to gear their industrialization programmes to the priority manufacture of essentials to raise the standard of living and health of farm workers, who accounted for 80-90% of the total population of Africa. The alternate Chairman, Mr Martial M'Boumba, Director-General of Public Health, Gabon, chaired a plenary session during which each of the three Group Rapporteurs presented a summary of their respective group discussions.

199. The document identified three categories of farm workers:

- (i) workers in major agricultural enterprises and state farms;
- (ii) workers in cooperatives and medium-size farms;
- (iii) private small farmers who constitute the majority of farm workers.

200. It outlined their health problems, and the need to adopt the PHC approach to solving them. It stressed the need to identify the root causes of the health problems of farm workers and to cut through bureaucracy to solve them more quickly. It also stressed the growing importance of agriculture as reflected in the Lagos Plan of Action, which now had to be translated into a firm commitment and vigorous action, taking into account the need for low-cost technology, legislation, intersectoral action, information/education, adequate training at all levels and applied research.

201. Participants stressed the need to integrate health services for farm workers into PHC programmes at national, regional and local levels, taking into consideration the special health needs of farm workers, e.g. tetanus immunization, prevention of poisoning by insecticides, other occupational health hazards and promotion of environmental health conditions. These PHC programmes should be planned in cooperation with the target groups, giving due attention to their existing positive traditional health practices/behaviour. Women constituted a high-risk farm workers group because, in many African countries, they did most of the agricultural work in addition to looking after the home and the children, and often being left on their own when their husbands departed as migrant workers.

202. Participants also emphasized that successful implementation of PHC for farm workers required:

- (i) appropriate training of community health workers, and of existing workers in agriculture;
- (ii) promotion of applied research, particularly on farm workers' life-style and on their traditional health habits and behaviour patterns;
- (iii) adequate information and education for health and development;
- (iv) community involvement in planning, implementation and evaluation of PHC activities;

- (v) strong intersectoral coordination for integrated planning and rational use of the existing resources of the various sectors and agencies concerned.

203. Coordinated and comprehensive national planning was required that involved all ministries, in particular the ministries of health, agriculture, labour, planning, education, public works, etc. The Ministry of Health could act as a catalyst of health and social services. That role could also be performed by other sectors.

204. Coordination and collaboration were also needed between WHO, FAO, ILO, UNEP, UNIDO, UNICEF, World Bank, OAU, ECA, other international agencies and nongovernmental organizations to work out a multisectoral approach to rural health in the framework of integrated rural development.

205. The intersectoral approach is particularly indicated for the provision of adequate housing, water supply, sanitation, solar energy, etc., all of which would raise the general living standards of farm workers, increase their health status and their productivity. Besides, setting up transportation and marketing facilities could encourage farmers to stay on the land and to improve their motivation.

206. National legislation needed to be restructured to provide a sound basis for the introduction of measures to improve the health coverage and the social protection of farm workers. It was also suggested that WHO/AFRO strengthen its workers' health programme, giving special attention to farm workers, and develop pilot/demonstration projects at district level with ongoing PHC activities. Exchange of PHC experiences in different African countries for farm workers should receive active support through the existing TCDC programmes.

207. The Regional Committee adopted Resolution AFR/RC36/R11 on The Technical Discussions of the thirty-sixth session of the Regional Committee.

CHOICE OF SUBJECT FOR THE TECHNICAL DISCUSSIONS IN 1987

208. The Regional Committee chose the following subject for the technical discussions at its thirty-seventh session: "Operational support for primary health care (peripheral level)".

209. The Committee adopted Decision No.7 on this item.

NOMINATION OF THE CHAIRMAN AND ALTERNATE CHAIRMAN OF THE TECHNICAL DISCUSSIONS IN 1987

210. On the proposal of the Chairman, the Committee nominated Dr Dibandala Ngandu-Kabeya and Dr Martin P. Mandara as Chairman and alternate Chairman respectively of the technical discussions at the thirty-seventh session of the Regional Committee.

211. The Committee adopted Decision No.8 on this item.

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

212. In presenting document AFR/RC36/18, the Director, Support Programme, drew attention to Article 48 of the Constitution which provides that Regional Committees shall meet as often as necessary and shall determine the place of each meeting. The attention of the Committee was also drawn to the high cost of Regional Committee sessions when held away from the Regional Office.

213. Therefore, in the light of Executive Board resolution EB75.R7 which 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, the Regional Committee adopted resolution AFR/RC35/R10 at its thirty-fifth session in Lusaka, and resolved that the Regional Committee shall meet at least once every two years at the Regional Office.

214. Accordingly, the Committee decided to hold its thirty-seventh session in Bamako (Mali) in September 1987, and its thirty-eighth session in Brazzaville (Congo) in September 1988. The Committee consequently took Procedural Decision No.9.

215. Furthermore, the Regional Committee took note of the kind invitations that had been extended by the Republic of Niger and the Republic of Burundi. These invitations will be considered for the thirty-ninth and forty-first sessions respectively, in accordance with resolution AFR/RC35/R10.

Respect of commitments under the Agreement between the host country's Government and the World Health Organization

216. The Regional Director recalled the difficulties experienced by the Secretariat in recent years in regard to the proper organization of the session when held away from the Regional Headquarters. He requested the Member States to give attention to the requirements under the agreement between the host country's Government and the Organization vis-à-vis the material facilities and services required for the Regional Committee session.

CONCLUSIONS

217. The thirty-sixth session of the Regional Committee for Africa of the World Health Organisation was opened on 10 September 1986 in Brazzaville, in the presence of His Excellency Colonel Denis Sassou Nguesso, President of the Peoples' Republic of the Congo and current Chairman of the Organization of African Unity. The opening ceremony included statements by the Director-General of WHO, Dr H. Mahler, the Acting Chairman, Professor Agbeta, the Regional Director, Dr G. L. Monekosso, and the President of the Republic. They all referred to the difficult socioeconomic situation facing the African Region and the international organizations, and called for exemplary leadership to reverse the trend.

218. The deliberations of the Committee, under the chairmanship of Gen. X. S. Yangongo, Minister of Health of the Central African Republic, centred on the work of WHO in the African Region in 1985, correlations between the work of the Regional Committee, Executive Board and the World Health Assembly, the report of the Programme Sub-Committee and the Technical Discussions.

219. The Committee noted the gloomy financial backdrop against which the regional programme had been conducted in 1985, and which continued to have adverse effects on the scope and impact of regular programme operations. In the light of this difficult financial context, the Committee commended the Regional Director on measures taken to reorganize the regional secretariat in order to respond better to the needs of Member States, make optimal use of WHO resources and upgrade the overall effectiveness of the programme. The Subregional Health Development Offices were seen as a key element in the decentralization process.

220. The Committee also welcomed the increasing emphasis on implementation of primary health care activities at the local level in the context of the Regional Director's three-year overlapping plan for accelerating the achievement of HFA/2000 in Member States of the Region. The need was recognized to build up adequate trained manpower with technical, managerial and leadership skills in all programme areas, and in particular to strengthen the managerial process for national health development.

221. Among other salient measures the Committee endorsed the proposal of the Cameroon Government to have a "Dr Comlan A. A. Quenum Prize for Public Health in Africa" established, adopted the Proposed Programme Budget 1988-1989, approved the regional contribution to the Eighth General Programme of Work, as amended by its Programme Sub-Committee, and underscored the need to review the membership of the African Advisory Committee for Health Development and other similar committees so as to make them more consistent with the emerging development challenges and the process of restructuring the Organization.

ANNEXES

CLOSURE OF THE SESSION

222. In his closing remarks, His Excellency General Xavier Sylvestre Yangongo, Minister of Health of the Central African Republic and Chairman of the thirty-sixth session of the Regional Committee, underlined an unprecedented event in the history of the Regional Committee: the opening of the session by a current Chairman of the Organization of African Unity, His Excellency Colonel Denis Sassou Nguesso, President of the People's Republic of Congo. He requested the Minister of Public Health and Social Affairs of the People's Republic of Congo to extend to the President of the Republic the profound gratitude of the Committee.

223. Having noted the happy and warm atmosphere that had characterized the Committee's proceedings, he mentioned four themes that he thought had emerged in the course of the session: the organizational changes and new directions instituted by the Regional Director in order to adapt WHO/AFRO to the new development imperatives of the Region, including especially the need to accelerate progress towards HFA/2000 by focusing efforts on the district level; recognition of the indispensable role of women in health development; and establishment of Dr Comlan A. A. Quenum prize for Public Health in Africa.

224. The Chairman paid special tribute to traditional healers who in his view could play a valuable role in promoting PHC at the district level. He urged that traditional medicine and drugs, being more easily accessible to the community, should be integrated into national health systems.

ADDRESS BY DR H. MAHLER
DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION

Accountability for Health for All

Mr Chairman,
Excellencies,
Honourable Representatives,
Ladies and Gentlemen,
Colleagues and Friends,

Thirty-ninth World Health Assembly

1. Four months ago the Thirty-ninth World Health Assembly took place in Geneva. To judge from the press coverage, it was a political jamboree with little health content. The reality was very different. It was full of health content in spite of the ever-present danger of political explosions. That that danger was averted is a tribute to the good sense that prevailed when matters came to the brink of disaster. Honourable representatives, you, we, all of us need to keep up that good sense all the time if your Organization is to survive as the socially relevant international health Organization.

Evaluation of the Strategy for Health for All

2. The most important single item at the Thirty-ninth World Health Assembly was the worldwide evaluation of the Strategy for Health for All to which your region made a valuable contribution. Ninety percent of Member States reported on their strategies. I would say that that is a rather unique social phenomenon, a sure sign that you are taking the goal of Health for All by the Year 2000 seriously, and a slap in the face to those who claim that our goal is a mere WHO artefact. The most important single lesson we learned is that evaluation must be undertaken by you in your countries as a normal part of the management of your health system, and certainly not because you have to write a report to WHO in two years' time. And we learned also that evaluation has to be a springboard for action and not a mere exercise in history. So good sense dictates that whatever you learn from your evaluation has to be ploughed

back into the improvement of your health system. What is more, recent memories are more vivid than distant ones, except perhaps for very old arteriosclerotics; but none of us have reached that stage as yet. So it is good sense to use the findings of your evaluation right away to improve your health system rather than referring back at some later date to an evaluation report.

District health systems

3. In my presentation to you last year, I talked about targeting on health for all and advocated establishing action programmes for primary health care to reach your targets. I mentioned briefly district health systems in that context. Well, that theme was taken up and widely reviewed at the recent Health Assembly. As a result, further ideas on the matter crystallized out, and I should like to share them with you so that you can put them to good use. That is as it should be in a democratic organization like WHO; ideas floated at the Regional Committees are then considered by the Organization's supreme policy organ and returned to the Regional Committees for further action.

4. It has become clear that district health systems can provide a good opportunity for people to become genuinely involved in shaping their own health care; because the size of the system places it within their grasp, they can see for themselves what is going well and what is not, and they are close enough to those who manage the system to be able to influence their decisions. But we must not over-romanticise the situation. Decentralization to districts has to take place within a sound national policy framework and in a politically and fiscally responsible manner. District authorities have to be given power to act, but also responsibility to act with good sense. They have to be accountable not only to the people in the district, but also to the central authorities. These central authorities, as part of their political and fiscal responsibility, have to define the country's health policy as a basis for action, as well as certain technical and financial standards. At the same time they have to allow for initiative within that policy and those standards, otherwise decentralization of authority becomes a mere pretence. I should add that the health system is only one part of the country's social and

economic system, so its administrative pattern has to be able to relate harmoniously to the administrative pattern of the country as a whole. Of course, the health system can pioneer administrative innovation, but the political authorities have to be persuaded to accept that. I mention these few points because if we neglect them we will find ourselves facing a wall of political opposition to our good intentions.

5. But the opposite situation can also arise - where the transfer of authority from centre to district is understood to mean unconstrained and uncontrolled freedom of action. I recently came across a country in which the President had decreed absolute decentralization to districts. So the district hospitals proceeded to buy drugs locally without respect for the country's drug policy and for the list of essential drugs that had been drawn up for the country as a whole. These hospitals soon exhausted their budget for drugs, whereas central purchasing could have reduced costs by 40% and enabled them to have sufficient drugs for the whole year. A similar situation could arise regarding other supplies, as well as equipment, logistics and communication systems. A district is part of a whole. Decentralization does not imply anarchy; it demands responsible management.

6. But the main message I want to get across is that we should not consider the establishment of district health systems as a new economic exercise surrounded by its own mystique. All the ingredients for setting them up are there and have been amply described - in the Alma-Ata Report and the Global Strategy for Health for All - and they have formed the baseline for the evaluation of national strategies. These ingredients have to be mixed in the right amounts. Here is a glorious challenge for down-to-earth health systems research. Your WHO is ready to work with each and every one of you - anxious to work with you - in facing up to that challenge. But in the final analysis the challenge is yours; the era of paternalism has come to an end.

Political and fiscal responsibility

7. Honourable representatives, just as the transfer of responsibility from the central level of government to the district level has to take place within a national policy framework and in a politically and fiscally responsible manner, so the transfer of responsibility in WHO to the governments of its

Member States has to take place within a collective policy framework and in a politically and fiscally responsible manner. I need not elaborate on the collective policy framework. We have built it up together, we are living in it and we are not afraid to evaluate its consequences. So I shall start with fiscal responsibility. To make the most of what your WHO has to offer, you have to squeeze all its resources to the maximum. These are far greater than financial resources alone. They include human resources, moral, emotional and intellectual ones, information, and the fruits of experience. They are vast because they represent the sum total of human endeavour for health in all 166 Member States. The financial resources are not vast; they are severely limited and the belt is tightening.

8. It is precisely in order to help you to use your WHO's resources optimally - it is precisely for that reason that we have been devoting so much energy to establishing regional programme budget policies. I have personally provided you with guidelines that sum up years of work together to heighten the relevance of our investments in health and improve the efficiency with which they are used. These guidelines show how your collective resources can be used sensibly to support you in building up your health systems so that they really do reflect your strategies for health for all. They show how you can consistently reinforce your own capacities to do that and to manage the system by yourselves, by using the information - the knowledge, the know-how, the experience - that has been accumulating in WHO over the years, thanks in no small measure to your own efforts. And they show how you can use your WHO to rationalize and mobilize your own resources and reach that longed-for status of national self-reliance in health matters. To crown it all, they show how all that can be done in a highly democratic manner, as befits the WHO of the 1980s and the 1990s.

9. Why then, I ask, why then honourable representatives are so many of you reluctant to seize the opportunity you have been offered? Why do so many of you continue to use your Organization as only one of many funding agencies feeding you with crumbs? Why do so many of you still consider your Organization as a donor rather than a partner? As long as you do that you will misuse your collective resources. But if you accept that partnership you will realize what I have been repeating year after year, day after day, over and over again, WHO is your Organization. You can be your own executioners; you can be your own saviours.

10. Now why am I using such words - executioners, saviours? Why such apocalyptic pronouncements? I am using them because we are facing attacks from without and managerial weakness from within, and the two are not unrelated. We are doing splendid work in planning, in monitoring, in evaluating. Unfortunately, our performance in supporting national programmes inside countries is not so splendid. We are still not spending as wisely as we could and should in countries. In spite of the highly flexible process of programme budgeting of our resources in countries, in spite of emerging regional programme budget policy, in spite of the managerial arrangements we have introduced to make it easier to use our resources optimally in support of your health programmes managed by your health personnel, in spite of all that, too many of you are still spending far too much on ad hoc supplies and equipment and too much of that is taking place in the last quarter of the budgetary biennium; sometimes you are spending more on these items in that last quarter than in the three previous ones. That is a sure signal to our critics that we are not spending our money on planned activities. Too many of you are still sending people on fellowships in an unplanned way, not using the fellows properly on their return and not even letting your organization know what happens to them and to our joint investment.

11. There is nothing new in what I am saying, I have been telling you that for years. It is almost masochistic to repeat it. But, honourable representatives, I am repeating it more forcefully than ever this year because the external climate has changed. Past indulgence towards well-meaning if somewhat romantic health administrators has given way to disillusionment, suspicion and even outright hostility. I will not pretend that this is due entirely to our managerial weaknesses, but these add too much fat to the fire. I have seen the writing on the wall for too long. Two years ago I warned you that if the management of our cooperative activities in countries did not improve, the technical cooperation component in our regular budget could be criticized out of existence, leading to the end of our constitutional regional arrangements. That is why I was in such a hurry to introduce regional programme budget policy, and to initiate a new kind of financial audit that reveals how your collective resources are being used by Member States, or are not being used by them; to set up the kind of policies and programmes you voted for in the governing bodies.

12. It may be too late. The financial squeeze is on, and the squeeze starting in one part of the globe could easily lead to similar squeezes from other parts and to an eventual financial landslide. The early signs are there, and the less said about them in public the better.

Confidence crisis

13. Honourable representatives, we call this euphemistically a liquidity crisis, but in reality it is far more than that; it is a confidence crisis. How can we restore that confidence? Not by verbal acrobatics, but by demonstrating in practice that we are capable of practising what we preach; that we can use our resources efficiently and effectively; and that we will reach our goal by the year 2000.

14. I know that a number of countries are demonstrating just that. But there are far too few of them. We need a critical mass of countries like these to give living evidence beyond doubt that our strategy is not only viable, but that it is the only reasonable response in a situation of growing problems and diminishing resources. Yes, it is a miraculous strategy, but not a supernatural miracle - a very down-to-earth one that can be produced by hard work and good sense. I could be genuinely optimistic, I could infect others with that optimism, if only I were sure that you are indeed doing your utmost to make the most of what your Organization has to offer. When I say you, I mean all of us. I am not exonerating the Secretariat from the defect of unnecessary bureaucracy. There is still far too much of that, impeding the speed of our action and casting shadows on the sincerity of our efforts. We must loosen up that bureaucracy to make way for initiative - the kind of initiative I mentioned a few moments ago that thrives in a climate of collective policy and political and fiscal responsibility.

15. Honourable representatives, we are on trial. We could emerge with flying colours if only we used the tools we have. We have a unique policy and strategy. We have a reasonably sound general programme of work: it can help you to build up health infrastructures that conform to the collective policy and use technology that is really appropriate to your country. We have a programme budget that is not a mere bagatelle, but a powerful instrument - if

we want to use it as a powerful instrument. And I should add that the organizational arrangements that your Regional Director has introduced - the subregional outposts of the Regional Office - bring the Organization's resources closer to you than ever. But I shall not beg of you to use my guidance for regional programme budget policy. I shall not beg of you to start auditing the way you use your collective resources - or do not use them - to set up sound policies and soundly manage your programmes to give effect to them. It is not for me to beg any more. Your Organization has set up these tools on your behalf. It is up to you to decide if you want to use them and how best to use them. That is your political responsibility, and I am sure you will display good sense in discharging it. If we use our collective resources wisely, come what may your Organization will not only survive, it will flourish under the momentum of its powerful collective decisions and wise knowledge and experience that it has accumulated. But if you continue to use resources in an ad hoc short-term manner, these resources will vanish, leaving little behind but the skeleton of a once-thriving Organization.

Accountability

16. Well, you may ask, if WHO faded into oblivion, would the difference be the same? I think it would make a vast difference. Organizations may not be important, but people are. The people of this region need your continued support and guidance until they attain that long-awaited state of self-reliance on health matters. You are their regional health guardians. As for you, within your WHO, each and every one of you is accountable to your collective selves. That is by no means a relinquishment of your individual responsibility; quite apart from your moral responsibility in all the people in the region, it is you who bear the consequences of your action within your own country.

17. Now, I said that within your Organization you are accountable to your collective selves. And outside the Organization? Outside you are being judged daily by the world surrounding you, which still does not consider action for health as an investment in development, but rather as a troublesome consumption of resources that could be better used elsewhere to boost the economy. There is only one way to combat that hostile environment. It is to

demonstrate in practice that by the proper use of your own resources and of those you share collectively in WHO, by the proper use of these and of the resources of other enlightened external supporters, you can and do forge ahead towards the attainment of the goal of Health for All by the Year 2000, and through that to the attainment of the other social and economic goals of your people.

18. Yes Mr Chairman, honourable representatives, the value system that inspired the goal of health for all could also inspire other social and economic goals; unfortunately it has not done so as yet. If, thanks in no small measure to your WHO, there has been a high degree of national interdependence and international solidarity regarding health, there has been little or no international solidarity regarding other sectors of development. On the contrary, North-South and South-North relationships have degenerated into a dialogue of the deaf, and the deafness I am sorry to say affects both sides and all ears. There is a terrible danger that that deafness will infiltrate international health endeavours. You, honourable representatives, can help to restore that mutually lost confidence by exemplary action in the field of health.

19. To succeed, you will have to display outstanding leadership, if only to overcome the all-too-prevalent cynicism and no less pernicious apathy. What is more, if you succeed with regard to health, you may even influence the restoration of confidence in other international social and economic spheres. And if strong leadership is needed to attain a goal that has been so clearly defined and universally accepted as health for all, you can imagine the intensity of leadership required to make sure that our common health goal does indeed give rise to broader socioeconomic development goals and genuine international dialogue to attain them. You can exert that leadership if you try hard enough, fortified by your Organization's common but most uncommon value system and resulting health policy. By exerting it, you will fill an all-too-evident vacuum, not for personal glorification, but for the benefit of your people, for in the final analysis, you are accountable to them, to your people. And in the final analysis, your WHO is accountable to all people everywhere.

Thank you.

ADDRESS BY PROFESSOR AISSAH ABGETRA, MINISTER OF PUBLIC HEALTH,
SOCIAL AND WOMEN AFFAIRS OF TOGO, OFFICIATING CHAIRMAN OF THE
THIRTY-FIFTH SESSION OF THE REGIONAL COMMITTEE

Your Excellency Mr President of the People's Republic of the Congo,
Honourable Ministers and dear Colleagues,
Mr Director-General of WHO,
Mr Regional Director,
Distinguished Delegates,
Ladies and Gentlemen,

I consider it an unusual honour and a very great pleasure to welcome here, at the Headquarters of our African Region, His Excellency President Denis Sassou Nguesso, President of the People's Republic of the Congo, current Chairman of the OAU, who in spite of his high responsibilities and countless concerns has been kind enough to grace with his presence the formal opening ceremony of this thirty-sixth session of our Committee.

Mr Chairman, there are occasions when speeches seem superfluous because the feelings are so deep and concord so complete. That is the feeling which doubtless inspires the present assembly that is now united to welcome for the first time in the history of the Regional Committee the current Chairman of the Organization of African Unity, in this century for dialogue and consultation about the health problems which are undermining our entire continent. We would like to assure you that your presence alone at our side is a consolation and a real encouragement in our search for feasible solutions to our various problems.

You will therefore allow me, your Excellency Mr President, while reaffirming the admiration that we, as Africans, feel for your illustrious person, to take the opportunity of this very special occasion, and on behalf of the Honourable Ministers, the Heads of Delegations and the Distinguished Delegates present here, to present to you our warmest and most respectful congratulations on the well-deserved trust that your peers, and through them, all of Africa, placed in you at the last Assembly of the OAU at Addis Ababa, when it entrusted you with that high responsibility.

Mr Chairman, in order to understand the scope and nature of your work for our continent, it may suffice to recall the stirring appeal that you issued only recently at your address of investiture when you invited all your peers, and I quote your words, "to set their own houses in order." In a world where the future is uncertain, where the cloud of continual crisis hangs overhead, we Africans must indeed become increasingly aware of our responsibilities.

The people of Africa are aware of the determination with which you pursue your aims and they place all their hope in you. Your determination has already been translated into the action that your country, under your energetic leadership, has taken in the search for solutions to the problems disturbing the African world. The Congo today has become a land of mediation and conciliation where our African brothers meet to discuss a number of differences.

No African worthy of the name can feel completely free when he knows that his brothers are denied, in one way or another, the right to feel they are men on their ancestors' own land.

That is why, Mr President, we, as the officials responsible for health, cannot let this opportunity pass without praising your Excellency's brilliant efforts, and the striking role that he has played, in many places, to rehabilitate human values, and to set up a more just economic order that will satisfy our populations' fundamental needs.

We cannot conclude, Mr President, without taking the liberty of saying that we are certain in advance that your wise guidance that you will give to our session will mark, without any doubt, a decisive turning point in our countries' forward march towards an overall improvement in the welfare of our stalwart peoples.

In conclusion may I be allowed to convey to you, and through your person to our brother people of the Congo, on behalf of the Honourable Ministers, the Heads of Delegations and the Distinguished Delegates, our deep gratitude for the generous African hospitality that we have at all times received, whenever we meet in this charming city of Brazzaville.

We have also the privilege of welcoming today the Director-General of the World Health Organization, Dr Halfdan Mahler who, once again this year, has done us the honour of attending our session.

Mr Director-General, we are very grateful to you for the attachment that you have never ceased to show to our Region, and upon which you act whenever your timetable allows you to do so by attending our Regional Committee in person. We know that you understand our problems better than any one and that we can rely upon you and your colleagues to take up the challenge of Health for All by the Year 2000. You have accustomed us, Mr Director-General, to veritable programme addresses and it is always a great joy for us to hear you on the subject of primary health care. Your last address to the Thirty-ninth World Health Assembly, in May 1986, captured all our attention, showing us that in the implementation of primary health care your ideas are identical to our own.

Please believe one thing, and in that, all my colleagues with us here share my view: the political will to implement primary health care is neither a myth nor a vain word in our Region. The essential problem for us is permanent monitoring of those "crocodiles" to which you so cleverly alluded in Geneva and which, unaware of our good people's deeper motives, are reaching us in various forms, ready to devour us. At the time when the marshy areas of health work appear to be spreading further and deepening in some of our Regions you will agree with us that we must be more vigilant than ever.

Honourable Ministers, dear Colleagues,
Ladies and Gentlemen,

We have therefore come together once again at our headquarters in order to compare our experiences, lay new foundations for our programming and work out new guidelines for the year to come.

Tradition requires that on this occasion the Chairman of the session discharge the pleasant duty of saying a few words to the various fellow delegations attending our Committee.

It is even more of a pleasure for me to observe that tradition because a year ago in Lusaka you paid me the signal honour of electing me as first Vice-Chairman of our Committee. An accident of circumstance decreed that sometime afterwards our officiating Chairman was called to higher responsibilities, leaving vacant a chair in which you have once again been kind enough to install me, and, strengthened by the trust so placed in me I represented you at the Thirty-ninth World Health Assembly in Geneva, last May, as Vice-President.

It is not, therefore, without a certain emotion that I take the opportunity afforded me today not only to welcome the Honourable Ministers and Distinguished Delegates who have taken the trouble to travel to the present session but also and above all to convey to you my country's deep gratitude, as well as my own, for that mark of trust and renewed fraternal feeling.

I would be failing in my duty if I did not express my sincere thanks to the entire team of our Regional Secretariat that considerably facilitated my labours throughout my term of office.

Distinguished Delegates, Ladies and Gentlemen, a brief glance through the agenda proposed to us shows that we shall be dealing with subjects of capital importance. However, the essential theme of our meeting will be the traditional consideration of the health work carried out in our Region during the past year and the prospects apparent to us for future action. As you know, since our last meeting the health situation has remained difficult and unstable in most of our countries.

In this regard you must allow me first of all, on your behalf to extend to the Regional Director, Professor G. L. Monekosso, our Executive Secretary and his collaborators, all our congratulations on the celerity and determination with which the new structures of the Regional Office have been set up, in order to improve efficiency. I am thinking in particular of the establishment of the Sub-Regional Offices that have already become operational, of AFROPOC, the new managerial system at AFRO and the strengthening of the WHO Representatives' Offices in the countries, which is

under way. Our Regional Director is a man of the field and since his assumption of Office he has visited a number of countries, including Togo, in order to see for himself the real problems facing the implementation of primary health care.

Meanwhile African Immunization Year has been given a very warm reception everywhere, despite a late start.

All our countries have strengthened their work on raising the populations' awareness and mobilizing the people, with the aid of a number of agencies, including of course our Organization, WHO, by designing posters, holding discussion groups and organizing radio and television broadcasts on the expanded programme on immunization and more particularly on 1986 as African Immunization Year.

You will agree with me that successful preparation is the main thing since it will determine all EPI activities until 1990, by which year we must have immunized at least 75% of the target population.

No one is in doubt that our Regional Office has given support to all the countries of Africa and this will become more effective and efficient when the decentralization of the Regional Office has become a reality.

In regard to the resolution concerning the acceleration of primary health care at local level (for certain countries, district level, for others prefectoral or by commune), in other words at the level of the smallest political and administrative unit within each country; several meetings have been devoted to this subject and have allowed us to develop a scenario enabling each of us to envisage, if not the acceleration at least the effective implementation of primary health care, as from the local level.

Needless to say, it is also at the local level that intersectoral health action seems to be easier to put into effect. Our Executive Secretariat has organized a meeting at Brazzaville during which the Ministers of Health and other sectors of our countries' national economies discussed subjects such

as: health and agriculture, health and education, health and hydraulics and sanitation. Some of our colleagues present here attended that meeting and they understood that we must try to break down the administrative barriers dividing our ministries and the others, in order to improve coordination and execute in a rational manner all the actions undertaken by our respective sectors to further our populations' welfare.

In my country, Togo, the EPI awareness campaign is in full swing and at the end of this month the Head of State, General Gnassingbé Eyadema, will personally and officially launch that great operation which will give an undeniable impetus to all the people of Togo, to ensure the full success of the campaign.

In another area, our country has completed its national health programming which takes account of policies, objectives, strategies and plans of action for the implementation of primary health care. The earlier health system has been modified and regional departments have been set up to give greater support to the activities carried on in the prefectural districts, that is to say the local level.

This decentralization of the national health system will enable more concrete progress to be made towards the target of Health for All by the Year 2000.

Honourable Ministers,
Distinguished Heads of Delegation,
Ladies and Gentlemen,

There is one question that comes immediately to mind and it concerns the ways and means of implementation of action to solve our health problems in concrete fashion, for while our continent has immense potential natural resources, most of our countries remain in a condition of general under-development. Year by year our responsibilities are increasing, as new developments threaten our continent.

We must in fact acknowledge that the economic crisis, although it seems to favour the industrialized countries, remains pitiless in its effect on Africa, which is in the throes of fratricidal conflicts and wars maintained by destabilizing manoeuvres or apartheid. Many problems that require urgent solutions are still arising, and they are crucial ones, such as those occasioned by natural catastrophes, including the migratory locusts that yet again neutralized at a stroke the efforts made by certain countries only just recovering from the devastating effects of drought. None the less agriculture and the improvement of productivity must be a constant concern if we can hope to achieve effective control of malnutrition.

It is equally clear that our other present-day concerns include, high on the list, the acquired immuno-deficiency syndrome (AIDS), an affliction which while spreading terror throughout the world appears for reasons of pure expediency to have been assigned an African origin.

The Regional Office, as you may well imagine in such circumstances, has taken the necessary steps to collect all information on AIDS and has begun to set up in the countries a programme for an action plan against AIDS.

The main aim will be to avoid the contamination of our populations through blood transfusion and also to inform them on the mode of transmission of this new scourge and thus prevent the introduction of another public health problem into Africa.

All this should spur us to close ranks at all levels and devise a policy suited to our resources by relying first and foremost on our own strength.

Your Excellency the current Chairman of the OAU,
Mr Director-General of WHO,
Mr Regional Director of WHO,
Honourable Ministers,
Distinguished Heads of Delegations,
Distinguished Delegates,
Ladies and Gentlemen,

I have touched upon some of the difficulties that lie on the path towards Health for All by the Year 2000.

I am sure that we are all convinced that an analysis of our common problems, as well as the proposed solutions, will comprise stages that must not be cut short, or we may see that fine undertaking, primary health care, fall victim to a broadside of criticisms orchestrated by outsiders of whom none of us approves or supports. The strength derived from our unity of approach to our problems will enable us to go forward and overcome every obstacle.

On this note of wisdom that befits our African custom I now invite you all, individually and severally, to display your usual mastery and comprehension in the discussions that are about to begin.

Thank you.

OPENING ADDRESS BY DR G. L. MONEKOSSO
WHO REGIONAL DIRECTOR FOR AFRICA

Succeed we must

This is the subject I have chosen for my address.

Your Excellency, President of the People's Republic of the Congo, current
Chairman of the Organization of African Unity,
Honourable Ministers,
Distinguished delegates,
Ladies and Gentlemen,

1. It is no exaggeration to say that we are condemned to succeed for two reasons, on the one hand to safeguard our Organization and, on the other, for the sake of Africa our motherland. Never, since their foundation, have the United Nations agencies been so decried as today.

2. In the wake of the war, a noble ideal inspired their creation: to promote peace and to help the less prosperous and newly founded States to build their future. At a time of economic prosperity, resources were in plentiful supply. However, abetted by sliding oil prices, the hard currencies have taken to fluctuating wildly. No great power can escape market forces and any and every saving is in order. The UN agencies, including the most highly specialized ones such as our own, are coming under close scrutiny - contributions are dwindling and criticism is unsparing of the paltry results obtained from the resources made available. The UN agencies are being challenged and their very raison d'être is imperilled. We must therefore adapt to the economic situation and be more realistic, not only in the formulation of projects and the use of appropriate technologies that can be adapted to the countries but also in our approach to work with governments, while trying to avoid paralysing and obstructive bureaucratic procedures. More than any other Organization, ours is destined to succeed, first of all for itself and secondly for the continent of Africa for which it is responsible.

3. This continent, in the first place, contains the majority of the most deprived and vulnerable countries in the world. According to the World Bank, twenty of the 30 least developed countries are in Africa. The per capita income is US \$316. Africa is desperately poor as any indicator will show: life expectancy, infant mortality, literacy, access to drinking water or human resources.

4. In the second place, medium-term prospects for economic growth are more gloomy than in other regions. Taking an optimistic stance, the 1981 World Development Report forecast an increase in per capita income of 0.1% per annum during 1980-1990.

5. Thirdly, among low-income countries in the world, those in Africa stand to draw least benefit from the expansion in world trade. The proportion of non-oil exports from Africa is extremely low and the Region concentrates mainly on groups of low-return primary commodities.

6. Fourthly, Africa is still very dependent on concessional aid because of its poor debt servicing credibility. Finally, only enhanced assistance combined with a policy and a determination to bring about necessary reforms could fulfil the promise of profitable investment leading to accelerated growth over the next decade.

7. Left without any choice or alternative, our only way out condemns us to succeed.

8. Our peoples, reduced to slavery and, in more recent times, to repression, have often heard the knell tolling like a sentence to prison or to death. Many have little by little lost their moral and physical health and at the same time their human dignity. Being doomed certainly is a sentence that subjects one to an obligation, but our sentence is a sentence to life rather than to death and our obligation is to succeed rather than to fail. Our balance-sheet is in deficit and the health of our continent is failing.

Djenné Jené, even though it was the first city of the Niger to be built before Christ, is no longer what it was, and Timbuktu is no longer the golden way. We find ourselves wondering where to look for help. The crises in the industrialized countries themselves constitute a crushing burden, while the North-South dialogue has long been deadlocked.

10. Man's strength is in his own faith. He has always been a great builder. He can be the maker of his own happiness or the instrument of his misfortune. A heritage has been handed down to him and he must pass it on. In giving life to a new generation of mankind, he should be able to look his sons in the face, with the feeling of duty bravely done.

11. Today is not a time for philosophy or reflection. It is a time for action, as the words of our theme imply. There is no one standing behind us today to protect us or prevent us from falling down like a child taking its first steps. Our independence, even though it is of recent date, is an accomplished fact. St Francis of Assisi said that the main thing in life is not to prevent oneself from falling but to rise again if one falls, and to rise up proudly to meet the challenge and achieve the particular purpose within a limited time.

12. That challenge is our peoples' health. We cannot copy others since there is no ideal model. The ways and means must be found within ourselves, and around us, in our immediate environment.

13. Since I assumed my duties, I have conceived the various components of health as indices integrated into socioeconomic development viewed in the wide-ranging context of multisectorality.

14. Our strategy for action covering three years was proposed to and accepted by the Regional Committee in Lusaka in 1985. At that point we prepared a working paper on ways and means of accelerating the achievement of Health for All by the Year 2000 in Member States of the African Region. The document was sent to all Member States for purposes of discussion and adaptation to local service settings. It was subsequently proposed to the countries that they should put its recommendations into practice at district level, which is the most peripheral of all.

15. Accordingly, many countries modified their ordinance survey maps. The result is that districts, city wards and zones of limited extent, with a small population that can easily be monitored, have been more clearly demarcated, for instance in the form of local government areas in Nigeria, communes in Burundi, zones in Zaire and villages in Burkina Faso. These examples are of course not an exhaustive list. There is a very real desire on the part of all the Member States to get those activities off the ground.

16. It was then proposed to the countries that they set up administrative committees for district development. These already existed in many countries, although they were not necessarily fully operational. Others set about creating and/or reorganizing theirs. Being decentralized institutions, they serve as vehicles of government strategy.

17. District health committees are the natural complement to these administrative committees. In collaboration with some countries, the Regional Office of WHO has sent multidisciplinary teams into the field in order to assess the situation and identify priorities for action. This team of workers from many sectors operates hand in hand with national counterparts. Those nationals receiving training will subsequently become trainers themselves.

18. This critical mass can provide administrators and health module research workers who may become the constituent components of a national health development centre. This institution, acting in an advisory capacity to the Ministry of Health and as coordinating agency with other health-related ministries, will be provided with all available data and statistics on the organizational chart of field-based workers and national health geography. In addition, in the field, educationists, information personnel and social assistants are active among the people with a view to promoting education, hygiene and health through social mobilization.

19. Once the district health infrastructure has been set up, it should follow a managerial cycle that, first of all, defines health priorities in order to promote individual self-care, family self-reliance and community self-management; secondly, launches multidisciplinary activities to be

carried on by health workers and those in related sectors and, finally, monitors those activities by evaluating community health status and well-being, the degree of health and medical coverage, and satisfaction of the populations' health and related needs.

20. Health care will be monitored objectively by means of health indicator cards that are being computerized. Their use does not call for any special training and they can be given a broader application by professionals. They will provide a clear picture of activities in each district, making it possible to pinpoint priorities for immediate attention.

21. Once district activities are operational they should then be extended to cover the whole country. Data will gradually be recorded on to district maps and follow-up ensured by means of quarterly, half-yearly and yearly reports from the countries. The selection of sites for these activities is the prerogative of the governments, so that there will be no trial experiments nor laboratory zoning nor even pilot projects.

22. We are quite aware that we still have a good deal of ground to cover. Our efforts are still far from achieving our ambitions, and much remains to be done. Conditions in the field constantly compel us to align our activities with realistic norms and standards.

23. We have had to adapt our administrative structures to our strategy of decentralization.

- (a) The WHO Representative in the country spearheads our plan of action in the field and his role has been strengthened. He is now responsible for local work at district level and should report on progress and constraints. His contribution is of a technical, educational and logistic nature. He enjoys maximum scope according to the country's needs and in complete agreement with the ministry concerned, in other words the Ministry of Health which is the vehicle of state policy. Our country offices are at the service of the Member States.

- (b) Our three Subregional Offices are the instrument of our policy of decentralization. They respond to requests from the countries and are not a hierarchical level between the countries and the Regional Office. Their main tasks involve promotion of health development in the countries of the Sub-Region and strengthening of cooperation and technical support at district level. The Director of each Office, assisted by a multidisciplinary and multi-purpose team, respond to the countries' requests without having to go through the usual sluggish bureaucratic channels. Not all of these Offices are fully operational as yet, although they will be very shortly.
- (c) Finally, the Regional Office itself has been reorganized and a system called AFROPOC installed. The WHO Representative in the country works hand in hand with health officials and formulates a plan for the organization of their activities. The AFROPOC Unit stores all the programming planned for the current year and all activities are budgeted. This computerized system is meticulous but not inflexible; it requires careful management in the use of funds while at the same time gives consideration to unprogrammed situations and their justification. Moreover, the degree of achievement of Health for All is being monitored by a computer terminal and a specialized service attached to the Office of the Regional Director. Health indicators are itemized by district and country so that any delays or constraints in carrying out activities can be quickly overcome.

24. Mindful of the dearth of human resources, we have begun to review the training programme for our health leaders so that, on the one hand, they may be in a position to ensure health care from the highest down to the lowest levels and, on the other, having completed their training, they may themselves become trainers, team leaders or even research workers.

25. For our part, we work in conjunction with other United Nations agencies. AFRO's links are particularly close with UNICEF and UNDP and are to be strengthened with FAO, since health cannot be considered apart from agriculture and nutrition. Although we are proceeding under severe budgetary

cut-backs and using our resources to the utmost, we cannot hope to carry on the struggle alone. The topmost levels of our Organization are assisting us both technically and materially. This aid should be increased two-fold because the time has come for delivery. Words must now be put into action.

26. Last but not least, we need the support of this entire continent and first and foremost of its populations, but also of its governments and regional bodies such as OAU, ECA, ADB and others so that this working tool may become, in the hands of its own makers, the means of achieving success and health for our communities.

27. Although Africa has to find its own way, it should not work in isolation. While ostracism would be to its disadvantage, assistance from whatever source should be integrated with ongoing plans of health activities. Poorly coordinated proposals arrest rather than accelerate the process once it is launched, and also lead to confusion. The disorder arises from the fact that the world we live in has been devised by others. We should therefore, when collaborating with the rest of the world, let ourselves be guided by an enlightened spirit of analysis and a realistic sense of proportion as to both our needs and our resources.

28. The African populations, WHO Member States and their Regional Office in Africa are already on the march. However, the morale of the troops needs to be constantly rekindled. In the words of Napoleon, the secret of any victory lies in silence. Accordingly we are taking action with unrelenting firmness of purpose and, relying on your total and unfailing collaboration, we are mindful of the fact that we alone shall be judged by results. If we suit the action to the word, we - or you, to be more accurate - will bring about for your peoples this health revolution of Health for All by the Year 2000 which should not be regarded merely as a deadline. In the words of Jaurès, you will have achieved an ideal on the basis of hard facts. The Year 2000 should not be regarded as a slogan, but rather as driving force for surpassing one's own self and achieving a state that every human being is entitled to claim: a decent standard of health for himself and for his children. Only then will he be in a position to recover his dignity and that of the world's entire population, two-thirds of whom are today deprived.

Your Excellencies,
Ladies and Gentlemen,

29. Thank you for your kind attention, and the assistance of the interpreters to whom I convey my respects, not forgetting the entire staff of WHO. I hope that I have managed to make myself clear, and better still, that we understand each other.

ADDRESS BY HIS EXCELLENCY COLONEL DENIS SASSOU NGUESSO
PRESIDENT OF THE CENTRAL COMMITTEE OF THE CONGOLESE WORKERS' PARTY,
PRESIDENT OF THE REPUBLIC, HEAD OF THE GOVERNMENT OF THE PEOPLE'S REPUBLIC
OF THE CONGO, CURRENT CHAIRMAN OF THE ORGANIZATION OF AFRICAN UNITY

Mr Chairman of the thirty-sixth session of the Regional Committee for Africa
of the World Health Organization,

Mr Director-General of WHO,

Mr Regional Director for Africa of WHO,

Your Excellencies the Ambassadors and Heads of diplomatic missions,

Distinguished Delegates,

Ladies and Gentlemen,

Our people, our Party and our Government greatly appreciate the privilege
of being host, here in Brazzaville, to the thirty-sixth session of the
Regional Committee for Africa of the World Health Organization. In their
name, therefore, and in my personal capacity, I wish all participants welcome
to our African land, the Congo.

This occasion provides us with an excellent opportunity to offer our
congratulations:

- to Dr Mahler, Director-General of the World Health Organization, for
his keen perception of the problems of the Third World in general and
of Africa in particular and for the excellence of the relations he has
helped to establish between WHO and its Member States;
- to Dr Monekosso and all his staff for the skill with which they have
ensured the continuity of their mission and for the new ideas they
have introduced into the search for ways of achieving the goal of
Health for All by the Year 2000.

I particularly welcome Dr Aissatou Kone Diabi who has been appointed
Director, Programme Management, and who, as second in command of the Regional
Office, has proved by her competence and her feeling for human relations that
African women are entering into a new era of responsibility.

Mr Chairman,

Being gathered in this hall on such an important occasion, we cannot fail to remember that great man and great humanist, the late Dr Alfred Auguste Comlan Quenum, first African Director of our Office who was suddenly taken from us on 15 August 1984. Let us all pay tribute to him here.

Mr Chairman,

Distinguished Directors,

Your Excellencies,

Ladies and Gentlemen,

The economic crisis that is disrupting the world is felt particularly acutely in the Third World and has reached dramatic proportions in Africa, where it is hampering the efforts of our Organization and our countries to improve the health of our populations.

Furthermore, the agonizing spectacle of the fratricidal wars perpetuated by selfish vested interests continually threatens the precious yet fragile achievements in the field of health. This situation, with the crisis and its effects, with natural disasters and fratricidal wars, has made health development in Africa resemble the Danaids and their barrel. However, the harder the effort the greater the merit, and that is why harnessing our energies to such an endeavour, with determination and strength of purpose, must be our essential task, since it is centred on man, our most precious capital, for he is the focal point of all promotion, renewal and development efforts.

Thus, from this standpoint, the People's Republic of the Congo, measuring the ground that has been covered, considers that there is no reason to throw in the towel or give up the fight because, despite many and varied ups and downs, the World Health Organization has done and continues to do work the sum total of which commands admiration and proves that the struggle is not unavailing.

We are especially grateful to the Organization for its support in the form of human, financial and material resources and for its contribution to the reorganization of the health systems of Member States, particularly those of our Region.

Mr Chairman,

We note, on reading the provisional agenda, that during the present session you will be discussing the regional programme budget policy, the diarrhoeal disease control programme and the revised malaria control strategy. These are among the subjects the timing, relevance and interest of which strike us as being particularly apt in the light of our specific problems and priorities.

We also appreciate the subject chosen for the technical discussions, namely: "The primary health care approach to the promotion and protection of the health of farm workers during the Industrial Development Decade in Africa".

The People's Republic of the Congo, confident that the slogan: "Food self-reliance by the year 2000", is meaningful only when seen in terms of agricultural development, and hence of improvement of the health of farm workers, is convinced that this subject is among the principal concerns of the majority of the countries in our Region.

The conclusions of those discussions will, I feel sure, be put to proper use by all the Member States.

Mr Chairman,

Honourable Directors,

Your Excellencies the Ambassadors and Heads of diplomatic missions,

Ladies and Gentlemen,

Although the People's Republic of the Congo is, like all the countries of the Region, a victim of the world economic crisis and its disastrous repercussions, it none the less remains determined to consolidate what it has achieved on the road to Health for All by the Year 2000. Bearing in mind the commitment to health and social promotion made by our country in full view of

the world, in particular since the Alma-Ata Conference, our Party, the Congolese Workers' Party, has given a clearcut orientation for the formulation and implementation of the programme for health and social development as part of our first five-year plan 1982-1986.

We were able to report on the efforts that we had already made at the thirty-third session of the Regional Committee. Since then we have taken further action, thereby indicating our unflinching will to guarantee the health of our peoples.

Thus, we have instituted the National Primary Health Care Programme, whose objectives and Action Programme 1986-1990 have just been examined by the National Council for Health and Social Affairs. The 1986 component is being fulfilled in secondary urban centres and rural areas under the control of health committees set up for the purpose at different levels in our administrative machinery.

This programme will enable us to continue with and strengthen, inter alia, prevention and treatment measures through the supply of essential drugs, on the one hand, and through the expanded programme of immunization through hygiene and sanitation, and through food and nutrition, on the other. Our future efforts will also be directed towards putting into practice one of the basic recommendations of the National Council for Health and Social Affairs, namely to ensure enhanced popular participation and better participation by related sectors that are basic to primary health care.

Within the framework of the African Immunization Year, we hope to increase immunization coverage from 40 to 80% on the occasion of the National Immunization Campaign planned for November 1986.

Appropriate solutions to current health problems call for improvements in the treatment system. We are therefore continuing to carry out the programme of appointing and equipping health units, despite our economic difficulties. Furthermore, new units have come into being, and others are being built.

Thus, under the 1986 part of the programme, we shall bring into operation two district hospitals, which we call "base hospitals", between now and December, and five integrated health centres, while the Central Teaching Hospital in Brazzaville is being renovated and will be operational by 1988.

Reorganization of the national health system is in progress to fit it to the guiding strategy of primary health care. This is proceeding in parallel with a precise post description of the various categories of health personnel.

The targets that we have set ourselves in this area are to train and retrain health and welfare personnel capable of helping the people to take responsibility for their own well-being.

As you see, the People's Republic of the Congo is making considerable efforts to resolve the health problems of the broad masses of the people. It also knows how to assess the assistance that is greatly needed to back up its efforts. I should like here to pay special tribute to the World Health Organization and to say what a beneficial effect its support has had on our efforts, especially in the field of health manpower training, where its contribution under the programme budget has been very large.

Mr Chairman,

The promotion of health for all may at first sight appear very ambitious for us, as developing regions; obstacles of all kinds stand in the way of realizing such an ambition, not least among them: ignorance, poverty, underdevelopment and natural calamities.

With certain minor exceptions, almost all the countries of the region are in this situation; it is therefore their task to pool their efforts for the solution of health problems.

Technical cooperation among the countries of the Region is proving to be not merely necessary, but essential to the achievement of such a noble objective.

The Organization for Co-ordination in Control of Endemic Diseases in Central Africa (OCEAC) is one of the fortunate manifestations of this cooperation. The People's Republic of the Congo may congratulate itself on its active participation in the control of trypanosomiasis and onchocerciasis within that Organization.

There is, however, a need further to develop regional cooperation in health. As far as it is concerned, the People's Republic of the Congo wants to achieve a qualitative improvement of that cooperation and to work to open up new horizons at the continental level.

Mr Chairman,
Mr Director-General,
Honourable Delegates,

The shared resolve of Africans to pursue with tenacity the objective of health for all remains, however, dependent upon one prior condition: the peace and social justice that are indispensable to our entire continent and, more generally, to the world.

Your respective Heads of State, by unanimously subscribing to the objective of the World Health Organization, have by the same token committed themselves to extirpating from our beloved continent the evils that are hampering that programme: social unrest, fratricidal wars, racism and apartheid. Without peace and social justice there can be no true health for Africa.

In a context of racial discrimination, Africa can never know true health. With the institutionalized racism that apartheid constitutes, there can be no true health for Africa. That is the glaring fact which is borne upon all of us.

Mr Chairman,
Ladies and Gentlemen,

In face of the concern voiced by the international community, despite general reprobation, and only a few days after the Eighth Summit Meeting of Non-aligned Countries, held at the very gates of South Africa, the racist

regime in Pretoria has once again responded by contempt and arrogance to the desire for change expressed with daily increasing determination by those struggling for freedom with the backing of all peoples and all the forces for peace.

Thus, to the already too long list of victims of apartheid have now been added three sordid murders of freedom fighters.

I am spokesman for the whole of Africa in condemning these odious crimes as nothing less than a threat to peace and international security, and in appealing to all international agencies, in particular the United Nations, to all men of goodwill, and to all the Western powers that support the regime in Pretoria, so that together we may combat this genocide by decisive measures calculated to put an end to this unjust and retrograde regime, for otherwise the objective of "Health for All by the Year 2000" can have no real meaning in racist South Africa.

Mr Chairman,
Honourable Directors,
Your Excellencies, Ladies and Gentlemen,

The elimination of the diseases and sores which these obstacles also constitute is therefore basic to the realization of our aspiration, the success of our undertakings, and the consummation of our endeavours in the health field. May each of us take this imperative to heart and strive in his own sphere to ensure our common victory.

I am confident that our present session will make a valuable contribution to this. Our wishes for success go with you.

Long live African Unity
Long live the World Health Organization

I declare open the thirty-sixth session of the WHO Regional Committee.

Thank you.

MESSAGE OF HIS EXCELLENCY SECRETARY GENERAL
OF THE ORGANIZATION OF AFRICAN UNITY

Madam Chairperson,
Honourable Ministers, Members of the Regional Committee,
Distinguished Delegates,

I have the honour to convey to you all, the warm greetings and congratulations of the OAU Secretary General His Excellency Mr Ide Oumarou for the successful endeavour you have just concluded.

Madam Chairperson,

Yesterday our WHO/AFRO Regional Director, Professor G. L. Monekosso, had mentioned the OAU Health Ministerial meeting due to be convened in April 1987 in Cairo, Egypt. In my capacity as the Director of OAU Health Bureau, I would like to throw some light on this subject matter to the eminent attendants of this Regional Committee.

Madam Chairperson,

The OAU summit of Heads of States and Governments meeting during their twenty-first session at Addis Ababa in July 1985, had adopted a resolution to convene an OAU Health Ministerial meeting, to meet every year prior to the WHO World Health Assembly meeting in May. The Egyptian Minister of Health while in Geneva during the Thirty-ninth World Health Assembly last May had offered to host this meeting in April 1987.

Secondly, the main objective, among others, of holding this meeting of OAU Health Ministers is to bring all Member States of the OAU together in one forum to put harmonized strategies for health that can be channelled through the OAU Council of Ministers to the OAU highest political forum on the

continent, namely the summit of Heads of States and Governments with a view to obtaining the needed political support for our decisions to facilitate their implementation. The best example of this is the intersectoral action for health promotion mentioned by the Regional Director yesterday.

Madam Chairperson,

There is one more point of clarification here that I wanted to mention, this is, that not all OAU Member States belong to one WHO Region. We have six other OAU Member States that are outside the African Region, they belong to the East Mediterranean Region (EMRO) of Alexandria. Hence the need to bring them all together in one OAU forum.

Thirdly, preparations for this meeting are underway between the OAU General Secretariat namely its Health Bureau and the Egyptian Government. This is going on in close collaboration with the WHO/AFRO and WHO/EMRO Regional Offices in Brazzaville and Alexandria respectively.

Finally, Madam Chairperson, I hope that I have made myself clear in this brief presentation. However, more details on the subject matter will be conveyed to all Member States with the invitation, programme and draft agenda for their participation in the meeting.

The meeting will be arranged in such a way that the OAU Health Ministers will be able to attend on their way to Geneva for the Fortieth World Health Assembly.

Madam Chairperson, thank you for your attention.

AGENDA

1. Opening of the thirty-sixth session (document AFR/RC36/1)
2. Adoption of the provisional agenda (document AFR/RC36/11 Rev. 1)
3. Constitution of the Sub-Committee on Nominations (resolution AFR/RC23/R1)
4. Election of the Chairman, Vice-Chairman and Rapporteurs
5. Appointment of the Sub-Committee on Credentials (resolution AFR/RC23/R17)
6. The work of WHO in the African Region
 - 6.1 Succinct report of the Regional Director (document AFR/RC36/3 and AFR/RC36/3 Add.1)
 - 6.2 Review of diarrhoeal diseases control programme (document AFR/RC36/20)
 - 6.3 Comlan A. A. Quenum Prize (document AFR/RC36/21)
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/RC36/5 and AFR/RC36/5 Add.1)
 - 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 Rev.1)
 - 7.4 Technical discussions at the Fortieth World Health Assembly (1987) (document AFR/RC36/8)

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8. Report of the Programme Sub-Committee (document AFR/RC36/9)
 - 8.1 Regional programme budget policy (document AFR/RC36/4)
 - 8.2 Proposed Programme Budget 1988-1989 (documents AFR/RC36/2 and AFR/RC36/2 Add.1 and Corr.1)
 - 8.3 Eighth General Programme of Work covering the specific period 1990-1995 (documents AFR/RC36/10 and AFR/RC36/10 Corr.1)
 - 8.4 Revised regional anti-malaria strategy (document AFR/RC36/22 and Errata)
 - 8.5 Report of Subregional Programme Meetings (document AFR/RC36/12)
 - 8.6 Report of the African Advisory Committee for Health Development (document AFR/RC36/13)
 9. Technical discussions
 - 9.1 Presentation of the report of the technical discussions: "The primary health care (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 1987 (document AFR/RC36/17)
 10. Dates and places of the thirty-seventh and thirty-eighth sessions of the Regional Committee in 1987 and 1988 (document AFR/RC36/18)
 11. Adoption of the report of the Regional Committee (document AFR/RC36/19)
 12. Closure of the thirty-sixth session.

LIST OF DOCUMENTS

- AFR/RC36/1 - Inaugural ceremony of the thirty-sixth session of the Regional Committee for Africa of the World Health Organization.
- AFR/RC36/2 and Corrigendum - Proposed Programme Budget for 1988-1989.
- AFR/RC36/2 Add. 1 - Regular Budget Estimated Obligations and Analysis of Increases and Decreases by Programme.
- AFR/RC36/3 - The Work of WHO in 1985.
- AFR/RC36/4 - Regional Programme Budget Policy.
- AFR/RC36/5 - Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board.
- AFR/RC36/5 Add.1 - Review of current guidelines concerning WHO relations with nongovernmental organizations (NGOs).
- AFR/RC36/6 - Agendas of the seventy-ninth session of the Executive Board and the Fortieth World Health Assembly: Regional repercussions.
- AFR/RC36/7 Rev.1 - Method of work and duration of the World Health Assembly.
- AFR/RC36/8 - Technical discussions at the Fortieth world Health Assembly (1987).
- AFR/RC36/9 - Report of the Programme Sub-Committee.
- AFR/RC36/10 and Corrigendum - Eighth General Programme of Work (8GPW).
- AFR/RC36/11 Rev.1 - Provisional agenda.
- AFR/RC36/12 - Report of the Subregional Programme Meetings.
- AFR/RC36/13 - Report of African Advisory Committee on Health Development (AACHD).
- AFR/RC36/14 - Provisional list of participants.
- AFR/RC36/15 - Report on the technical discussions: "The primary health care approach to the promotion and protection of the health of farm workers during the Industrial Development Decade in Africa".
- AFR/RC36/16 - Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1987.
- AFR/RC36/17 - Choice of subject of the technical discussions in 1987.

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- AFR/RC36/18 - Dates and places of the thirty-seventh and thirty-eighth sessions of the Regional Committee in 1987 and 1988.
 - AFR/RC36/19 - Draft report of the Regional Committee.
 - AFR/RC36/20 - Review of the diarrhoeal diseases control programme.
 - AFR/RC36/21 - Comlan A. A. Quenum Prize.
 - AFR/RC36/22 and Errata - Regional antimalaria strategy.
 - AFR/RC36/23 - Provisional programme of work of the Programme Sub-Committee.
 - AFR/RC36/24 - Distribution by countries of functions during preceding Regional Committees.
 - AFR/RC36/25 - Programme of work of the meeting of the Programme Sub-Committee held on 17 September 1986.
 - AFR/RC36/26 - Participation by Members of the Programme Sub-Committee in meetings of programming interest - 1986-1987.
 - AFR/RC36/27 - Report of the Programme Sub-Committee meeting held on 17 September 1986.
 - AFR/RC36/TD/1 - Technical discussions: "The primary health care (PHC) approach to the promotion and protection of the health of farm workers during the Industrial Development Decade in Africa".
 - AFR/RC36/TD/2 and Corrigendum - Guide for the technical discussions.
 - AFR/RC36/Conf. Doc./1 - Address by Dr H. Mahler, Director-General of the World Health Organization
 - AFR/RC36/Conf. Doc./2 - Address by Professor Aissah Agbeta, Minister of Public Health, Social and Women Affairs of Togo, officiating Chairman of the thirty-fifth session of the Regional Committee.
 - AFR/RC36/Conf. Doc./3 - Opening address by Dr G. L. Monekosso, Regional Director for Africa.
 - AFR/RC36/Conf. Doc./4 - Address by His Excellency, Colonel Denis Sassou Nguesso, President of the Central Committee of the Congolese Workers' Party, Head of Government of the People's Republic of the Congo, current Chairman of the Organization of African Unity.
 - AFR/RC36/WP/01 - Sub-Committee on Nominations
 - AFR/RC36/SSC/1 - Sub-Committee on Credentials
 - AFR/RC36/SSC/2 - Report of the Sub-Committee on Credentials.

LIST OF PARTICIPANTS
LISTE DES PARTICIPANTS
LISTA DOS PARTICIPANTES

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SAO TOME ET PRINCIPE
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REPORT OF THE PROGRAMME SUB-COMMITTEE

INTRODUCTION

1. The Programme Sub-Committee met in Brazzaville from 3 to 5 September 1986 under the Chairmanship of Mr Hailu Meche (Ethiopia). The list of participants is attached as Appendix 1.
2. Dr G. L. Monekosso, Regional Director, having welcomed the participants and highlighted the functions of the Programme Sub-Committee, called for a thorough perusal of the documents before the Sub-Committee so that a clear picture of the programme could be presented to the Regional Committee the following week. He then wished the participants a good stay in Brazzaville.
3. The Chairman thanked the Regional Director and his staff for the excellent reception given them on their arrival. He referred to the resolutions and decisions that established the Programme Sub-Committee, and underlined the seven functions of the Sub-Committee. He noted that only six members were present but seven were needed to form a quorum. One participant was expected during the day and two the following day.
4. The Programme of Work was adopted unanimously (see Appendix 2).

REGIONAL PROGRAMME BUDGET POLICY

Introductory statement

5. Document AFR/RC36/4, Regional Programme Budget Policy, was introduced by Dr A. Tekle. He underlined the joint efforts of Member States and WHO to make optimal use of health development resources, particularly in the implementation of national HFA policies and strategies.
6. Those joint efforts were governed by the regional programme budget policy, geared to:

- (i) establishment of techniques for precise definition of the most relevant development issues related to the achievement of HFA objectives;
- (ii) selection of priority development areas for resource allocation during the biennial period;
- (iii) identification of the forms of WHO collaboration most appropriate to the programme objectives;
- (iv) institution of a programming, monitoring and evaluation system.

7. The regional programme budget policy additionally emphasized the need for sound programme budgeting mechanisms at national and regional levels, designed to support effectively the accelerated attainment of HFA/2000. At the operational level, specific activities and programmes were identified during the detailed programming process. Programme budget implementation was subject to the full range of managerial control procedures, in particular a monitoring and evaluation system.

Discussions

8. Following the introduction, the Sub-Committee examined the document chapter by chapter.

Main thrusts of the Regional Programme Budget policy

9. The Sub-Committee took note of the priority given in the Proposed Programme Budget 1988-1989 to the three programmes for 1990 (water supply and sanitation, immunization, and nutrition).

10. It observed that 21 countries had made provision for nutrition in their country budgets, 37 for immunization, and 36 for water supply and sanitation.

11. A country that had made budgetary provision for one of the three priority projects for 1990 could obtain massive external resources in support of the programme. The question arose whether the funds in the WHO country project could be used for another important programme.

12. Albeit the answer was in the affirmative; every effort should be made to retain WHO as a partner and to ensure compliance with the Organization's basic policies on programme implementation.

Strengthening of national capacities

13. Given current constraints, careful consideration should be given, when allocating resources, to the determination of priorities and to absorptive capacity.

14. One question asked concerned the status of health systems research in the Region.

15. In reply, the Regional Officer concerned said a network of centres for health systems research existed, namely:

Sub-Region I

- National Institute of Public Health - Abidjan, Côte d'Ivoire
- The Department of Community Medicine - Enugu, Nigeria
- The Department of Social and Preventive Medicine - Ibadan, Nigeria
- The National Institute for Research in Public Health - Bamako, Mali

Sub-Region II

- The Department of Public Health - Kinshasa, Zaire
- The Department of Community Medicine - Addis Ababa, Ethiopia
- The Department of Community Medicine - Nairobi, Kenya

Sub-Region III

- National Institute of Public Health - Maputo, Mozambique
- Tropical Diseases Research Centre - Ndola, Zambia

16. However, impact so far had not achieved the level originally envisaged.

17. With reference to a question raised as to how countries without universities and similar institutions should develop health systems research, a consensus was reached that health systems research could be developed within any health system. Ministries of health should promote and encourage health systems research as an integral component of every health programme and at all levels, especially at the district or operational level.

18. It was explained that, in view of the importance attached to health systems research, each Subregional Health Development Office had a strategic support team whose responsibilities include research.

Technical cooperation among developing countries (TCDC)

19. The Sub-Committee agreed that TCDC had not made the desired impact.

20. It was explained that, with the restructuring of the Regional Office and the establishment of the Subregional Health Development Offices, it was confidently anticipated that the situation would improve. It was expected that TCDC activities would be guided by the Directors of those offices.

21. The Subregional Health Development Office might identify problems peculiar to individual countries or groups of countries, as well as available resources for promoting TCDC activities.

Optimum use of resources

22. In response to a question as to how many Member countries had established mechanisms for the optimal use of WHO resources at country level, it was observed that mechanisms existed in all countries but that they varied from country to country, particularly with respect to effectiveness.

23. Referring to the brain drain and the failure of nationals to return home after training in foreign countries, the participants enquired how WHO could prevent or minimize that state of affairs, which created serious problems.

24. Existing measures were outlined; they had not been effectively implemented in the past, but were now being vigorously promoted.

Programme budgeting process

25. Problems likely to arise from differences between budgeting in countries and the WHO programme budgeting process were mentioned. In that connection it was asked how many countries had adopted the WHO programme budgeting process.

26. While information was not immediately available, it was hoped that as many countries as possible would adopt the process.

27. The Sub-Committee appreciated the WHO budgeting process and recommended that the Organization should plan workshops and seminars to train nationals in the process.

28. The functions of the Subregional Health Development Offices in general and the relationships and linkages between them, the WHO country offices, and the Regional Office were clarified.

REVISED REGIONAL ANTIMALARIA STRATEGY

Introductory statement

29. Dr E. G. Beausoleil introduced document AFR/RC36/22, "Revised regional antimalaria strategy". The Regional Committee had adopted an earlier AFR/RC35/R11 antimalaria strategy by resolution AFR/RC31/R11, at its thirty-first session. Since that time, certain developments, including the emergence of chloroquine resistance, had made its revision necessary. The revision of the regional strategy was requested in resolution AFR/RC35/R5, adopted by the Regional Committee in 1985 at its thirty-fifth session. The regional officer then introduced the seven chapters of the document.

30. The analysis of the epidemiological situation and the classification of the malarious areas, according to the operational goals of antimalaria activities, highlighted five areas:

- (i) areas where malaria had never existed or had disappeared and where there was no risk of infection, and which were not receptive;
- (ii) areas where malaria eradication had been achieved but which were receptive. Two contrasting countries were Réunion, where there was no re-establishment of transmission, and Mauritius, where transmission had been re-established;
- (iii) areas where transmission had been reduced to a low level, as a result of a long period of organized vector control;
- (iv) areas where transmission was seasonal, with endemicity levels ranging from hypo- to meso-endemic and epidemic potential;
- (v) areas where malaria was stable, with endemicity levels ranging from hyper- to holo-endemic; in them the situation had not changed significantly over generations and there were no organized antimalaria activities. That group comprised most countries of the Region.

31. He described the main characteristics of the principal vectors, Anopheles gambiae and Anopheles funestus, that made them the most efficient vectors in the world and difficult to control.

32. After underlining the public health and socio-economic importance of the disease, he drew the Sub-Committee's attention to what he considered were two important issues. The first was the implications of continuing the single dose chloroquine treatment regimen, adopted by the Regional Committee at its thirty-first session with the current regional antimalaria strategy; the second related to implications of the emergence and spread of the phenomenon of resistance of P. falciparum to chloroquine in the Region.

33. That situation required a change in the standard treatment regimen.

34. Chapters 2, 3 and 4 respectively listed, the main objectives of the revised antimalaria strategy, which had remained unchanged; briefly outlined a malaria control strategy; and described the four tactical variants for malaria control. The Thirty-first World Health Assembly had adopted resolution WHA31.45 to that effect in 1978.

35. Chapter 5 outlined the basic conditions for implementing and maintaining an antimalaria programme. Special attention was given to three of those conditions:

- recognition of malaria as a problem and firm commitment at all levels to taking action against the disease;
- ability to maintain a programme after implementation;
- development of antimalaria action as part of primary health care.

36. Chapter 6 touched on the criteria for selection of appropriate control technologies, while Chapter 7 defined the role of WHO and suggested the kind of support and collaboration that Member States might expect to obtain from the Organization.

Discussions

37. In regard to the objectives of the regional antimalaria strategy (Chapter 2), it was questioned whether they were realistic and could be achieved. The participants agreed that prevention/reduction of malaria-related mortality and morbidity was attainable by developing facilities and services for prompt diagnosis, recognition and adequate treatment of confirmed and suspected malaria cases. A further measure would be the administration of antimalaria drugs as chemoprophylaxis for the protection of vulnerable groups, such as pregnant women. There was a need to develop such antimalaria action as part of primary health care and to provide supportive action, including referral systems, for the management of severe, complicated cases and for coping with the problem of drug resistance and treatment areas.

38. Reference was also made to the use of antimalaria action as an entry point for other primary health care activities in areas where primary health care had not yet developed. While this was acceptable, it was felt that MCH and child survival activities were more appropriate as entry points for PHC activities.

Recommendations

39. Public education and information aimed at heightening awareness of the problem of malaria and promoting antimalaria action at all levels, especially the family and community levels, should be intensified.

40. Research on malaria in pregnancy should be promoted and intensified.

41. Integrated vector control measures, especially at the community level and in urban areas, should be promoted.

42. The participants made a number of suggestions to improve the wording of the document.

Chapter 6 - Selection of control measures (Paragraph 64)

43. The French text should be amended to correspond with the English text in order to reflect correctly the idea that the four tactical variants need not follow a sequential order.

Chapter 7 - Role of WHO

44. It was suggested that the document should contain additional annexes to provide useful information on, for example, antimalaria vaccine development and research and development of new antimalaria drugs.

PROPOSED PROGRAMME BUDGET 1988-1989

Introductory statement

45. Mr A. M. B. Clarke, Acting Director, Support Programme, introduced document AFR/RC36/2, "Proposed Programme Budget 1988-1989", on behalf of the Regional Director. The document reflected the emphasis placed on activities at country level. Furthermore, all programme statements included a clear reference to the budgetary implications of the proposed programme budget. Those changes brought out more clearly all aspects of the Proposed Programme Budget for 1988-1989.

46. The overall regional allocation showed an increase of 16.1% compared to 1986-1987, bringing the regular budget for 1988-1989 up to US \$114 828 100. That figure would, however, remain provisional until the budget proposals for the Organization as a whole were finalized.

47. The Proposed Programme Budget had been prepared by using an exchange rate of 350 CFA to the US dollar. Should the dollar rate fall below the 350 CFA level, that would create difficulties in the implementation of the programmes. On the other hand, should the rate rise above the 350 CFA level the gains would have to be surrendered to WHO to help finance the next biennium. However, resolution WHA39.4 made it possible for Regional Offices to avail themselves of cash resources from casual income to cover adverse effects arising from exchange rate fluctuation. It was expected that such a facility would become available in 1988-1989.

48. The programme budget level took into account the components of the strategy for Health for All by the Year 2000 but also, and in particular, budgetary constraints. A zero growth rate in real terms had been set for the overall regional allocation.

49. The allocations for the individual countries were only provisional figures subject to revision when the budget proposals for the Organization as a whole were established.

50. The provisions included under the heading "Other Sources" were those for which financing was either assured or expected at the time the documents had been prepared. Generally speaking, a reduction in funds under that heading was due to the fact that the various funding agencies were subject to different programming/budgeting cycles and consequently additional funds would probably become available closer to the start of the 1988-1989 biennium.

Analysis of the Regional Programme

51. The presentation of the Programme Budget 1988-1989 emphasizes activities in the countries, the nature and scope of WHO's commitment, and the use of resources in relation to the targets and goals of national health programmes. The Regional Programme narrative statements have been prepared on the basis of a review and analysis of the country statements. However, the Committee decided not to examine the country statements in the document.

52. The managerial process for national health development has been accepted by all the countries. The WHO Representatives are included in this programme in order to introduce a uniform managerial process in liaison with that of the countries. The countries are convinced of the need to rationalize managerial processes and in the course of the thirty-third session of the Regional Committee they adopted resolution AFR/RC33/R4, by which the Regional Director is requested to provide increased support to the Member States in order to improve management of the resources made available to them.

Discussions

53. A detailed examination was made of the various programmes.

Programme 1.3 - Regional Committee

54. The budget for the Regional Committee reflects an increase of 13.5%. This minor increase is due to the fact that the Regional Committee is held in Brazzaville once every two years, as against once every three years in the past.

Programme 2.1 - Executive Management

55. The creation of a new unit for promotion and monitoring of the implementation of Health for All by the Year 2000 was the main reason for the 12% increase in this programme.

Programme 2.2 - Regional Director's Development Programme

56. No change in the budgetary allocation has been reflected under this programme.

Programme 2.3 - General Programme Development

57. The substantive increase of 100% is mainly due to the creation of the new Subregional Health Development Offices (SRHDO). It covers the cost of administrative personnel, operational expenses and administrative support to the Inter-Country Project (ICP) teams, while the ICP teams themselves are reflected under their individual programmes.

Programme 2.4 - External Coordination for Health and Social Development

58. This programme (COR) now covers three well-defined activities:

- Health Resources Mobilization.
- Emergency and Relief Operations.
- Coordination with the UN system.

59. This division has already proved successful in obtaining extrabudgetary funds for approximately US \$3 million to be used for programmes on AIDS, EPI and CCCD. Further, an improvement in the relationship between UNICEF and AFRO has been mainly due to the work of COR.

Programme 3 - Health Systems Development

60. The budget of this Programme reflects a 28% increase under country activities, which is the result of increasing the provision for health situation and trend assessment. The major part of the increase is for developing the managerial process for health development in the country offices to provide increased support to the Member States, in order to improve management of the resources made available to them. The small but significant increase under Health Legislation reflects the wish to assist Member States in formulating their health legislation. This activity is also supported by assistance from headquarters.

Programme 4 - Organization of health systems based on PHC

61. The increase in the budget allocations made by the countries is quite significant and is due not only to the large number of countries participating but also to the importance accorded at country level to the three-year scenario.

Programme 5 - Health manpower

62. The total budget allocation for health manpower is almost 20% of the proposed total regular budget allocation. Nearly 25% of the overall country appropriation is allocated to health manpower training. Training programmes organized for teams of health workers should be encouraged with a view to rationalizing the use of the resources. The increase in the regional allocation reflects the increased support offered by the Subregional Health Development Office.

Programme 6 - Public information and education for health

63. Activities under this programme have been increasing during the last biennium and show the awareness in Member States of this important element of the national strategies for health. Nearly all countries have now sent nationals to the WHO country offices to promote this programme. Much encouragement is now given to the use of the mass media.

Programme 7 - Health promotion and development, including research on health promoting behaviour

64. In all programmes there is an element of research. At the country level, support is given to research and development activities through consultative committees. At the Regional Office coordination of research is done by RPD, and it is within the cabinet of DPM. Health Systems Research, Human Reproduction and Tropical Disease Research are coordinated by the Programme Managers I, II and III respectively.

65. Priorities differ in the three Sub-Regions. Sub-Region I is mainly concerned with environmental problems; Sub-Region II with population aspects and Sub-Region III concentrates on human problems of the frontline States. The Committee felt that the sociological aspects of health should be given more attention.

Programme 8 - General health protection and promotion

66. The nutrition programme commands high priority in this area, as reflected in the fact that more than half the countries have included it in their budget provisions. This programme also benefits from important extrabudgetary resources.

67. Resources under Accident Prevention are minimal but the programme is managed in consultation with Workers' Health and with Rehabilitation.

Programme 9 - Protection and promotion of the health of specific population groups

68. A major percentage of the African population consists of women and children. However, the health of the elderly has an important influence on the health of children, due to the special role the elderly perform in African society. The countries have not shown, in terms of budgetary allocations, a comparable interest in maternal and child health programmes and the implementation of the programme depends heavily on external funds. In the case of the elderly, more activities should be encouraged to increase the awareness of their needs.

Programme 10 - Protection and Promotion of Mental Health

69. The budgetary allocation for the programme does not correspond to the demands foreseen in the coming years for this important area.

Programme 11 - Promotion of Environmental Health

70. Although a significant budgetary allocation is reflected, the effect of the programme may not be as desired so long as activities are fragmented and uncoordinated. It is important that water and sanitation activities should both be well integrated at village level. AFRO is now implementing PHC in an integrated manner at village level.

71. The Committee recommended that countries consider setting aside resources equal to about 2-5 per cent of the country allocation to improve the managerial process, so that progress may also be made in that area.

Programme 12 - Diagnostic, Therapeutic and Rehabilitative Technology

72. The increase at the country level is due to the increased attention to clinical, laboratory and radiological technology. At the regional level, a significant decrease has been due to withdrawal of the working capital for pool procurement of essential drugs; that capital was never taken up by the countries of the Region in previous biennial periods.

Programme 13 - Disease Prevention and Control

73. The overall decrease in this programme does not mean that it commands less priority, but is rather due to budgetary constraints facing the Organization. Substantial extrabudgetary funds have been made available to the programme and it is expected that this situation will continue in future. The overall budgetary situation for the programme would appear to be satisfactory.

74. There are indications that governments have begun taking over the financing of activities, which would demonstrate their self-reliance.

Programme 14 - Health Information Support

75. An increase may be seen in connection with the establishment of the new library at the Regional Office.

Programme 15 - Support Services

76. Two-thirds of the increase in the budgetary provision for this programme is due to exchange rate adjustments, while one-third is due to statutory increases and inflation.

EIGHTH GENERAL PROGRAMME OF WORK COVERING SPECIFIC PERIODS 1990-1995

Introductory statement

77. Document AFR/RC36/10, constituting the regional contribution to chapter 7 of the Eighth Global GPW, was introduced by Dr A. Kone-Diabi, DPM/AFRO. The Programme Sub-Committee was reminded that, in accordance with the Constitution, the Executive Board would submit the Eighth Global GPW, covering the period 1990-1995, to the World Health Assembly in May 1987. It was the second of the three programmes within the period covered by the strategy for Health for All by the Year 2000.

78. In accordance with the Organization's guidelines, the main principles and overall structure of the Eighth General Programme of Work followed those of the Seventh, now in process of execution (1984-1989).

79. Certain minor adjustments should however be noted; they highlighted some important entries in the classified list of programmes for the period of execution of 8GPW.

80. The General Programme would become the basis, in close consultation with Member States, for preparation of the medium-term programmes and the biennial budgets reflecting the national and regional variations during the period under review.

81. Finally, emphasis had been placed on the interrelationships between 8GPW, the new decentralized structure of the Regional Office, and the managerial mechanisms for health development that had been set up at the national, subregional, regional and global levels to ensure implementation of the strategies for Health for All by the Year 2000.

82. Document AFR/RC36/10 had been given prior study by the African Advisory Committee for Health Development (AACHD) from 14 to 16 July 1986. The AACHD had made recommendations bearing mainly on improving the approaches that the Organization had proposed with a view to strengthening national capabilities in a spirit of self-reliance. The AACHD had also emphasized the need to pursue the Organization's efforts in regard to training all categories of manpower in health planning and management.

83. The Sub-Committee was then invited to consider document AFR/RC36/13, the report of the sixth meeting of the AACHD, together with document AFR/RC36/10, setting out 8GPW.

Discussion

84. The Programme Sub-Committee found that the regional contribution to the Eighth Global GPW reflected the present concerns of Member States in the short and medium terms with a view to attaining the social target of HFA/2000. It underlined the relevance of the programmes envisaged, in accordance with the guidelines laid down by the governing bodies. While reserving the right to comment on certain specific programmes, the Sub-Committee accordingly declared itself satisfied with the overall presentation of document AFR/RC36/10, 8GPW.

85. The discussions that followed the detailed analysis of 8GPW enabled the Programme Sub-Committee to emphasize certain important questions relative to the programmes enumerated hereinunder.

86. The Sub-Committee considered that the new Programme 2.6, Informatics Management, met the Region's need to keep pace with technological advances in that field. It took note with satisfaction of the studies under way in certain countries aimed at equipping the Representatives' Offices with

informatics support whenever the criteria and conditions of feasibility defined by the Director-General were met. The Sub-Committee took note of the efforts deployed by the Organization to mobilize extrabudgetary funds with a view to harmonizing at regional level the establishment and development of the indispensable informatics networks linking the Regional Office and the countries.

87. In regard to Programme 4, Organization of health systems based on PHC, the Sub-Committee reaffirmed its support for implementation of the health system at district level. It hoped there would be a more sustained effort on the part of the Regional Office to strengthen managerial capacity at all levels of national health systems, particularly at district level. This would contribute to ensuring rational development and operations with a view to accelerating the achievement of Health for All by the Year 2000.

88. On Programme 13, Disease prevention and control, the Sub-Committee expressed its satisfaction with that part of the document. However, it recommended that the Organization, in close collaboration with Member States, should participate in setting up and strengthening the structures and mechanisms that were indispensable for epidemiological surveillance and effective control of communicable diseases at the national, subregional and regional levels.

89. The Regional Director had placed special emphasis on the flexibility of 8GPW, which could be used by each country to supply a specific response to its priority problems.

90. Meanwhile the Programme Sub-Committee was informed that the Executive Board, at its forthcoming meeting, was scheduled to debate whether or not it would be timely to set up a full programme for "adolescents", as a source of constant concern to all officers on a world-wide scale.

REPORT OF THE SUBREGIONAL PROGRAMME MEETINGS

Introductory statement

91. Pursuant to resolution AFR/RC35/R12 and to procedural decision No. 7 of the thirty-fifth session of the Regional Committee, the Subregional Programme Meetings were convened in Brazzaville from 3 to 7 March 1986. The purpose of these meetings was to enable Member States to deepen dialogue with the Regional Director on the regional health programme and more specifically, to harmonize the subjects before the TCDC subregional working groups with those of the technical discussions of the Regional Committee in 1987, 1988 and 1989. As from next year, these meetings will be decentralized to the subregional level, and staged under the auspices of the newly established Subregional Health Development Offices.

92. The meetings focused on five topics of critical importance to the future of health development in the African Region, namely African Immunization Year; AFROPOC system; Proposed Programme Budget 1988-1989; Achieving HFA/2000 through Operational Support for PHC; and, finally AIDS.

93. In his opening address, the Regional Director emphasized the need for increased WHO support to Member States at the operational level, and the importance of health manpower development as a key to the achievement of HFA/2000.

94. The participants reviewed the progress made by countries of the Region in translating into operational reality the Expanded Programme on Immunization, and more particularly the goals set for the African Immunization Year, which are (a) to increase substantially immunization coverage of target population groups during 1986, and (b) to establish a mechanism for sustained immunization services designed to ensure universal immunization delivery and high vaccination coverage of target groups by 1990. It was agreed that the African Immunization Year concept should be built into the Regional Medium-Term Programme within a 4 to 5 year perspective, and implemented by means of approaches and strategies best suited to each country. Despite funding difficulties, Member States would be best advised not to rely solely on external assistance which currently accounts for two-thirds of vaccines available in the Region.

95. The newly established AFRO Programme Operations Coordinations System (AFROPOC) was welcomed as a managerial tool designed to ensure the optimal use of WHO resources in support of the health policies and objectives collectively agreed by the Member States. Among other benefits, AFROPOC should rationalize the programming, implementation and evaluation of WHO collaborative activities with the countries. This new mechanism should be understood and mastered, through appropriate training, by government officials in the context of the managerial process for national health development. Additionally, it could ultimately be instituted in the Ministry of Health of each country as an assistance to improved rational planning, programming, monitoring and evaluation of national health development activities.

96. The report contains an analysis of the first draft of the Proposed Programme Budget 1988-1989, which overall is based on "Zero real growth" but, nevertheless, projects a 2% real increase over the previous biennium for country activities only. The country statements exhibit considerable disparities in the choice of programmes, thus suggesting that regular budget funds have either been allocated to priority programmes as differently perceived by the countries, or been spread over a large number of programmes in order to attract other sources of funds to the health sector. The Health Resource Mobilization Unit newly created at the Regional Office is intended to facilitate the tapping of all potential sources of funds required to plug gaps in national health budgets and complement support under the WHO regular budget.

97. The report also elucidates in addition the general framework proposed by the Regional Director for the organization of national health systems based on PHC. It is recommended to intensify action at the operational level through the establishment of appropriate health infrastructures designed to accelerate the attainment of HFA/2000.

98. Finally, on the AIDS issue, participants recommended a number of measures at national and intercountry as well as global levels in order to enable Member States effectively to control this disease, which is considered a serious public health concern.

Discussion

99. The Programme Sub-Committee members made brief comments that mainly concerned the African Immunization Year.

100. Delegates emphasized the constraints caused by insufficient financial resources, the foreign exchange crisis, and lack of material resources such as vaccines, fuel, cold-chain equipment, etc. Breakdown in vaccine supply, fuel shortages, etc., would certainly hamper the motivation of mothers to take their children to a health facility for immunization.

101. In regard to the extent of use of mobile strategy during African Immunization Year, it was made clear that many countries adopted a mix of complementary strategies with an emphasis on fixed and outreach strategies to achieve long-term impact. However, depending on local conditions and vaccine coverage rates the mobile strategy would also be a useful instrument to increase the accessibility of health interventions, including immunization.

102. On the subject of the AFROPOC system, it was regarded as a mechanism for making a coordinated response to any request from the countries, functioning like a reflex arc with sensory circuits that were under the responsibility of the Director, Programme Coordination, Promotion and Information, with motor circuits constituted by the services of the Director, Support Programme and a nerve centre constituted by the Regional Director and the Director, Programme Management.

103. The Programme Sub-Committee felt that it was preferable to consider 1986 as a year of research and learning while the system was being set up.

104. The Programme Sub-Committee took note of the new term that had been approved for the AIDS virus: human immunodeficiency virus (HIV) that should be used instead of the earlier acronym LA/HTLV-III.

REPORT OF THE SIXTH MEETING OF THE AFRICAN ADVISORY COMMITTEE
FOR HEALTH DEVELOPMENT (AACHD)

Introductory statement

105. Document AFR/RC36/13 was presented by Mrs R. A. De Almeida. The Sub-Committee reviewed the report of the Sixth Meeting of the African Advisory Committee (AACHD) which was held in Brazzaville from 14 to 16 July 1986 and attended by 12 members of the Committee and three members of the Programme Sub-Committee. The report summarized AACHD's discussions on the four main subjects, namely: the new terms of reference of the Committee; indicators for monitoring and evaluation of strategies for HFA/2000; WHO fellowship policy and national health manpower development; and the Eighth General Programme of Work.

106. The thirty-fifth session of the Regional Committee which was held in Lusaka (Zambia) in September 1985, resolved to have a three-year health development scenario. The Regional Secretariat had been accordingly restructured, with emphasis on the establishment of three Subregional Health Development Offices manned by health development teams for technical, strategic and administrative support for strengthening Primary Health Care implementation at the district or operational level. The main thrusts of WHO collaborative programmes in the Region have been directed towards accelerating the implementation of strategies for HFA/2000 in Member States. In line with this approach, the terms of reference of the African Advisory Committee for health development have been modified and submitted to the Committee for its consideration. Reviewing the draft terms of reference, the Committee noted that there was need to reinforce its multisectoral nature with representation from all sectors concerned, including population and demography, social and biomedical services, sanitary engineering, etc. The new terms of reference was adopted by the Committee.

107. The three-year scenario adopted by the Regional Committee involves preparation of a Plan of Work for each country that would specify clearly the activities and support required for Primary Health Care at operational, technical and strategic levels. Monitoring and evaluation is an integral part of the managerial process for health development. To facilitate this process,

health indicators are needed, and a working paper on indicators for monitoring and evaluation of HFA strategies at the operational level was discussed by the Committee. The Committee examined the appropriateness of the proposed indicators in relation to the actual needs at the operational level, the people who use them, and the resulting action.

108. The third topic reviewed by the Committee relates to the new WHO fellowship policy and the national health manpower development plans. The Committee reviewed the new WHO fellowship policy which stresses the need for Member States to develop a national health manpower development policy, and noted that it was only within a systematic framework of health manpower development that the WHO fellowship programme could be put to optimum use.

109. Finally, the Committee discussed the draft regional contributions to the Eighth General Programme of Work covering the period 1990-1995. It examined the document in detail, reviewing each programme in accordance with the classified list of programmes, and made its observations and suggestions for further improvement.

Discussion

110. With regard to the review of the terms of reference of AACHD, it was explained that the reorganization of programmes was mainly geared to helping Member States apply to best effect the key PHC strategies (community participation, intersectoral collaboration, selection of health technologies) at district/peripheral or local level.

111. With regard to equity and health the members strongly expressed the view that the urban bias common to most development strategies should be avoided.

112. It was felt that consideration of "equity" in health care provisions should weigh more in favour of rural areas which have been neglected so far.

113. The Sub-Committee noted that the three-year scenario adopted by the Regional Committee in September 1985 was the basis for the reorientation of programmes in the Region and the restructuring of the Organization.

114. On indicators, members noted that facts needed to calculate some of the indicators were available in countries and asked whether the methods for such calculations were available. It was explained that WHO guidelines exist for this purpose, for example, HFA No.4 and AFRO Technical Report Series No.12. They explain the type and nature of indicators, the criteria and method for choice of indicators, various sources from which the information needed can be obtained and how to obtain them, and the method of calculating the indicators. More recently, a framework has been developed by AFRO, document RPM9/WP/03/Rev.2, for use by countries in expediting the implementation of strategies, including monitoring and evaluation.

115. The Sub-Committee emphasized the need for using non-conventional or qualitative indicators, especially for monitoring and evaluating the changing attitude of individuals and communities as a result of health development. It was recognized that there would be need for continuing health education activities to have a lasting effect on individuals by developing the attitude necessary for healthy living.

116. The Sub-Committee also noted that there was need for training statisticians in the collection and use of reliable information.

117. On coordination of health development activities undertaken with support of various UN agencies, it was noted that the responsibilities rested primarily with the government. The UN agencies also had an important role to play in facilitating such coordination, usually at the initiative of WHO Representatives.

118. The Sub-Committee expressed satisfaction at the multisectoral approach adopted for the development and use of indicators. It was noted that national guidelines would have to be developed using the framework provided by AFRO.

119. The critical issues in the management of the fellowship programmes were considered to relate to relevance and efficiency. Regarding the award of a fellowship, three kinds of decisions were required:

- (i) choice of an adequate candidate;
- (ii) choice of a relevant field of study;
- (iii) choice of an appropriate training programme or institution.

The Sub-Committee felt that any of the three types of decision could spark multi-faceted debate.

120. A national selection committee should be constituted and should guarantee that the right decisions are taken concerning the selection of the candidate and of the field of study. WHO/AFRO will review suggestions made by governments in line with the new WHO fellowship policy.

121. The difficulties encountered in the planning, training and utilization of fellows were viewed as symptomatic of a more profound problem, which is the lack of national health manpower development policies and plans. In the absence of a framework to refer to, the fellowship programme is very often managed on an ad hoc basis and therefore does not always respond with optimum effect to national requirements in health manpower.

122. WHO/AFRO is ready to collaborate with countries to develop national health manpower development policies, and organize workshops or advisory services designed to rationalize the planning, training and utilization of health personnel. If this were done the fellowship programme would become an integrated and relevant part of the national health development policy.

123. The Sub-Committee expressed general agreement with the recommendations formulated by the AACHD, although it voiced a reservation on the subject of the wording of subparagraph 23 (vii) of the document.

124. In reviewing the section of the report dealing with the Eighth General Programme of Work, the Sub-Committee felt it should be emphasized that the scientific approach must support the traditional group. Traditional methods being pragmatic, they needed to be supported by scientists.

125. It was also noted that religious groups were sectoral in nature and that to avoid divisiveness it was better to enlist the support of sociocultural groups.

126. Members thought that there was need for WHO support to continue updating health legislation in Member States.

CONCLUSIONS

127. The Programme Sub-Committee considered the regional programme budget policy and expressed agreement with the proposed guidelines.

128. The revised antimalaria strategy was accompanied by concrete recommendations that the countries might wish to put into effect.

129. Close attention was paid to the Proposed Programme Budget 1988-1989. The members of the Sub-Committee gave detailed consideration to various programmes and proposed that the Regional Committee should adopt it.

130. The regional contribution to the Eighth General Programme of Work was a reflection of Member States' current concerns in the short and medium terms and the Sub-Committee was satisfied at the way it had been presented.

131. The Programme Sub-Committee endorsed the conclusions and recommendations of the Sixth Meeting of the African Advisory Committee for Health Development (AACHD).

132. The members of the Sub-Committee were informed of the report of the Sub-Regional Programme Meetings held in pursuance of Decision 7 taken by the Regional Committee at its thirty-fifth session.

APPENDIX 1

LIST OF PARTICIPANTS
LISTE DES PARTICIPANTS

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Dr A. Banga-Bingui
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Appendix 1

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Ministry of Health
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Appendix 1

SECRETARIAT

Dr G. L. Monekosso
Regional Director/Directeur régional

Dr A. Koné-Diabi (DPM)
Director, Programme Management
Directeur, Gestion du Programme

Dr A. Tekle (DCP) a.i.
Director, Coordination, Promotion and Information
Directeur, Coordination, Promotion et Information

Mr D. E. Miller (DSP)
Director, Support Programme
Directeur, Programme de Soutien

Prof. P. O. Chuke (PM1)
Programme Manager, Support to National Health Systems
Chef de Programme, Soutien aux Systèmes nationaux de Santé

Dr S. Butera (PM2)
Programme Manager, General Health Protection and Promotion
Chef de Programme, Protection et Promotion de la santé en général

Dr E. G. Beausoleil (PM3)
Programme Manager, Disease Prevention and Control
Chef de Programme, Prévention et Lutte contre la Maladie

Dr F. Aboo Baker (CTD)
Technical Adviser to the Regional Director
Conseillère technique auprès du Directeur régional

Dr J. C. Alary (PHD)
Technical Adviser to DPM
Conseiller technique au DPM

Mr A. M. B. Clarke (MGT)
Administrative Management and Staff Development
Gestion Administrative et Développement du Personnel

Mr H. Ben Aziza (HED)
Health Education and Information
Education pour la Santé et Information

Dr B. Y. Boganda (HLE)
Health Legislation/Législation sanitaire

Dr D. Buriot (CDD)
Diarrhoeal Diseases Control
Lutte contre les Maladies diarrhéiques

Appendix 1

Mrs Chatue Kanga (AWD)
Women in Health Development
Femmes et Développement sanitaire

Mr W. D. Chelemu (EDV)
Essential drugs and Vaccines
Médicaments essentiels et Vaccins

Dr M. E. Chuwa (NCD)
Cancer, Cardiovascular Diseases, other non-communicable Diseases,
Tobacco and Health, Prevention of Blindness
Cancer, Maladies cardio-vasculaires, Maladies non transmissibles
Tabac et santé, Prévention contre la Cécité

Mrs M. Kenneally (COR/HRM)
Health Resources Mobilization
Mobilisation des Ressources sanitaires

Mr M. Koussitashev (PEI)
Water Supply and Sanitation
Approvisionnement en eau et Assainissement

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Information Service, Public Relations and Protocol
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Mr C. V. G. Nair (PHS)
Health situation and Trend Assessment
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APPENDIX 2

PROGRAMME OF WORK

1. Opening of the meeting
2. Regional programme budget policy (document AFR/RC36/4)
3. Proposed Programme Budget 1988-1989 (document AFR/RC36/2)
4. Preparation of Eighth General Programme of Work (document AFR/RC36/10)
5. Revised regional antimalaria strategy (document AFR/RC36/22)
6. Report of the African Advisory Committee for Health Development (AACHD) (document AFR/RC336/13)
7. Report of Subregional Programme Meetings (document AFR/RC36/12)
8. Adoption of the Report of the Programme Sub-Committee (document AFR/RC36/9)
9. Distribution of tasks for presentation of the report of the Programme Sub-Committee (document AFR/RC36/9)
10. Closure of the meeting.

REPORT OF THE PROGRAMME SUB-COMMITTEE MEETING
HELD ON 17 SEPTEMBER 1986

INTRODUCTION

1. The Programme Sub-Committee met on Wednesday, 17 September 1986 in Brazzaville (Congo), immediately after closure of the thirty-sixth session of the Regional Committee. The list of participants is in Appendix 1.
2. The Sub-Committee elected Dr V. Raharijaona (Madagascar) the outgoing Vice-Chairman, as Chairman; Dr E. T. Maganu (Botswana) as Vice-Chairman; and Dr I. Gomes (Cape Verde) as Rapporteur. The Chairman thanked members of the Programme Sub-Committee for the honour and confidence placed in his country and himself by his election as Chairman.
3. The programme of work was adopted without amendment (Appendix 2).

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

4. The Director, Support Programme, presented document AFR/RC36/26 which contained, inter alia, two meetings of programming interest to be attended by members of the Programme Sub-Committee during 1986/1987. After examining the document, the Sub-Committee unanimously agreed on representation as set out in the following Table:

Table

MEETINGS OF PROGRAMMING INTEREST TO BE ATTENDED BY
MEMBERS OF PROGRAMME SUB-COMMITTEE - 1986/1987

Name, place and date of meeting	Objective	Language	Participating members
1. Subregional Programme Meetings (SPM) - Bamako - Bujumbura - Harare Successively/simultaneously in February 1987	Modalities of technical and logistic support to Member States in their efforts to provide primary health care to their populations	E/F/P	SR/I - Burkina Faso SR/II - Burundi SR/III - Tanzania
2. African Advisory Committee on Health Development (AACHD) Brazzaville, June/July 1987	Preparation of a plan to set up Sub-Committees to reflect AACHD multisectoral nature	E/F/P	SR/I - Algeria SR/II - Chad SR/III - Madagascar

5. The Programme Sub-Committee observed that in accordance with the new development (Decision 5 of the report of the thirty-sixth session of the Regional Committee), it would appear that in effect the Sub-Committee will now meet once in every two years.

6. There was some discussion in which it was noted that resolution AFR/RC25/R10 established the Programme Sub-Committee which was charged with the detailed examination of the proposed Programme Budget before the opening of Regional Committee session during which the Programme Budget will be discussed. Subsequently, in Decision 8 of the Final Report of its twenty-seventh session, the Regional Committee amended the Sub-Committee's terms of reference by adding the participation in other meetings of programming interest, and collaboration with the Regional Director in solving problems arising out of the implementation of the regional programme. Thus there were three items in the terms of reference. It was noted that it was the second item only which was under consideration. Other meetings relating to the third item could be called by the Regional Director.

7. It was also observed that the Subregional Programme Meetings (SPM) would include and encompass the former TCDC meetings. The issues to be considered by SPM would be based on the TCDC working groups' three-year scenario. This would help TCDC to be less ad hoc and to harmonize its focus with regional strategies.

DATE AND PLACE OF THE NEXT MEETING

8. The Chairman informed members of the Sub-Committee that the date and place of the next meeting of Programme Sub-Committee would be communicated to them in future by the Secretariat. He commented that this agenda item needed no discussion.

CLOSURE OF THE MEETING

9. The Chairman thanked members for their support and lively contributions to the discussions. He wished them all the best, and "bon voyage".

APPENDIX 1

LIST OF PARTICIPANTS

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Conseiller du Ministre de la Santé
Ministère de la Santé
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BENIN

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Directeur général du Ministère de la Santé publique
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CAPE VERDE

Dr Ireneu F. Gomes
Ministro da Saude, Trabalho e Assuntos Sociais
Praia

Dra Maria da Luz Neves Nobre Leite
Directora Geral de Farmacia

Appendix 1

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Ministre de la Santé publique
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*Unable to participate.

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/RC36/26)
4. Date and place of the next meeting
5. Closure of the meeting.

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".

INTRODUCTION

1. The technical discussions at the thirty-sixth session of the Regional Committee were held in Brazzaville on 13 September 1986 on the subject "The PHC approach to the promotion and protection of the health of farm workers during the Industrial Development Decade in Africa". They were chaired by Professor George Oluwole Sofoluwe¹ who was elected by the thirty-fifth session of the Regional Committee. The thirty-sixth session of the Regional Committee nominated as rapporteurs of the technical discussions:

- (i) Dr Antonio Soares Marques Lima (Sao Tome and Principe)
- (ii) Dr E. K. Njelesani (Zambia)
- (iii) Dr H. Sanoussi (Benin)

2. Discussions took place in three working groups, one multilingual, one English-speaking and one French-speaking. The working groups elected the following as Chairmen:

- (i) Dr J. Maneno (Kenya)
- (ii) Dr D. G. Makuto (Zimbabwe)
- (iii) Dr Azara Bamba (Burkina Faso).

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Introductory statement

3. The working paper, document AFR/RC36/TD/1, prepared by Dr A. Abaglo, Chief Medical Officer, Togolese Phosphate Agency and Professor Bernard Obiang Ossoubita, Head of Department of Public and Occupational Health, University Centre for Health Sciences, Libreville, was introduced by Dr G. Oluwole Sofoluwe. He stressed the opportunity facing African countries during the present industrial development decade to gear their industrialization programmes to the priority manufacture of essentials to raise the standard of living and health of farm workers, who accounted for 80-90% of the total population of Africa. The alternate chairman, Mr Martial M'Boumba, Director General of Public Health, Gabon, chaired a plenary session during which each of the three Group rapporteurs presented a summary of their respective group discussions.

4. The document identified three categories of farm worker, outlined their health problems, the need for a PHC approach to them and modalities to PHC. It stressed the need to identify the root causes of the health problems of farm workers and to cut through bureaucracy to solve them more quickly. It also stressed the growing importance of agriculture as reflected in the Lagos Plan of Action, which now had to be translated into a firm commitment and vigorous action, taking into account the need for low-cost technology, legislation, intersectoral action, adequate training at all levels and applied research. The present session might even consider a resolution on the local manufacture of low-cost housing, piped water for all houses, and the installation of sewers and electricity in all villages or wherever farm workers in Africa lived and worked. In that connection the assistance of UNDP, UNIDO, the World Bank and WHO should be called upon.

5. He discussed the agricultural situation in Africa. Farming households constitute 85%-90% of the total population. They engage predominantly in subsistence type for home food production, but large-scale farms also exist in most countries for producing food and/or cash crops. The agricultural situation is critical because of rapid population growth with slower increases in food production and unfavourable trends on world markets for African products. Few countries have reached food self-reliance. To be realistic, however, food production as well as cash crop production must be undertaken simultaneously and be judiciously balanced.

6. Health issues were presented in more details. Farmers are affected by a very wide range of rural health problems including some specific hazards such as accidents, poisonings, zoonoses, snakebite. More general health needs are those provoked by poor environmental conditions such as inadequate water supplies and sanitation, housing, energy supplies, communications and transportation, and health infrastructure, as well as inadequate food supplies and education, and poverty. It must be added that in 1966 the infant mortality rate among cocoa plantation workers in (Malabo) - in Equatorial Guinea was 20 o/oo. This was due mainly to the generous provision of wash hand basins; water closets, sewers, electricity for light, mass information and leisure purposes.

7. The chairman mentioned the appropriate new approaches to promoting farmers' health. There is a growing awareness at national level of the priority importance of agriculture, as expressed for instance in the OAU Lagos Plan of Action. But it must be translated into firm commitment and vigorous action to promote PHC programmes specifically geared to the health needs of farmers. In this type of action there is a need for appropriate low-cost technology and legislation, intersectoral action jointly with agricultural and other sectors, intensive training of administrators, and applied research aimed at identifying and solving the real health problems of farming communities. Examples of these abound scatteredly throughout Africa. A resolution at this committee meeting is required to encourage the local manufacture of low-cost housing, including water piped into houses for wash hand basins, water closets and sewers, and electricity in all villages where farm workers in Africa live and work. The urgent assistance of WHO, UNIDO, UNDP, World Bank and other international agencies should be sought.

8. Participants who have seen the exhibition on Expanded Programme on Immunization (EPI) will see that the abundant sunshine in our countries has been harnessed cheaply to generate electricity for lighting; for refrigerator to keep our vaccines effective and our food free of germs; for leisure purposes; mass education and information as well as provision of potable water supply which could be piped into the houses. This is just an example of how it has thus been brought to the reach of all African countries to make villages healthy and generate more employment opportunities for our youths in villages, thus keeping them away from crime and prisons in urban centres.

9. Finally the chairman prayed the Almighty God to direct all of them especially those who are now holding positions of Cabinet portfolios as Ministers of Health to drastically improve the health of farm workers and their families by generating wealth through appropriate industries and creation of much needed employment opportunities.

FARM WORKERS AND PRIMARY HEALTH CARE

PHC programmes for farm workers and rural dwellers in Africa

10. Though rural population exceeds 80% of the total population in most African countries and that farm workers constitute a significant portion of rural population, participants considered it necessary to distinguish between the various categories of farm workers. Specific detailed surveys of all aspects of the farm workers problems were needed to produce the data on which to base valid planning of health and health-related activities/programmes.

11. Three major categories of farm workers were identified:

- (i) Workers in major agricultural enterprises and State farms which generally use up-to-date production methods (mechanization, extensive use of fertilizers and pesticides, high-yield seeds, etc.); these workers are salaried and in principle are entitled to the same benefits as their counterparts in major industrial firms.
- (ii) Workers on medium-sized farms, which are usually privately-owned or belong to farming cooperatives with limited operating resources constitute the second category. They are engaged in activities geared mainly to the production of food products. Farming methods combine traditional and semi-mechanical techniques (animal-assisted farming). Occasionally farms with major funding resources use modern agricultural machinery. The legal status of manpower varies in different cases. Health and social welfare coverage may or may not be provided.

(iii) The third category include small farmers who make up by far the greatest number. They own small parcels of land on which, with the assistance of family members, they cultivate food crops or even, encouraged by the authorities, cash crops. The authorities in some cases provide technical support, high-yield seeds, fertilizers and pesticides. In other places, itinerant cultivation involving burning for clearance obliges rural dwellers to cover ever greater distances in search of fertile lands. Weather conditions do far more harm to them than to any other social group. This leads to dramatic situations for them and their families, often placing their very survival in jeopardy. In terms of health coverage, they may benefit from the services provided by health units where available in the Region, or else rely totally on traditional forms of medicine.

12. Distinction among categories of farm workers is useful, because, for example, the problems of small farmers were quite different from those of workers employed in large-scale commercial farming. Thus, the latter usually lived in squalid conditions, were separated from their homes and families for long periods, and were exposed to special hazards, such as those associated with the use of machinery and agricultural chemicals. It was important to identify the needs of farm workers, not only for health care as such, but also for increasing their productivity and thereby raising their standard of living. However, it was also necessary to identify the current health practices of farm workers and to strengthen what already existed. Special attention should be paid to vulnerable groups.

13. Working conditions of farm workers may vary considerably in and between individual countries. However, certain features are common to all the countries of the Region, and in particular:

- (a) the dispersion of farm workers in remote areas where the health infrastructure is frequently inadequate;
- (b) the diversity of the tasks carried out by these workers;
- (c) the predominant influence of seasonal changes on work tempo;

- (d) the lack of any clear boundary between working space and living space;
- (e) the crucial influence of weather and soil conditions on work;
- (f) critical situations due to bad weather (drought or flooding), devastation by locusts, certain wild animals and uncontrolled bush-fires;
- (g) the inadequacy or total lack of individual protective equipment;
- (h) the difficulty of implementing legislation, where this exists, concerning the working conditions of women and children, despite the fact that these children start work at a very early age;
- (i) the near total absence of legislation governing social welfare;
- (j) the problem of monitoring the health status of migrant or seasonal workers.

14. Participants emphasized the crucial role of women's health. Women were at risk because they did most of the agricultural work, while also looking after the home and the children, and were often left behind on their own when their husbands were migrant workers. They ran the household (cooking, childcare, fetching water and firewood) as well as their arduous work in the fields, even during pregnancy. Women often did not have the leisure to take advantage of the health services available, for example, take children for treatment.

15. All countries already had PHC systems which are meant to cover the majority of the population and, in Africa, that consisted precisely of the small farmers. There was therefore a need to focus on aspects such as accident prevention; workers compensation, for which special legislation was necessary; social security; the training of farm workers in the proper use of fertilizers and pesticides; the use of appropriate technology, which could reduce drudgery; research on antidotes to toxic substances, and sociological research on the behavioural patterns of farm workers, e.g. food taboos.

16. It was emphasized that unsuitable agricultural chemicals were being dumped on developing countries, thus creating additional hazards. In addition to PHC, therefore, appropriate legislation was necessary and chemicals should be controlled in the same way as drugs; for this purpose, the assistance of WHO and FAO was necessary.

17. Since farm workers formed the vast majority of the rural population, their PHC programmes must be integrated into national, regional or local community health services. However, there must be some provision for farm workers' special needs by providing, e.g. tetanus immunization, prevention of poisoning by insecticides and other occupational health hazards and problems.

18. Different views were expressed by participants on the role of traditional medicine (TM). The use of traditional cures should be encouraged, since they had been shown in many instances to be highly effective. Scientific analysis of the existing effective traditional medical practice, drugs and appliances should be immediately undertaken. However, TM should not be seen simply as a means of providing low-cost health care and saving on foreign exchange. Intensive research on traditional medicine should be undertaken and this should include surveys of existing TM practitioners; scientific analysis of their effective drugs, and appliances; and operational research on integrating effective ones into scientific medical practice.

19. The need for community participation was stressed since most ministries of health have insufficient funding from the treasury. However, this should be seen by the State as a source of supplementary support. Farm workers should be involved in the planning and implementation of all services intended for them.

20. To improve coverage, governments should be encouraged to use existing agricultural extension officers by giving them reorientation courses in health-related programmes. The large plantations and cooperative farms should cooperate with the government to provide full coverage of PHC for all farm workers and rural dwellers living in the areas. The point was made that health was part of the overall well-being of the community and that

improvement of farming incomes and living conditions, i.e. rural development in general, would improve the health of rural communities. It was therefore recommended that WHO should coordinate with FAO, UNIDO, WFP, World Bank and other agencies to work out a multisectoral approach to rural health as part of overall rural development.

Implementation of PHC programmes for farm workers

21. It was agreed that the Ministry of Health should coordinate intersectoral activities, but the other sectors were not always willing to accept this. Ministries of Health could act as catalyst, but certain tasks were better performed, e.g. by Ministries of Labour and Agriculture. An Interministerial Committee for PHC should be established. In addition, coordinated comprehensive national planning was needed, in which all ministries concerned should participate. Intersectoral cooperation was also needed to obtain the information necessary for establishing a common policy for improving the health of farm workers. In order to encourage farmers to stay on the land and to improve their motivation to produce, the State should see to it that proper transportation and marketing facilities for their products should be set up. Help could also be given by stabilizing farm prices and by introducing improved strains of seed (for example in palm oil production) which would enable farmers to become better off economically. Malnutrition in the rural areas should be combatted.

22. There was a need for an intersectoral approach for the provision of adequate housing, water supply, sanitation, which would not only raise general living standards, but also increase the health status of the rural population, including farm workers. It was agreed that the approach to planning PHC for farm workers should be multisectoral, and it should be clear whether the rural population in general, which included peasant farmers, or specifically farm workers employed on large estates were to be covered.

23. Any assistance given should be planned according to seasonal needs, so that it would be sure to arrive at the appropriate time. Better information should be given on the risks involved in the use of pesticides and fertilizers. The State should legislate for a minimum wage for farm workers,

and should require employers to give their workers a medical examination. Compensation should be provided by law if it could be shown that conditions of employment had resulted in disability or death. The State should also mobilize resources for improving water supply and sanitation in rural areas.

24. Other ways in which the State could play a role were by encouraging the development of solar energy to provide heat and light in rural areas. It could also encourage reforestation in order to increase supplies of wood for fuel and building for the rural population. As well as improving communications, it could provide social amenities in rural areas to prevent workers from being attracted to the cities. Small-scale industries (soap making, basket weaving) should also be encouraged as a way of stopping young people from leaving the villages.

25. In view of the important role of women in farm work and as women were unable to care for their children while working on the land, the State should encourage employers to provide proper creches, day care, nutrition and education for children, perhaps calling on the help of nongovernmental organizations such as the churches which already had experience in this area. Mothers who were also rural workers should be helped to provide food for their families while they were at work.

26. National legislation needed to be restructured to provide a sound basis for the introduction of measures to improve the health coverage of farm workers and the general rural population. WHO and Subregional organizations could help by drafting model texts which countries could adapt to their specific circumstances.

Role of community health workers (CHWs) in providing PHC for farm workers

27. Since the vast majority of the population in African countries was rural and the majority of workers in rural communities were involved in agriculture, in other words the rural community was a single entity, any specific care for farm workers should be provided by the community health workers and integrated into the general primary health care systems being developed by countries. Two separate systems should not be in operation.

28. It was essential to define clearly the kind of person to be selected as a community health worker as that would have a major impact on results. The community health worker should be from the community served and should be chosen and accepted by the community itself. He should be a person of a certain standing in the community, over a certain age and thus likely to stay in the community (women should also be considered as candidates since they were likely to be more dedicated and permanently settled in the community), and be engaged in the productive activity of the community as well as delivering primary health care (i.e. sharing the concerns of the community). It was agreed that the community health worker should have a certain level of education but views differed as to what that level should be, what degree of literacy was required and what the language of training should be.

29. It was agreed that in order to encourage individuals to be willing to become and remain community health workers, the status of the community health worker in the community (in other words whether his services were to be voluntary or remunerated) had to be clearly defined in advance and accepted by the community. Opinions differed on whether such services should be voluntary or remunerated, and if the latter, whether the necessary funds should come from the community or the State or both.

Training and operational research

30. Community health workers should have basic training in the eight components of primary health care, as well as training in the health risks specific to local agricultural and environmental conditions. Such specific features of training should be determined in advance by visits to the field and consultation with local communities. The tasks expected of community health workers should be within their capacities and effective back-up and supervision provided. Staff at higher level of the health care system and teaching staff needed themselves to be convinced of the worth of primary health care if that conviction was to be passed on to community health workers. Some speakers felt that training programmes should include seminars.

31. A national central school should be established for community health workers and should produce teaching materials and aids. Training relating to specific agricultural health matters should focus primarily on environmental health and prevention. Training should be reviewed in the context of overall planning for Health for All by the Year 2000.

32. In addition, efforts should be made to promote awareness of the interrelationships between health standards and general levels of economic development, including agricultural productivity within communities responsible for remunerating their own community health workers.

33. The central authorities needed to be convinced of the value of primary health care for rural workers in order to help communities to realize its usefulness. Moreover, the communities themselves must fully understand the rationale behind the scheme and research should be undertaken to ensure proper communication with, and a good knowledge of the target population. The mass media could usefully be mobilized for the purpose. Adult literacy programmes should be undertaken. Greater commitment was required on the part of the government to enhance the credibility of the scheme and thereby increase the receptiveness and involvement of the community, notably through the provision of effective financial support. If farm workers could be made to realize that the solution of their health problems would help to improve their incomes and overall standards of living it would encourage them to support primary health care and the community health worker.

34. Participants stressed the need to promote the exchange of experiences related to the health of farm workers particularly through appropriate TCDC mechanisms. Governments, international organizations and NGOs should support the implementation of all measures related to promotion of farm workers in the PHC context.

CONCLUSIONS

35. The following conclusions were made:

- (i) The quick realization of Health for All by the Year 2000 could be achieved by providing a hundred percent coverage of PHC for farm workers who constitute 80% to 90% of the total population in African countries and by judiciously gearing the industrialization programmes to manufacture of articles which will promote better health for all.
- (ii) The provision of pipe borne water supply into the well guarded low-cost houses; the provision of water closets; septic tanks or sewers; electricity provided for example from solar energy for light; mass information, education and leisure purposes will have the most significant effect in reducing infant mortality raising the standards of living as well as providing much needed employment opportunities to reduce massive rural-urban migration.
- (iii) PHC programmes in African countries should concentrate their attention on women who are not only rearing children but producing food and so on as most of their husbands migrate to towns.
- (iv) PHC programmes for farm workers must be the same as for all rural dwellers but the special health problems of farm workers as for example poisoning by agricultural chemicals must receive attention.
- (v) Ministries of Health should coordinate intersectoral activities especially with Ministries of Agriculture, Labour, Education and Industries, and must ensure that economic activities like stabilization of prices of farm produce; marketing and transportation, receive good attention.
- (vi) Intersectoral approach for the provision of adequate and safe housing, water supply, and sanitation, must receive priority attention.

Legislation

- (vii) Government must enact legislations to provide the following:
- (a) minimum wages for farm workers;
 - (b) employers must undertake preemployment, preplacement, periodic and other occupational health screening and medical examinations;
 - (c) rehabilitation and compensation for accidents and death of farm workers and their families;
 - (d) social security;
 - (e) welfare facilities and provisions.
- (viii) Government must mobilize all government and private sector resources for improving water supply and sanitation in all rural areas.
- (ix) Government should give priority attention to harnessing solar energy at low cost prices.
- (x) Government should encourage reafforestation to provide wood for building, furniture and possibly also fuel.
- (xi) Priority attention should be given to creating small scale factories.
- (xii) Efforts are required to reduce massive rural migration by the provision of urban attractions in rural areas.
- (xiii) Provision of creches, day nurseries, balanced nutrition and education of children should be provided mostly by voluntary organizations, but catalysed by the government and industrialists.

- (xiv) WHO/AFRO should strengthen its Workers' Health programme, giving special attention to farm workers. WHO and FAO should draw a list of agricultural chemicals and pesticides and produce leaflets to advise farm workers on the prevention of toxic effects.

RECOMMENDATIONS

36. A special Round Table or expert committee meeting with panel members chosen from both African and International experts should immediately be convened by the Regional Director to produce draft model texts similar to "The Primary Health Worker" to assist and guide African countries. The meeting should produce three different special texts as follows:

- (a) for African countries with less than 250 000 people;
- (b) for African countries with less than 1.5 million people, and
- (c) for African countries with up to 50 to 100 million people or more.

37. WHO/AFRO should generate pilot projects to produce models of PHC for farm workers. This could be undertaken at district level with ongoing PHC activities.

38. Training programmes for Community Health Workers (CHWs) should be adjusted to promote health of farm workers and rural dwellers. The CHWs should be adequately remunerated and should receive practical training in special service demonstration zones.

39. Research should be practically oriented and intensified. Research grants should therefore be generously provided by governments, international organizations as well as agricultural industries, national farmers' unions, etc.

40. Exchange of experiences between different African countries on PHC for farm workers should receive active promotion through the existing TCDC programmes.

41. Governments, international organizations, nongovernmental organizations, industries as well as farmers and farm workers should give priority attention to raising the standards of living; generating new employment opportunities by inter-alia the manufacture of low cost housing and appliances for piping water into houses, and improving sanitation, electrification, mass information and encouraging leisure and balanced nutrition for all rural dwellers.

PROVISIONAL AGENDA OF THE THIRTY-SEVENTH SESSION
OF THE REGIONAL COMMITTEE FOR AFRICA

1. Opening of the thirty-seventh session
2. Adoption of the provisional agenda
3. Constitution of the Sub-Committee on Nominations
4. Election of the Chairman, the Vice-Chairman and the Rapporteurs
5. Appointment of the Sub-Committee on Credentials
6. The work of WHO in the African Region
 - 6.1 Biennial report of the Regional Director
 - 6.2 Report on the optimal utilization of WHO's resources (programme budget policy)
 - 6.3 First annual report (situational analysis) of progress towards Health for All in Member States of the African Region
 - 6.4 Review of the AIDS control programme (GPC.18, par. 2.5)
 - 6.5 Comlan A. A. Quenum Prize
7. Correlation between the work of the Regional Committee, the 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
 - 7.2 Agendas of the eighty-first session of the Executive Board and the Forty-first World Health Assembly: Regional repercussions
 - 7.3 Method of work and duration of the World Health Assembly
 - 7.4 Technical discussions of the Forty-first World Health Assembly

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8. Report of the Programme Sub-Committee
 - 8.1 Second evaluation report on HFA/2000
 - 8.2 Eighth General Programme of Work covering the specific period 1990-1995
 - 8.3 Report of Subregional Programme Meetings
 - 8.4 Report of the African Advisory Committee for Health Development (AACHD)
 9. Technical discussions
 - 9.1 Presentation of the report of the technical discussions: "Operational support for primary health care (local level)"
 - 9.2 Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1988
 10. Dates and places of the thirty-eighth and thirty-ninth sessions of the Regional Committee in 1988 and 1989
 11. Adoption of the report of the Regional Committee
 12. Closure of the thirty-seventh session.